2025 Community Health Needs Assessment

UC DAVIS HEALTH | MEDICAL CENTER

2025 Community Health Needs Assessment

Conducted on behalf of

UC Davis Health
UC Davis Medical Center
2315 Stockton Blvd.
Sacramento, CA 95817

Conducted by

January 2025

UC DAVIS HEALTH | MEDICAL CENTER

Acknowledgments

We appreciate the many dedicated individuals who contributed to this community health needs assessment conducted on behalf of the healthcare systems serving Sacramento County. This assessment was enriched by the time and expertise of community health experts and members of various social service organizations serving the most vulnerable members of the community. 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. To everyone who supported this important work, we extend our heartfelt gratitude.

Community Health Insights conducted the assessment on behalf of the healthcare systems serving Sacramento County. 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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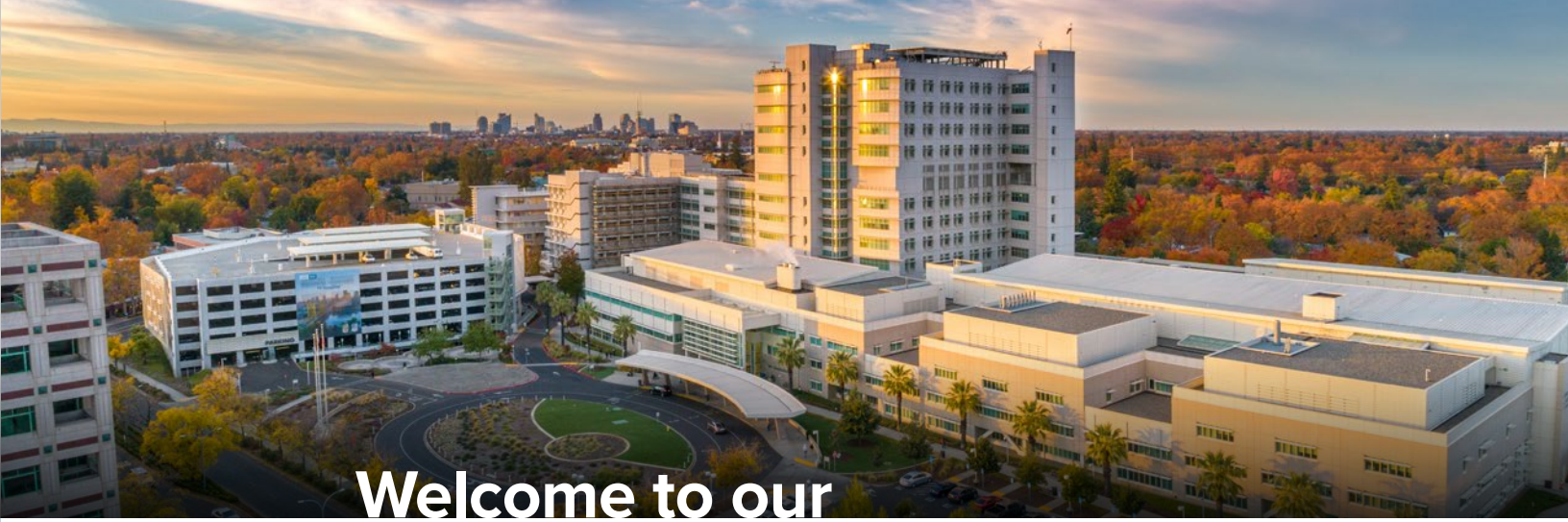
- **Traci Van,** Senior Community Impact Specialist of Community Health Insights



Welcome to our 2025 Community Health Needs Assessment

UC Davis Health is proud of the work we do to build a healthier Sacramento region through our mission of clinical care, research and education. We are deeply committed to collaborating to reduce inequities and health disparities. The community health needs assessment (CHNA) is a valuable opportunity for us to partner with other health systems, non-profit organizations, social services providers, residents and Sacramento County Public Health with the goal of identifying and prioritizing the significant health needs of our community.

The priorities identified in this report and the needs articulated by the people who contributed to its creation help guide our community benefit activities and initiatives to improve community health. The Implementation Strategy that we develop is our roadmap for the next three years — it will help us focus our resources and position us to more innovatively address health inequities. It will also align with and leverage our Anchor Institution Mission for community health, which is our commitment to intentionally apply UC Davis Health's long-term, place-based economic power and human capital in partnership with community to mutually benefit the long-term well-being of both.

Each time we engage in the CHNA we strive to learn something new about the communities we serve. For this report, we asked people about the impacts of climate on health needs. Climate-related events such as extreme temperatures and wildfires have negative impacts on health, including mental health, and disproportionately impact vulnerable populations.

This report — and the Impact of Actions section that highlights UC Davis Health's work to address our community's health needs — focuses on Sacramento County. UC Davis Health's impact extends across our local region, deep into the 33 counties that make up our catchment area, and well beyond California.

I invite you to read this CHNA report, reflect on the challenges in our communities, and consider assets and opportunities. We encourage you to share your feedback with us at **community.relations@health.ucdavis.edu**.

Michael Condrin
Interim Chief Executive Officer and Chief Operating Officer

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Data and the Technical Section of the report can be found online at: **health.ucdavis.edu/about/community-engagement/.**

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Report Summary

Purpose

The purpose of this community health needs assessment (CHNA) was to identify and prioritize significant health needs of the Sacramento County 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.

Community Definition

The definition of the community served included most portions of Sacramento County and a small portion of western El Dorado County, California. Regarded as a highly diverse community, Sacramento County covers 994 square miles and is home to approximately 1.6 million residents. The CHNA used this definition of the community served, as this was the primary geographic area served by the seven nonprofit hospitals that collaborated on this CHNA.

Assessment Process and Methods

The data used to conduct the CHNA were identified and organized using the widely recognized Robert Wood Johnson Foundation's County Health Rankings model.[1] This model of population health includes many factors that impact and account for individual health and well-being. Furthermore, to guide the overall process of conducting the assessment, a defined set of data collection and analytic stages were developed. These included the collection and analysis of both primary (qualitative) and secondary (quantitative) data. Qualitative data included one-on-one and group interviews with 43 community health experts, social service providers, and medical personnel. Furthermore, 107 community residents or community service provider organizations participated in 12 focus groups across the service area. Finally, 63 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.

Process and Criteria to Identify and Prioritize Significant Health Needs

Primary and secondary data were analyzed to identify and prioritize significant health needs. This began by identifying 13 potential health needs (PHNs). These PHNs were identified in previously conducted CHNAs. Data were analyzed to discover which, if any, of the PHNs were present in the service area. These PHNs were selected as significant health needs. These significant health needs were prioritized based on rankings provided by primary data sources. Data were also analyzed to detect emerging health needs beyond those 13 PHNs identified in previous CHNAs.

1 Robert Wood Johnson Foundation and University of Wisconsin. (2024). County Health Rankings Model. Retrieved 18 July 2024 from: https://www.countyhealthrankings.org/health-data/methodology-and-sources/methods.

List of Prioritized Significant Health Needs

The following significant health needs identified for Sacramento County 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. Health Equity
5. System Navigation
6. Safe and Violence-Free Environment
7. Increased Community Connections
8. Access to Specialty and Extended Care
9. Access to Functional Needs
10. Healthy Physical Environment
11. Injury and Disease Prevention and Management
12. Active Living and Healthy Eating
13. Access to Dental Care and Preventive Services

Resources Potentially Available to Meet the Significant Health Needs

In all, 900 resources were identified in the service area that were potentially available to meet the identified significant health needs. The identification method included starting with the list of resources from the 2022 CHNA, verifying that the resources still existed, and then adding newly identified resources into the 2025 CHNA report.

Conclusion

This CHNA report 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 Sacramento County 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.

Report Adoption, Availability, and Comments

The Governing Body of UC Davis Medical Center reviewed, approved and adopted this CHNA on May 19, 2025.

This main report and the data and Technical Section is widely available to the public on the hospital's website at **health.ucdavis.edu/aboutus/community-engagement/index.html**, and a paper copy is available for inspection upon request at UC Davis Health, Community Integration Department, 1651 Alhambra Blvd., Suite 110, Sacramento, CA 95816. Written comments on this report can be submitted by email to **community.relations@health.ucdavis.edu**.

Introduction and Purpose

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

This report documents the processes, methods, and findings of a CHNA conducted on behalf of the nonprofit hospitals listed below. Collectively, these nonprofit hospitals serve Sacramento County, California, located in the north-central part of the state. The total population of the service area was 1,626,432. The CHNA was conducted over a period of 10 months, beginning in March 2024 and concluding in December 2024. This CHNA report meets requirements of the Patient Protection and Affordable Care Act (and in California, Senate Bill 697) that nonprofit hospitals conduct a CHNA at least once every three years.

Dignity Health Affiliates	Sutter Health Affiliates	UC Davis Health
Mercy Hospital of Folsom 1650 Creekside Dr. Folsom, CA 95630	Sutter Medical Center, Sacramento 2825 Capitol Ave. Sacramento, CA 95816	UC Davis Medical Center 2315 Stockton Blvd. Sacramento, CA 95817
Mercy San Juan Medical Center 6501 Coyle Ave. Carmichael, CA 95608		
Mercy General Hospital 4001 J St. Sacramento, CA 95819	Sutter Center for Psychiatry 7700 Folsom Blvd. Sacramento, CA 95826	
Methodist Hospital of Sacramento 7500 Hospital Dr. Sacramento, CA 95823		

Community Health Insights conducted the CHNA on behalf of the participating hospitals. 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 Community Health Assessments (CHAs) for multiple health systems and local health departments over the previous decade. For this assessment Community Health Insights collaborated with Applied Survey Research (ASR), a consulting firm working on behalf of Kaiser Permanente to conduct a CHNA in the Sacramento region, by sharing primary data.

2 Additional Requirements for Charitable Hospitals; Community Health Needs Assessments for Charitable Hospitals. (Wednesday, December 31, 2014). *Federal Register*, 79:250, 78,954-79,016. Department of the Treasury, Internal Revenue Service.

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.[3] This model of population health includes the many factors that impact and account for individual health and well-being. Furthermore, to guide the overall process of conducting the assessment, a defined set of data collection and analytic stages were developed. For a detailed review of methods, see the Technical Section of this report.

Public Comments from Previously Conducted CHNAs

Regulations require that nonprofit hospitals include written comments from the public on their previously conducted CHNAs and most recently adopted implementation strategies. The 2022 CHNA was made public for UC Davis Medical Center in Sacramento County. The community was invited to provide written comments on the CHNA reports and Implementation Strategies both within the documents and on the web site where they are widely available to the public. The email address **community.relations@health.ucdavis.edu** was created to ensure comments were received and responded to. No written comments were received.

Data Used in the CHNA

Data collected and analyzed included both primary or qualitative data and secondary or quantitative data. Primary data included 23 interviews with 43 community health experts, 12 focus groups conducted with a total of 107 community residents or community-facing service providers, and 63 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 sub-county levels was used to identify portions of the hospital service area with greater concentrations of disadvantaged populations and poor health outcomes. A set of county-level indicators was collected from various sources to help identify and prioritize significant health needs. Additionally, socioeconomic indicators were collected to help describe the overall social conditions within the service area. Health outcome indicators included measures of both mortality (length of life) and morbidity (quality of life). Health factor indicators included measures of 1) health behaviors, such as diet and exercise and tobacco, alcohol, and drug use; 2) clinical care, including access to quality care; 3) social and economic factors such as income, educational attainment, employment, neighborhood safety, and similar; and 4) physical environment measures related to issues such as climate, air and water quality, transit and mobility resources, and housing affordability. In all, 85 different health-outcome and health factor indicators were collected for the CHNA.

Data Analysis

Primary and secondary data were analyzed to identify and prioritize the significant health needs within the Sacramento County service area. This included identifying 13 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.

3 Robert Wood Johnson Foundation and University of Wisconsin. (2024). County Health Rankings Model. Retrieved 18 July 2024 from: https://www.countyhealthrankings.org/health-data/methodology-and-sources/methods.

Findings — Sacramento County

Prioritized Significant Health Needs

Primary and secondary data were analyzed to identify and prioritize the significant health needs in the Sacramento County service area. In all, 13 significant health needs were identified. Primary data were then used to prioritize these significant health needs.

Prioritization was based on three measures of community input. The first two measures came from the key informant interview and focus group results. These included the percentage of sources that identified a health need as existing in the community, and the percentage of times the sources identified a health need as a top priority. The last measure was the percentage of Community Service Provider survey (CSPS) respondents that identified a health need as a top priority. It is important to note that these values were not used in identifying significant health needs; only to prioritize those needs that were identified. (For a description of the health need identification process see the Technical Section of the CHNA report.) Table 1 shows the value of these measures used in prioritization for each significant health need.

Table 1: Health need prioritization inputs for the Sacramento County 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 CSPS Respondents that Identified Health Need as a Top Priority
Access to Basic Needs Such as Housing, Jobs, and Food	100%	32%	65%
Access to Mental/Behavioral Health and Substance Use Services	91%	19%	65%
Access to Quality Primary Care Health Services	80%	8%	25%
Health Equity	74%	7%	25%
System Navigation	69%	5%	27%
Safe and Violence-Free Environment	54%	8%	17%
Increased Community Connections	54%	6%	14%
Access to Specialty and Extended Care	51%	4%	8%
Access to Functional Needs	63%	4%	2%
Healthy Physical Environment	51%	3%	2%
Injury and Disease Prevention and Management	37%	3%	5%
Active Living and Healthy Eating	29%	2%	3%
Access to Dental Care and Preventive Services	17%	~	5%

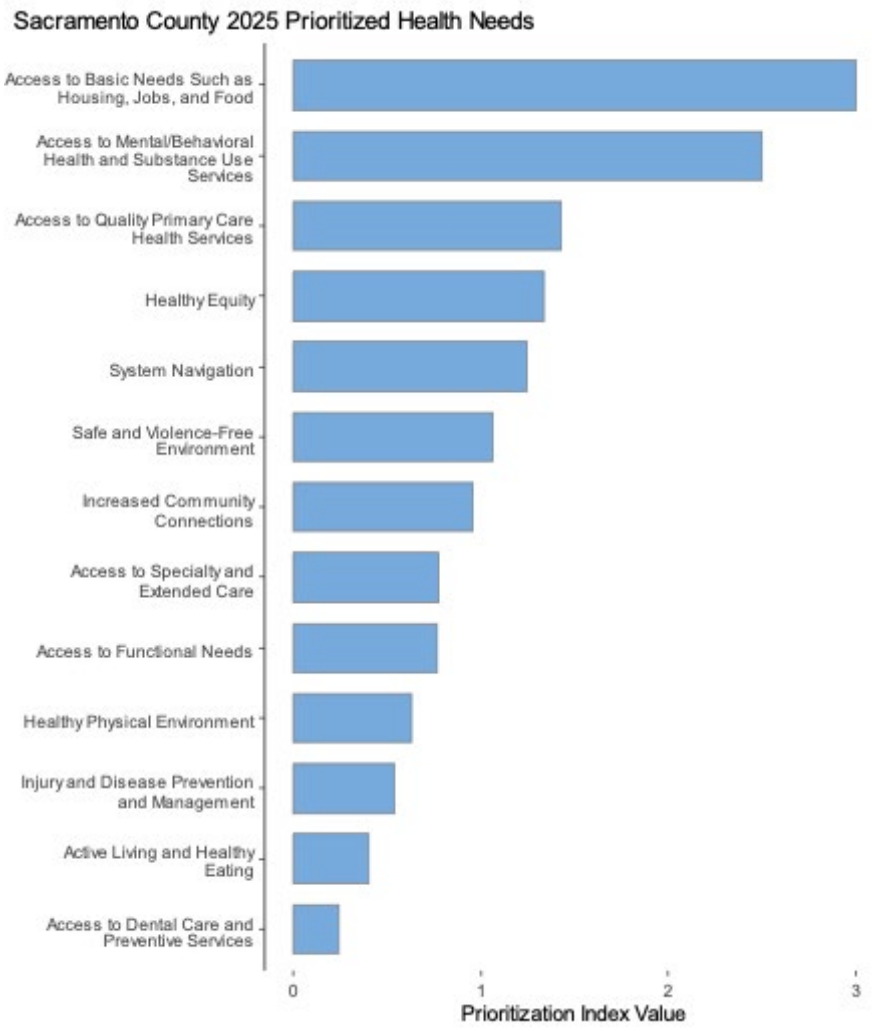
~ Health need not mentioned

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.[4] The prioritization index values are shown in Figure 1, where health needs are ordered from highest priority at the top of the figure to lowest priority at the bottom.

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

These significant health needs are described below. The secondary data indicators used in the CHNA that performed poorly compared to benchmarks are listed in the table below each health need and are 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. The order in which these items are listed is random and not meant to denote priority. (A full listing of all quantitative indicators can be found in the Technical Section of this report).

Figure 1: Prioritized significant health needs for the Sacramento County service area.



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

5 McLeod, S. (2020). *Maslow's Hierarchy of Needs*. Retrieved 31 Jan 2022 from: http://www.simplypsychology.org/maslow.html.

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

<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><th>Key Informant and Focus Group Responses</th><th>Community Service Provider Survey Responses</th></tr>
<tr><td>▪ There is a severe shortage of affordable housing and shelters, especially for families and individuals with medical or behavioral health needs.
▪ Rising rents and insufficient housing assistance further exacerbate the housing problem.
▪ Communities resist shelter construction, leading to inadequate shelter space.
▪ Access to affordable, nutritious food is limited, especially for low-income and elderly populations.
▪ Many rely on food banks or fast food as healthier options are often unaffordable or unavailable nearby.
▪ Job opportunities with livable wages are scarce, especially for refugees, immigrants, and individuals with criminal records.
▪ Available jobs are often low-paying or undesirable, impacting physical and mental health.
▪ Unhoused individuals often lack basic health resources, and rising costs of healthcare, food, and utilities force many to prioritize essentials over medical needs.
▪ Homelessness and poverty affect youth in schools, with large populations struggling to meet basic needs.
▪ Job training and life skills programs are necessary to support youth and adults transitioning into stable employment.
▪ Access to essential services such as showers, toilets, and healthcare is limited for unhoused populations.
▪ Partnerships with local businesses are needed to foster economic growth and reduce generational poverty.</td><td>▪ Housing is unaffordable.
▪ Additional low-income housing options are needed.
▪ Services for homeless residents are insufficient.
▪ Many people do not make a living wage.
▪ It is difficult to find affordable childcare.
▪ Poverty is high.
▪ Many residents struggle with food insecurity.
▪ Services are inaccessible for Spanish-speaking and immigrant residents.
▪ Employment opportunities are limited.
▪ Educational attainment in the area is low.</td><td>▪ Infant Mortality
▪ Child Mortality
▪ Life Expectancy
▪ Premature Age-Adjusted Mortality
▪ Premature Death
▪ Hypertension Mortality
▪ Low Birthweight
▪ Poor Mental Health Days
▪ Frequent Mental Distress
▪ Poor Physical Health Days
▪ Frequent Physical Distress
▪ Poor or Fair Health
▪ Asthma ED Rates
▪ Asthma ED Rates for Children
▪ Drug Induced Death
▪ Adult Obesity
▪ Limited Access to Healthy Foods
▪ Food Environment Index
▪ Medically Underserved Area
▪ Disconnected Youth
▪ Third Grade Reading Level
▪ Third Grade Math Level
▪ Children in Single-Parent Households
▪ Children in Poverty
▪ Median Household Income
▪ Homelessness Rate</td></tr>
</table>

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**	
▪ Limited psychiatric beds and substance use facilities, especially in Northern California, restrict access to care. ▪ Unhoused individuals face high levels of anxiety and stress, with limited access to mental health resources, adding to a cycle of trauma and instability. ▪ The prevalence of drugs like fentanyl and meth has exacerbated addiction issues across all age groups, from teens to adults. ▪ Youth mental health, particularly anxiety, depression, and behavioral issues, has increased. ▪ There's a shortage of mental health services and coping mechanisms in schools and communities. ▪ Long wait times, cultural stigma, and financial barriers prevent people from seeking timely mental and behavioral care, even when available. ▪ Language and cost are hurdles when seeking mental and behavioral healthcare services, particularly for those with low incomes or on public insurance. ▪ Behavioral health crisis is often handled by emergency departments or law enforcement, leading to trauma and sometimes incarceration rather than treatment. ▪ There is a need for resilience-building, more counselors in schools, grief support, and recreational activities for youth as preventive measures. ▪ There is a need for cultural education and trauma-informed services for immigrants and refugees to ease adjustment challenges. ▪ The community needs more resources, infrastructure, and public education on mental health and addiction, with a particular emphasis on making services more accessible and culturally responsive. ▪ There is a need for harm reduction and targeted interventions.	▪ There aren't enough mental health providers or treatment centers (e.g., psychiatric beds, therapists, support groups). ▪ It's difficult for people to navigate mental/behavioral healthcare. ▪ Additional services for those who are homeless and experiencing mental/behavioral health issues are needed. ▪ There aren't enough services for those who are homeless and dealing with substance-abuse issues. ▪ There aren't enough substance-abuse treatment services available (e.g., detox centers, rehabilitation centers). ▪ Treatment options for those with Medi-Cal are limited. ▪ Substance-abuse is a problem (e.g., use of opiates and methamphetamine, prescription misuse). ▪ There is a lack of infrastructure to support acute mental health crises. ▪ Additional services specifically for youth are needed (e.g., child psychologists, counselors and therapists in the schools). ▪ The cost for treatment is too high. ▪ The stigma around seeking mental health treatment keeps people out of care. ▪ Substance-abuse is an issue among youth in particular. ▪ Awareness of mental health issues is low. ▪ Mental/behavioral health services are available, but people do not know about them. ▪ The use of nicotine delivery products such as e-cigarettes and tobacco is a problem. ▪ Substance-abuse treatment services are available, but people do not know about them.	▪ Life Expectancy ▪ Premature Age-Adjusted Mortality ▪ Premature Death ▪ Suicide Mortality ▪ Poor Mental Health Days ▪ Frequent Mental Distress ▪ Poor Physical Health Days ▪ Frequent Physical Distress ▪ Poor or Fair Health ▪ Drug Induced Death ▪ Adult Smoking ▪ Mental Health Care Shortage Area ▪ Medically Underserved Area ▪ Mental Health Providers ▪ Firearm Fatalities Rate ▪ Juvenile Arrest Rate ▪ Disconnected Youth ▪ Homelessness Rate

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.

<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><th>Key Informant and Focus Group Responses</th><th>Community Service Provider Survey Responses</th></tr>
<tr><td>▪ Many patients fall into a coverage gap where they don't qualify for Medi-Cal but can't afford necessary care.
▪ Primary care access is limited due to high demand and few providers accepting Medi-Cal, resulting in long wait times and reliance on emergency rooms for routine care.
▪ There are insufficient shelters with medical support, delays in medication access, lack of healthcare providers, high staff turnover, and inadequate cultural and language support, particularly for refugees and immigrants.
▪ Training for healthcare staff to build trust with unhoused and underserved populations is needed.
▪ Patients face challenges with bureaucratic health systems, high deductibles, poor-quality care, and inadequate preventive services.
▪ Access barriers are especially pronounced for specific groups like Black patients, pregnant teens, refugees, and large families.
▪ There is a need for universal healthcare, more clinics, culturally sensitive care, telemedicine, and expanded insurance options to address these gaps.</td><td>▪ Wait-times for appointments are excessively long.
▪ Too few providers accept Medi-Cal.
▪ Patients seeking primary care overwhelm local emergency departments.
▪ Quality health insurance is unaffordable.
▪ There aren't enough primary care providers.
▪ It's difficult to obtain appointments outside of regular business hours.
▪ The quality of care is low (e.g., providers lack cultural or linguistic competence).
▪ Out-of-pocket costs are too high.
▪ Primary care services are available, but they are difficult to navigate.
▪ Specific services are unavailable (e.g., 24-hour pharmacies, urgent care, telemedicine).</td><td>▪ Infant Mortality
▪ Child Mortality
▪ Life Expectancy
▪ Premature Age-Adjusted Mortality
▪ Premature Death
▪ Stroke Mortality
▪ Chronic Lower Respiratory Disease Mortality
▪ Diabetes Mortality
▪ Heart Disease Mortality
▪ Hypertension Mortality
▪ Cancer Mortality
▪ Alzheimer's Disease Mortality
▪ 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
▪ Asthma ED Rates
▪ Asthma ED Rates for Children
▪ Medically Underserved Area
▪ Preventable Hospitalization
▪ Homelessness Rate</td></tr>
</table>

4. Health Equity

Health equity means that everyone has a fair and just opportunity to be as healthy as possible. 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 (RWJF Definition).

The health equity table contains only the results of primary data analysis. Quantitative indicators and analysis are reported in the Health Equity section of this report.

Primary Data Analysis	
The manner in which the health need appeared or was expressed in the community was described as follows by key informants and focus group participants:	
▪ Homeless individuals often face discrimination in medical settings, they are treated with disrespect and their needs dismissed. ▪ Prejudice in healthcare settings affects those who are visibly poor or rely on Medicaid. ▪ There is a lack of culturally competent providers, especially for Latino and Afghan communities, and insufficient language support for non-English speakers, impacting immigrants' and refugees' access to healthcare. ▪ The profit-driven nature of healthcare limits the system's capacity to meet marginalized communities' needs. ▪ Marginalized groups, particularly refugees, immigrants, and those from low-income areas, lack representation in policy-making, and their community-specific needs are often overlooked. ▪ There's limited support for economic resources and services tailored for marginalized groups, especially new immigrant communities. Those with accents face discrimination in the job market. ▪ Marginalized communities, especially Black and unhoused individuals, report over-policing and racial profiling, which foster fear and distrust of law enforcement. ▪ Youth in marginalized communities are often labeled as problematic without addressing the systemic factors that contribute to behavioral issues.	▪ There is a strong need for cultural humility among service providers, as racial and cultural insensitivity limits the effectiveness of healthcare, education, and other support services. ▪ Communities emphasize the need for providers who understand and respect cultural differences and who actively work to bridge language gaps, especially with the use of cultural brokers. ▪ Disparities in neighborhood infrastructure (parks, walkability, safety) disproportionately affect low-income areas. ▪ A prevalent digital divide exacerbates difficulties in accessing services, education, and mental health support, particularly during the pandemic. ▪ Affordable housing, transportation, and adequate insurance remain significant barriers, particularly for undocumented individuals and low-income households. ▪ The bureaucratic complexity of accessing social services, including Medicare, limits access to essential support. ▪ Issues such as racism, economic inequality, and lack of adequate community safety resources have fueled mistrust in public institutions, especially among marginalized groups. ▪ The disparity between communities like Natomas and Del Paso Heights exemplifies the broader inequities in resource distribution and safety.

5. System Navigation

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

<table>
<tr><th colspan="2">Primary Data Analysis</th><th>Secondary Data Analysis</th></tr>
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<tr><th>Key Informant and Focus Group Responses</th><th>Community Service Provider Survey Responses</th></tr>
<tr><td>▪ Managed care plans often deny post-acute care, have long wait times, and lack transparency, making it difficult for people to access necessary health resources.
▪ Health and social service systems are siloed and difficult to navigate, especially for non-English speakers and those unfamiliar with bureaucratic processes.
▪ Patients and their families often bear the burden of coordinating care without compensation or guidance.
▪ There is a need for system navigators and case managers to assist people in accessing services, understanding health insurance, and completing complex forms, especially for immigrants and those recently released from prison.
▪ Effective support for unhoused individuals requires comprehensive wraparound services, including basic life skills training and financial education.
▪ There's a need for better alignment and integration between state programs to avoid issues like losing SNAP benefits when gaining employment.
▪ Limited language support hampers access for non-English speakers, with inadequate translations for critical resources like driver's exams and discharge instructions.
▪ Materials need to be provided in accessible formats and multiple languages.
▪ Community education is lacking, especially regarding available resources.
▪ Community health workers, marketing campaigns to raise awareness, and improved health literacy can help ensure people are aware of services.
▪ Complicated eligibility requirements for programs like Medi-Cal and CalFresh, as well as extensive paperwork, often disqualify individuals unfairly or make it difficult to maintain support.
▪ There is a need for a centralized, culturally competent "one-stop shop" for accessing services, better care coordination, and robust language support emerges as critical for improving access and outcomes.</td><td>▪ Automated phone systems can be difficult for those who are unfamiliar with the healthcare system.
▪ It is difficult to navigate multiple health care systems.
▪ Some people just don't know where to start in order to access care or benefits.
▪ People may not be aware of the services they are eligible for.
▪ More navigators are needed to connect people to services.
▪ People have trouble understanding their insurance benefits.
▪ Medical and insurance paperwork can be overwhelming.
▪ Medical terminology is confusing.
▪ There aren't enough bilingual navigators.</td><td>▪ 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
▪ Poor Mental Health Days
▪ Frequent Mental Distress
▪ Poor or Fair Health
▪ Asthma ED Rates
▪ Asthma ED Rates for Children
▪ Mental Health Care Shortage Area
▪ Medically Underserved Area
▪ Dentists
▪ Mental Health Providers
▪ Preventable Hospitalization</td></tr>
</table>

7 Natale-Pereira, A. et. Al. (2011). The Role of Patient Navigators in Eliminating Health Disparities. *US National Library of Medicine, National Institutes of Health, 117*:15, 3,543-3,552.

6. Safe and Violence-Free Environment

Feeling safe in one's home and community is fundamental to overall health. Next to having basic needs met (e.g., food, shelter, and clothing) is having physical safety. Feeling unsafe affects the way people act and react to everyday life occurrences. Additionally, research has shown that individuals exposed to violence in their homes, communities, and schools are more likely to experience depression and anxiety and demonstrate more aggressive, violent behavior.[8]

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<tr><th>Key Informant and Focus Group Responses</th><th>Community Service Provider Survey Responses</th></tr>
<tr>
<td>▪ Schools are increasingly unsafe, with youth violence rising and incidents of students bringing weapons on campus.
▪ Unhoused individuals report feeling unsafe on the streets and within shelters, where they encounter violence and abuse.
▪ There are serious safety concerns within various communities, highlighting violence, inadequate resources, and lack of security measures.
▪ Afghan children face bullying due to cultural differences.
▪ LGBTQIA+ individuals struggle to find safe, inclusive shelter options, especially those over 24, who often face transphobia.
▪ Public spaces and neighborhoods lack adequate police presence, leading to increased gun violence, theft, and harassment, with community members feeling afraid to walk in their own neighborhoods.
▪ The lack of secure community centers and activities for youth contributes to engagement in negative behaviors, while safety on public transport remains unreliable.
▪ There is a need for parenting classes, conflict resolution in schools, and education on gun safety.
▪ Domestic and gang violence, especially in economically strained areas, remain prevalent, with marginalized groups, including Latino women, hesitant to report incidents due to fear.
▪ Community members call for equitable safety measures, accountability, and violence prevention to foster a more secure and inclusive environment for all.</td>
<td>▪ Youth need more safe places to go after school.
▪ Human trafficking is an issue.
▪ People feel unsafe because of crime.
▪ Public parks seem unsafe because of illegal activity taking place.
▪ Domestic violence and sexual assault resources are insufficient.
▪ Gang activity is an issue.
▪ Isolated or poorly lit streets make pedestrian travel unsafe.
▪ Specific groups in this community are targeted because of characteristics like race/ethnicity, age, sexual orientation, or gender identity.
▪ The current political environment makes some concerned for their safety.</td>
<td>▪ Life Expectancy
▪ Premature Death
▪ Hypertension Mortality
▪ Poor Mental Health Days
▪ Frequent Mental Distress
▪ Frequent Physical Distress
▪ Poor or Fair Health
▪ Homicide Rate
▪ Firearm Fatalities Rate
▪ Juvenile Arrest Rate
▪ Motor Vehicle Crash Death
▪ Disconnected Youth
▪ Homelessness Rate</td>
</tr>
</table>

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

7. Increased Community Connections

As humans are social beings, community connection is a crucial part of living a healthy life. People have a need to feel connected with a larger support network and the comfort of knowing they are accepted and loved. Research suggests "individuals who feel a sense of security, belonging, and trust in their community have better health. People who don't feel connected are less inclined to act in healthy ways or work with others to promote well-being for all."[9] Assuring that community members connect with each other through community opportunities like programs, services, and civic engagement is important to foster a healthy community. Furthermore, healthcare and community support services are more effective when they are delivered in a coordinated fashion, where individual organizations collaborate with others to build a network of care.

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<tr><th>Key Informant and Focus Group Responses</th><th>Community Service Provider Survey Responses</th></tr>
<tr><td>▪ Initiatives like the Youth and Family Collective (YFC) showcase the power of collective action over isolated efforts.
▪ Smaller, trusted organizations within communities can act as key connectors to support outreach and engagement.
▪ Communities need platforms for organizations to share data, resources, and abilities to help people navigate complex systems and access support, which also opens doors to larger funding opportunities.
▪ Increased community involvement and civic engagement are essential, especially focusing on prevention strategies to improve public health, reduce violence, and build resilience in areas with concentrated poverty.
▪ Youth need mentoring, safe spaces, and activities to engage them and provide role models that reflect their potential.
▪ Collaborations between healthcare providers, law enforcement, schools, and local community organizations are necessary to address interconnected issues like homelessness, health disparities, and safety without defaulting to punitive measures.
▪ Leveraging deep-rooted, generational connections, especially in areas like Del Paso Heights, is essential to foster healthy relationships and disrupt harmful cycles.
▪ To counteract social isolation and loneliness among older adults, community spaces and gatherings should focus on health topics, familial support, and youth empowerment to foster intergenerational connections.
▪ Ultimately, a community-driven ecosystem with cross-sector collaboration, engaging religious, nonprofit, and civic groups, is essential for sustainable improvement in health, safety, and economic opportunities.</td><td>▪ City and county leaders need to work together.
▪ Building community connections doesn't seem like a priority.
▪ Health and social-service providers operate in silos; cross-sector connections needed.
▪ There isn't enough funding for social services.
▪ Relations between law enforcement and the community need to be improved.
▪ The community needs to invest more in the local public schools.
▪ People in the community face discrimination from local service providers.</td><td>▪ Infant Mortality
▪ Child Mortality
▪ Life Expectancy
▪ Premature Age-Adjusted Mortality
▪ Premature Death
▪ Stroke Mortality
▪ Diabetes Mortality
▪ Heart Disease Mortality
▪ Hypertension Mortality
▪ Suicide Mortality
▪ Unintentional Injuries Mortality
▪ Low Birthweight
▪ Poor Mental Health Days
▪ Frequent Mental Distress
▪ Poor Physical Health Days
▪ Frequent Physical Distress
▪ Poor or Fair Health
▪ Drug Induced Death
▪ Mental Health Care Shortage Area
▪ Medically Underserved Area
▪ Mental Health Providers
▪ Preventable Hospitalization
▪ Homicide Rate
▪ Firearm Fatalities Rate
▪ Juvenile Arrest Rate
▪ Disconnected Youth
▪ Children in Single-Parent Households
▪ Homelessness Rate
▪ Access to Public Transit</td></tr>
</table>

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

8. 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 together, 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.

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<tr><th>Key Informant and Focus Group Responses</th><th>Community Service Provider Survey Responses</th></tr>
<tr>
<td>▪ Patients struggle with access to specialty care, such as vascular, oncology, neurology, and cardiology.
▪ Long wait times, convoluted referral processes, and low reimbursement rates discourage providers from accepting Medi-Cal patients, further limiting specialty care access for the underinsured.
▪ There is a shortage of beds in nursing facilities, affordable assisted living, and long-term care for the elderly and developmentally delayed.
▪ Many patients are forced to remain in hospitals due to limited placements, increasing hospital strain.
▪ Dialysis access is challenging for less-mobile patients, with few transport options from skilled nursing facilities.
▪ Post-discharge support is lacking, leaving gaps in wound care and oxygen support.
▪ Unhoused populations face barriers in hospice and prenatal care access.
▪ High costs of in-home and assisted care further hinder care access for vulnerable populations.
▪ There is a significant demand for prenatal, postpartum, and infant care, especially among the homeless and African American populations, who suffer from high rates of maternal and infant mortality.
▪ There are not enough healthcare providers or caregivers available, leading to long wait times and short appointment slots, impacting quality of care.
▪ Affordable long-term and specialty care options for elderly and disabled individuals are insufficient, creating financial burdens for families.
▪ Issues such as elder abuse, intergenerational trauma, and lack of trust in specialists exacerbate shortages, and additional support is needed to address these systemic gaps.
▪ Shortages and system inefficiencies result in a crisis affecting care accessibility, particularly for low-income and vulnerable groups.
▪ Elderly individuals, especially those with dementia, and developmentally delayed persons need more specialized facilities.</td>
<td>▪ Not all specialty care is covered by insurance.
▪ Out-of-pocket costs for specialty and extended care are too high.
▪ Too few specialty and extended care providers accept Medi-Cal.
▪ It is difficult to recruit and retain specialists.
▪ More extended care options for the aging population are needed (e.g., skilled nursing homes, in-home care).
▪ People must travel to reach specialists.
▪ Wait-times for specialist appointments are excessively long.
▪ Additional hospice and palliative care options are needed.
▪ The area lacks a specific kind of specialist or extended care option: medical respite, recuperative care for homeless.</td>
<td>▪ Infant Mortality
▪ Life Expectancy
▪ Premature Age-Adjusted Mortality
▪ Premature Death
▪ Stroke Mortality
▪ Chronic Lower Respiratory Disease Mortality
▪ Diabetes Mortality
▪ Heart Disease Mortality
▪ Hypertension Mortality
▪ Cancer Mortality
▪ Alzheimer's Disease Mortality
▪ Poor Mental Health Days
▪ Frequent Mental Distress
▪ Poor Physical Health Days
▪ Frequent Physical Distress
▪ Poor or Fair Health
▪ Lung Cancer Prevalence
▪ Asthma ED Rates
▪ Asthma ED Rates for Children
▪ Drug Induced Death
▪ Preventable Hospitalization
▪ Homelessness Rate</td>
</tr>
</table>

9. Access to Functional Needs

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

<table>
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<tr><th>Key Informant and Focus Group Responses</th><th>Community Service Provider Survey Responses</th></tr>
<tr><td>▪ Current bus and light rail services lack coverage, run infrequently, and do not operate at convenient times, especially for shift workers and those needing to attend healthcare appointments or jobs.
▪ Routes are limited, and delays are common, causing issues for low-income individuals, seniors, and those without personal vehicles.
▪ The cost of public transportation is prohibitive, especially for individuals with low income.
▪ Existing financial assistance programs for transportation services are reimbursement-based, making it hard for people who cannot afford upfront costs.
▪ Walkways and public spaces are often inaccessible for people with disabilities and age-related issues.
▪ Public transport does not adequately serve those with mobility needs, and some bus drivers have language barriers that complicate navigation for non-English speakers.
▪ Lack of transportation restricts youth from participating in after-school programs and other extracurriculars.
▪ Poor transit access leads to social isolation and limits access to healthcare, groceries, and other essential services.
▪ Vulnerable individuals, including seniors, are unable to reliably access healthcare appointments and face long wait times.
▪ Transportation services need expanded, including ride-share options, and better financial support to make transportation accessible and affordable for all.</td><td>▪ Medical transport is limited or unreliable.
▪ Public transportation is more difficult for some residents to use (e.g., non-English speakers, seniors, parents with young children).
▪ Public transportation schedules are limited.
▪ Public transportation service routes are limited.
▪ Roads and sidewalks are not well-maintained.
▪ The distance between service providers is inconvenient for those using public transportation.
▪ The geography makes it difficult for those without reliable transportation to get around.
▪ Using public transportation to reach providers can take a very long time.</td><td>▪ Disability
▪ Frequent Mental Distress
▪ Frequent Physical Distress
▪ Poor or Fair Health
▪ Adult Obesity
▪ Homelessness Rate
▪ Access to Public Transit</td></tr>
</table>

10. Healthy Physical Environment

Individual health is determined by several 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.[10]

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<tr><th>Key Informant and Focus Group Responses</th><th>Community Service Provider Survey Responses</th></tr>
<tr><td>▪ Unmaintained parks and trails, particularly near rivers, deter public use and limit accessibility.
▪ Vulnerable populations face more severe effects of climate change, such as extreme heat and poor air quality, increasing risks of dehydration, asthma, and other health issues.
▪ Low-income areas lack trees and green spaces, intensifying heat and air pollution problems and contributing to respiratory illnesses.
▪ Some seek shelter in hospitals due to a shortage of heating and cooling centers in the community.
▪ Highways and toxic waste affect air quality, while climate change threatens water cleanliness, with pesticides impacting those unable to afford organic food.
▪ Climate anxiety, political concerns, and extreme weather lead to stress, compounded by unclean streets and poor neighborhood aesthetics.
▪ Beautification campaigns could improve community pride and mental health.
▪ Apartment and community space fires, especially in vacant lots with dry grass, worsen air quality.
▪ More accessible and walkable streets, better ventilation in homes, and emergency water distribution during power outages and storms are essential.
▪ Additional cooling and warming centers are needed to support community health during extreme weather.</td><td>▪ Heavy traffic harms the air quality.
▪ Industrial activity harms the air quality.
▪ Low-income housing is substandard.
▪ The air quality contributes to high rates of asthma.
▪ Water quality is poor.
▪ Wildfires harm the air quality.</td><td>▪ Infant Mortality
▪ Life Expectancy
▪ Premature Age-Adjusted Mortality
▪ Premature Death
▪ Chronic Lower Respiratory Disease Mortality
▪ Hypertension Mortality
▪ Cancer Mortality
▪ Frequent Mental Distress
▪ Frequent Physical Distress
▪ Poor or Fair Health
▪ Colorectal Cancer Prevalence
▪ Breast Cancer Prevalence
▪ Lung Cancer Prevalence
▪ Asthma ED Rates
▪ Asthma ED Rates for Children
▪ Adult Smoking
▪ Homelessness Rate
▪ Air Pollution — Particulate Matter
▪ Projected Difference in Extreme Heat Days</td></tr>
</table>

10 Blum, H. L. (1983). *Planning for Health*. New York: Human Sciences Press.

11. Injury and Disease Prevention and Management

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

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<tr><th>Key Informant and Focus Group Responses</th><th>Community Service Provider Survey Responses</th></tr>
<tr><td>▪ Issues like diabetes, hypertension, and heart disease are prevalent, highlighting the need for more prevention programs, health education, and proper nutrition guidance.
▪ Staff training is important for campus-related health issues, while young people need better access to reproductive and sexual health information and services.
▪ Increased access to education on contraception, childcare, practical life skills (e.g., financial literacy in high school), and overall disease prevention is needed, particularly for single parents, youth, and Black communities.
▪ There is a need for education on nutrition, including how to utilize canned foods, understanding food labels, and managing diet-related chronic diseases effectively.
▪ The need for affordable and equitable education, more accessible healthcare, and better resource networks is underscored.</td><td>▪ Health education in the schools needs to be improved.
▪ Nutrition education opportunities are needed.
▪ There should be a greater focus on chronic disease prevention (e.g., diabetes, heart disease).
▪ Patients need to be better connected to service providers (e.g., case management, patient navigation, or centralized service provision).
▪ Prevention efforts need to be focused on specific populations in the community (e.g., youth, Spanish-speaking residents, the elderly, LGBTQ individuals, immigrants).
▪ Vaccination rates are low.</td><td>▪ Infant Mortality
▪ Child Mortality
▪ Stroke Mortality
▪ Chronic Lower Respiratory Disease Mortality
▪ Diabetes Mortality
▪ Heart Disease Mortality
▪ Hypertension Mortality
▪ Suicide Mortality
▪ Unintentional Injuries Mortality
▪ Alzheimer's Disease Mortality
▪ Low Birthweight
▪ Poor Mental Health Days
▪ Frequent Mental Distress
▪ Frequent Physical Distress
▪ Poor or Fair Health
▪ Asthma ED Rates
▪ Asthma ED Rates for Children
▪ Drug Induced Death
▪ Adult Obesity
▪ Adult Smoking
▪ Firearm Fatalities Rate
▪ Juvenile Arrest Rate
▪ Motor Vehicle Crash Death
▪ Disconnected Youth
▪ Third Grade Reading Level
▪ Third Grade Math Level
▪ Homelessness Rate</td></tr>
</table>

12. 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 experience food insecurity, absent the means to consistently secure food for themselves or their families, relying on food pantries and school meals that may be lacking in sufficient nutrition for maintaining health.

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<tr><th>Key Informant and Focus Group Responses</th><th>Community Service Provider Survey Responses</th></tr>
<tr><td>▪ The community faces significant barriers to a healthy lifestyle, including limited access to culturally appropriate and affordable healthy foods, with grocery stores and farmer's markets often far away.
▪ Rising obesity rates are compounded by a lack of affordable gym memberships, nearby parks, and accessible exercise equipment.
▪ The few available options for exercise, like tai chi and swimming, have limited hours, making it challenging for women and older adults to stay active.
▪ There is a need for more community exercise events and spaces, and increased tree canopies and parks could improve neighborhood health.
▪ The high cost of healthy food makes junk food the more affordable option, leaving residents concerned about their dietary health compared to food options in their home country.</td><td>▪ Food insecurity is an issue.
▪ Fresh, unprocessed foods are unaffordable.
▪ The built environment doesn't support physical activity (e.g., neighborhoods aren't walk-able, roads aren't bike-friendly, parks are inaccessible).
▪ There are food deserts where fresh, unprocessed foods are not available.
▪ Homelessness in parks or other public spaces deters their use.
▪ Nutrition education programs are needed.
▪ Recreational opportunities are unaffordable (e.g., gym memberships, recreational activity programming).
▪ There aren't enough recreational opportunities (e.g., organized activities, youth sports leagues).</td><td>▪ Life Expectancy
▪ Premature Age-Adjusted Mortality
▪ Premature Death
▪ Stroke Mortality
▪ Diabetes Mortality
▪ Heart Disease Mortality
▪ Hypertension Mortality
▪ Cancer Mortality
▪ Poor Mental Health Days
▪ Frequent Mental Distress
▪ Poor Physical Health Days
▪ Frequent Physical Distress
▪ Poor or Fair Health
▪ Colorectal Cancer Prevalence
▪ Breast Cancer Prevalence
▪ Asthma ED Rates
▪ Asthma ED Rates for Children
▪ Adult Obesity
▪ Limited Access to Healthy Foods
▪ Food Environment Index
▪ Homelessness Rate
▪ Access to Public Transit</td></tr>
</table>

13. Access to Dental Care and Preventive Services

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

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<tr><th>Key Informant and Focus Group Responses</th><th>Community Service Provider Survey Responses</th></tr>
<tr><td>▪ Many dental services, such as root canals and extractions, aren't covered by Medi-Cal, which leaves many cases untreated and sometimes leads to hospitalizations.
▪ Dental care under Medi-Cal is costly and difficult to access, with few available providers.
▪ Unlike countries like Ukraine and Afghanistan, where dental care is free, accessible, and offers over-the-counter pain relief, U.S. dental care often requires visits to multiple clinics, leading to prolonged pain and challenges in managing food intake.
▪ Patients experience long wait times for appointments, and there is a need for comprehensive coverage—including braces and implants—to ensure effective, timely, and high-quality dental care.</td><td>▪ It's hard to get an appointment for dental care.
▪ The lack of access to dental care here leads to overuse of emergency departments.
▪ Dental care is unaffordable, even if you have insurance.
▪ People have to travel to receive dental care.
▪ There aren't enough dental care providers.</td><td>▪ Frequent Mental Distress
▪ Poor Physical Health Days
▪ Frequent Physical Distress
▪ Poor or Fair Health
▪ Dentists
▪ Homelessness Rate</td></tr>
</table>

Description of Community Served

Sacramento County (with the exception of a small portion) and a small part of El Dorado County was the designated area served by the participating hospitals for the 2025 CHNA. This definition of the community served was used because this is the primary geographic area served by the seven nonprofit hospitals that collaborated on this CHNA.

Sacramento County was incorporated in 1850, and much of its rich history was influenced by the discovery of gold in the area in 1848. The county is home to California's capital city, Sacramento. The county includes seven incorporated cities, with the City of Sacramento being the largest. Covering a geographic area of 994 square miles and home to approximately 1.6 million residents, Sacramento County sits at the northern portion of California's Central Valley, situated along the Interstate 5 corridor. The area consists of both urban and rural communities and includes the Sacramento—San Joaquin Delta that connects the Sacramento River to the San Francisco Bay through some 700 miles of winding waterways. Sacramento is a diverse community, and a report ranked the city the fourth most racially and ethnically diverse large city in the U.S.[11]

Sacramento County has over 30 cities, census-designated places, and unincorporated communities that include neighborhoods with rich heritages such as Oak Park, known as Sacramento's first suburb, to newer communities such as the City of Rancho Cordova, incorporated in 2003. Sacramento County ranks as California's 26th most overall healthy county among the 58 in the state.[12] The area is served by several healthcare organizations, including those that collaborated on this assessment.

In this CHNA, one additional ZIP Code from El Dorado County, a neighboring county east of Sacramento, was included to capture the portion of the community served by Mercy Hospital of Folsom, located near the border of these two counties. With some exceptions, findings described in this report are organized both at the county level and, as detailed later in this report, by designated regions within the county.

11 McCann, A. (May 3, 2018). *2018's Most Diverse Cities in the U.S.* Washington DC: WalletHub. Retrieved from: **https://wallethub.com/edu/most-diverse-cities/12690/#methodology**.

12 See: **https://www.countyhealthrankings.org/app/california/2021/rankings/outcomes/overall**

Regions of Sacramento County

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

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

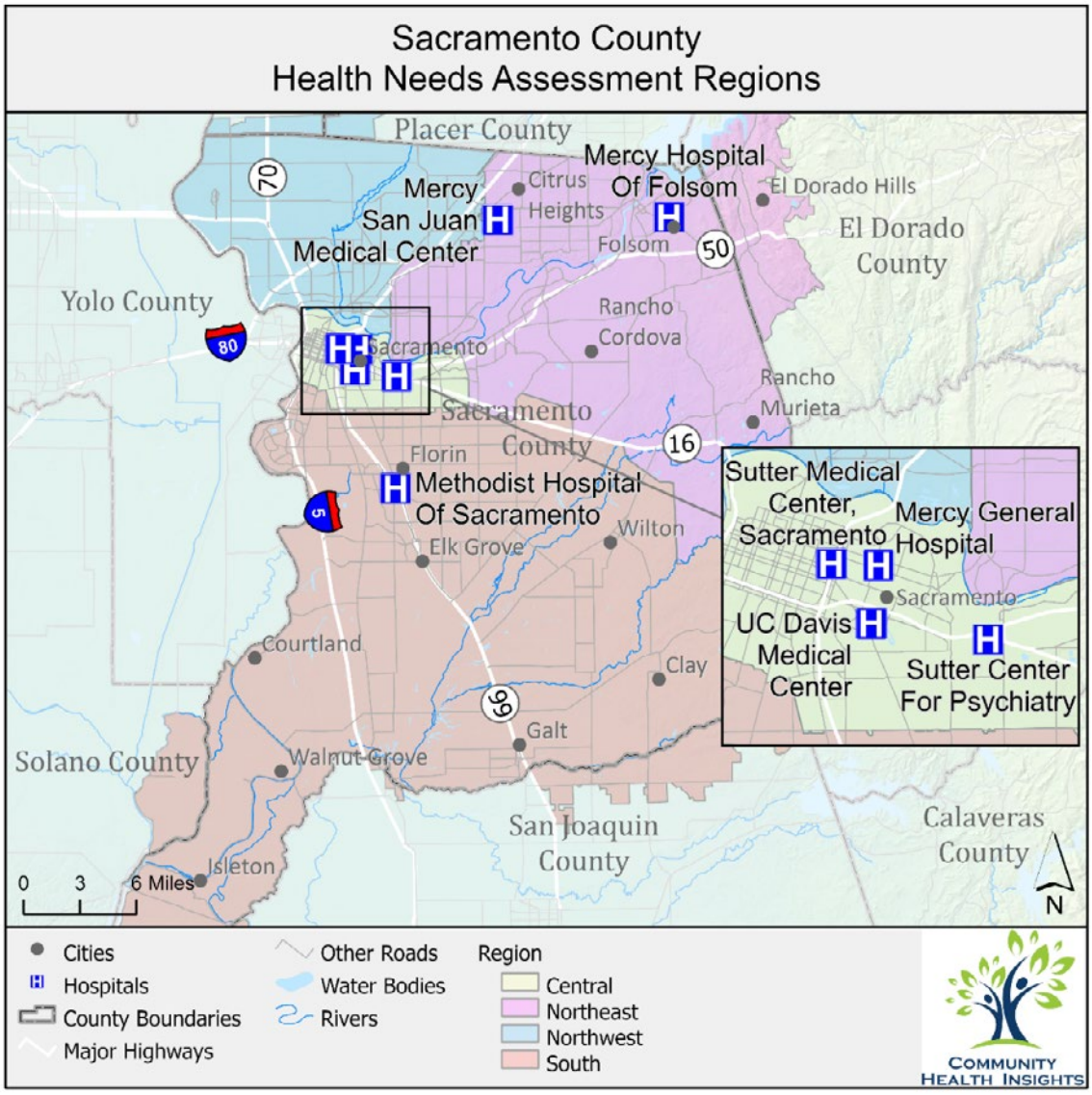


Figure 2: Regions of Sacramento County.

Community Vulnerability Indices — Sacramento County

Vulnerability indices provide information that describe and compare the sociodemographic characteristics of communities. For this CHNA report, three indices are used: 1) the California Healthy Places Index (HPI)[13] 2) the Center for Disease Control and Prevention's Social Vulnerability Index, (SVI)[14] and 3) the Vizient Vulnerability Index (VVI).[15] Though each is somewhat distinct from the other, all three indices aggregate and combine social and demographic data from reliable sources that have known relationships to life expectancy and other health outcomes. For each index the values of multiple indicators are combined to create a score that is assigned to a particular census tract, ZIP Code, or county that denotes the community's vulnerability to poor health outcomes. Scores are divided into groups, and each group is represented by color gradation maps, also referred to as "heat maps." These maps offer a visual representation of communities in the service area where poorer health outcomes were more likely to be present.

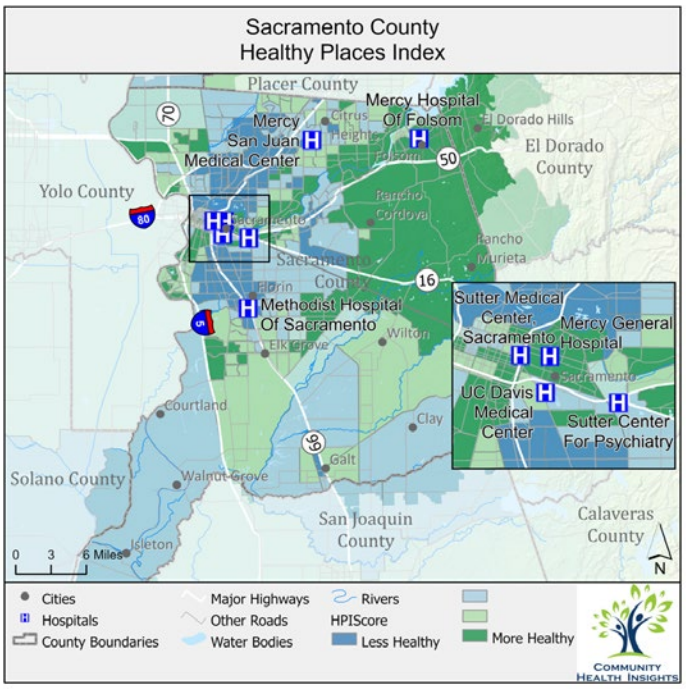


Figure 3: Healthy Places Index for Sacramento County.

The HPI map is presented in Figure 3 for Sacramento County. (HPI maps are also presented for each region in later sections of this report.) Maps displaying the additional indices can be found in the appendices of this report.

In the figure, census tracts that are shaded with darker blue are those with less healthy conditions, according to the index. These communities are in the western portion of the county and are concentrated around the southern Highway 99 and northern Interstate 80 corridors. A smaller area is located centrally in the county along Highways 50 and 16.

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

14 Centers for Disease Control and Prevention and the Agency for Toxic Substances and Disease Registry. (2024). *Social Vulnerability Index*. Retrieved 6 December 2024 from **https://www.atsdr.cdc.gov/place-health/php/svi/index.html**.

15 Vizient, Inc. 2024. *Vizient Vulnerability Index, Public Access*. Retrieved 6 December 2024 from **https://www.vizientinc.com/what-we-do/health-equity/vizient-vulnerability-index-public-access**.

Communities of Concern — Sacramento County

Communities of Concern are geographic areas in Sacramento County that have the greatest concentration of poor health outcomes and are home to more medically underserved, low-income, and diverse 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 area likely experiencing the greatest health disparities. Geographic Communities of Concern were identified using a combination of primary and secondary data sources. (Refer to the Technical Section of this report for an in-depth description of how these are identified).

A total of 56 ZIP Codes were included in this assessment, and 20 of these met the requirements to be included as a Community of Concern. The total population within these communities was approximately 750,000 residents, representing 46% of the total population in the service area. These communities are displayed in Figure 4 .

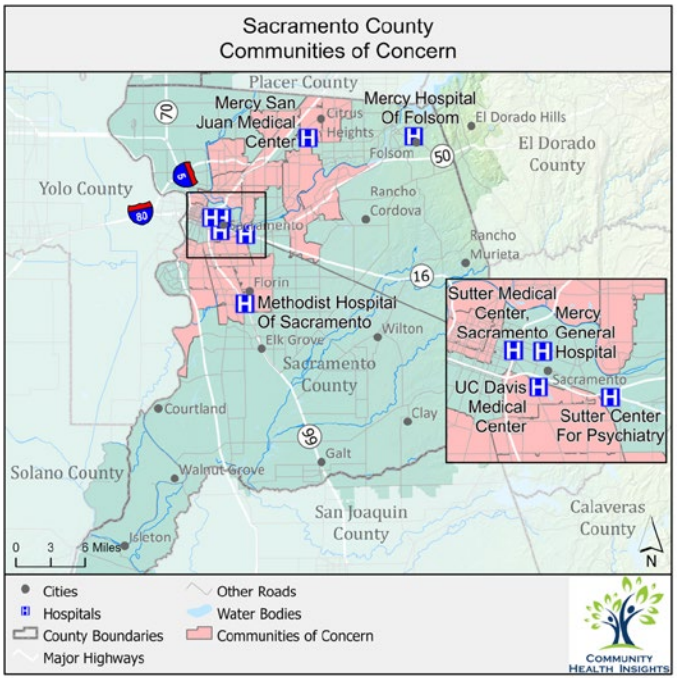


Figure 4: Communities of Concern for Sacramento County.

Findings for Each Region

Prioritized Significant Health Needs by Region

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

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

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

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

~The health need was not identified for this region.

Northeast Region

The total population of the Northeast Region was 562,808. Population characteristics for each ZIP Code in the region are presented in Table 3. These are compared to the state and county for descriptive purposes. Any ZIP Code with values that compared negatively is highlighted.

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

ZIP Code	Total Population	% Hispanic\Latinx or Non-White	Median Age (yrs.)	Median Income	% Poverty	% Unemployment	% Uninsured	% Without High School Graduation	% With High Housing Costs	% With Disability
95608	63,715	35.0	42.8	$79,371	12.4	5.3	5.1	7.3	39.1	14.9
95610	46,219	30.7	36.8	$75,370	10.3	6.3	6.8	8.8	41.6	15.6
95621	42,089	34.4	39.4	$74,573	10.3	6.3	7.1	9.9	37.8	14.8
95628	44,256	27.5	43.0	$110,012	8.3	5.6	4.0	4.8	30.8	11.6
95630	76,599	41.9	40.0	$134,844	5.3	5.0	3.1	2.9	28.9	8.3
95655	4,954	49.1	33.6	$123,893	10.6	4.7	0.9	4.1	20.7	5.1
95662	32,436	26.6	42.1	$92,507	9.0	4.8	4.1	5.7	32.6	11.7
95670	59,449	48.8	37.0	$86,905	11.3	5.6	4.2	10.5	34.8	15.9
95671	4,478	81.7	39.6	$157,857	0.0	0.0	0.0	39.8	0.0	0.0
95683	6,330	33.6	55.2	$128,264	3.8	3.4	0.8	5.0	22.5	12.4
95742	14,883	58.4	36.9	$149,613	3.6	5.0	1.7	4.1	25.3	10.3
95821	37,436	48.4	38.6	$56,019	17.3	9.9	5.3	13.1	47.9	13.8
95825	37,310	62.8	32.6	$56,604	28.2	8.0	8.4	12.6	50.9	13.6
95827	21,084	53.3	35.4	$80,810	11.8	6.0	7.6	11.4	35.5	14.0
95864	25,728	30.3	43.8	$123,535	9.6	4.7	2.7	4.7	32.4	12.9
Sacramento	1,579,211	57.8	36.8	$84,010	13.1	6.3	5.2	11.6	37.4	12.3
95762	45,842	29.5	45.2	$162,464	4.4	3.5	1.2	2.4	27.1	7.7
El Dorado	191,713	24.5	46.2	$99,246	8.6	4.6	4.2	5.3	34.6	12.3
California	39,356,104	64.8	37.3	$91,905	12.1	6.4	7.1	15.6	39.9	11.0

Source: 2022 American Community Survey 5-year estimates; U.S. Census Bureau.

Community Vulnerability for the Northeast Region

Figure 5 displays the HPI values for the Northeast Region. (The SVI and VVI values for this region can be viewed in Appendix A).

Areas with the darkest blue shading in Figure 5 have the lowest overall HPI scores, indicating factors leading to less healthy neighborhoods. There are likely to be a higher concentration of residents in these locations experiencing health disparities.

Communities of Concern

Geographic Communities of Concern were identified for the Northeast Region 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 seven ZIP Codes that met the criteria to be classified as Communities of Concern. These are noted in Table 4 with the census population provided for each and are displayed in Figure 6.

Figure 6 displays the ZIP Codes highlighted in pink that are Communities of Concern for the Northeast Region.

Table 4: Identified Communities of Concern for the Northeast Region.

ZIP Code	Community\Area	Population
95608	Carmichael	63,715
95610	Citrus Heights	46,219
95621	Citrus Heights, Antelope	42,089
95670	Rancho Cordova	59,449
95821	Arden Arcade, North Highlands	37,436
95825	Arden Arcade, North Highlands	37,310
95827	Rancho Cordova, Rosemont	21,084
Total Population in Communities of Concern		307,302
Total Population in Hospital Service Area		562,808
Percentage of Service Area Population in Community of Concern		54.6%

Source: 2022 American Community Survey 5-year estimates; U.S. Census Bureau.

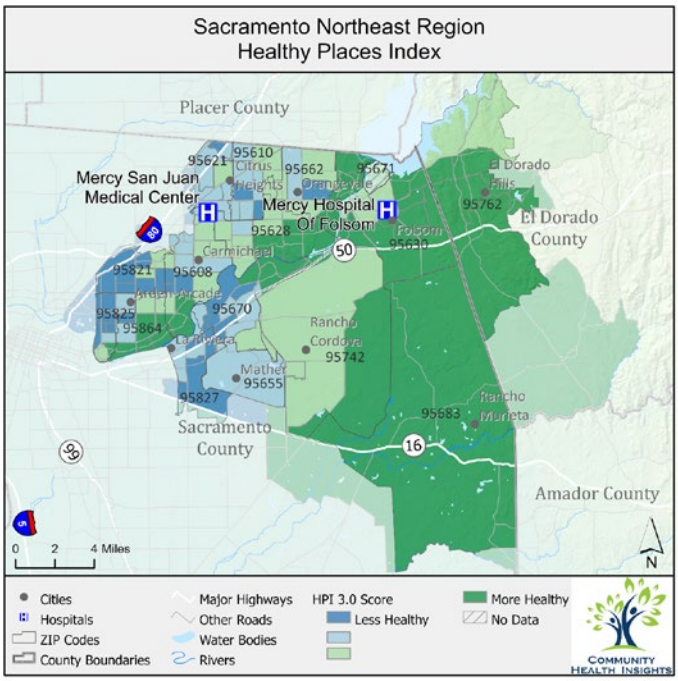


Figure 5: Healthy Places Index for the Northeast Region.

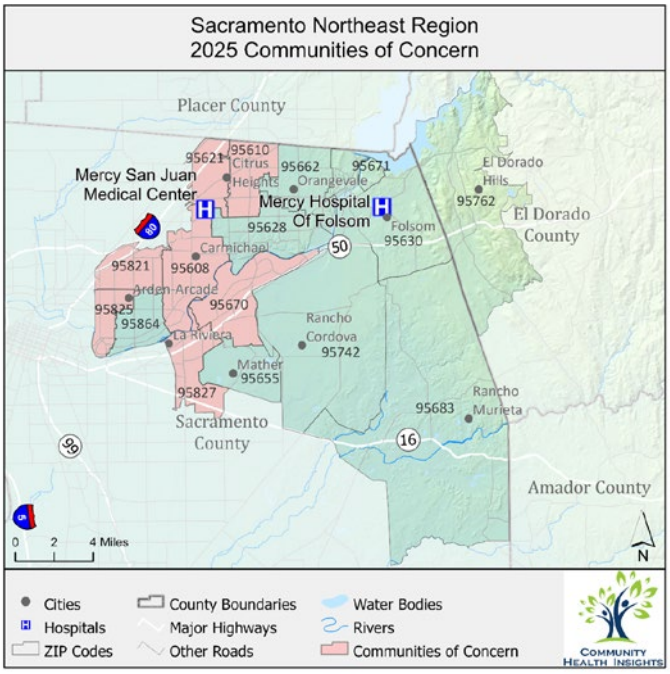


Figure 6: Communities of Concern for the Northeast Region.

Northwest Region

The total population of the Northwest Region was 347,570. Population characteristics for each ZIP Code in the service area are presented in Table 5. These are compared to the state and county characteristics for descriptive purposes. Any ZIP Code with values that compared negatively is highlighted.

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

ZIP Code	Total Population	% Hispanic\ Latinx or Non-White	Median Age (yrs.)	Median Income	% Poverty	% Unemployment	% Uninsured	% Without High School Graduation	% With High Housing Costs	% With Disability
95626	5,845	37.1	44.6	$89,395	10.1	3.7	5.8	8.4	37.8	12.4
95652	1,193	71.0	20.9	$24,766	45.7	2.9	0.9	10.3	52.7	9.5
95660	35,458	56.6	32.9	$63,429	19.6	5.6	9.0	18.4	42.4	11.7
95673	16,665	35.8	36.6	$88,866	13.2	4.9	4.4	11.8	33.1	11.7
95815	26,523	72.3	33.3	$54,747	23.7	9.1	7.7	22.5	48.3	13.9
95833	40,908	73.5	35.1	$82,694	9.9	4.5	5.8	11.6	38.1	11.7
95834	34,892	78.1	34.0	$93,684	13.3	5.6	4.4	10.7	39.4	8.9
95835	40,957	70.1	38.4	$114,201	4.5	3.6	2.5	6.2	33.9	8.0
95837	306	3.3	50.6	$121,563	13.1	7.8	10.1	7.5	36.2	18.6
95838	41,311	79.8	32.4	$58,253	20.0	8.6	9.8	23.0	50.7	13.1
95841	21,542	42.1	34.6	$62,697	16.2	5.2	8.5	7.7	45.7	11.1
95842	34,775	52.6	33.0	$64,269	19.1	8.0	6.2	12.6	45.4	14.2
95843	47,195	43.2	35.7	$92,336	10.2	6.8	5.8	11.0	35.4	11.1
Sacramento	1,579,211	57.8	36.8	$84,010	13.1	6.3	5.2	11.6	37.4	12.3
California	39,356,104	64.8	37.3	$91,905	12.1	6.4	7.1	15.6	39.9	11.0

Source: 2022 American Community Survey 5-year estimates; U.S. Census Bureau.

Community Vulnerability for the Northwest Region

Figure 7 displays the HPI values for the Northwest Region. (The SVI and VVI values for this region can be viewed in Appendix B).

Areas with the darkest blue shading in Figure 7 have the lowest overall HPI scores, indicating less healthy neighborhood conditions. There are likely to be a higher concentration of residents in these locations experiencing health disparities.

Communities of Concern

Geographic Communities of Concern were identified for the Northwest Region 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 four ZIP Codes that met the criteria to be classified as Communities of Concern. These are noted in Table 6 with the census population provided for each and are displayed in Figure 8.

Table 6: Identified Communities of Concern for the Northwest Region.

ZIP Code	Community\Area	Population
95660	North Highlands	35,458
95815	North Sacramento	26,523
95838	Del Paso Heights	41,311
95842	Arden Arcade, North Highlands, Foothill Farms	34,775
Total Population in Communities of Concern		138,067
Total Population in Hospital Service Area		347,570
Percentage of Service Area Population in Community of Concern		39.7%

Source: 2022 American Community Survey 5-year estimates; U.S. Census Bureau.

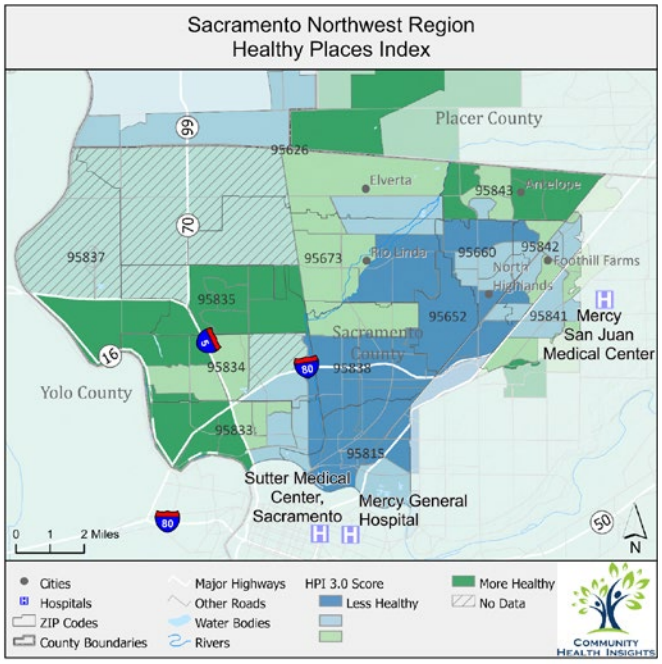


Figure 7: Healthy Places Index for the Northwest Region.

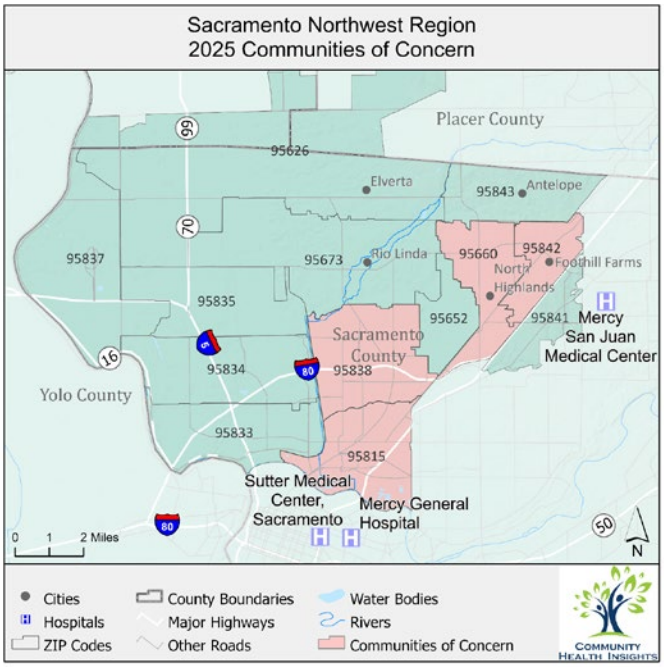


Figure 8: Communities of Concern for the Northwest Region.

Figure 8 displays the ZIP Codes highlighted in pink that are Communities of Concern for the Northwest Region.

Central Region

The total population of the service area was 172,648. Population characteristics for each ZIP Code in the service area are presented in Table 7. These are compared to the state and county characteristics for descriptive purposes. Any ZIP Code with values that compared negatively to the state is highlighted.

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

ZIP Code	Total Population	% Hispanic\Latinx or Non-White	Median Age (yrs.)	Median Income	% Poverty	% Unemployment	% Uninsured	% Without High School Graduation	% With High Housing Costs	% With Disability
95811	8,456	49.4	32.4	$75,826	20.9	4.3	6.9	7.3	35.4	14.0
95814	12,248	51.6	36.0	$44,537	27.9	6.2	5.2	11.8	52.1	25.3
95816	18,334	30.3	34.6	$83,933	9.9	3.4	5.6	2.6	34.4	9.5
95817	14,513	57.6	33.8	$60,362	21.9	8.5	4.8	9.4	43.8	15.7
95818	23,062	42.7	40.0	$113,733	12.2	5.1	2.3	6.9	28.5	8.4
95819	19,806	33.8	37.5	$124,916	6.8	6.5	2.0	2.9	25.9	7.2
95820	36,024	68.5	35.3	$64,501	19.8	6.8	8.9	18.7	41.1	14.0
95826	40,205	54.3	33.9	$77,685	16.3	6.4	4.5	6.7	36.5	14.4
Sacramento	1,579,211	57.8	36.8	$84,010	13.1	6.3	5.2	11.6	37.4	12.3
California	39,356,104	64.8	37.3	$91,905	12.1	6.4	7.1	15.6	39.9	11.0

Source: 2022 American Community Survey 5-year estimates; U.S. Census Bureau.

Community Vulnerability for the Central Region

Figure 9 displays the HPI values for Central Region. (The SVI and VVI values for this region can be viewed in Appendix C).

Areas with the darkest blue shading in Figure 9 have the lowest overall HPI scores, indicating less healthy neighborhood conditions. There are likely to be a higher concentration of residents in these locations experiencing health disparities.

Communities of Concern

Analysis of both primary and secondary data revealed four ZIP Codes that met the criteria to be classified as Communities of Concern. These are noted in Table 8, with the census population provided for each, and are displayed in Figure 10.

Figure 9: Healthy Places Index for the Central Region.

Table 8: Identified Communities of Concern for the Central Region.

ZIP Code	Community\Area	Population
95811	Downtown Sacramento	8,456
95814	Downtown Sacramento	12,248
95817	Oak Park	14,513
95820	Oak Park, Tahoe Park	36,024
Total Population in Communities of Concern		71,241
Total Population in Hospital Service Area		172,648
Percentage of Service Area Population in Community of Concern		41.3%

Source: 2022 American Community Survey 5-year estimates; U.S. Census Bureau.

Figure 10 displays the ZIP Codes highlighted in pink that are Communities of Concern for the Central Region.

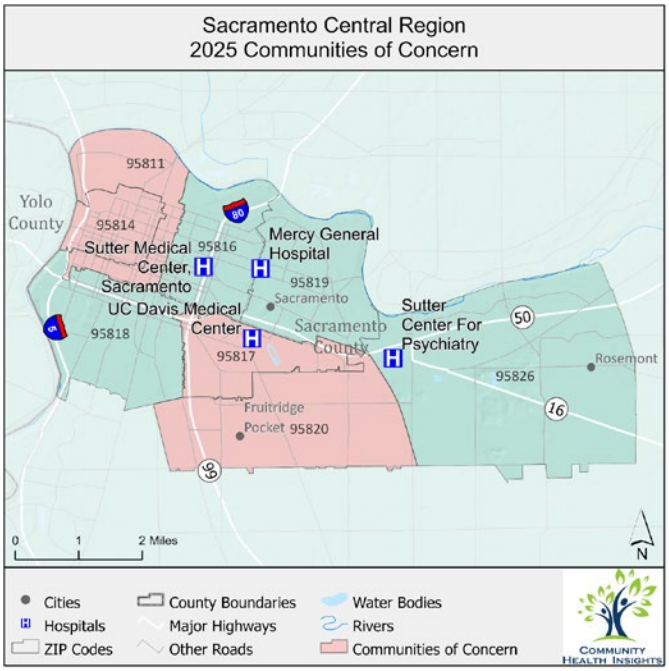


Figure 10: Central Region Communities of Concern.

South Region

The total population of the South Region was 543,406. Population characteristics for each ZIP Code in the service area are presented in Table 9. These are compared to the state and county characteristics for descriptive purposes. Any ZIP Code with values that compared negatively is highlighted.

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

ZIP Code	Total Population	% Hispanic\Latinx or Non-White	Median Age (yrs.)	Median Income	% Poverty	% Unemployment	% Uninsured	% Without High School Graduation	% With High Housing Costs	% With Disability
95615	1,147	52.2	48.8	$67,633	7.1	0.0	2.4	3.5	24.4	9.8
95624	67,915	60.9	38.1	$114,558	7.9	6.7	3.3	10.9	30.6	10.1
95632	31,217	53.1	39.0	$91,315	7.3	7.0	5.3	16.6	28.6	12.3
95638	2,246	33.7	50.6	$94,167	8.6	7.1	6.1	6.3	32.4	17.7
95639	314	93.9	45.2	~	15.0	11.5	0.0	0.0	56.9	4.8
95641	1,517	33.2	53.8	$52,035	25.6	13.7	5.4	11.4	33.8	19.4
95680	9	~	~	~	~	~	~	~	100.0	100.0
95690	1,621	55.6	33.0	$71,250	17.6	6.4	9.4	13.9	35.2	9.1
95693	7,624	35.2	50.0	$136,411	5.9	2.1	2.8	4.1	19.1	12.0
95757	53,232	78.3	37.7	$128,216	10.0	4.5	2.1	8.2	33.8	7.8
95758	66,153	70.4	39.3	$102,306	10.3	7.5	2.6	9.4	33.4	11.7
95822	46,413	73.2	37.3	$76,774	12.5	7.2	5.8	14.3	33.4	11.8
95823	82,983	87.3	31.8	$59,547	19.8	8.7	6.5	24.2	48.5	13.9
95824	30,556	84.5	32.3	$50,387	25.3	7.0	8.5	32.1	44.7	16.0
95828	60,850	83.4	35.6	$74,493	15.0	7.9	6.3	21.9	37.0	13.0
95829	31,297	73.6	36.7	$111,523	12.8	5.0	3.8	13.2	34.7	11.1
95830	746	53.6	48.2	$130,139	13.4	0.0	1.5	21.4	41.0	20.8
95831	44,450	68.4	42.1	$93,449	8.4	5.3	3.7	5.5	32.8	12.2
95832	13,116	88.0	30.9	$75,071	19.5	13.2	5.4	24.2	41.9	12.0
Sacramento	1,579,211	57.8	36.8	$84,010	13.1	6.3	5.2	11.6	37.4	12.3
California	39,356,104	64.8	37.3	$91,905	12.1	6.4	7.1	15.6	39.9	11.0

Source: 2022 American Community Survey 5-year estimates; U.S. Census Bureau.

Community Vulnerability for the South Region

Figure 11 displays the HPI values for the South Region. (The SVI and VVI values for this region can be viewed in Appendix D).

Areas with the darkest blue shading in Figure 11 have the lowest overall HPI scores, indicating less healthy neighborhood conditions. There are likely to be a higher concentration of residents in these locations experiencing health disparities.

Communities of Concern

Analysis of both primary and secondary data revealed five ZIP Codes that met the criteria to be classified as Communities of Concern for the South Region. These are noted in Table 10, with the census population provided for each, and are displayed in Figure 12.

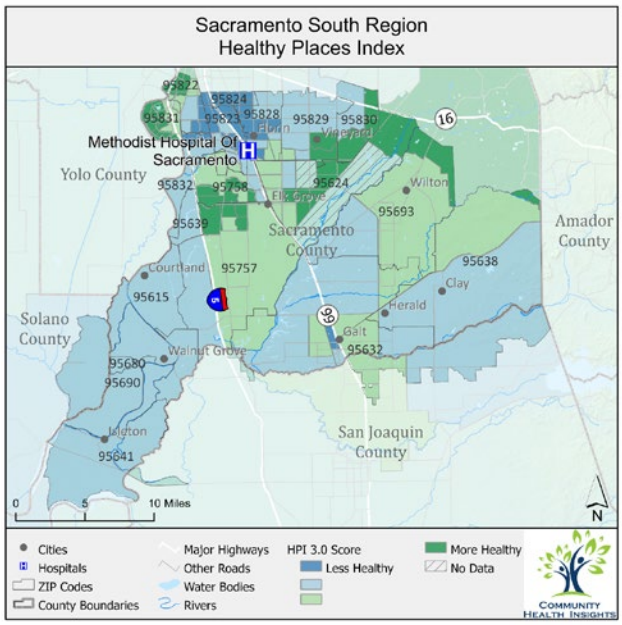


Figure 11: Healthy Places Index for the South Region.

Table 10: Identified Communities of Concern for the South Region.

ZIP Code	Community\Area	Population
95822	South Sacramento	46,413
95823	South Sacramento	82,983
95824	South Sacramento	30,556
95828	South Oak Park, South Sacramento	60,850
95832	Meadowview, Freeport	13,116
Total Population in Communities of Concern		233,918
Total Population in Hospital Service Area		543,406
Percentage of Service Area Population in Community of Concern		43%

Source: 2022 American Community Survey 5-year estimates; U.S. Census Bureau.

Figure 12 displays the ZIP Codes highlighted in pink that are Communities of Concern for the South Region.

Figure 12: South Region Communities of Concern.

Health Equity

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

"*Health equity means that everyone has a fair and just opportunity to be healthier. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.*"[16]

Inequities experienced early and throughout one's life, such as limited access to housing or healthcare, have health consequences that appear later in life as health disparities. Health disparities are defined as "preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health experienced by populations, and defined by factors such as race or ethnicity, gender, education or income, disability, geographic location or sexual orientation."[17]

In the US, including Sacramento County, inequities become apparent when comparing various racial and ethnic groups to one another. This section of the report shows inequities in health factors and outcomes, comparing these between race and ethnic groups. Understanding this data provides an opportunity to explore and seek to address the underlying sources of health disparities.

Health Outcomes — The Results of Inequity

Table 11 displays disparities among race and ethnic groups for the HSA for life expectancy, mortality, and low birthweight.

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

Health Outcomes	Description	American Indian\ Alaska Native	Asian	Black	Hispanic	Native Hawaiian\ Pacific Islander	White	Overall County
Child Mortality	Number of deaths among residents under age 18 per 100,000 population.	~	27.3	91.8	42.1	75.7	42	46.8
Infant Mortality Rate	Number of infant deaths (within 1 year) per 1,000 live births.	~	3.2	9.6	5.7	~	3.8	4.9
Life Expectancy	Average number of years people are expected to live.	76.3	83.4	72.6	80.4	78.8	77.9	78.4
Low Birthweight	Percentage of live births with low birthweight (< 2,500 grams).	6.9%	8.2%	11.9%	6.7%	9.6%	5.3%	7.1%
Premature Age-Adjusted Mortality	Number of deaths among residents under age 75 per 100,000 population (age-adjusted).	478.0	228.9	624.0	308.1	476.2	371.5	361.8
Premature Death	Years of potential life lost before age 75 per 100,000 population (age-adjusted).	10,645.6	4,327.2	13,792.6	6,284.6	10,956.2	7,350.0	7,324.6

~ Data Not Available
Data sources included in the Technical Section of the report.

When comparing health outcome data across race and ethnic groups, disparities are apparent. For example, pre-mature age adjusted mortality for Blacks was over twice the rate than the lowest group – Hispanics. Also, the infant mortality rate for Blacks was three times higher than the lowest group – Asians.

16 Robert Wood Johnson Foundation. (2017). What is Health Equity? And What Difference Does a Definition Make? Health Equity Issue Brief #1. Retrieved 18 July 2024 from https://buildhealthyplaces.org/content/uploads/2017/05/health_equity_brief_041217.pdf.

17 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 Factors — Inequities in the Service Area

Inequalities can be seen in data that help describe health factors in the service area, such as education attainment and income. These health factors are displayed in Table 12, Table 13, and Table 14.

Table 12: Injury-related health factors comparing race and ethnicity in the Sacramento County service area.

Health Factors	Description	American Indian\ Alaska Native	Asian	Black	Hispanic	Native Hawaiian\ Pacific Islander	White	Overall County
Juvenile Felony Arrests	Felony juvenile arrests per 1,000 juveniles.	~	~	8.1	1.1	~	0.8	1.5
Firearm Fatalities	Number of deaths due to firearms per 100,000 population.	~	4.2	24.0	7.6	~	10.2	9.9
Injury Mortality[a]	Number of deaths due to injury per 100,000 population.	89.7	33.4	113.7	48.9	47.0	85.4	68.7
Motor Vehicle Crash Deaths	Number of motor vehicle crash deaths per 100,000 population.	~	5.7	21.5	10.5	11.4	13.1	11.9
Homicides[b]	Number of deaths due to homicide per 100,000 population.	~	3.6	23.9	6.0	~	3.9	6.4
Suicides[c]	Number of deaths due to suicide per 100,000 population (age-adjusted).	~	6.6	7.8	7.9	~	16.8	12.3
Drug Overdose Deaths[d]	Number of drug poisoning deaths per 100,000 population.	~	4.3	47.7	16.2	~	31.3	23.6

~ Data Not Available

Unless otherwise noted, data sources included in the Technical Section of the report.

[a]From County Health Rankings: National Center for Health Statistics - Mortality Files; Census Population Estimates Program, 2017–2021

[b]From County Health Rankings: National Center for Health Statistics - Mortality Files; Census Population Estimates Program, 2015–2021

[c]From County Health Rankings: National Center for Health Statistics - Mortality Files; Census Population Estimates Program, 2017–2021

[d]From County Health Rankings: National Center for Health Statistics - Mortality Files; Census Population Estimates Program, 2019–2021

Injury-related health factor data revealed disparities among groups. For example, firearm fatalities for Blacks were nearly six times greater that the group with the lowest rate – Asians. Suicides were highest among Whites with a rate over twice that of all other groups.

Table 13: Education and income-related health factors comparing race and ethnicity in the Sacramento County service area.

Health Factors	Description	American Indian\ Alaska Native	Asian	Black	Hispanic	Native Hawaiian\ Pacific Islander	White	Overall County
High School Completion[a]	'Percentage of adults ages 25 and over with at least a high school diploma or equivalent.'	81.7%	83.1%	91.4%	76.7%	~	94.5%	88.4%
Math Scores	Average grade level performance for 3rd graders on math standardized tests.	~	3.0	2.1	2.4	~	2.9	2.7
Reading Scores	Average grade level performance for 3rd graders on English Language Arts standardized tests.	~	3.1	2.3	2.6	~	3.1	2.8
Some College[a]	Percentage of adults ages 25 and over with some post-secondary education.	52.8%	65.0%	66.4%	50.3%	~	73.6%	66.5%
Median Household Income	The income where half of households in a county earn more and half of households earn less.	$73,017	$93,760	$61,476	$73,735	~	$90,847	$83,985
Children in Poverty	Percentage of people under age 18 in poverty.	16.8%	19.9%	27.0%	20.5%	~	9.6%	15.4%
Uninsured Population[b]	Percentage of the civilian non-institutionalized population without health insurance.	8.1%	4.0%	4.4%	8.8%	~	3.8%	5.2%
Homelessness Rate	Number of homeless individuals per 100,000 population.	5,759.2	81.3	1,912.3	492.1	814.3	548.9	587.7

~ Data Not Available
Unless otherwise noted, data sources included in the Technical Section of the report.
[a]From 2022 American Community Survey 5-year estimates tables B15002, C15002B, C15002C, C15002D, C15002H, and C15002I.
[b]From 2022 American Community Survey 5-year estimates table S2701.

When examining education factors across race and ethnic groups, disparities are apparent. For example, high school completion rates for Hispanics were lowest among all other race and ethnic groups. Furthermore, median household income for Asians was over 30% higher than the lowest income group — Hispanics.

Table 14: Clinical-related health factors comparing race and ethnicity in the Sacramento County service area.

Health Factors	Description	American Indian\ Alaska Native	Asian	Black	Hispanic	Native Hawaiian\ Pacific Islander	White	Overall County
Preventable Hospital Stays[a]	Rate of hospital stays for ambulatory-care sensitive conditions per 100,000 Medicare enrollees.	3,974	2,024	3,570	2,538	~	2,463	2,527
Mammography Screening	Percentage of female Medicare enrollees ages 65-74 who received an annual mammography screening.	25%	31%	31%	28%	~	39%	36%
Teen Births	Number of births per 1,000 female population ages 15–19.	12.3	4.5	20.0	17.9	15.5	7.0	12.5

~ Data Not Available
Unless otherwise noted, data sources included in the Technical Section of the report.
[a]From County Health Rankings: Mapping Medicare Disparities Tool, 2021

Disparities were apparent when comparing clinical related health factors among race and ethnic groups. For example, the teen births rate for Blacks was nearly four times higher than that of Asians.

Population Groups Experiencing Disparities

The figure below describes populations in the Sacramento County service area identified through qualitative data analysis that were experiencing health disparities. Interview participants were asked, "What specific groups of community members experience health issues the most?" Responses were analyzed by counting the total number of times all key informants and focus-group participants mentioned a particular group as one experiencing disparities. Figure 13 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.

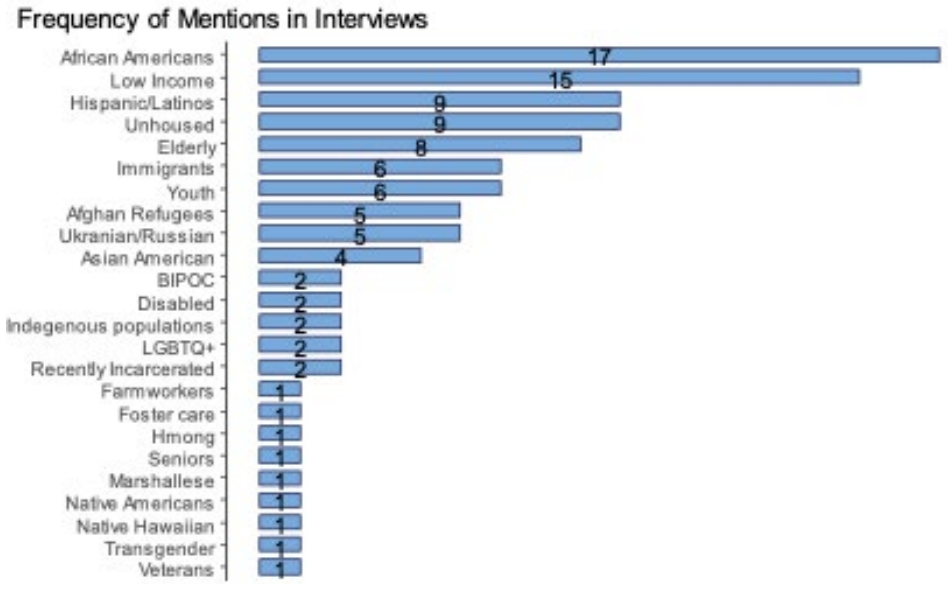


Figure 13: Populations experiencing disparities in the Sacramento County service area.

The Impact of Climate-related Extreme Events on Health Needs

Climate change can be defined as "a long-term change in the average weather patterns that have come to define Earth's local, regional and global climates."[18] Climate-related extreme events include floods, drought, wildfires, extreme temperatures, and storms. The *Fifth National Climate Assessment*[19] notes that these events can have negative impacts on community health, resulting in higher rates of heat-related morbidity and mortality, higher incidences of infectious and vector-borne diseases, and declines in food and water security. Furthermore, these outcomes disproportionately impact more vulnerable populations, worsening social inequities. Emissions reductions, effective adaptation measures, and climate-resilient health systems can protect human health and improve health equity.

This CHNA examined the impact of climate on health needs from several perspectives. First, key informants were asked: "In the past three years has anyone in the community you serve been impacted by any of the following climate hazard events: extreme heat, wildfire, drought, extreme rainfall, and/or other (e.g., air/water quality, loss of power, insect infestations)? If so, describe the event and its impact." In the majority of key informant interviews (79%), respondents reported that extreme climate events had impacted the communities they served and described the effects.
The following themes were extracted from the notes taken to describe these observations.

Extreme Heat

- Severe impact on homeless people, with limited access to cooling centers and free water.
- The high cost of air conditioning affects low-income families, often forcing them to choose between running the AC and affording other necessities.
- Heat leads to fatigue, headaches, and health complications, particularly for those without proper cooling systems.

Flooding and Rainfall

- Heavy rains cause rivers to rise, forcing homeless individuals to relocate frequently.
- Power outages affect neighborhoods differently based on infrastructure investment, particularly impacting areas like Arden Arcade.
- Flooding causes food spoilage due to electricity loss.

Wildfires

- Wildfire smoke worsens air quality, causing respiratory problems, asthma, and allergy flare-ups.
- Fire season increases hospital visits, especially among displaced or affected individuals.

Drought

- Rising water costs, restrictions, and city-imposed penalties create stress for residents.
- Shame associated with using more water than neighbors is common.

Health Impacts

- Climate-related extreme events disproportionately affects low-income areas, exacerbating conditions like asthma, COPD, and cardiovascular disease, especially in communities near freeways and lacking tree cover.

Power Outages

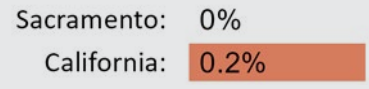
- These affect hospital capacity, making it difficult to discharge patients due to the lack of places for them to go.
- Backup power for medical supplies in homes is limited, posing risks during outages.

18 National Aeronautics and Space Administration (October 21, 2024). What is Climate Change? Retrieved from: https://science.nasa.gov/climate-change/what-is-climate-change/.
19 Crimmins, A.R., C.W. Avery, D.R. Easterling, K.E. Kunkel, B.C. Stewart, and T.K. Maycock, Eds. (2023). Fifth National Climate Assessment. U.S. Global Change Research Program, Washington, DC, USA. Retrieved from: https://doi.org/10.7930/NCA5.2023

Psychosocial Impacts

- Climate anxiety, especially related to extreme weather events, is growing in affected communities, leading to mental health concerns.
- **Environmental Inequities**
- Certain neighborhoods, such as Del Paso Heights, experience more intense heat due to older infrastructure, fewer trees, and limited cooling centers.
- Communities near industrial areas are exposed to poor air quality, potentially causing long-term health problems.

Furthermore, a quantitative assessment was conducted for Sacramento County to measure the effect of climate-related extreme events. These indicators are displayed below and in the Technical Section of this report. In the table data are displayed for the county and compared with the state rate.

Indicators	Description	Sacramento	California	
Drought Frequency	Percentage of weeks a county was shown as in a moderate or more severe drought by the United States Drought Monitor from 2000–2021.	39.0%	40.0%	
Projected Difference in Extreme Heat Days	Projected difference in extreme heat days as compared to the historical period, 2016–2045, RCP 8.5 emissions scenario, 99th percentile temperature threshold.	8.0	7.9	
Projected Difference in Extreme Precipitation Days	Projected difference in extreme precipitation days as compared to the historical period, 2016–2045, RCP 8.5 emissions scenario, 99th percentile precipitation threshold.	0.0	0.3	
Wildfire Probability	Mean annual probability of wildfire burning in 30-meter grid cells within the location.	0.0%	0.2%	

In all, Sacramento County was experiencing the impacts of climate-related extreme events consistent with the state averages.

Resources Potentially Available to Meet the Significant Health Needs

In all, 900 resources were identified in the Sacramento County service area that were potentially available to meet the identified significant health needs. These resources were provided by a total of 325 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 2022 Sacramento County CHNA, verifying that the resources still existed, and then adding newly identified resources into the 2025 CHNA report. Examination of the resources revealed the following number of resources for each significant health need as shown in Table 15.

Table 15: 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	137
Access to Mental/Behavioral Health and Substance Use Services	111
Access to Quality Primary Care Health Services	79
Health Equity	5
System Navigation	58
Safe and Violence-Free Environment	78
Increased Community Connections	175
Access to Specialty and Extended Care	44
Access to Functional Needs	12
Healthy Physical Environment	12
Injury and Disease Prevention and Management	90
Active Living and Healthy Eating	83
Access to Dental Care and Preventive Services	16
Total Resources	900

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

Impact and Evaluation of Actions Taken by Hospital

Regulations require that each hospital's CHNA report include "an evaluation of the impact of any actions that were taken since the hospital facility finished conducting its immediately preceding CHNA to address the significant health needs identified in the hospital facility's prior CHNA(s) (p. 78969)."[20] UC Davis Medical Center invested efforts to address the significant health needs identified in the prior CHNA. Appendix A includes details of those efforts.

Conclusion

CHNAs play an important role in helping nonprofit hospitals and other community organizations determine where to focus community benefit and health improvement efforts, including focusing 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 context to work in collaboration to engage in meaningful community work. Please send any feedback about this CHNA report to **community.relations@health.ucdavis.edu** with "CHNA Comments" in the subject line. Feedback received will be incorporated into the next CHNA cycle.

20 Additional Requirements for Charitable Hospitals; Community Health Needs Assessments for Charitable Hospitals. (Wednesday, December 31, 2014). *Federal Register, 79*:250, 78,954-79,016. Department of the Treasury, Internal Revenue Service.

Appendix A: Impact of Actions Taken by UC Davis Medical Center

The 2022 Implementation Plan addressed many of the significant health needs identified in the UC Davis Medical Center's Community Health Needs Assessment (CHNA). The following is an overview of the actions taken since the last CHNA.

Each Significant Need includes the high-level objectives and strategies UC Davis Health employed to address the goal, as well as their anticipated impact, and the activities conducted under each need.

Significant Need #1: Access to Mental, Behavioral and Substance Use Services

Goal: Increase access to and quality of mental health and substance use services through outpatient community-based programs.	
Objectives/Strategies	**Anticipated Impact**
▪ Provide mental and behavioral health services in the community, focused on vulnerable populations ▪ Conduct research on behavioral health services and substance use treatment options ▪ Support medical residents and advance practice providers through behavioral health training programs ▪ Increase funding support for services focused on populations living in Communities of Concern	▪ Increase community access to high quality mental and behavioral health care and substance use services ▪ Reduce the percentage of residents who experience delays obtaining needed behavioral health and substance use services

Programs & Partners

- Clinicians and residents from UC Davis Health's Department of Psychiatry and Behavioral Sciences deliver psychiatry care services to over 105,0500 patients per year at multiple Sacramento County-run facilities, including the Adult Psychiatric Support Services Clinic, Sacramento County Mental Health Treatment Center (a 50-bed inpatient unit), Sacramento County Health Center and the Mental Health Urgent Care Clinic. They also provide care at the Sacramento County Jail, where they see patients at the 17-bed inpatient unit and deliver intensive outpatient programming to 300 patients and other outpatient programs, and at the Department of State Hospitals — Napa.
  - UC Davis Health provides more than 160 full-time or part-time psychiatrists, psychologists, nurse practitioners, and licensed clinical social workers to work at Sacramento County-operated or funded facilities and the Department of State Hospitals — Napa, providing direct behavioral health services.
  - UC Davis Health supports the need for critical care in the community by prioritizing community-based residency and fellowship placements. Annually, 22 general psychiatry, child psychiatry, combined internal medicine/psychiatry, and family medicine/psychiatry and forensic residents and fellows rotate through a county facility.
- UC Davis Health Psychiatry established a collaboration with the largest community-based health and behavioral health provider in Sacramento, WellSpace Health, to conduct a unique case management program for incarcerated individuals with a mental health or substance use disorder who were ready to engage in services upon release, dubbed the SAFE-T (Sub-Acute Facilitated Engagement and Transitions) Program. Participants meet with a WellSpace Health case manager prior to discharge, and once discharged, the case manager works intensively with the client to develop a tailored multi-component service plan that includes assisting them with linking to existing community resources specific to their needs (housing, food, identification, social services, medical or psychiatric care). If crisis care is needed, the case manager, who is experienced and extremely knowledgeable of community services, acts as a facilitator. From May 2022 to April 2023, 65 individuals received case management in the SAFE-T Program. The pilot SAFE-T Program appeared to have significant effect on the one-year rate of rearrests (17%) and ED visits (3%) as prior studies of the population have estimated rearrests as up to 70% in the one-year period and ED visits as up to 30% in a one-month period. A number of participants entered long term housing (4.6%) and were successfully discharged from the program.

- Given the early success of the program, in April 2024 a $1.5 million federal grant via the Substance Abuse and Mental Health Services Administration (SAMHSA) allowed for the expansion of the program to include an arm for individuals who are defined as “at risk” in terms of mental health or substance use disorders, but not yet ready to engage in case management. For those individuals, the UC Davis Co-Lab created a SAFE-T Program “App”, that provides a digitized version of the resources available in an easily accessible form. In addition, individuals are reassessed for their readiness to engage by follow up text message two days, five days, one week and two weeks after release; if potential participants indicate that this has changed in a positive way, they are linked with the SAFE-T Case Management program. The SAMHSA grant also allowed for an expansion of the SAFE-T Program for case management of additional individuals; between April-October 2024, an additional 57 recently incarcerated persons have participated in intensive case management.

- UC Davis Health’s Early Psychosis Programs are nationally recognized for early psychosis care and offer expertise in state-of-the-art assessments and evidence-based practices for early identification and intervention for psychotic disorders. Eligible patients and their families receive individualized, comprehensive, multidisciplinary treatment that includes medical and pharmacological treatment, case management, individual and group therapy, substance abuse treatment and supported employment/education. After two years of comprehensive care, patients are transitioned into treatment in community settings. In FY 2024, the SacEDAPT program served 130 clients and families from diverse backgrounds through a contact with Sacramento County.

- Launched in 2018 and initially supported with funding through the Department of Health Care Services (DHCS)’s CA Bridge Program, UC Davis Health connects people with substance use disorders to Medication-Assisted Treatment (MAT) in the emergency department and links them to ongoing treatment at Federally Qualified Health Centers in the community. This model of care treats substance use disorders like any other life-threatening illness – by providing life-saving treatment along with access to care. UC Davis Health was one of the first CA Bridge pilot sites. UC Davis Health continues to provide MAT and other critical services to people with substance use disorders in the ED and inpatient settings. Between January 2022 and September 2024, more than 15,000 individuals were seen by UC Davis Health’s substance use intervention team. The team facilitates treatment in both inpatient and outpatient settings with a focus on connections to outpatient treatment. The team is launching a telehealth Bridge Clinic to provide further support for patients and ensure they do not fall through the cracks. The team also provides ongoing technical assistance to partners in Sacramento, including the Sacramento County Juvenile Detention Center and Sacramento State Student Wellness Center for MAT for youth and young adults with opioid use disorder.

- Supporting Stable Reunification for Children in Foster Care: A brief parenting intervention, Parent-Child Care (PC-CARE), was developed at UC Davis Child and Adolescent Abuse Resource and Evaluation Center (CAARE Center) as a six-session dyadic treatment program for families with children ages 1-10 years old. The purpose of this project was for CAARE Center staff to provide PC-CARE to parents and children participating in CPS reunification services. Since January 2022 CAARE Center screened 279 children and provided PC-CARE to 173 children and their caregivers. During this time, the following outcomes were observed:

  - Retention rate – Approximately 80% of parents agreed to participate in PC-CARE and 73% of caregivers and children completed the intervention once they began.
  - Significant reductions in child behavior problems and trauma symptoms, increases in parent skills – Comparisons of pre and post-intervention assessments revealed statistically significant changes in these meaningful outcome measures.
  - Effective reunification – At the one-month mark, for the 123 families that were available for follow-up, 66% were in the same placement, 33% reunified with parents, and 1% changed foster placements. Out of the 92 children for whom we have placement information at 6 months after completing PC-CARE, 50% had reunified with their parents and 39% were in the same foster placement. Of the children reunified 1 month after PC-CARE, 88.5% were still with their parents 6-months after PC-CARE.

- Parenting Skills into a Community of Care for Children Exposed to Trauma: Training in PC-CARE and PC-CARE Toolbox. This project is designed to expand the workforce able to provide PC-CARE by training community providers to provide this brief parenting intervention, increasing families' access to needed mental health services. This free training is offered to licensable mental health providers and non-licensable providers such as community health workers, family navigators, peer support workers, and case managers. Between January 2022 and October 2024, 756 people received PC-CARE Training and 106 people were certified as providers.
- Resources, Education, Advocacy and Counseling for Homeless (REACH) Families therapists provide trauma-informed onsite mental health and navigation services to children and families experiencing homelessness at the Mustard Seed School, St. John's Program for Real Change and the Volunteers of America Bannon Street Shelter. The program works with partners to identify needs of children with social skills, crisis counseling and mental health services, as well as screening for symptoms of trauma. A family navigator assists families with obtaining housing and connecting with key community services. Between January 2022 and October 2024, the REACH Families program served 539 children and families.
- The UC Multi-Campus Psychiatric Mental Health Nurse Practitioner (PMHNP) program, administered by the Betty Irene Moore School of Nursing at UC Davis, welcomed the first cohort of students to the multicampus UC PMHNP graduate academic certificate program in 2021. Since that time, 112 PMHNPs have graduated from the program. Licensed nurse practitioners participate in course work and clinical experiences that allow them to qualify for a national board certification exam, enabling them to become board-certified PMHNPs and care for psychiatric and mental health patients in their local communities. Local clinical rotation sites include Communicare+OLE and Sacramento behavioral health facilities, as well as rural Central Valley locations.
- UC Davis Health provided a grant to Opening Doors in 2023 to help bridge the health equity gap in mental health counseling access. Through the grant Opening Doors was able to partner with three providers with experience in serving the Sacramento newcomer community. Combined, all three therapy providers speak several languages including Dari, Pashto, Farsi, Arabic, Spanish, Urdu, and English. Clients were linked to a mental health counseling provider based on native language, location preference and provider capacity. A total of 33 clients attended six, biweekly counseling sessions over a span of three months.

Significant Need #2: Access to Basic Needs Such as Housing, Jobs and Food

Goal: Promote health by providing access to jobs and healthy food.	
Objectives/Strategies	**Anticipated Impact**
▪ Implement AIM for Community Health local hiring initiatives ▪ Build strong, sustainable relationships with community organizations and community members to co-design solutions to advance community health ▪ Expand career pathway and training programs ▪ Assist local nonprofit organizations addressing food insecurity ▪ Promote access to healthy food choices ▪ Connect patients and community members to resources to address food insecurity ▪ Support UC Davis Health employees as volunteers at local community-based organizations	▪ Increase in percentage of UC Davis Health's workforce that resides in AIM neighborhoods ▪ Residents in AIM neighborhoods are better prepared for well-paying jobs ▪ Increased percentage of AIM neighborhood residents earning a living wage ▪ Residents in Communities of Concern have reduced food insecurity and increased access to healthy foods

Programs & Partners

- Through our AIM for Community Health initiative, UC Davis Health is committed to serving as an economic catalyst that increases the health and well-being of under-resourced Sacramento communities by providing stable, well-paying jobs; stimulating business opportunities; and purchasing local goods and services. UC Davis Health strives to strengthen and expand existing recruitment efforts by supporting robust community outreach in AIM neighborhoods, partnering with Los Rios Community College District to increase pipeline programs and paid internship opportunities, and collaborating with the City of Sacramento and community-based organizations including La Familia Counseling Center, Inc., Greater Sacramento Urban League, Asian Resources, Inc., and People Working Together to increase the health system's workforce from neighboring communities. Human Resources organized more than 65 local outreach activities and events in FY 2024 and hosts quarterly job fairs in partnership with the City of Sacramento, SETA and other organizations. They also launched an in-person "You Belong Here" job talk series to support applicants and foster inclusive recruitment practices. Total new non-licensed hires from 13 AIM communities increased from 14 percent to 20.7 percent between 2021 and 2024. UC Davis Health has also focused on increasing access and networking with its supply chain management team by improving online resources and conducting an annual Small and Diverse Supplier Expo. In FY 2024, UC Davis Health increased local spend by 19 percent compared to the prior FY.
- In spring 2022, the Clinical and Translational Science Center (CTSC) Clinical Trials Office created "Join the Team," a comprehensive Clinical Research Coordinator training program to address the CRC workforce shortage. This program includes shadowing opportunities, on-line self-study, in-person training at interactive workshops, and student stipends. As of October 2024, 27 community trainees in 5 cohorts have successfully graduated from the program, and 21 found jobs in clinical research or healthcare. In 2023, the CTSC received a grant to expand the training to individuals residing in neighboring zip codes to UC Davis Medical Center. This expansion was undertaken in collaboration with the Greater Sacramento Urban League, which facilitated student enrollment and provided wrap-around social support to trainees.
- In 2024, UC Davis Health's Central Sterile Processing Department partnered with La Familia Counseling and Career Center to pilot a Sterile Processing Training Program. UC Davis' Continuing and Professional Education provided program management, curriculum development and classroom education, and Aggie Square provided strategic coordination, program management and classroom space. Sterile processing jobs are expected to see strong growth at healthcare systems throughout the greater Sacramento area and the state. The pilot was funded by the state's CaliforniansForAll program through the City of Sacramento.

- La Familia recruited individuals ages 18–30 from four zip codes close to the UC Davis Health Medical Center and part of the Aggie Square Community Benefits Partnership Agreement. La Familia provided supportive services, including job application assistance and interview training. Two cohorts of six participants attended 10 weeks of classes that prepared them for an intensive, 10-week, 400-hour externship at UC Davis Health, followed by the state's certification exam. Participants received stipends during the classroom portion and externship to remove the financial barriers that often prevent people from low-income backgrounds from gaining access to this high-wage career with excellent promotional opportunities. Eleven participants completed the full program, and of those, at least five have passed the sterile processing certification exam. Four participants have been hired by UC Davis Health to-date.

- As Sacramento's oldest, continuously operating food bank, River City Food Bank's (RCFB) mission is to alleviate hunger in Sacramento County by providing emergency food and other assistance, offering referrals and promoting self-sufficiency. In 2023, RCFB served more than 3 million pounds of healthy food to 308,005 people facing hunger in Sacramento County, a 20 percent increase from the prior year. In 2023, UC Davis Health provided funding for a temporary, part-time CalFresh outreach worker who is fluent in Ukrainian/Russian, as well as program costs associated with the Emergency Food Distribution — Arden Site, including healthy, culturally meaningful food, distribution supplies and transportation. During the grant term, RCFB's CalFresh Outreach team processed 338 applications, provided 739 assists or follow-ups and conducted 8,303 pre-screenings, serving an estimated 14,070 individuals. UC Davis Health continued to support bilingual CalFresh outreach and emergency food access in 2024.

- UC Davis Health has increased social risk factor screening for patients, including patients seen at the Sacramento County Health Center. The Office of Population Health and Accountable Care leverage data to help identify patients who are at risk for food insecurity and connect them to services, including medically tailored meals. As part of this work they engaged with community-based organizations providing food and nutrition services such as the Orangevale Food Bank, Salvation Army and Sacramento Family Food Bank and worked to improve the coordination and referral of patients with food-related needs. Patients enrolled in certain care management programs (Ambulatory Case Management General Care, Chronic Kidney Disease Care Management and High-Risk Primary Care Management) are screened for food insecurity along with other social drivers of health as part of program intake. Preliminary validation on screening rates is ongoing.

- The Food Literacy Center teaches children in Sacramento City Unified School District's low-income elementary schools cooking, nutrition, gardening, and active play to improve health. UC Davis Health provided grants in 2023 and 2024 to produce special projects, including 16 kids' farmers' markets that reach approximately 100 students per market, as well as summer field trips to the Food Literacy Center cooking school and garden for all fifth grade classes in Robla Elementary School District. The farmers' markets celebrate the completion of the 10-week curriculum that is taught in after-school programs. The markets are scheduled before major school breaks to ensure that students who experience food and nutrition insecurity go home with fresh fruits and vegetables.

- UC Davis Health also provided financial support for the Oak Park Farmers' Market, which features a diverse group of vendors selling locally produced fruits and vegetables, breads, cheese, tamales, and more. Since its opening, the market has served an average of 1,500 visitors per week. One third of sales at the market come from CalFresh EBT, and the market is able to provide a match for EBT, allowing customers in this community with a high rate of food insecurity to purchase more. The market also hosts a variety of interactive activities each week to strengthen community connections, including live music, activities for children, and special events such as Celebrate Oak Park.

Significant Need #3: Access to Quality Primary Health Care Services

Goal: Improve access to high quality primary care services.	
Objectives/Strategies	**Anticipated Impact**
▪ Provide comprehensive primary care at the Sacramento County Health Center ▪ Expand primary care services by supporting the region's Federally Qualified Health Centers (FQHCs) ▪ Support programs that train physicians and other health care clinicians who provide primary care in under resourced communities ▪ Provide continuing education programs for primary care clinicians at the region's FQHCs	▪ Increased availability and access to primary and preventive care services ▪ Reduced percentage of community members who delay obtaining needed medical care ▪ Measurable improvement in patient quality health outcomes and provider satisfaction at FQHCs engaging in provider training opportunities

Programs & Partners

- More than 17 full-time equivalent clinical professors from the School of Nursing and faculty physicians from the School of Medicine from the departments of Internal Medicine, Family Medicine, Pediatrics, and Psychiatry provide care at the Sacramento County Health Center. This is a 40 percent increase from 2020, demonstrating UC Davis Health's continued investment in this partnership. They are joined throughout the year by more than 80 residents and fellows completing their clinical training.
  - In FY 2024, the Sacramento County Health Center provided more than 43,000 visits, representing 16,500 unique patients. This is an increase of approximately 25 percent more visits than in FY 2020. The majority of patients are covered by Medi-Cal and about 10 percent are seen in the County's Refugee Health Clinic, which provides comprehensive culturally and linguistically concordant health assessments to newly arriving refugees and asylees.
  - The Clinic at Loaves and Fishes: Internal medicine and family medicine physicians and advance practice clinicians from the School of Nursing provide care to people experiencing homelessness at a clinic site within Loaves and Fishes. In FY 2023 and 2024, 440 patients were seen at the Loaves and Fishes site. Sacramento County also greatly expanded its services to people experiencing homelessness through the addition of a mobile clinic and street medicine services (discussed in Health Equity: Access to Opportunities to Be Healthy).
  - Complex Care Management Clinic: Fourth year Internal medicine and psychiatry residents, and nurse practitioner and/or physician's assistant students, oversee the clinic for Health Net/UC Davis Health Medi-Cal members who have had multiple emergency department or hospital admissions and who need additional support with care coordination and addressing health-related social needs. Under the direction of the lead complex care management physician, the team creates a comprehensive care plan with the patient that addresses medical and mental health conditions and supports patients' health by providing education, improving medication adherence, assisting with appointment scheduling, facilitating transportation and addressing other concerns.
  - CIRCLE Clinic (Comprehensive Integration of Resilience into Child Life Experiences): An integrated pediatric primary care clinic for children and families currently involved in or at-risk of getting involved with child welfare system. This multidisciplinary clinic offers full-scope medical care, as well as mental health care and family resource navigation at every visit. Children with developmental concerns are seen by MIND Institute Developmental Behavioral Pediatrics specialists who are in clinic every week to provide assessment and on-going care. To help preserve placements, all children and their resource caregiver and bio parents are offered PC-CARE, a brief parenting intervention developed at the UC Davis CAARE Center. Since opening in November 2020, the CIRCLE Clinic has seen 321 patients, with 165 active in the program in October 2024; 65 patients were assessed by Developmental Behavioral Pediatricians and 92 received PC-CARE services.

- UC Davis Health also provides primary care services at other FQHCs in the Sacramento region.
  - Building on their legacy as the area's largest HIV services provider, One Community Health is dedicated to providing comprehensive primary, specialty and behavioral health care centered around a patient's unique needs. UC Davis Health family medicine physicians and residents see more than 600 patients at One Community Health sites throughout Sacramento County.
  - Sacramento Native American Health Center (SNAHC) is committed to enhancing quality of life by providing a culturally competent, holistic and patient-centered continuum of care and by partnering with more than 40 community-based organizations to enhance access to social and other service programs. Faculty and residents from the Department of Pediatrics saw more than 1,100 patients at SNAHC annually between 2019 and 2024.
  - UC Davis Health also partners with CommuniCare+OLE Health Centers, a network of FQHCs in Yolo, Napa and Solano counties, that provides comprehensive health care. Faculty members and residents provide care at West Sacramento, Davis, and Woodland clinic sites and see approximately 2,600 patients annually.
- The UC Davis Health departments of Internal Medicine, Family and Community Medicine and Pediatrics offer educational opportunities for medical students, residents and post-doctoral professionals, with a focus on providing diverse community training experiences. The Community Health Scholars (CHS) programs at the School of Medicine train medical student leaders to identify, understand, and serve the unique health needs of California's rural, urban and valley communities. Four, four-year CHS programs, each focused on different communities in California, are offered:
  - Rural and Frontier regions: Rural Program in Medical Education (Rural-PRIME) — UC Davis Rural-PRIME was created in 2007 to train future physician leaders committed to advancing health equity for California's rural communities. Rural PRIME offers medical students immersive clinical training in rural communities, mentorship and networking with rural physicians, and increased training and skills to reduce health inequities in rural communities. Rural PRIME enrolls 8–12 students each year.
  - Native American and Indigenous communities: Tribal Health PRIME — A new academic pathway funded in the 2021 State budget, Tribal Health PRIME aims to provide students with the appropriate knowledge and skills to practice medicine in California's urban, rural and tribal communities. Tribal Health PRIME enrolls 4–6 students each year.
  - Urban Underserved: Transforming Education and Community Health for Medical Students (TEACH-MS) — Launched in 2011, TEACH-MS is a four-year tailored MD program for students with a strong interest in primary care for urban underserved communities. The TEACH-MS program seeks to improve access to effective, culturally respectful and equitable health services for underserved communities by providing rewarding community-based experiences that support interest in primary care among medical students. TEACH-MS enrolls 8 students each year.
  - Central Valley: Reimagining Education to Advance central California Health (REACH) – Launched in 2018, REACH is focused on training physicians to meet the health care workforce needs of California's Central Valley. REACH medical students complete the majority of their clinical training in the Central Valley, in partnership with Kaiser Permanente. REACH enrolls 6–8 students each year.
- The School of Medicine also offers programs that support students prior to medical school entry, as well as a pathway that reduces the amount of time it takes to become a practicing physician:
  - Preparando Estudiantes Para Ser Medicos or Preparing Students to Be Physicians (Prep Mëdico) — In partnership with Kaiser Permanente, UC Davis Health supports this intensive, six-week residential pipeline program for freshmen and sophomore college and community college students from Northern California or the Central Valley who are interested in becoming physicians and who have demonstrated an interest in serving Latino communities.
  - California Medicine Scholars Program (CMSP) AvenueM — CMSP AvenueM is a community college to medical school pathway program that aims to reduce barriers to entry to medical and other health care careers. The UC Davis School of Medicine partnered with three 4-year institutions — UC Davis; California State University, Sacramento; and Cal Poly Humboldt — and a network of community colleges to establish this robust educational

ecosystem for students interested in pursuing medicine and supporting medically underserved communities in Northern California. Avenue M provides support and mentorship to students from economically and educationally disadvantaged backgrounds.

  - Accelerated Competency-based Education in Primary Care (ACE-PC) — The ACE-PC program, a three-year accelerated program in partnership with Kaiser Permanente, allows students to complete their MD education in three years, enter a partner residency well-prepared for internship and begin their primary care practices earlier. Graduating medical school with less debt may also influence their choice of specialty, allowing more students to pursue primary care specialties rather than other more highly paid specialties. ACE-PC enrolls 4–8 students each year.

- For more than 35 years, student-run clinics affiliated with the UC Davis School of Medicine have been operating in the Sacramento neighborhoods, providing free health care to uninsured, low-income and other underserved populations. Operating on weekends, these clinics provide culturally sensitive health care in a respectful and comfortable environment, often in partnership with community-based organizations. Each clinic is overseen by volunteer physicians. Undergraduate students act as interpreters, patient advocates, receptionists and lab workers. These clinics provide more than 8,400 patient care visits annually. To support these visits, the UC Davis Health Pathology Department provided $782,000 in services in FY 2023, which allowed patients to receive needed lab services at the time of their visit at no cost.
- UC Davis Health gives tuition scholarships to clinicians from the Sacramento FQHC network to participate in advanced primary care training through the UC Davis/UC Irvine Train New Trainers Primary Care Psychiatry Fellowship; Train the Trainer: Primary Care Pain Management Fellowship; and Provider Wellness — the Clinician Health and Well-being Fellowship. Collectively, these programs aim to increase primary care providers' ability to care for patients with more complex care needs and allow them to share learnings with their colleagues. State funding became available in 2022 for scholarships for clinicians from FQHCs and practice sites that serve medically underserved patients, reducing the need for UC Davis Health to provide financial support. In 2022–23, four providers from local FQHCs completed the programs through scholarships from UC Davis Health.

Significant Need #4: System Navigation

Goal: Increase referrals to community-based health care and social support services and strengthen the local navigation system.	
Objectives/Strategies	**Anticipated Impact**
▪ Support community-based organizations that provide system navigation and enrollment support services for vulnerable communities ▪ Provide patient navigation services within UC Davis Health ▪ Support community-wide efforts to develop an information exchange platform to improve care coordination	▪ Increased community member linkages to programs addressing health care coverage and social needs ▪ Increased referrals for UC Davis Health patients to community-based social support services ▪ Increased linkages to primary care medical homes for Medi-Cal beneficiaries ▪ Improved care coordination for Medi-Cal beneficiaries, including community members experiencing homelessness ▪ Enhanced capacity of community-based programs

Programs & Partners

- Since its launch in 2020, UC Davis Health's Health Navigator Program has grown significantly in scope and impact. Originally starting with 15 navigators, the program now includes 20 navigators providing vital support across multiple settings. In the Emergency Department (ED), six navigators offer services seven days a week, and nine inpatient navigators assist admitted patients. Five navigators operate within the LINC (Linkage, Integration, and Navigation of Community Resources) initiative, supporting key ambulatory care services. LINC navigators deliver in-person and telephonic post-discharge care coordination, facilitating follow-up appointments, transportation, electronic medical record activation, and referrals to community-based organizations. Between January 2022 and October 2024, the navigation program facilitated more than 58,000 patient encounters, strengthening care transitions for patients and helping them access primary care rather than using the ED.
  - Additionally, to address the need for timely follow-up care, in April 2023 UC Davis Health established the Post Discharge Clinic, a transitional care clinic for high-risk patients unable to see their primary care providers promptly. Health navigators play a crucial role by directly scheduling patients into the clinic, ensuring they receive timely follow-up care while also coordinating additional services within the patient's medical home. Data through September 2024 demonstrates the clinic's impact: high-risk patients discharged from the ED who completed follow-up visits within seven days of discharge had a significantly lower 7-day readmission or revisit rate (8 percent) compared to those who did not (36 percent). By enhancing access to quality care and addressing barriers such as transportation, the program continues to support and improve outcomes for vulnerable patients.
- UC Davis Health hospital-based Substance Use Intervention Teams and Substance Use Navigators in the hospital customize treatment plans for patients and connect patients with local programs and resources (including through the CA BRIDGE Program). Between January 2022 and September 2024, these teams of certified drug and alcohol counselors had 28,766 patient encounters.
- Community HealthWorks focuses on improving the overall health of residents by helping clients address some of the most complicated issues that impact one's health including access to health and behavioral health care, adequate food and housing. Since 2015, UC Davis Health has funded a patient navigator in the emergency department to provide onsite assistance to patients. Navigators are able to establishes immediate rapport with patients, support in mitigating access barriers (e.g., transportation, health coverage, language), schedule appointments, screen for Medi-Cal CalAIM program eligibility and make appropriate referrals. Navigators also provide follow-up to ensure that patients are connected to a primary care physician.
  - The on-site navigator is supported by a desk navigator at Community HealthWorks' offices, who works closely with UC Davis Health's internal health navigators. 2,100 patients were referred to and/or identified by Community HealthWorks navigators for assistance between April 2023 and June 2024. Forty-four percent of patients received

education or help making an appointment, a slight decrease from prior years. This also reflects the challenges navigators have reaching patients by telephone after they leave the emergency department, especially as navigators focus more on patients experiencing homelessness and other harder to reach residents.

- Social workers in the emergency department continue to make referrals to navigators from Bay Area Community Services who provide services through the Sacramento County-funded Crisis Navigation Program and coordinate with the navigators during their visits to the hospital. The Crisis Navigation Program supports people exiting crisis hospitalization to navigate the behavioral health system of care to stabilize and meet ongoing needs for housing/shelter, vocational, legal, benefits, substance use treatment, and other services in the community.
- UC Davis Health participates in efforts led by Sacramento County Department of Health Services to develop a county-wide social health information exchange platform to improve care coordination for Medi-Cal beneficiaries, with a focus on participants receiving CalAIM services, people experiencing homelessness, people involved in the justice system, and people engaged in county mental health programs. In coordination with Sacramento Steps Forward and the other area health systems, UC Davis Health has also worked to improve coordination of housing and health services for people experiencing homelessness by signing a data sharing agreement that allows for the exchange of data between UC Davis Health and the Homeless Management Information System (HMIS) managed by Sacramento Steps Forward. The data sharing agreement will support future collaborative efforts on street medicine and case conferencing.

Significant Need #5: Injury and Disease Prevention and Management

Goal: Reduce preventable injuries and diseases and improve disease management.	
Objectives/Strategies	**Anticipated Impact**
▪ Develop programs that reduce the cancer burden ▪ Increase the use of safety equipment and knowledge of how to prevent childhood injuries ▪ Provide trauma prevention and outreach programs ▪ Conduct research, develop resources and provide training on firearm injury prevention ▪ Provide COVID-19 testing and vaccinations in partnership with community organizations and Sacramento County ▪ Support local cancer, asthma and diabetes nonprofit organizations that provide education and outreach activities, including by providing employee volunteers at local events	▪ Increased diagnosis and treatment of cancers in populations that are historically under-diagnosed ▪ Increased public awareness of ways to prevent injuries ▪ Reduction in preventable injuries, including firearm violence ▪ Increase in vaccination rates and associated decrease in prevalence of COVID-19 in Communities of Concern ▪ Improved chronic disease management skills ▪ Increased number of UC Davis Health employees who volunteer at local events

Programs & Partners

- During 2023–2024, the UC Davis Comprehensive Cancer Center's Office of Community Outreach and Engagement (COE) participated in 172 cancer prevention and screening events reaching almost 12,000 people throughout the 19 counties in the UC Davis Health catchment area. These events include participation in health fairs, community celebrations, speaking engagements, community workshops, screening events, and trainings for health care professionals. Topics covered cancer screenings, modifying behavioral risk factors for cancer, and addressing cancer health inequities in diverse populations. COE maintains relationships with over 70 community partners including FQHCs, faith-based organizations, non-profit agencies, and other similar groups to accomplish this outreach. Additionally, the COE works to foster bidirectional engagement between Cancer Center researchers and community members and supports efforts to reach under-represented community members with information and opportunities for clinical trials participation.
- The Injury and Violence Prevention Program at UC Davis Health is dedicated to preventing and reducing injuries through the strength of community partnerships. By combining injury surveillance data from local and regional sources with input from community partners, the program identifies leading causes of injuries impacting communities in the Sacramento region. The program works with a wide array of organizations to implement evidence-based injury prevention programs to improve safety across the age continuum. Programs include:
  - Child Passenger Safety Program — The Child Passenger Safety Program addresses the transportation safety needs of children and families in the Sacramento region. The program provides no-cost car seats, car seat education classes, installation events, inspection stations and train-the-trainer classes. Parents and caregivers participate in car seat classes that provide comprehensive instruction in English or Spanish on how to properly install and use child safety seats. During 2022–2024, the program provided more than 700 free car seats to families and completed more than 900 free car seat inspections.
  - Helmet Safety Program — The Helmet Safety Program focuses on increasing helmet use among children who ride bikes, scooters, skateboards, and skates. Working with school districts and non-profits in the Sacramento area, the Helmet Safety Program distributed more than 700 helmets in 2022–2024. Program partners included the American River Bike Patrol. Patrol members distribute helmets at community events and to children spotted without helmets on the river trail.
  - Wraparound Program — The Wraparound Program is a free comprehensive post-injury recovery support service for UC Davis Health patients between the ages of 13–30 years who were injured by interpersonal violence. The program extends care of youth and young adults who are violently injured beyond the hospital, to support long-term healing and recovery. The program uses nationally certified Violence Prevention Professionals (VPP)

to provide relationship-based mentoring, referrals to culturally affirming intensive, individualized case management to support physical, mental and emotional recovery. Trauma informed mental health services are provided by a licensed Mental Health Therapist. During 2022-2024, Wraparound provided comprehensive support for 40 youth who had been violently injured.

  - Stop the Bleed — The UC Davis Injury and Violence Prevention Program offers free Stop the Bleed trainings to schools, faith-based organizations, non-profit organizations, and lay-members of the public. The in-person 90-minute training, taught by UC Davis Health trauma nurse practitioners, nurses, and physicians, teaches bystanders the skills and knowledge to provide immediate bleeding control to victims at the scene of an event. Over 300 individuals were trained in the lifesaving Stop the Bleed skills during 2022–2024.
  - Matter of Balance — A Matter of Balance (MOB) is a program designed to reduce the fear of falling and increase activity levels among adults who are older and less active. MOB includes 8 two-hour weekly sessions for a small group of 8–12 participants led by a trained facilitator. The UC Davis Health Injury and Violence Prevention Program has trained facilitators from UC Davis Health Management and Education, ACC Senior Services, Auburn Senior Center, City of Sacramento Community Centers, and Marshall Medical Center to lead MOB workshops. In 2022–2024, more than 100 older adults participated in classes led by UC Davis Health-trained facilitators, for a total of 1,600 program hours.

- Through the UC Davis Children's Hospital Passenger Safety Program, UC Davis Health provides a free car seat to all patients in need, including seats for newborns and replacement seats for pediatric patients involved in motor vehicle collisions. During 2022–2024, the program provided more than 1,000 free car seats for pediatric patients being discharged from the hospital. Staff also provides ongoing education to nurses and physicians on current laws, best practices, and hospital resources for child passenger safety. The program partners with Occupational Therapy to assess pediatric patients with special transportation needs and provide families with a specialized loaner car seat when needed.
- The BulletPoints Project is a state-funded curriculum designed to provide clinicians with the knowledge and tools they need to discuss the risks of firearm access with their patients and to intervene when someone is at increased risk. It was developed by an interdisciplinary team at the UC Davis Centers for Violence Prevention, along with input from health care providers, researchers, legal experts, medical educators, and firearm owners. It provides information on a variety of clinical scenarios; interventions such as safe storage, temporary firearm transfers and civil protective orders; and how societal factors like discriminatory policies, educational opportunities, poverty, and racism affect a person's risk of firearm injury. The website features extensive resources, printables and continuing education offerings including a free, one-hour, on-demand continuing education course for medical and mental health care providers. As of September 2024, more than 1,200 people had registered for the continuing education course and more than 1,000 people had completed the training.
- The Healthy Living Clinic Initiative (HLCI), led by the UC Davis Prevention Policy and Practice Group at the Center for Healthcare Policy and Research, provides intensive training and technical assistance to community clinics serving at-risk populations. Over the last three years, the HLCI has enabled clinics to implement quality improvement methods that improve tobacco cessation efforts and provide people who use tobacco with guidance in nutrition, physical activity, and stress management as part of a whole health approach. Twenty-seven community clinics in Northern, Central, And Southern California have partnered with HLCI, to-date, including CommuniCare Health Centers, El Dorado County Community Health Center, and WellSpace Health. Results from the first cohort of 10 clinics have demonstrated significant improvements in tobacco use screening, cessation counseling referrals to Kick It California/Asian Smokers' Quitline, and adherence to model tobacco-free clinic policies. Continued efforts to advance tobacco cessation among community clinic patients will continue through June 2026.
- UC Davis Health funds local nonprofit organizations that provide health education and outreach programs in the Sacramento region including the American Cancer Association, American Heart Association, National Kidney Foundation, Alzheimer's Association, Colorectal Cancer Alliance, and Triumph Cancer Foundation.

Significant Need #6: Health Equity: Access to Opportunities to be Healthy

Goal: Promote health equity for UC Davis Health patients and community members.	
Objectives/Strategies	**Anticipated Impact**
▪ Collaborate with partners to develop mobile health programs that leverage community assets and experience ▪ Build strong, sustainable relationships with community organizations and community members to co-design solutions to advance community health ▪ Ensure effective communication and language access for patients at UC Davis Health ▪ Create a Health Equity Advisor Program to inform program and policy design at UC Davis Health ▪ Provide anti-discrimination training to UC Davis Health clinical leadership and staff ▪ Provide anti-discrimination/diversity, equity and inclusion training and restorative healing circles open to community members through the Office of Health Equity, Diversity, and Inclusion	▪ Expanded access to care for people experiencing homelessness in Sacramento County ▪ Reductions in disparities in health outcomes ▪ Improvements in the health system's ability to provide person-centered care

Programs & Partners

- Physicians from UC Davis Health and faculty from the School of Nursing's Nurse-Led Mobile Clinic project worked with the Sacramento County Department of Health Services to develop mobile care capabilities as part of a collaborative effort to improve the health status of people experiencing homelessness. The Sacramento County Health Center's mobile medical van with two exam rooms launched in September 2022 with physicians and advance practice clinicians from UC Davis Health. A street medicine component was added in November 2022, using the van as a base and allowing providers to walk into encampments to provide services. Services include mental health evaluation and wound care, as well as tuberculosis evaluation and skin testing, HIV testing, radiology, and prescription refills. Between September 2022 and June 2024, more than 1,000 patients received care through the program.
- In 2023, the Betty Irene Moore School of Nursing established the Nurse-Led Mobile Clinic with funding from the Health Resources & Services Administration (HRSA). A retrofitted van with specially designed tents for the providers and supplies for future patients brings care to underserved populations, including people who are unsheltered, are refugees, or are unaccompanied children, while educating advanced practice provider (NP and PA) fellows on how to holistically care for vulnerable populations. The project is staffed by the Betty Irene Moore School of Nursing faculty, nurse practitioner fellows who take their health care services into the community three times a week. They plan to add nursing and physician assistant students in 2025.
- The Cancer Center's Office of Community Outreach and Engagement (COE) partnered with seven local FQHCs, several community-based organizations, medical groups serving Medi-Cal beneficiaries, UC Davis Health radiology and UC Davis student-run clinics to reduce barriers to mammography by bringing breast cancer screening services to the community. Throughout 2023–2024, across a total of 21 breast cancer screening events, 491 individuals were provided a screening mammogram. Additionally, COE staff provided health education for breast and other cancer screening to community members at events. In several instances, FQHC partners also addressed colorectal and cervical cancer screening with patients attending events for mammograms and COE provided educational support for these efforts too. The UC Davis Mobile Mammography Clinic, colloquially known as the MobileMammo+ bus, will provide state-of-the-art 3-D screening mammography to underserved communities in the Greater Sacramento area via partnerships with FQHCs beginning in 2025. The program will provide breast cancer screening, outreach, and navigation services to ensure access to both screening and diagnostic care.

- The UC Davis Health Digital Health Equity Project (DHE) is a federal funded project of the UC Davis Center for Reducing Health Disparities (CRHD) that focuses on bringing health services to where the communities are, at the point of need. The goal is to improve access and continuity of care for vulnerable populations in Sacramento and Northern California, using digital health and partnerships with FQHCs and other health organizations. During the first phase of the Project (October 2022 - July 2023), DHE partnered with the MOVE IT UP Project on the Test to Treat Digital Health Equity Pilot Project (T2T DHE) to provide telehealth services to COVID-positive patients. T2T DHE also encouraged continuity of care using Digital Health Navigators. Test-to-treat mobile teams operated six days a week, including regular evening and weekend hours, throughout Butte, Colusa, Glenn, Sacramento, and Sutter counties. The joint projects provided over 6,000 tests, including approximately 5,400 in Sacramento County, to underserved communities and hosted 215 testing clinics.
  - The second phase of the Project (October 2023 – December 2024) provides preventive health screenings for high blood pressure and for depression. The primary goal is to identify individuals who may benefit from remote patient monitoring (RPM) for hypertension and/or from behavioral health services for depression. Once individuals are identified, they will be connected with WellSpace Health or Ampla Health for follow-up and continuity of care. DHE aims to address health disparities in low-income populations by partnering with FQHCs and other community-based organizations. DHE will encourage continuity of care by using Digital Health Navigators (DHNs) who will provide guidance and support, helping individuals navigate the complexities of managing high blood pressure, and/or accessing behavioral health services. In addition, there is close collaboration with three UC Davis Health associated Student-run Clinics (Imani Clinic, Knights Landing Health Center, and Tepati Clinic) for the implementation of the RPM Hypertension Program with the populations they serve, and with the Mexican Consulate, Ventanilla de Salud Program for referrals for mental health services. As of the end of October 2024, the DHNs conducted 106 mobile clinics in which 736 blood pressure and 745 depression screenings were administered in Sacramento County.
- The Gregory Bunker Health Care Transitions Center (The Bunker), formerly the Interim Care Program, is a collaboration between the four Sacramento area health care systems, Sacramento County and WellSpace Health that provides recuperative care to ensure patients experiencing homelessness have a safe, clean place to recover from hospitalization. WellSpace Health delivers nursing care; medical and dental visits through their on-site FQHC; as well as case management and treatment supports with a focus on building relationships when patients enter the program to help them achieve goals and be independent. UC Davis Health has provided operational funding since the program's inception in 2005.
  - Between January 2022 and September 2024, UC Davis Health care teams referred more than 600 patients. WellSpace Health revised the referral criteria in April 2024 to align with the Medi-Cal CalAIM recuperative care benefit, which is only available to patients enrolled in Medi-Cal managed care plans. The program is constantly evolving to adapt to the increasing complexity of both medical and social needs among the patient population. In 2024, 66 percent of clients were linked to an Enhanced Care Management (ECM) provider and 72 percent were connected with a housing supports provider.
  - WellSpace added medical and dental care at its on-site FQHC beginning in 2023. In 2024 (through Q3), 34 percent of clients with a stay of 10+ days obtained a medical visit and 21 percent received a dental visit. For patients with providers at other FQHCs, WellSpace helps set appointments and arrange transportation, with the goal of connecting patients back to their medical home.
  - In 2022, UC Davis Health Food and Nutrition Services began preparing and delivering three meals a day, seven days a week to the Bunker at no cost, providing the same nutritious, local food offered to patients, staff and visitors at the Medical Center. Approximately 94,000 meals were provided in the first year, saving WellSpace more than $420,000 in food costs. In addition to providing nutritionally appropriate meals, staff also consulted on the new kitchen during construction and helped train WellSpace staff.

- The Office for Health Equity, Diversity, and Inclusion (OHEDI) at UC Davis Health is dedicated to ensuring fair treatment and access to health care for all. The office works to promote fair policies, build community partnerships, and nurture life-long learning in support of community and individual health. Our programs aim to enhance knowledge and build skills that help faculty, staff, leaders and students foster sensitive and respectful experiences/encounters with all patients, visitors and community members. We collaborate closely with community partners when developing and facilitating many of our programs. We support individual and professional development through training, communication, education, and partnerships including:
  - Growing as a Community: A learning series led by the Truth, Racial Healing, and Transformation Center (TRHT) to provide comprehensive educational opportunities and resources focused on strategies and techniques to support anti-discrimination, promote healing during difficult times, and build healthier and safer communities. In 2022–2024, there were 11 offerings with more than 1,620 participants, including members of the public.
  - Circle Practices: A series of small group discussion circles, both in-person and virtually, led by the TRHT that focus on providing a space for processing and building connection with one another. Offerings are also open to the public. In 2022–2024, there were 23 discussion circles with more than 175 participants.
  - SEED (Supporting Educational Excellence in Diversity): An optional training program focused on empowering faculty/providers to better support trainees and patients. The customized offering has statistically significant outcomes improving faculty emotional intelligence, faculty professionalism, and improving self-awareness with tools shown to improve skills of faculty navigating the "how" and "what" of difficult conversations. Advancing Inclusivity and Diversity (AID) is replacing SEED as an enhanced asynchronous module, allowing the expansion to a larger audience including UC Davis Health leaders, faculty, and staff, as well as healthcare professionals nationally. In 2022–2024, there were 7 offerings with 97 participants.
  - Refugee Health: This programming prepares providers to meet the mental and physical healthcare needs of Sacramento's growing refugee and migrant communities. Sessions have included the "Heal the Healer" series — mental health support sessions for healthcare providers supporting refugee community members (piloted in 2022) — and an October 2023 symposium open to clinical providers, staff, and medical students from all backgrounds interested in learning about issues affecting healthcare for Muslim patients. More than 470 people attended 15 offerings in 2022–2024.
  - Health Equity Advisors: Provide subject matter expertise, advising and consultation to promote equity within clinical, community, and evaluation contexts at UC Davis Health.
- The Health Resources and Outreach (HeRO) Program within the Clinical and Translational Science Center at UC Davis Health works to amplify the voices and diversify the participation of patients and the public in health research. HeRO seeks to accomplish this aim through bidirectional training, development and dissemination of self-service resources, individualized consultations with research teams, and public outreach and engagement. The program organizes and participates in one-time and recurring events to build knowledge of health conditions and research in diverse populations. Events are free and open to the public. HeRO programming includes a Vietnamese Mini-Medical School, featuring clinicians and scientists communicating to older adults in Vietnamese on the latest research into common chronic conditions; an annual event on Brain Health, Dementia, and Caregiving addressing the African American community; and collaborations with researchers and parents of children with neurodevelopmental disabilities. Common to each of these activities is robust partnering with community and patient advocacy groups.
- Representatives from UC Davis Health also serve on the Sacramento County Health Authority Commission to improve health outcomes and reduce health disparities for Medi-Cal beneficiaries by collaborating with stakeholders to ensure access to high quality, integrated health care. In 2023–2024, the Health Authority focused on reviewing Medi-Cal redetermination data and making recommendations to improve enrollment, understanding the managed care plans' progress on key initiatives, and identifying and addressing challenges with California Advancing and Innovating Medi-Cal (CalAIM) implementation.

Significant Need #7: Access to Specialty and Extended Care

Goal: Improve access to specialty care services.	
Objectives/Strategies	**Anticipated Impact**
▪ Develop and enhance partnerships with FQHCs to expand access to specialty services in community settings ▪ Provide specialty care services to community members who are underinsured and uninsured	▪ Expanded availability of and access to specialty care services ▪ Enhanced access to specialty consults and procedures for community members who are uninsured or underinsured ▪ Decreased wait times for individuals seeking specialty care consults

Programs & Partners

- In January 2023, UC Davis Health and WellSpace Health, the area's largest FQHC, launched Specialty Connect, which embeds UC Davis Health physicians in WellSpace Health's Oak Park Community Health Center to enhance the scope of services provided at WellSpace Health and care for Medi-Cal patients affiliated with FQHCs across Sacramento County. The program started with rheumatology and expanded to include an advanced heart failure clinic in September 2023. More than 360 patients received care through Specialty Connect between January 2023 and June 2024, with plans to expand to additional specialties in 2025. Three advanced practice providers from WellSpace Health also participated in a heart failure perceptorship at UC Davis Health on post-hospitalization, pre-acute and specialty pharmacy care for heart failure patients to increase WellSpace Health's capacity to provide high quality, comprehensive services.
- UC Davis Health's team of specialists at the Sacramento County Health Center has deepened the range of services available to patients who are on Medi-Cal, uninsured or underinsured. Specialists in women's health, rheumatology, cardiology, nephrology, hepatology and musculoskeletal disorders provided 460 visits in FY 2024. Hepatology, including treatment for Hepatitis C, was added in 2024.
- The Sierra Sacramento Valley Medical Society's Sacramento Physicians' Initiative to Reach out, Innovate and Teach (SPIRIT) Program meets the healthcare needs of the community by recruiting and placing physician volunteers to provide free medical services to people who live in the region who are uninsured. A collaborative partnership of the medical society, the four local health systems and Sacramento County, SPIRIT coordinates specialty consults and surgical services at local hospitals and ambulatory surgery centers. Patients are referred from a medical home, including patients who visit the UC Davis medical student-run clinics. UC Davis Health provided gastroenterology procedures to 131 patients between January 2022 and September 2024. In addition to contributing these services valued at $330,000, UC Davis Health provides a grant for annual operating support for the program.

Additional Investments that Address Community Health Needs

UC Davis Health is continually working to address health needs that impact the community through a variety of means. Efforts include:

Community Benefits and Community Financial Support

In Fiscal Year 2023 (July 2022 – June 2023), UC Davis Health provided $840 million in community benefits. Community benefits included financial assistance (charity care) and subsidized care, services provided to Medi-Cal and Medicare patients where reimbursement doesn't cover costs, health professions education, community health and wellness programs, and more. This includes $19 million in community health improvement services and $2 million in cash and in-kind contributions. More than 200 organizations have benefitted from the medical center's commitment to the nonprofit sector, which includes a formal sponsorship process that provides direct financial support to underwrite health and social service programs across Sacramento and neighboring counties.

Research

With more than 2,000 basic science, translational and clinical trial studies underway, UC Davis Health is actively exploring the underlying cases of disease and illness, including the socioeconomic factors that influence health conditions. In 2023, UC Davis Health received more than $400 million in external research funding. The UC Davis Alzheimer's Disease Research Center, UC Davis Center for Reducing Health Disparities, UC Davis Institute for Population Health, UC Davis MIND Institute, UC Davis Comprehensive Cancer Center, and UC Davis Institute for Regenerative Cures, among others, are all leaders in innovating to help improve lives and transform healthcare.

Employee, Faculty and Student Engagement

Employees participate in direct service to the community by donating time, goods, and professional services to nonprofit organizations such as food banks, foster youth programs, schools and shelters for people experiencing homelessness. Many of the volunteer activities, such as the emancipation baskets donated each December, have evolved into annual traditions. Staff and faculty in departments throughout UC Davis Health provide emancipation baskets containing new household and personal items (including kitchen and bath items and gift certificates for groceries) to young people transitioning to independent housing. The baskets are distributed to youth in the foster care system by social workers in the community. Each year UC Davis Health donates more than 120 baskets.

UC DAVIS HEALTH

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