COMMUNITY HEALTH ASSESSMENT 2023

10/6/2023

SACRAMENTO COUNTY PUBLIC HEALTH

SACRAMENTO COUNTY PUBLIC HEALTH
Promote • Prevent • Protect

MESSAGE FROM THE HEALTH OFFICER

It is my pleasure to share with you the 2023 Sacramento County Community Health Assessment (CHA). On behalf of Sacramento County Public Health staff and partners, I hope you find this information useful in planning and responding to the needs of our community.

I would like to thank the many people who live, work, play, and visit Sacramento County for contributing to this assessment as well as the many community-based organizations who collaborated with us as well. A special thank you to our SCPH Epidemiology Unit, Health & Racial Equity Unit and Accreditation Unit for their work gathering and analyzing the data shown within this document.

This CHA is part of an ongoing community health improvement process. The CHA provides data that assists us with identifying priority issues affecting health in Sacramento County. We will use the CHA as the foundation for health planning processes in the future.

A Community Health Improvement Plan (CHIP) is being developed as a companion to this document and will detail goals, objectives, and action plans for each of the focus areas identified.

Sacramento County Public Health has recently created a culture statement to guide staff.

Sacramento County Public Health strives to achieve excellence and envisions optimal health and well-being for all communities in Sacramento County. We accomplish this by utilizing a trauma informed approach that embraces a culture of safety, inclusivity, and transparency; ALL rooted in health & racial equity. We are committed to reducing inequities in the community and within our organization by intentionally building trusted relationships, improving communication, leaning into innovation and fostering inclusive and sustainable collaborations.

I hope you will join us in the challenging work that is necessary to improve the health and racial disparities that impact our residents.

Sincerely,

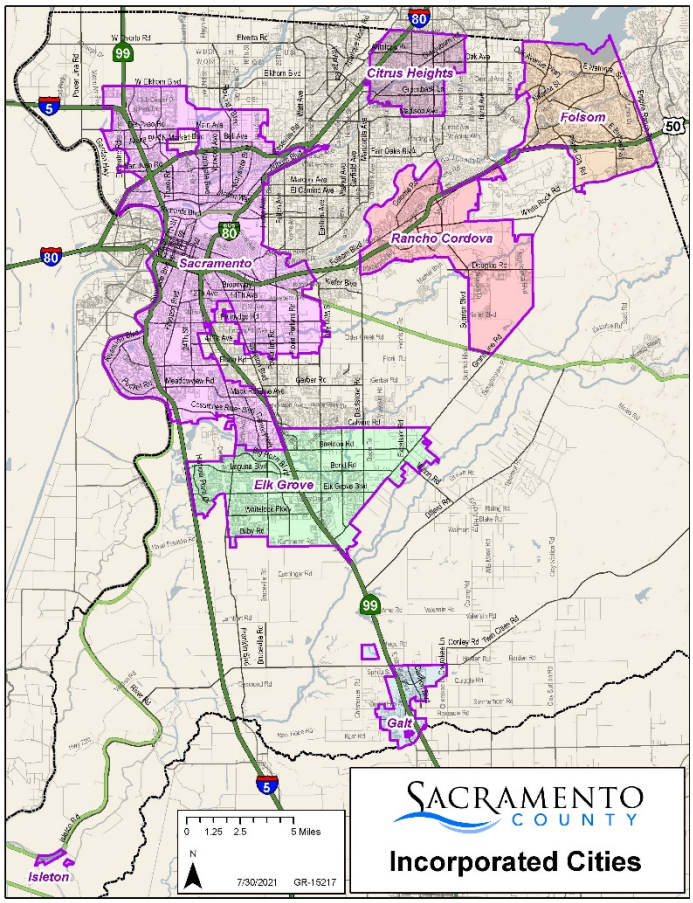
Olivia Kasirye MD

Olivia Kasirye, MD, MS
Public Health Officer

Table of Contents

Overview

SACRAMENTO COUNTY PUBLIC HEALTH



Sacramento County was incorporated in 1850 in response to the needs of a growing population. The County is one of the original 27 counties of California. Its largest city, the City of Sacramento, became the capital of the State of California in 1854. Sacramento also serves as the County seat. Sacramento County is governed by five members of the Sacramento County Board of Supervisors, each of whom are elected on a non-partisan basis to serve staggered four-year terms, to represent one of the five districts. Sacramento County has more than 30 departments and offices that provide services to the community. The Department of Health Services (DHS), under the supervision of the Board of Supervisors, was established in 1950 to provide community-wide health services to the Sacramento County population. DHS programs and services are provided through the divisions of Public Health, Behavioral Health Services, and Primary Health Services.

Sacramento County Public Health (SCPH), also known as the local county health department, provides health education and primary prevention services and is a central part of a comprehensive network of public health services responsible for providing accurate health information to the local communities. SCPH monitors the health status of Sacramento's residents, sets health priorities and evaluates the effectiveness of health initiatives.

MISSION

The mission of Sacramento County Public Health is to promote, protect, and assure conditions for optimal health and public safety for residents and communities of Sacramento County through leadership, collaboration, prevention, and response.

VISION

Optimal health and well-being for Sacramento County communities!

VALUES

COLLABORATION	We value collaboration and diversity.
DEDICATION	We are dedicated to meet the public health needs of Sacramento County residents and communities.
QUALITY	We provide high quality and effective services based on best practices and the most current information and resources.
COMPETENCE	We hire staff with essential skills, education, experience, and certification to accomplish program goals.
RESPONSIVENESS	We listen to community needs, monitor community health, and develop responses to match needs.
ACCOUNTABILITY	We accept responsibility and accountability for providing efficient and quality service. We conduct ourselves with integrity in delivering services.
DIVERSITY	We respect and value diversity within the community and strive to deliver services that are respectful and relevant to the needs, values, and beliefs of the community. We seek to recruit and hire diverse staffs that enhance our level of understanding of various populations and to promote cultural competence.
EFFICIENCY	We look for the most efficient way to get the job done.

STRATEGIC PRIORITIES

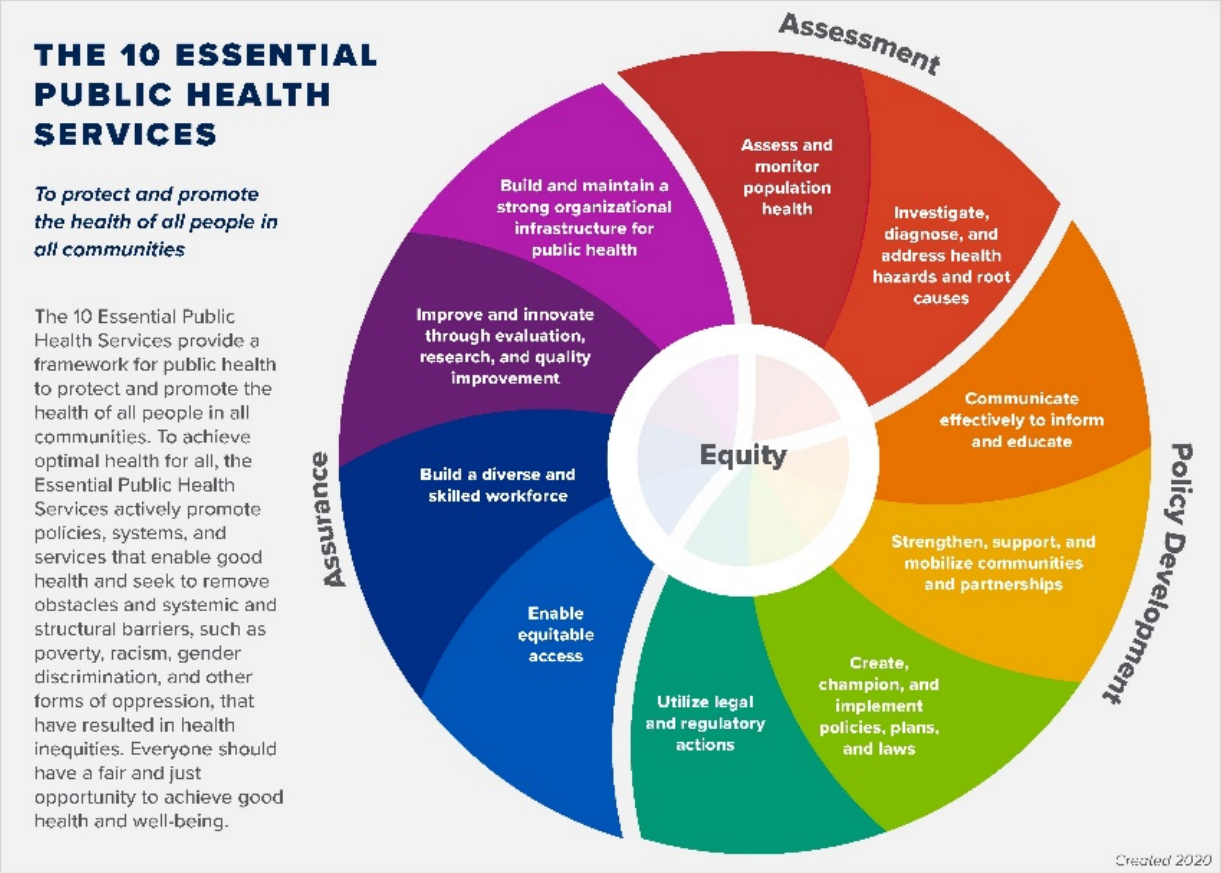
1. Enhance Community Access, Engagement, and Partnerships
2. Strengthen Infrastructure
3. Champion Health Equity
4. Improve Health and Community Well-Being
5. Emphasize a Culture of Continuous Quality Improvement and Excellence

CULTURE

Sacramento County Public Health strives to achieve excellence and envisions optimal health and well-being for all communities in Sacramento County. We accomplish this by utilizing a trauma informed approach that embraces a culture of safety, inclusivity, and transparency; ALL rooted in health & racial equity. We are committed to reducing inequities in the community and within our organization by intentionally building trusted relationships, improving communication, leaning into innovation and fostering inclusive and sustainable collaborations.

PUBLIC HEALTH ACCREDITATION

Accreditation is a well-established process for improving performance within organizations and takes place when a formal authority concludes that an organization meets predetermined standards (Riley, 2012). That authority is the Public Health Accreditation Board (PHAB), which was established in 2007 (PHAB, 2022). Accreditation can reduce inconsistency by comparing health departments to a set of standards against which performance can be measured, along with recognition for agencies meeting the standards. These standards identify opportunities to improve management, develop leadership, and advance relationships within the community (Riley, 2012). The 10 Essential Public Health Services align with the 10 domains that are required for accreditation. The assessment section aligns with Domain 1 – to assess and monitor population health status, factors that influence health, and community needs and assets (PHAB, 2022).



SCPH began their accreditation efforts in 2017 and by 2020, when SCPH had expected to apply for initial accreditation, much progress has been made towards application materials, including an initial Community Health Assessment; however, the COVID-19 pandemic halted all efforts and redirected resources towards emergency preparedness and response efforts. After two and

half years of COVID-19 response, SCPH leadership is committed to restarting accreditation efforts by creating a new Accreditation Unit, staffed by four Accreditation Coordinators and led by a Program Manager beginning July 1, 2022. SCPH is applying for initial accreditation with version 2022 of the PHAB Standards and Measures.

COMMUNITY HEALTH ASSESSMENT

One of the first and most important requirements for public health accreditation is the Community Health Assessment (CHA). The purpose of this is to assess the comprehensive health of Sacramento County. The CHA tells the community story and provides a foundation to improve the health of the population. It is the basis for priority setting, planning, program development, policy changes, and coordination of community resources, funding applications, and new ways to collaboratively use community assets to improve the health of the population.

A CHA identifies disparities among different subpopulations in the jurisdiction, and the factors that contribute to them, in order to support the community's efforts to achieve health equity. Data within the CHA may include information about mortality and morbidity, quality of life, attitudes about health behavior, socioeconomic factors, environmental factors (including the built environment), social determinants of health, community narrative, assets, and stories. Data should be obtained from a variety of sources, using various data collection methods (PHAB, 2022, p. 25).

In addition to these assessments, several other SCPH programs have conducted their own program specific assessments. These assessments include:

- Maternal, Child, and Adolescent Health (MCAH) Needs Assessment
- Oral Health Needs Assessment
- Ryan White Needs Assessment

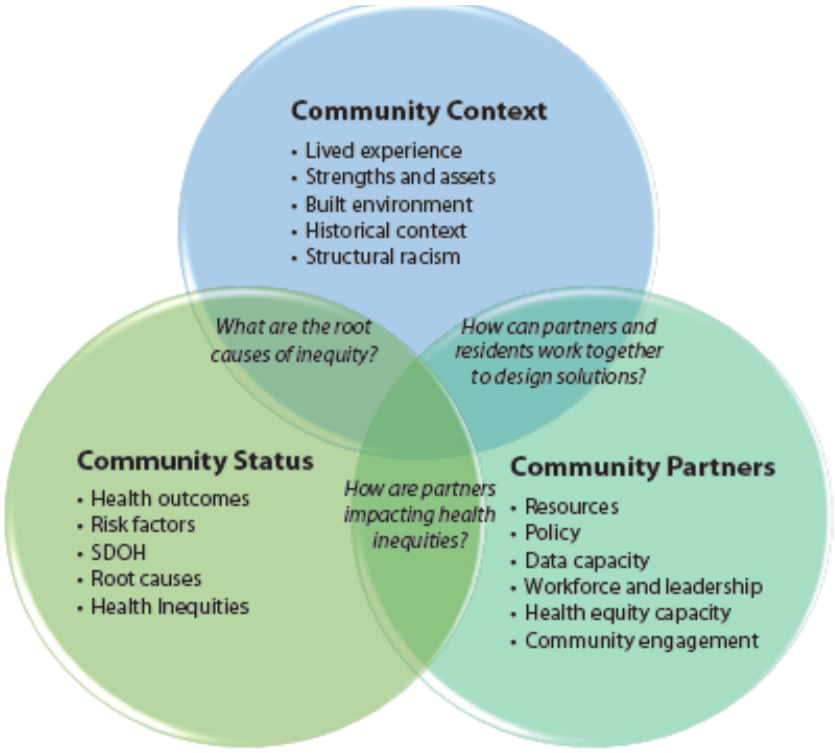
For additional information about SCPH programs and resources, please visit www.scph.com and for additional data resources and factsheets, please visit www.behealthysacramento.org.

MAPP PROCESS

Although a framework is not required for public health accreditation, SCPH has utilized the Mobilizing for Action through Planning and Partnerships (MAPP) framework to conduct their Community Health Assessment and Improvement Planning (CHA/CHIP) process. This framework was developed in 2001 by the National Association of County and City Health Officials (NACCHO) and is one of the most widely used community health improvement frameworks in public health because it provides a structure for communities to assess their most pressing

population health issues and align resources across sectors for strategic action (National, 2020). In November 2020, the MAPP process was revised to shift from four assessments to three, as shown in Figure 1 (National, 2020, p. 24).

FIGURE 1: Three CHA Assessments



DATA

Data included in this CHA was obtained from a variety of sources, including primary data via the Community Context Assessment – a survey of 1,644 community members; as well as the Community Partner Survey – a survey of 41 community organizations. Secondary data is also included in the CHA. The two most frequently used in-house data sources in this report were birth and death certificate data from the California Vital Records Business Intelligence System and reportable disease conditions from the California Reportable Disease Information Exchange (CalREDIE) system. Data sources are denoted throughout the report.

PARTNER ORGANIZATIONS

A list of partnering organizations can be found in the Community Partner Survey Appendix B. The partnering organizations provided thoughtful insight into their organizations and priorities for health in Sacramento County. A summary of the participating partners includes non-profits (26), other (8, including school districts, church, health plans, etc.), grassroots community (4), public and private hospitals/clinics (4). A minimum of 11 of these partner organizations specifically represent populations who are disproportionately affected by conditions that contribute to poorer health outcomes.

Partner organizations collaborated in the development of the CHA by assisting with the distribution of the community context survey to their community members who live, work, play or visit Sacramento County. In addition, partner organizations participated in completing the community partners assessment.

TIMELINE

SCPH started the CHA process in May 2022 and will finish in October 2023 (see Figure 2).

FIGURE 2: CHA Timeline

PLAN ALIGNMENT

The SCPH CHA process summarizes the community's overall health using a three-pronged approach that includes gathering community input about their perception of health (primary data), finding existing data about the population (secondary data), and asking partner organizations about their capacity to improve health and equity. All this information is then used to prioritize health needs and create a community health improvement plan (CHIP) that will be implemented by a coalition, consisting of SCPH staff, a variety of community-based organizations, and a facilitating organization.

Alongside this community-focused CHA/CHIP process, SCPH is looking internally through its strategic plan to ensure its infrastructure is set up to best support improving health outcomes. Once the strategic plan priorities are revised to meet current needs, agency operations will be aligned for optimal implementation, including workforce development (WFD), communications, quality improvement and performance management (QI/PM), and emergency operations (EOP) plans. Additionally, performance goals for units, programs, and employees will be revised to support SCPH's strategic direction.

When drafting action plans at all levels, SCPH will also infuse equity and consider alignment with national frameworks (Public Health Accreditation Board – PHAB, Healthy People 2030, etc.), as well as state-wide public health efforts within California.

All these efforts complement each other to allow SCPH to achieve its vision of optimal health for Sacramento County residents.

FIGURE 3: Plan Alignment

NEXT STEPS

COMMUNITY HEALTH IMPROVEMENT PLAN

This information presented in this CHA will be utilized to create a community health improvement plan (CHIP) that will provide guidance to SCPH, its partners, and stakeholders for improving the health of the Sacramento population for the next five years. The CHIP will be comprised of a collaborative planning process that includes significant involvement by key

partners within the public health system, prioritization of health issues highlighted in the CHA, and is the basis for taking collective action towards systemic change.

The SCPH CHA/CHIP team reviewed the three assessments within this document, along with local health system needs assessments, to determine the major health issues impacting Sacramento residents. Seven themes emerged:

- Social Determinants of Health (Food, Crime, Housing & Built Environment)
- Infectious Disease (COVID-19, STDs)
- Maternal, Child and Adolescent Health (Infant Mortality)
- Chronic Disease (Obesity, Cancer)
- Alzheimer's Disease
- Injury (Violence, Crime, Substance Abuse)
- Mental Health

These themes will be used to guide the CHIP prioritization process in August 2023.

COMMUNICATION

Internally, the CHA and its sub-assessments will be shared with all staff, including the County Board of Supervisors, leadership, and employees through the staff newsletter and/or email.

Externally, the CHA and its sub-assessments will be posted on the SCPH website's accreditation page (insert hyperlink). This information will also be shared with the CHIP team to support prioritization of health issues for the CHIP.

EVALUATION

This entire plan, along with its sub-assessments, will be revised every five years to align with public health accreditation requirements. To ensure SCPH is staying current on available data, an annual progress report will be completed to cover each calendar year, January through December, between revisions. These annual progress reports will be posted on the SCPH website, along with the CHA.

Health Status Assessment 2020

Sacramento County residents

Publication date: August 9, 2023

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DEMOGRAPHICS AND SOCIAL DETERMINANTS

Population Demographics

FIGURE 1: Current and 10-year projected County populations by race/ethnicity, 2020 vs. 2029[1]

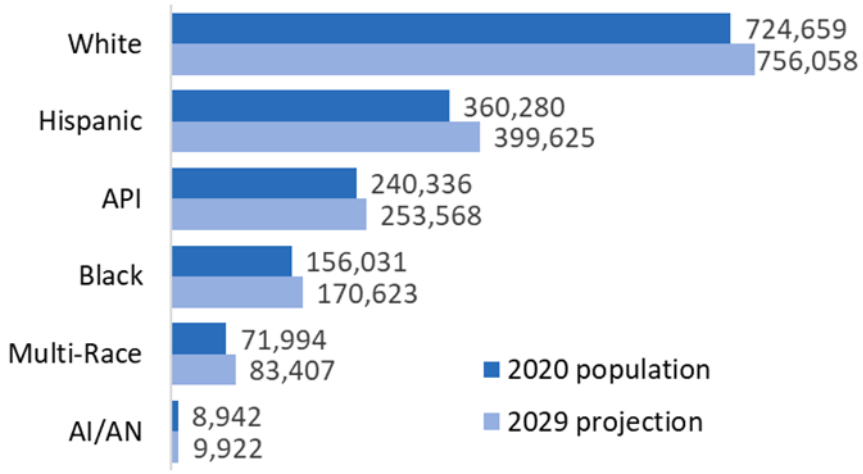
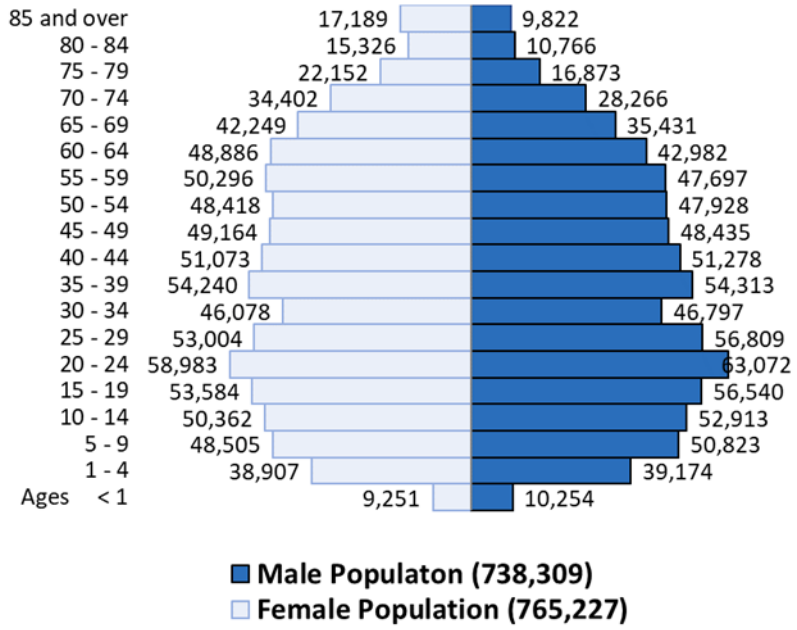


FIGURE 2: Population age-sex pyramid, 2020[1]



Source: 1. California Department of Finance P-2 County Population Projections 2010-2060

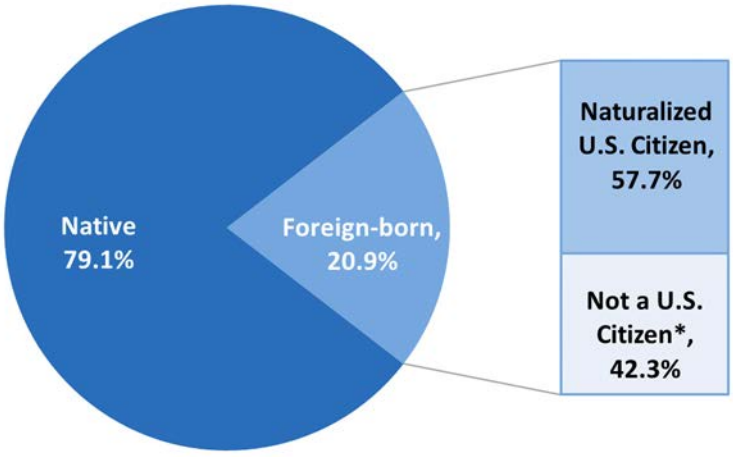
POPULATION DEMOGRAPHICS

Projections and race/ ethnicity: There was a total of 1,562,242 residents in the County in 2020 [Figure 1]. Whites were the largest group (46.4%), followed by Hispanics (23.1%), Asian/Pacific Islanders (15.4%), Blacks (10.0%), Multi-race (4.6%), and then American Indian/Alaskan Natives (0.6%). The County population is projected to increase by 7.1% to 1,673,203 over the next ten years. Multi-race is projected to have the largest percent increase by 2029 (+15.9%). Whites are projected to have the smallest percent increase (+4.3%) but will still remain the largest single racial/ethnic group in the County in 2029.

Age and sex: The County population pyramid [Figure 2] is stationary, meaning that the percentages of age and sex have remained generally constant over time. Stationary populations occur when there is a balance between birth, death and migration rates. Population decreases are observed in males at a slightly younger age compared to females. The somewhat larger 20 to 24 age group categories may be partially attributable to the several local colleges and universities in the County.

Nativity and Language

FIGURE 3: County population by nativity, 2020[1]



**Includes lawful permanent residents, certain legal non-immigrants (e.g., student or work visas), those admitted under refugee asylee status, and persons illegally residing in the United States.*

FIGURE 4: Foreign-born by world region of birth, County vs. State, 2020[1]

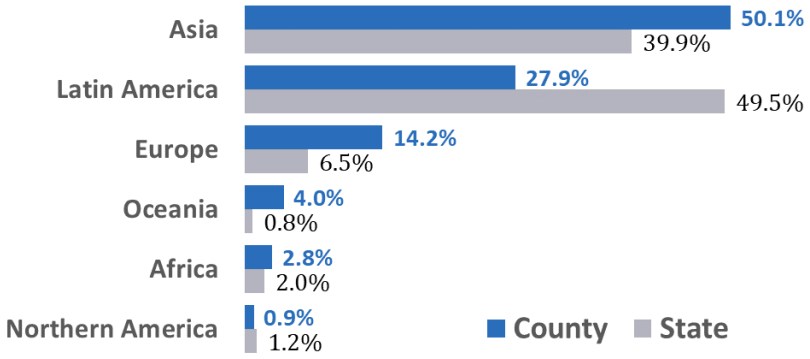


TABLE 1: Languages spoken at home (age >5), County vs. State, 2020[1]

Language	County	State
English only	67.6%	56.1%
Spanish	13.3%	28.3%
Asian/PI language	9.9%	10.0%
Other Indo-European languages	8.2%	4.5%

Source: 1. 2020 American Community Survey 5-year estimates

NATIVITY AND LANGUAGE

Nativity: Nearly 80% of persons residing in Sacramento County were U.S. Natives and about one-fifth were persons who were not U.S. citizens at birth [Figure 3]. The largest proportion of foreign-born persons residing in the County were born in Asia, followed by Latin America and then Europe [Figure 4]. The County has a larger proportion of foreign-born residents who were born in Asia or Europe and fewer who were born in Latin America compared to the State overall.

Language: More than two-thirds of persons age five and older in the County spoke only English at home compared to more than half of households in the State [Table 1]. Compared to the State, there was a similar proportion of persons who spoke Asian/Pacific Islander languages, fewer who spoke Spanish, and more who spoke other Indo-European languages.

Economic Characteristics

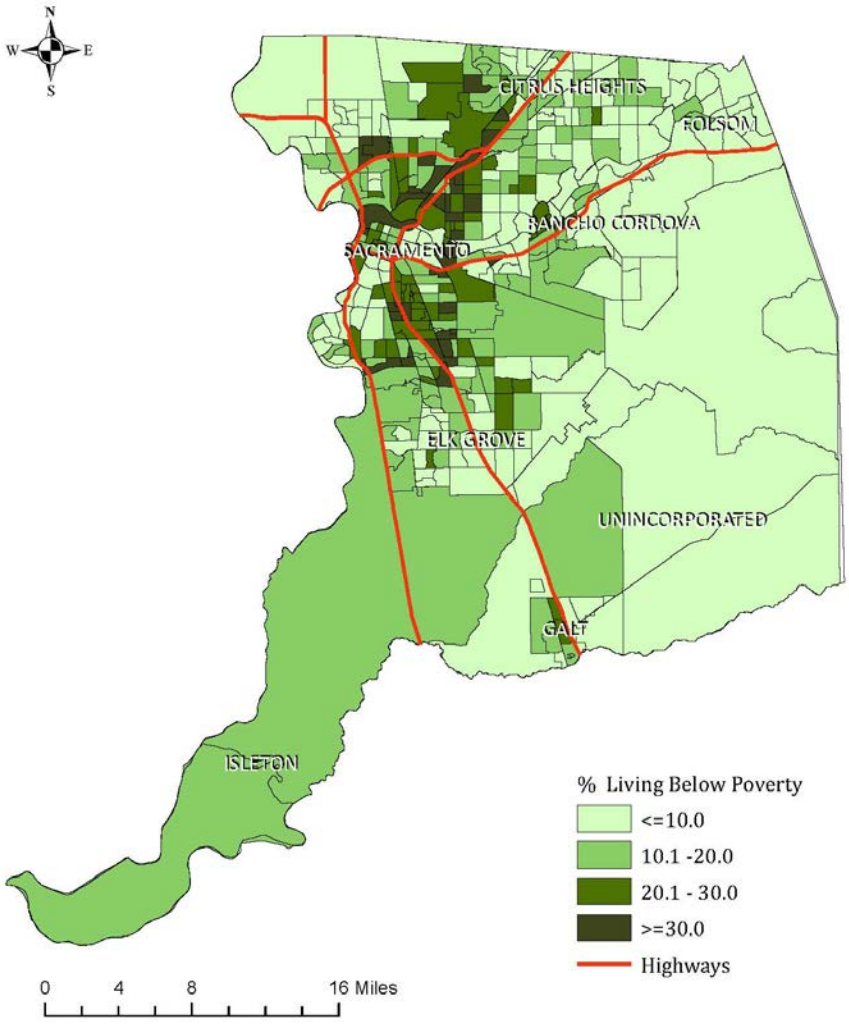
Median household income[1]: **$70,672**
Compared to State: $78,672

Receiving CalFresh benefits[1]: **11.3%**
Compared to State: 9.0%

Median student loan debt[2]: **$18,245**
Compared to State: $18,500

Unemployment (age ≥ 16)[1]: **6.2%**
Compared to State: 6.4%

FIGURE 5: Poverty rate by census tract, 2020



Sources: 1. 2020 American Community Survey 5-year estimates, 2. Urban Institute Debt in America: https://apps.urban.org accessed July 2022

ECONOMIC CHARACTERISTICS

Economic characteristics are key determinants of health. Greater income is associated with lower likelihood of disease and premature death, according to the National Center for Health Statistics.

Snapshot: The median household income in the County was just over $70,000 with the medium per capita income at $37,259. The County had a lower median household income, but lower unemployment rate compared to the State. A larger proportion of County residents received CalFresh benefits compared to the State. The median student loan debt was over $18,000 for both the County and State.

Poverty: The overall adult (age 18+) poverty rate for the County was 12.1% and the overall child (age <18) poverty rate was 16.9% in 2020. Poverty rates varied geographically within the County [Figure 5]. The areas of highest poverty were similar to those with lower high school graduation rates, more single-parent households, and higher unemployment.

Housing and Built Environment

Owner occupied[1]: **57.4%**
Compared to State: 55.3%

Median housing cost[1]: **$1,438**
Compared to State: $1,688

Long commute, driving alone[2]: **40%**
Compared to State: 42%

Food insecurity rate[4]: **11.7%**
Compared to State: 9.1%

FIGURE 6: Walkability scores by city[3]

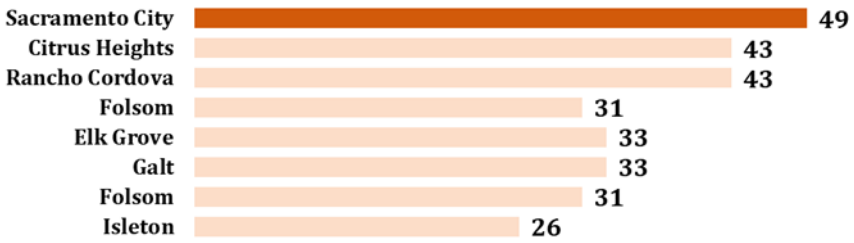
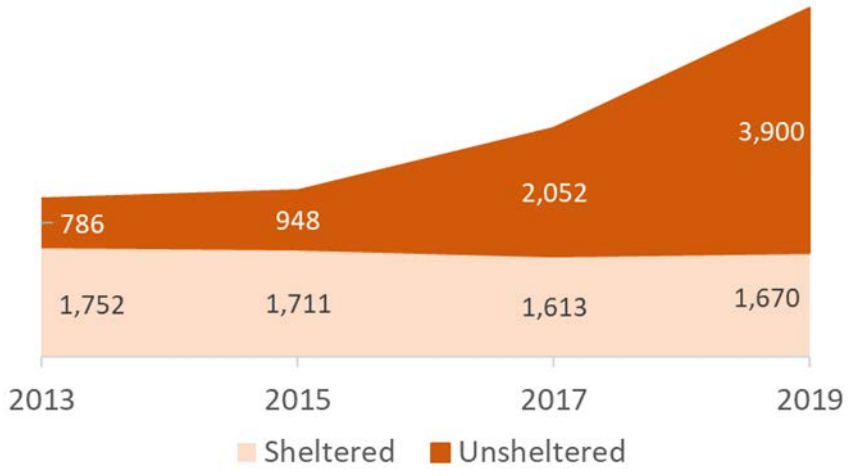


FIGURE 7: Sheltered and unsheltered homeless population point-in-time counts 2013-2019[3]



Sources: 1. 2020 American Community Survey 5-year estimates, 2. 2022 California Health Rankings (used years 2016-2020 data), 3.WalkScore, 4. Sacramento Steps Forward homeless point in time counts

HOUSING AND BUILT ENVIRONMENT

Accessible, quality and affordable housing is an essential social determinant of health. Built environment design (infrastructure, transportation, land use, etc.) can help mitigate climate change, influence lifestyles and improve public health.

Snapshot: Over half of homes in Sacramento County were owner-occupied in 2020. The medium housing cost was over $1,400 in the County. County residents were more likely than the State overall to commute alone and longer than 30 minutes to work.

Walkability: All major cities in Sacramento County were car-dependent (walk score <50) in 2020 [Figure 6]. The city of Sacramento was the most walkable city in the County whereas Folsom was the least walkable.

Homelessness: There was an estimated total of 5,570 persons experiencing homelessness in the County in 2019, 70% of whom were unsheltered [Figure 7]. The number of sheltered individuals remained relatively steady since 2013, but the number of unsheltered individuals increased nearly 396.2% from 2013 to 2019.

Educational Attainment

High school diploma (age ≥25): **87.9%**
Compared to State: 83.9%

Bachelor's degree or higher: **31.4%**
Compared to State: 34.7%

4-year cohort graduation rate: **80.6%**
Compared to State: 83.6%

Chronic absenteeism rate[2]: **16.4%**
Compared to State: 14.3%

FIGURE 8: Racial/ethnic disparities in suspension rates[2]

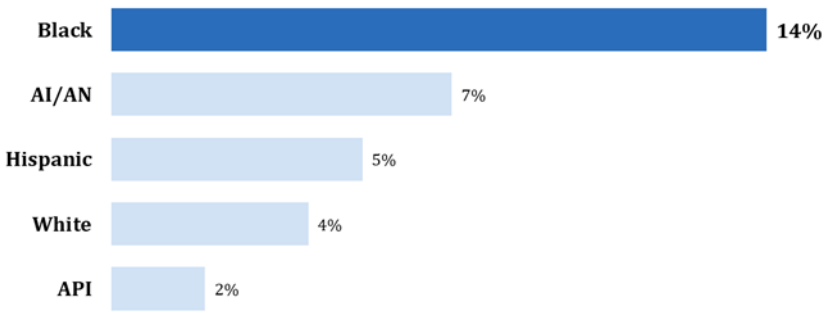
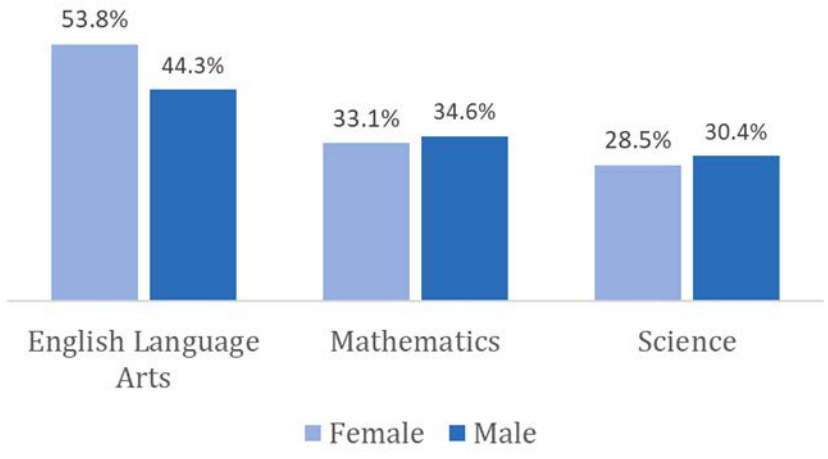


FIGURE 9: Percent meeting English language Arts, mathematics, and science achievement standards by sex, California



Sources: 1. 2020 American Community Survey 5-year estimates, 2. National Center for Education Statistics 2016-2017 academic year 3. California Department of Education DataQuest 2016-2017 academic year 4. California Department of Education California Assessment of Student Performance and Progress 2017

EDUCATIONAL ATTAINMENT

Education can create opportunities for better health. Applicants with more education are more likely to get higher paying jobs with benefits such as health insurance, and therefore have access to more health resources.

Snapshot: Most County residents (age ≥25) had a high school diploma or higher and over 30% had a bachelor's degree or higher in 2020. The County four-year cohort graduation rate was slightly lower than the State in the 2020-21 school year. Chronic absenteeism was higher in the County compared to the State in the 2020-21, and much higher than previous years, likely due to the COVID-19 pandemic.

Disparities in discipline: Black students were more likely than their non-Black peers to be suspended or expelled from school in 2020-21 [Figure 8].

Academic Achievement: Less than half of California students were meeting achievement standards in the 2020-21 school year with the exception of females in English Language Arts [Figure 9]. Due to the COVID-19 pandemic, testing participation varied and there was not enough participation to display County-specific results.

Crime & Safety

Violent crime rate[1]: **468.2** (per 100,000)
Compared to State: 439.9

Property crime rate[1]: **2,101.0** (per 100,000)
Compared to State: 2,128.5

Total Felony Arrests[1]: **12,115**

Sworn law enforcement[1] officers: **2,378**
(*Excludes CA Highway Patrol)*

FIGURE 10: Trend in number of domestic violence calls for assistance[1]

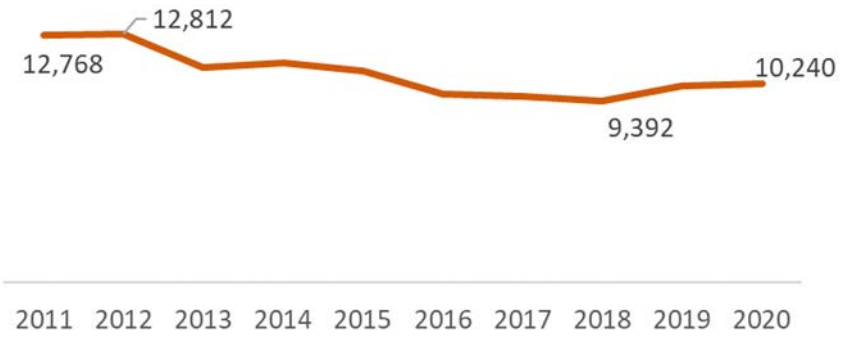
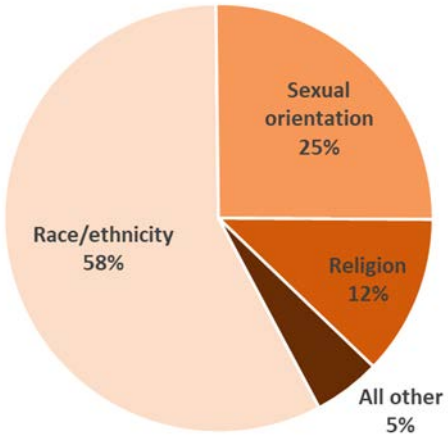


FIGURE 11: Reported hate crimes by major bias type 2011-2020[1]



Source: 1. California Department of Justice 2020 OPENJUSTICE data

CRIME AND SAFETY

Crime and safety affect communities and is a key social determinant of health. Crime can cause both physical injury and mental health conditions such as depression and post-traumatic stress disorder.

Snapshot: The County violent crime rate was slightly higher than the State overall, but the property crime rate was lower. There were over 12,000 felony arrests in the County in 2020, including 4,792 violent offenses, 1,110 drug offenses and 183 sex offenses.

Domestic Violence (DV): There was an overall decrease in the number of DV-related calls for assistance from 2011 to 2020, but 2020 had a slight uptick in DV calls [Figure 10]. Data should be interpreted with caution as DV is generally underreported, and many social and cultural factors can influence reporting likelihood.

Hate crimes: The number of reported hate crimes in the County decreased from 35 in 2011 to 22 in 2020 [Figure 12]. Of the 257 hate crimes during the ten-year period, over half were bias based on race/ethnicity or ancestry and more than one quarter were bias based on sexual orientation. Anti-Black was the most common racial bias and anti-Jewish was the most common religion bias.

INFECTIOUS DISEASE

COVID-19

COVID-19 is a disease caused by a novel strain of coronavirus (SARS-CoV-2) first identified in an outbreak in Wuhan, China in December 2019. On March 11, 2020, the World Health Organization declared COVID-19 a global pandemic. Efforts to contain COVID-19 were unsuccessful. The pandemic had sweeping medical, social, and economic impacts locally and worldwide. COVID-19 is mainly transmitted through close proximity to an infected individual. Symptoms typically appear 2 to 14 days after infection and include fever, chills, coughing, shortness of breath, headache, muscle aches, vomiting or diarrhea, and loss of taste or smell. Cases can range from showing no symptoms to severe illness requiring hospitalization or even death.

FIGURE 12: COVID-19 cases by month, 2020[1]

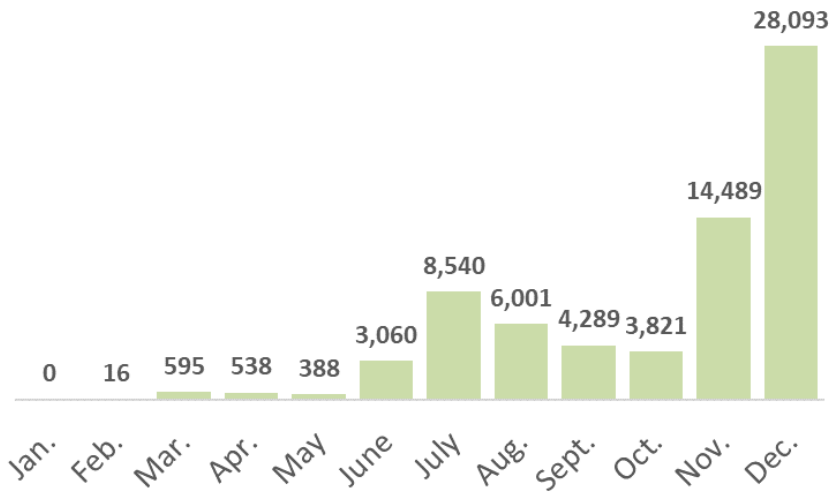


FIGURE 13: COVID-19 rates per 100,000 by month, County vs. State, 2020[1]

Source: 1. California Reportable Disease Information Exchange (CalREDIE); 2. California Department of Public Health

COVID-19

Cases by month: There were a total of 69,830 COVID-19 cases in the County in 2020. COVID-19 case counts drastically increased during 2020 [Figure 12]. The initial increase in cases in March 2020 resulted in Statewide stay-a-home public health orders as health response efforts shifted from disease containment to mitigation efforts. Cases surged in July of 2020. There was a 'second wave' again in December 2020 driven by the Delta variant.

Rates by month: County COVID-19 rates follow a similar monthly trend as cases [Figure 13]. The surge in case rates in December were greater in the State overall compared to the County.

FIGURE 14: COVID-19 deaths by month, 2020[1]

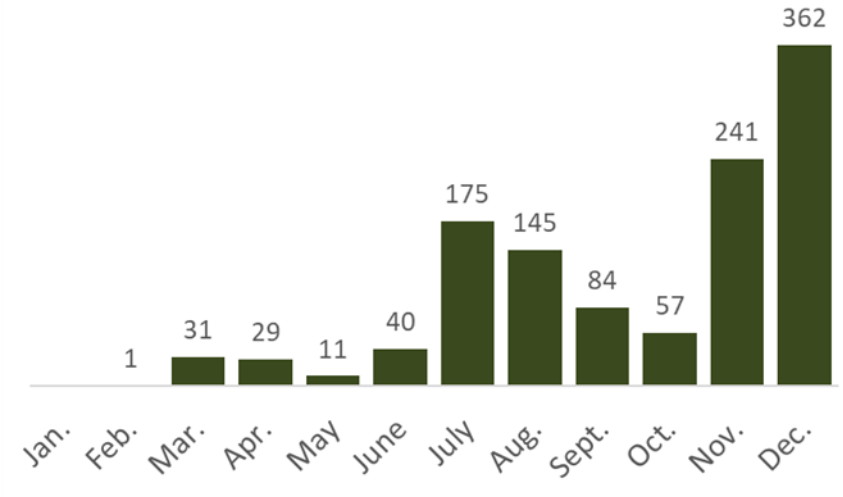
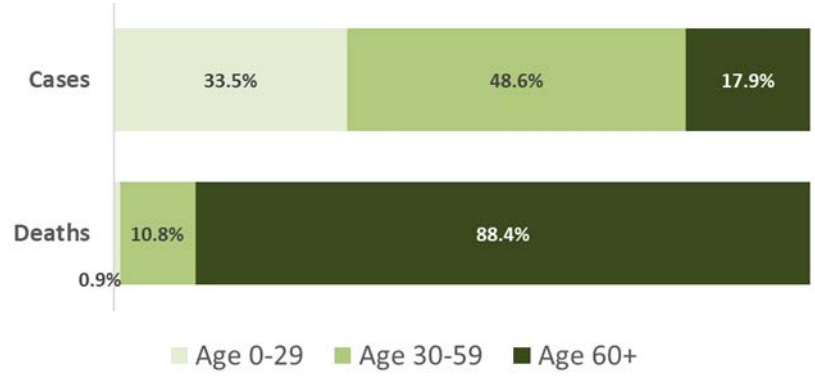


FIGURE 15: COVID-19 death rates per 100,000 by month, County vs. State[1, 2]

FIGURE 16: Age distribution of COVID-19 cases and deaths[1]



Source: 1. California Reportable Disease Information Exchange (CalREDIE); 2. California Department of Public Health

COVID-19

Deaths by month: There were a total of 1,176 COVID-19 deaths in the County in 2020. COVID-19 deaths by month in the County in 2020 followed a similar pattern as cases during 2020 [Figure 14]. During the July surge, 175 County residents passed away. The Delta surge in December was more than twice as deadly as the surge in July.

Rates by month: County COVID-19 death rates follow a similar monthly trend as number of deaths [Figure 15]. Similar to case rates, the surge in death rates in December was greater in the State overall compared to the County.

Age: COVID-19 infections affected all ages in 2020 [Figure 16]. Nearly half of all COVID-19 cases were among persons age 30 to 59. The vast majority of COVID-19 deaths were among adults age 60 and older, despite representing the lowest number of infections.

FIGURE 17: COVID-19 cases and deaths by sex[1]

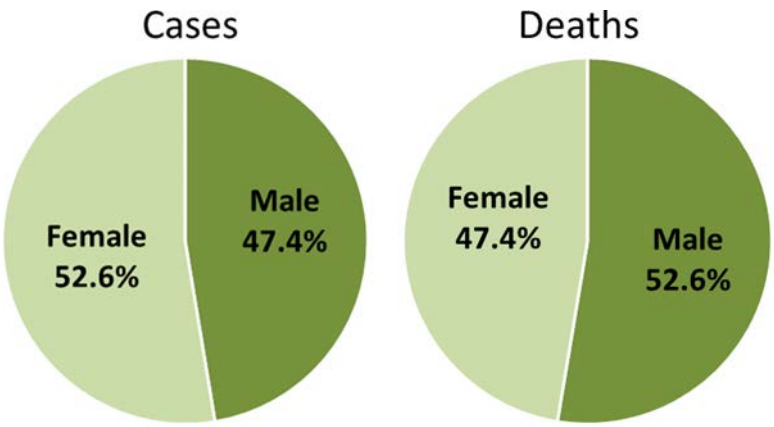


FIGURE 18: COVID-19 case rates per 100,000 by race/ethnicity[1]

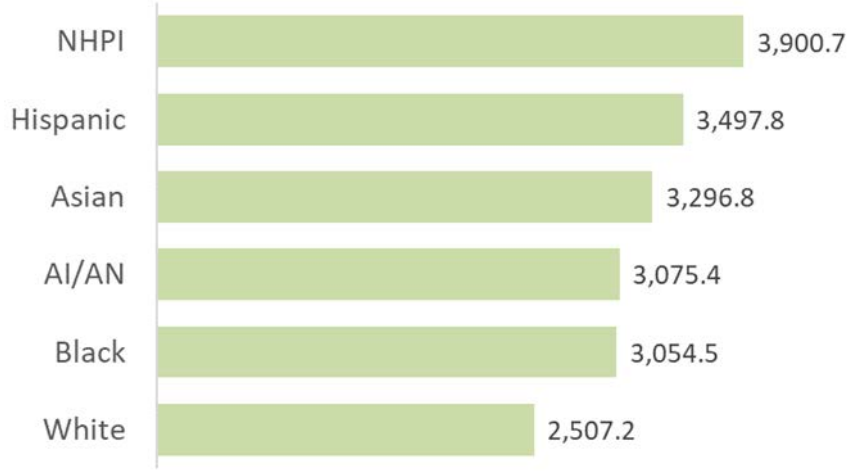
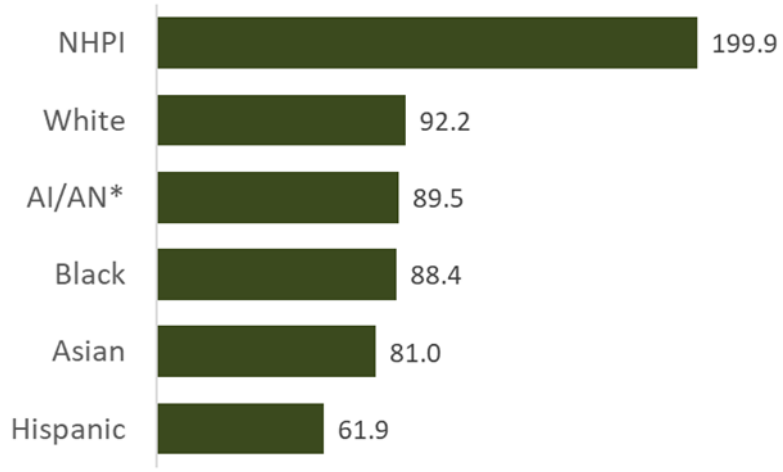


FIGURE 19: COVID-19 death rates per 100,000 by race/ethnicity[1]



Source: 1. California Reportable Disease Information Exchange (CalREDIE)

COVID-19

Sex: A slight majority of COVID-19 infections occurred among females in 2020 [Figure 17]. However, there were slightly more COVID-19 deaths among males.

Cases rates by race/ethnicity: COVID-19 case rates varied by race/ethnicity in the County [Figure 18]. Native Hawaiian and Other Pacific Islanders (NHPI), followed by Hispanics had the highest COVID-19 case rates in the County in 2020. Whites had the lowest case rates.

Death rates by race/ethnicity: NHPIs also had the highest COVID-19 death rates compared to all other racial/ethnic groups in County in 2020. Despite having the lowest case rates, Whites had the second highest death rates. Hispanics had the lowest death rates, despite relatively high case rates.

TABLE 2: Age distribution of COVID-19 hospitalizations[1]

Age group	Number (percent)
Age 0-17	51 (1.4%)
Age 18-49	771 (21.3%)
Age 50-64	930 (25.7%)
Age 65+	1826 (51.5%)

FIGURE 20: Racial/ethnic distribution of COVID-19 hospitalizations[1]

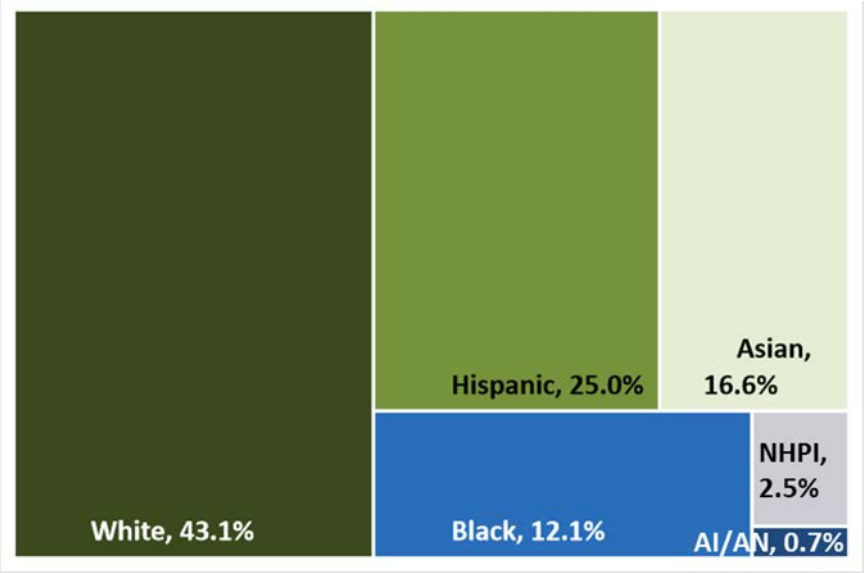
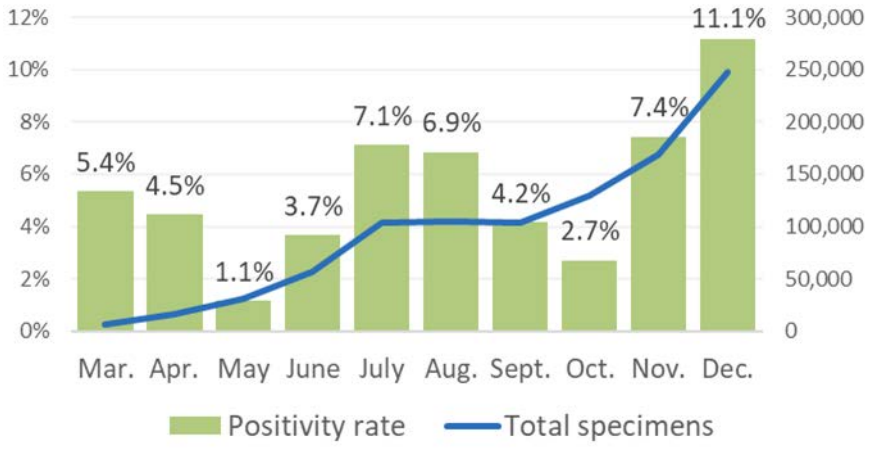


Figure 21: COVID-19 lab positivity and specimens tested by month[2]



Source: 1. California Department of Public Health Snowflake data; 2. California Reportable Disease Information Exchange (CalREDIE)

COVID-19

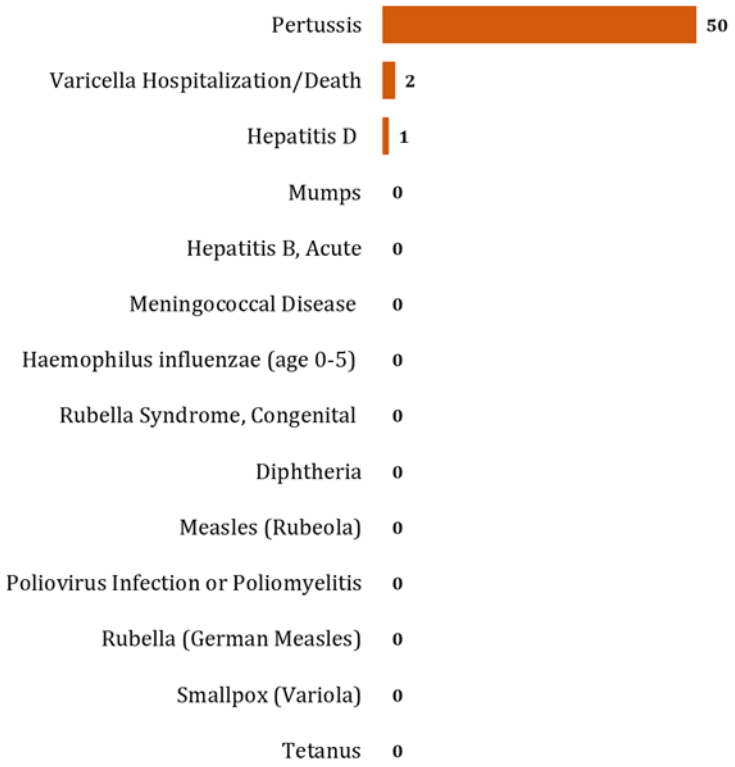
Hospitalizations: The median age of residents hospitalized due to COVID-19 infection was 65, ranging from age 0 to 104. More than three quarters of persons hospitalized due to COVID-19 were age 50 or older [Table 2]. These data do not include persons hospitalized for reasons other than COVID-19 infection who were later diagnosed with COVID-19 while in the hospital. The racial/ethnic distribution of persons hospitalized due to COVID-19 was similar to the racial/ethnic distribution of the County overall [Figure 20].

Lab positivity: Figure 21 shows the percent of total specimens tested for COVID-19 that yielded a positive COVID-19 test result from March through December 2020. The total number of specimens tested in the County increased from 5,996 in March to 247,948 in December. Early in the pandemic, COVID-19 testing could only be performed at the Centers for Disease Control and Prevention (CDC) and was not broadly available. Later, the California Viral and Rickettsial Disease Laboratory (VRDL), as well as the Sacramento County Public Health Laboratory (SCPHL) became certified to test COVID-19 specimens.

Other Vaccine-Preventable Diseases

Vaccine-preventable diseases (VPDs) are diseases for which vaccines have been developed to provide protection against the germs (e.g., viruses) causing the diseases. Vaccines work by introducing certain weakened parts of the germs (i.e., antigens) in very small, safe amounts so that the body's own natural immune system will recognize and make proteins (antibodies) to destroy the germs. Vaccines can prevent infectious diseases that once killed or harmed many infants, children, and adults. They help protect the individual receiving the vaccine and help prevent the spread of the disease in a community – which is especially important to protect the most vulnerable among us (e.g., very young children, immunocompromised) who cannot receive the vaccine themselves.

FIGURE 22: Number of vaccine-preventable diseases reported to the County, 2020[1]

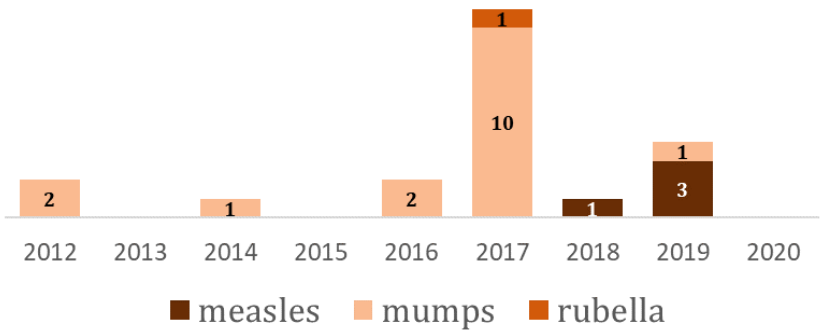


Source: 1. California Reportable Disease Information Exchange (CalREDIE)

VACCINE-PREVENTABLE DISEASES

Figure 22 shows some of the vaccine-preventable diseases (VPDs) reported to the County in 2020. De-duplicated 2020 counts for chronic Hepatitis B – the most commonly reported VPD – were not available from the State at the time of this report. Severe influenza cases were omitted as they are tabulated by influenza season rather than calendar year. Pertussis (whooping cough) cases vary drastically by year, with increases typically seen every 3 to 5 years. Even a few cases of other VPDs can be concerning due to their high level of infectiousness, severity of outcomes and/or resurgence in the United States after a period of near elimination.

FIGURE 23: Trend in measles, mumps, and rubella cases



Note: Rubella includes congenital Rubella

FIGURE 24: Pertussis cases by age group, 2016-2020

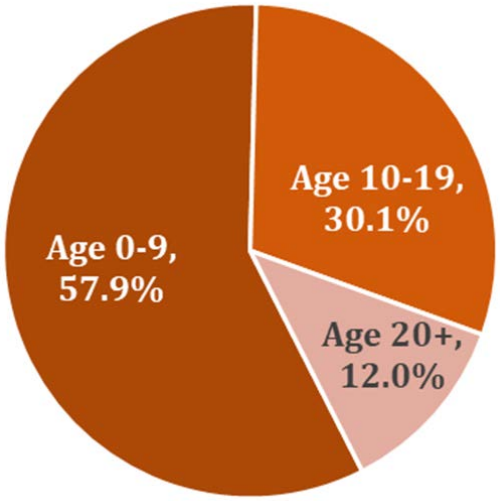
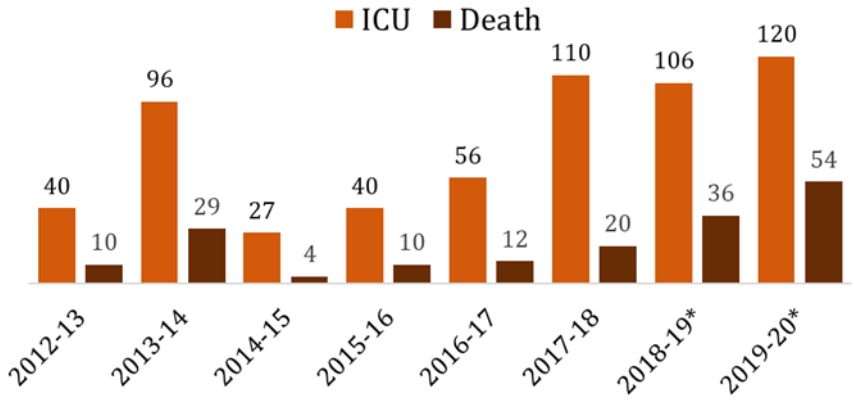


FIGURE 25: Influenza ICU cases and deaths by season



Note: Prior to the 2018-19 flu season only ICU and deaths under age 65 were reportable; all ICU cases and deaths were locally reportable starting the 2018-19 season

Source: 1. California Reportable Disease Information Exchange (CalREDIE)

VACCINE-PREVENTABLE DISEASES

Measles, Mumps and Rubella: The MMR vaccine is a safe and effective vaccine that prevents the spread and severity of three diseases: measles, mumps and rubella. The number of mumps cases increased dramatically in 2017 [Figure 23]. This increase was partially attributable to an outbreak of mumps at a local college affecting nine students, some of whom were County residents. Despite a State-wide outbreak of 125 measles cases between December 2014 and February 2015, no County residents were affected.

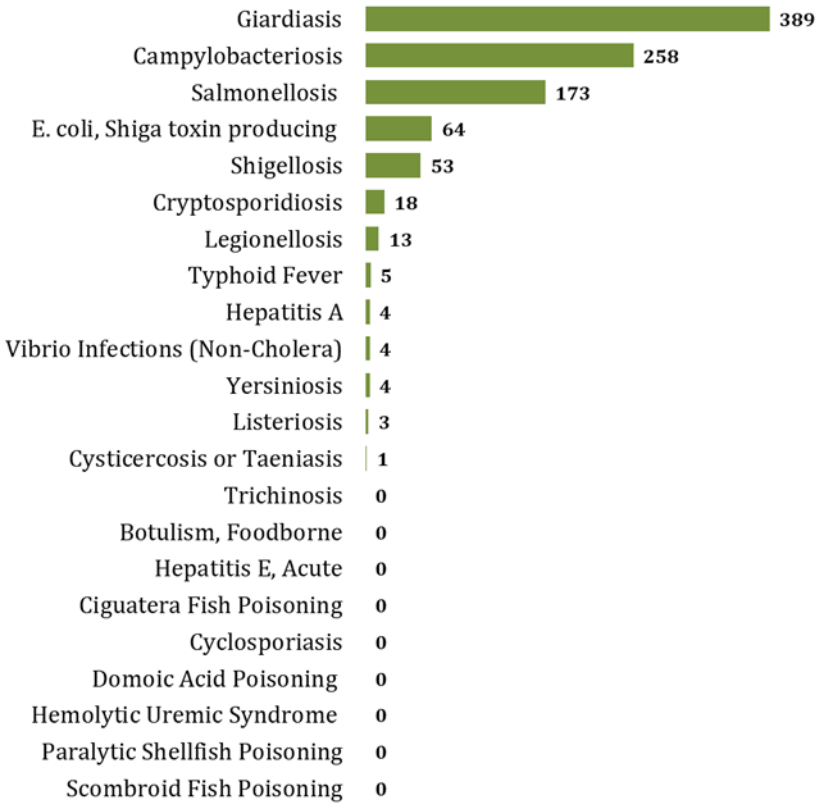
Pertussis: Pertussis (whooping cough) can occur at any age, but the majority of cases in 2020 were among children age 0 to 9 [Figure 24]. Pertussis fatalities are most common in young infants who are not yet eligible for vaccination.

Severe influenza: Only intensive care unit (ICU) flu cases and flu deaths under age 65 were reportable prior to the 2018-19 flu season. The 2017-18 influenza season was the most severe season in recent years [Figure 25]. All ICU and deaths became locally reportable in 2018-19.

Foodborne and Waterborne Illness

Foodborne illness (FBI) and waterborne illness (WBI) are common yet preventable. Each year, one in six Americans gets sick by consuming contaminated foods or beverages according to the Centers for Disease Control and Prevention (CDC). FBI/WBI infections are caused by swallowing a variety of different bacteria, viruses, or parasites. Typical symptoms may include upset stomach, nausea, vomiting, diarrhea and/or fever. FBI/WBI can result during bathing, washing, drinking or in food preparation. Following four basic food safety steps at home – clean, separate, cook and chill – can help prevent these illnesses.

FIGURE 26: Number of foodborne and waterborne illnesses reported to the County, 2020[1]



Source: 1. California Reportable Disease Information Exchange (CalREDIE)

FOODBORNE AND WATERBORNE ILLNESS

The most commonly reported FBI/WBI cases in the County in 2020 were giardiasis, campylobacter, and salmonellosis [Figure 26]. However, for some FBI/WBI illnesses, even a few cases are notable. For example, five cases of typhoid fever in a year are more than typical and is partially explained by travel. Typhoid fever is a life-threatening infection caused by the bacterium Salmonella Typhi. FBIs/WBIs are often under-reported due to lack of clinical specimen collections needed to obtain a more specific diagnosis than 'food poisoning' via laboratory confirmation.

Figure 27: Trend in giardiasis rate per 100,000, County vs. State[1-2]

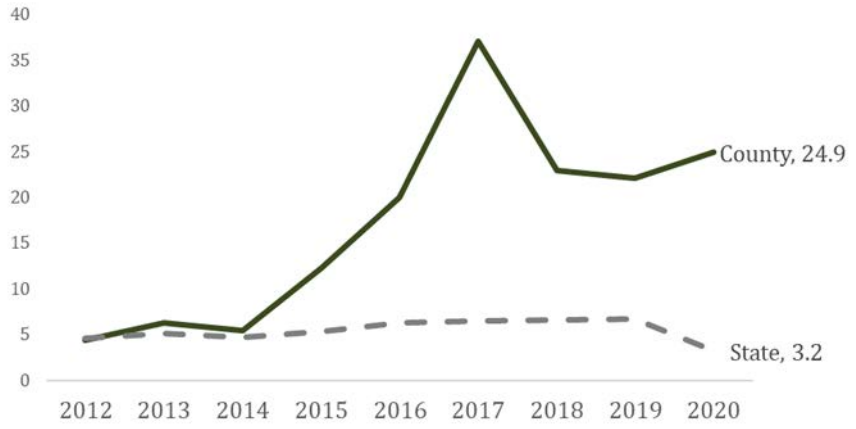
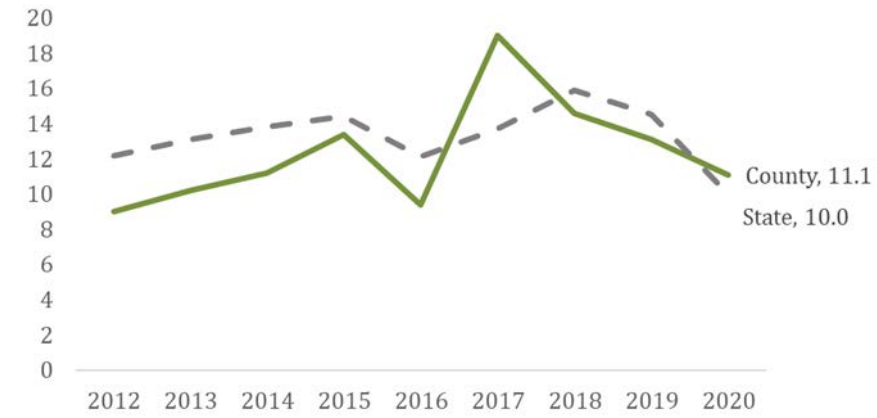


Figure 28: Trend in shiga-toxin producing *Escherichia Coli* rate per 100,000, County vs. State[1-2]

Figure 29: Trend in salmonellosis rate per 100,000, County vs. State[1-2]



Source: 1. California Reportable Disease Information Exchange (CalREDIE); 2. California Department of Public Health

FOODBORNE AND WATERBORNE DISEASES

Giardiasis: The rate of giardiasis infections per 100,000 population increased from 2012 to 2020, with a peak in 2017 (Figure 27). Increased laboratory testing for these infections, including testing performed at the Sacramento County Refugee Medical Evaluation Clinic, likely accounts for this increase.

Shiga-toxin producing Escherichia coli (STEC): STEC rates varied by year [Figure 28]. Localized outbreaks can explain some of the variation in these rates over time. A STEC outbreak associated with unpasteurized apple cider sickened 13 people, including 11 County residents in the fall of 2015. There was no single local outbreak that explained the increase in County cases in 2019, but the State overall experienced a similar increase.

Salmonellosis: Similar to STEC, localized outbreaks can explain some of the variation in County Salmonellosis rates over time [Figure 29]. Sixty-three persons, many County residents, became ill with *Salmonella infantis* in the spring of 2017 after eating a meal containing improperly cooked/handled chicken served at a school fundraiser.

Human Immunodeficiency Virus (HIV)

Human Immunodeficiency Virus (HIV) is most commonly spread through unprotected sexual contact or through sharing equipment for injection drug use. Acquired Immunodeficiency Syndrome (AIDS) is the last stage of HIV infection and occurs when the immune system is damaged to an extent that the person is vulnerable to life-threatening opportunistic infections. No effective cure exists for HIV. Antiretroviral therapy (ART) can help control HIV infection, slow progression to AIDS and reduce HIV transmission. Pre-exposure prophylaxis (PrEP) can be highly effective in reducing risk of HIV in certain populations when taken as directed under the care of a medical professional. Racism, stigma, homophobia, poverty, and barriers to health care drive disparities in HIV and other sexually transmitted infections.

FIGURE 30: Trend in rates of HIV diagnosis per 100,000 population, County vs. State, 2011-2020[1-2]

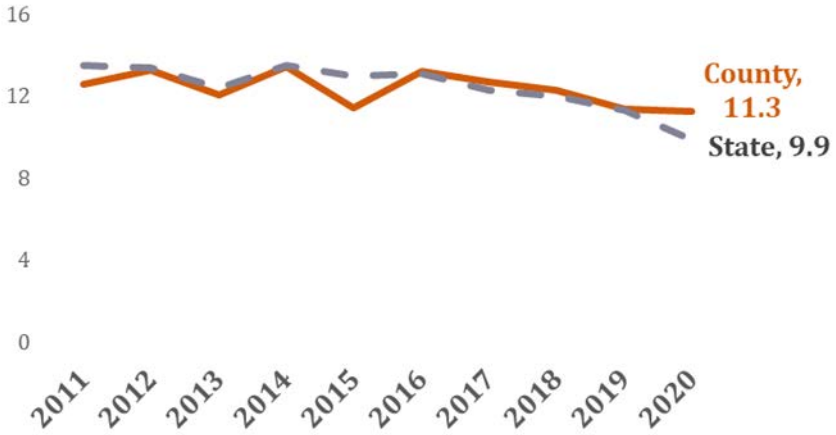
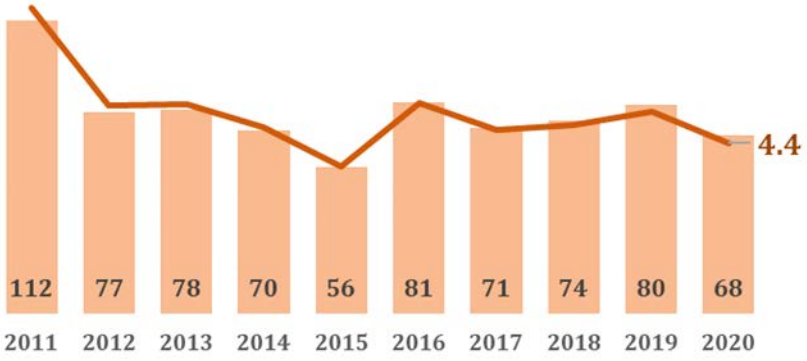


FIGURE 31: Trend in number and rates of AIDS diagnoses per 100,000 population, 2011-2020[1]



Sources: 1. California Department of Public Health (CDPH) Office of AIDS (OA) July 2022 Data Use Agreement File; 2. CDPH OA (State rates).

HUMAN IMMUNODEFICIENCY VIRUS

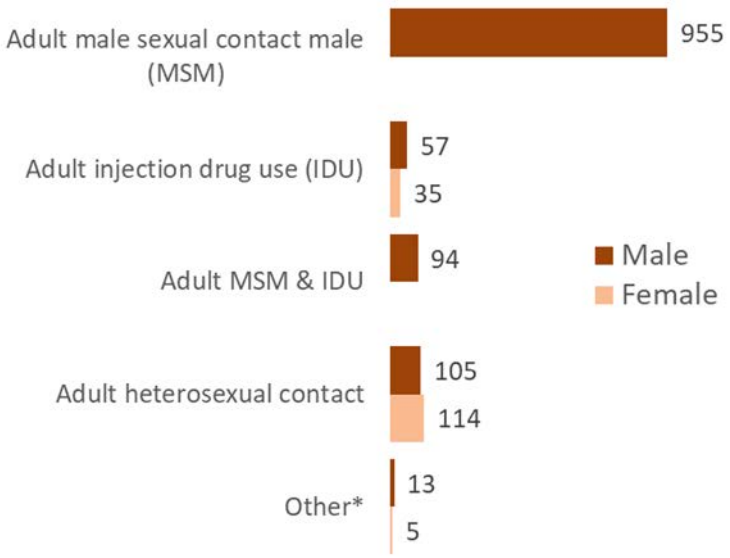
Newly diagnosed HIV: There were 176 newly diagnosed cases of HIV in 2020, or a rate of 11.3 per 100,000 population [Figure 30]. Trends in the County rates were relatively stable from 2011-2020. Recent slight decreases in rates may be due to delayed reporting.

***Newly diagnosed AIDS*:** The number and rate of newly diagnosed AIDS cases has decreased since 2011, indicating that local efforts to delay progression from HIV to AIDS have been effective in recent years [Figure 31].

TABLE 3: Newly diagnosed HIV cases by select race/ethnicity, 2020[1]

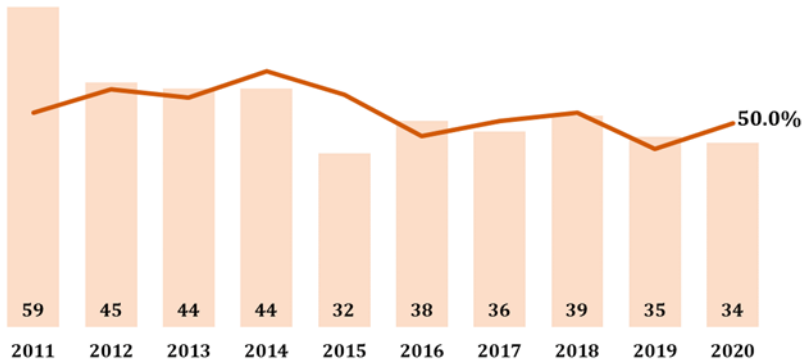
	Cases	Percent	Rate
Black	58	33.0%	37.2
Hispanic	39	22.2%	10.8
White	54	30.7%	7.5
API	10	5.7%	4.2

FIGURE 32: Number of HIV infections by sex and transmission category, 2011-2020[1]



**'Other' includes perinatal and other unspecified. Excludes no risk factor reported.*

FIGURE 33: Trend in number and percent of AIDS cases that were concurrently diagnosed with HIV and AIDS, 2011-2020[1]



Sources: 1. California Department of Public Health (CDPH) Office of AIDS (OA) July 2022 Data Use Agreement File

HUMAN IMMUNODEFICIENCY VIRUS (HIV)

Race/ethnicity: Blacks had the highest number, proportion and rate of newly diagnosed HIV infections in 2020 [Table 3]. Social determinants previously mentioned, including racism, contribute to these disparities.

Transmission category by sex: Transmission category is a classification of the risk factor most likely to have been responsible for spread of HIV. The most common transmission category among males from 2011-2020 was adult male sexual contact whereas the most common transmission category for females was adult heterosexual contact [Figure 32].

Concurrent diagnosis: HIV usually advances to AIDS in about ten years or longer without antiretroviral treatment. Concurrent diagnosis is when a person is diagnosed as having progressed to AIDS within a year of an initial HIV diagnosis. This means that individuals who are concurrently diagnosed may have been unknowingly exposing others to the infection for more than a decade prior to diagnosis. Half of the total AIDS cases in 2017 were concurrently diagnosed [Figure 33].

Other Sexually Transmitted Infections

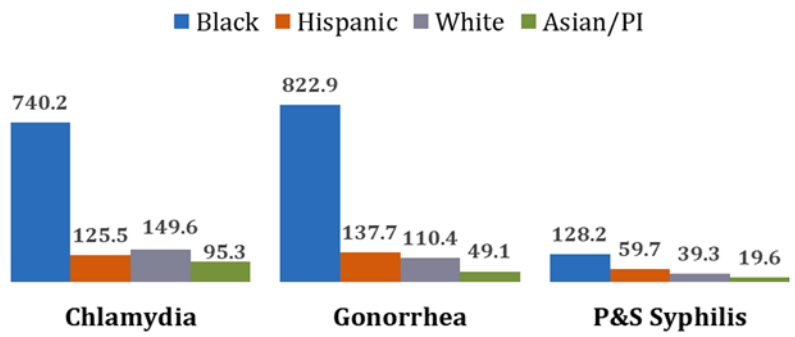
Sexually transmitted infections (STIs), also called sexually transmitted diseases (STDs) are some of most frequently reported infections at the local, state, and national level. Symptoms of STIs vary, and may be mild or absent, making routine screening vital to ensure prompt treatment. STIs can affect anyone, yet there are persistent disparities in rates of STIs based on age, sex, race/ethnicity, and sexual orientation. Bacterial STIs (e.g., chlamydia, gonorrhea) are curable, but untreated infections can cause irreversible damage such as female infertility. Pregnant women and unborn children are especially vulnerable to complications of STIs.

TABLE 4: Number and rates of sexually transmitted infections reported to the County, 2020[1-2]

Infection	Count	Rate*	State rank
Chlamydia	7,219		13
Gonorrhea	4,462		3
Syphilis	977		10
primary	*175*		
secondary	*212*		
early latent	*231*		
late latent/unknown duration	*359*		
Neuro-syphilis (any stage)	1		N/A
Congenital syphilis	18		

**Congenital syphilis rate is per 100,000 live births; all other rates are per 100,000 population*

FIGURE 34: Racial/ethnic disparities in select STI rates per 100,000 population, 2020[2]



Sources: 1. California Reportable Disease Information Exchange (CalREDIE); 2. California Department of Public Health Sexually Transmitted Diseases Branch

SEXUALLY TRANSMITTED INFECTIONS

Most commonly reported STIs: The most commonly reported STIs in the County in 2020 were chlamydia, followed by gonorrhea and then syphilis [Table 4]. Syphilis in the primary or secondary (P&S) stage accounted for about forty percent of all syphilis cases reported in 2020.

Racial/ethnic disparities: Blacks were disproportionately affected by STIs in 2020. Most notably, Blacks had a rate of gonorrhea over seven times that of Whites. [Figure 34]. Asian/Pacific Islanders had the lowest rates of STIs.

FIGURE 35: Chlamydia rates per 100,000 population by sex and age group, 2020[1]

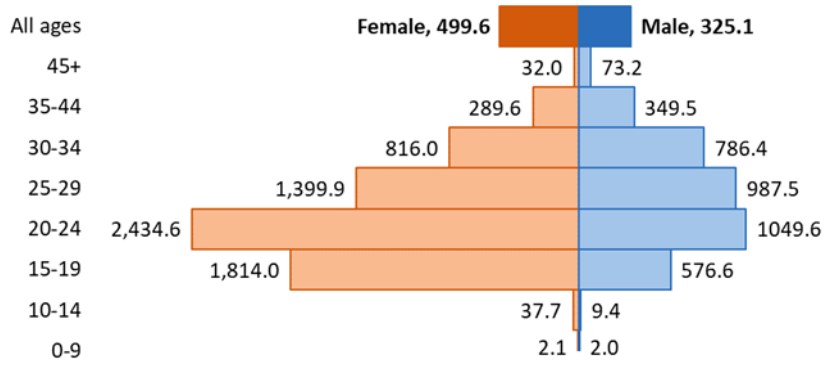


FIGURE 36: Gonorrhea rates per 100,000 population by sex and age group, 2020[1]

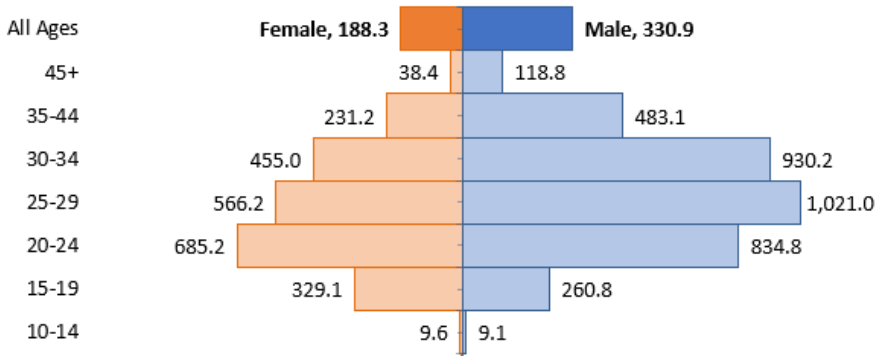
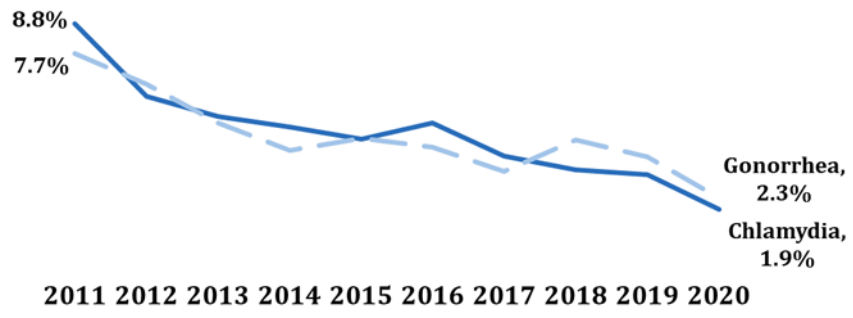


FIGURE 37: Trend in percent of female chlamydia and gonorrhea cases who were pregnant, 2011-2020[1]



Sources: 1. California Reportable Disease Information Exchange (CalREDIE)

SEXUALLY TRANSMITTED INFECTIONS

Chlamydia: Rates of chlamydia were higher for females than for males in 2020 [Figure 35]. The highest rates for female were between ages 15 and 29. Male cases were slightly older on average, with the highest rates between ages 20 to 34.

Gonorrhea: Rates of gonorrhea were higher for males than for females in 2020 [Figure 36]. Rates were the highest in age group 20 to 24 for females and age group 25 to 29 in males.

Pregnant cases: Rates of chlamydia and gonorrhea have increased statewide since 2011 [data not shown]. However, the proportion of female chlamydia and gonorrhea cases who were pregnant has decreased over time [Figure 37]. This may be partially due to increased hormonal birth control usage and/or increased targeted prevention and education efforts for women of childbearing age.

FIGURE 38: Trend in primary and secondary syphilis rates per 100,000 population, County vs. State, 2011-2020[1]

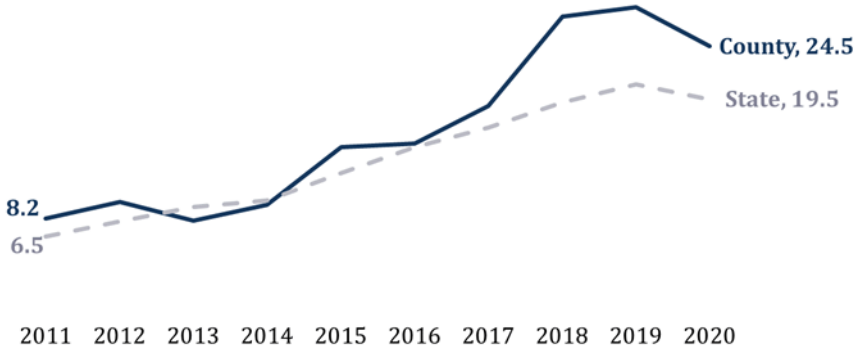


FIGURE 39: Primary and secondary syphilis rates per 100,000 population by sex and age group, 2020[1]

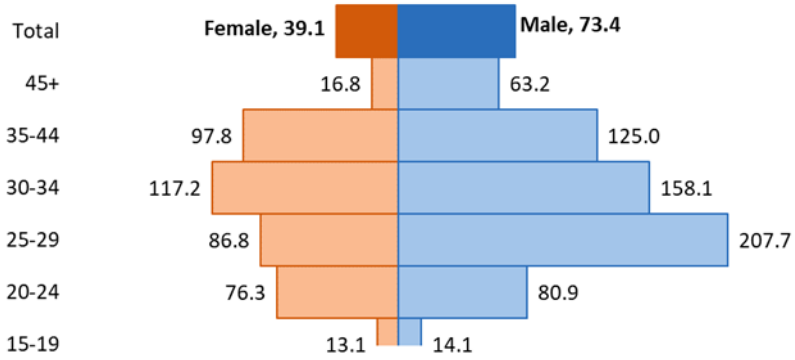
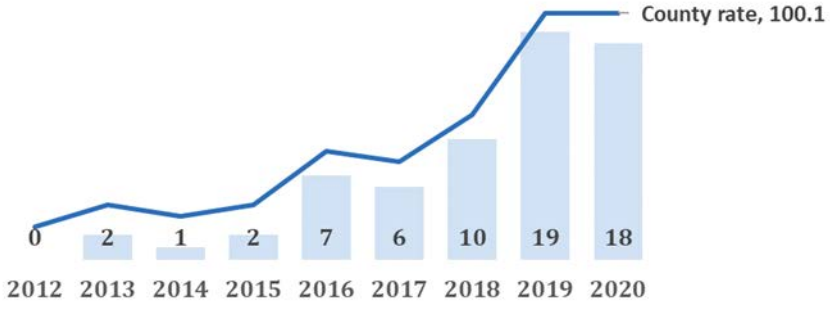


FIGURE 40: Trend in number and rate* of congenital syphilis, 2012-2020[1]



**Congenital syphilis rate is per 100,000 live births*

Sources: 1. California Reportable Disease Information Exchange (CalREDIE); 2. California Department of Public Health Sexually Transmitted Diseases Branch

SEXUALLY TRANSMITTED INFECTIONS

Syphilis trend: The County primary and secondary (P&S) syphilis rate increased 199% from 8.2 per 100,000 population in 2011 to 24.5 in 2017 [Figure 38]. This was very similar to the increasing trend statewide.

Syphilis sex and age: P&S syphilis rates were higher in males than females in 2020 [Figure 39]. This disparity is largely due to the state-wide syphilis outbreak initially among men who have sex with men (MSM) populations that later spread to heterosexual populations. Rates were highest in the 25 to 29 age group for males and 30 to 34 for females. Syphilis infections among women of child-bearing age (age 15 to 44) are especially concerning due to the potential risk of congenital syphilis. Syphilis infection in a pregnant female can cause miscarriage, stillbirth, prematurity, low birth weight, or death shortly after birth.

Congenital syphilis: The rate of congenital syphilis cases per 100,000 live births in the County greatly increased from 2012 to 2020 [Figure 40]. There were no congenital syphilis cases in the County in 2012, whereas there were 18 in 2020.

Tuberculosis

Tuberculosis (TB) is an infectious disease caused by Mycobacterium tuberculosis. TB is spread through the air from person to person. About 5-10% of infected persons who do not receive treatment for latent TB infection (LTBI) will later develop TB disease. The site of TB infection is most commonly the lungs (pulmonary TB), but infection can occur outside the lungs (extra-pulmonary TB). Common symptoms of pulmonary TB include a cough lasting at least three weeks, chest pain, and coughing up blood or sputum (phlegm in lungs). LTBI and TB disease are treatable with specific drug regimens. Treatment can be long and complicated depending on the characteristics of the patient (e.g., HIV co-infection) and the infection (e.g., drug resistance).

FIGURE 41: Trend in TB rates, County vs. State vs. HP2020 Objective, 2011-2020[1]

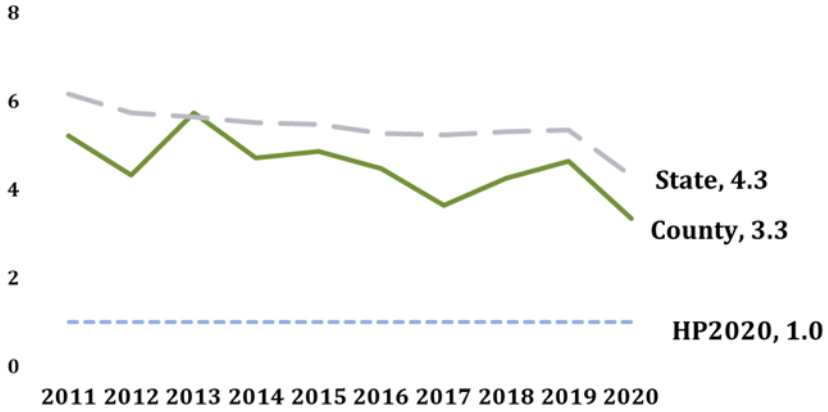
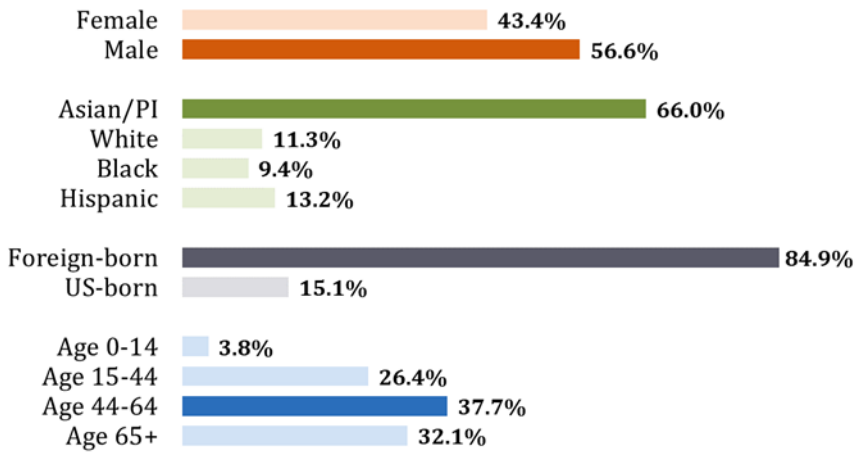


FIGURE 42: Select demographic characteristics of TB cases, 2020[1]



Source: 1. California Department of Public Health Tuberculosis Control Branch

TUBERCULOSIS

TB trends: There were 53 cases of active TB disease in the County in 2020. The rate of TB disease in the County declined 35.9% from 5.2 per 100,000 population in 2011to 3.3 in 2020 [Figure 41]. Both the County and State were above (i.e., did not meet) the Healthy People 2020 (HP2020) objective of a rate not more than 1.0.

TB demographics: A higher proportion of TB cases were male compared to female in 2020 [Figure 42]. Asian/Pacific Islanders and foreign-born persons were disproportionately represented among cases. About one-third (32%) of TB cases in 2020 were age 65 or older.

FIGURE 43: cases by site of disease, 2020[1]

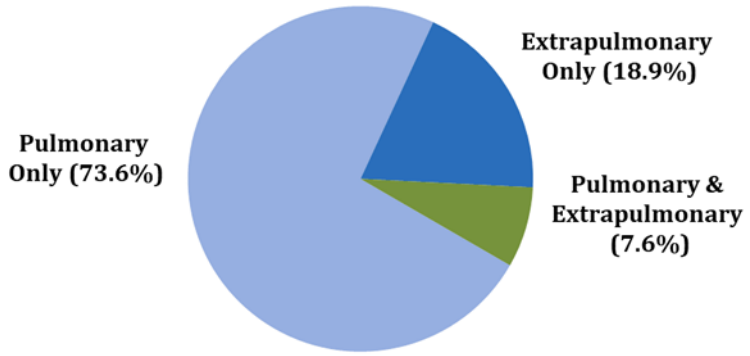


FIGURE 44: Trend in proportion of TB Cases with Diabetes, 2016-2020[1]

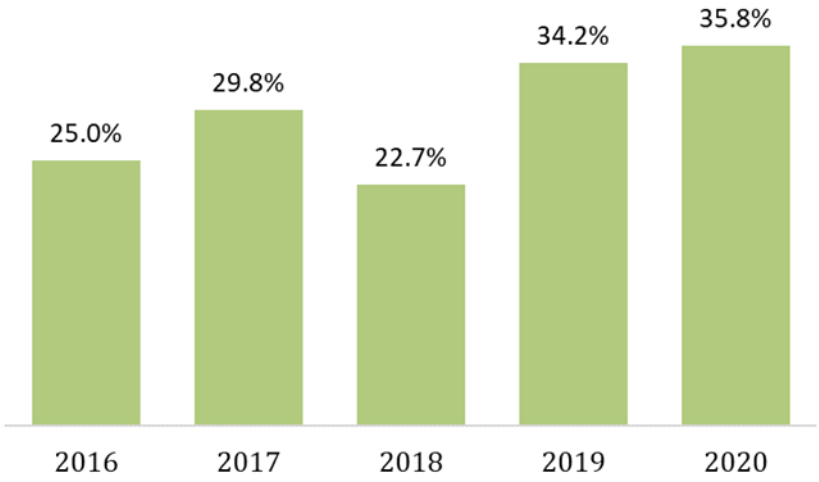
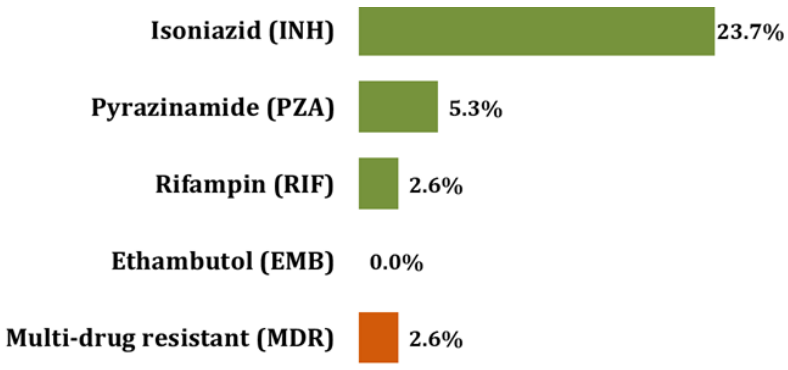


FIGURE 45: First-line TB drug resistance, 2020[1]



Source: 1. California Department of Public Health Tuberculosis Control Branch

TUBERCULOSIS

Site of disease: The majority of TB cases in the County in 2020 had TB infection of the lungs (pulmonary TB) only [Figure 43]. The most common extrapulmonary sites of disease were pleural and peritoneal [data not shown].

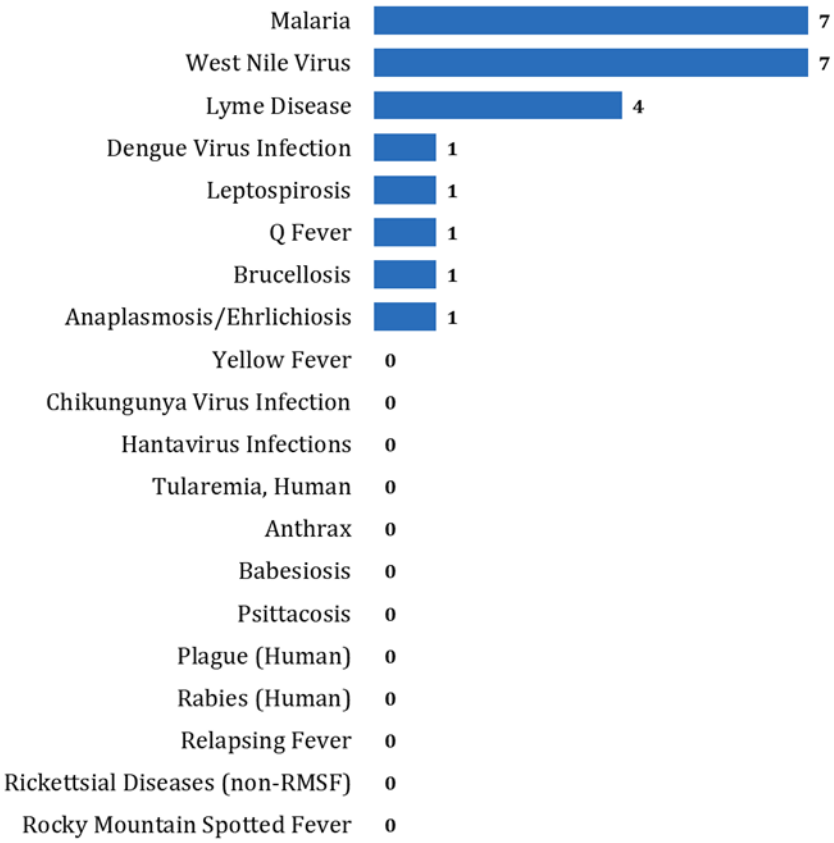
Diabetes co-morbidity: People living with diabetes mellitus who get infected with TB are more likely to develop active TB disease and become sick. Over one-third of County TB cases in 2020 also had diabetes [Figure 44].

Drug-resistance: In 2020, 37 of the 53 (69.8%) TB cases in the County were able to be tested for drug resistance. Of these cases, nine were resistant to Isoniazid (INH), two to pyrazinamide (PZA) and one to rifampin (RIF) [Figure 45]. Multi-drug resistant TB (MDR-TB) is when TB bacteria is resistant to at least INH and RIF. One TB case was MDR-TB in 2020.

Zoonotic Diseases

Zoonotic diseases are diseases that can be spread between animals and humans. Zoonotic diseases can be caused by viruses, bacteria, parasites, and fungi through contact with body fluids (blood, saliva, or waste) of infected animals. Vector-borne diseases (VBDs) are a subset of zoonotic diseases that are spread to humans through bites from mosquitoes, ticks, and fleas. Taking steps to prevent bites and reduce local population of the vectors is the best way to avoid these diseases. Common diseases that are considered both zoonotic and foodborne/water-borne (e.g., salmonellosis) were included in the foodborne section of this report.

FIGURE 46: Number of zoonotic diseases reported to the County, 2020[1]



Source: 1. California Reportable Disease Information Exchange (CalREDIE)

ZOONOTIC DISEASES

Three of the four most commonly reported zoonotic diseases in 2020 were vector-borne diseases transmitted through mosquito bite: malaria, West Nile virus, and Dengue [Figure 46]. The number of leptospirosis (1), Q-fever (1), and brucellosis (1), and anaplasmosis/ehrlichiois (1) cases were typical of the number reported each year to the County; these are bacteria often transmitted from contact with infected animals such as goats, sheep and cattle. Lyme disease is caused by the bacterium Borrelia burgdorferi and is spread to humans through the bite of infected blacklegged ticks. There were no other cases of tick-borne diseases besides Lyme reported to the County in 2020.

FIGURE 47: West Nile virus cases by type, 2012-2020

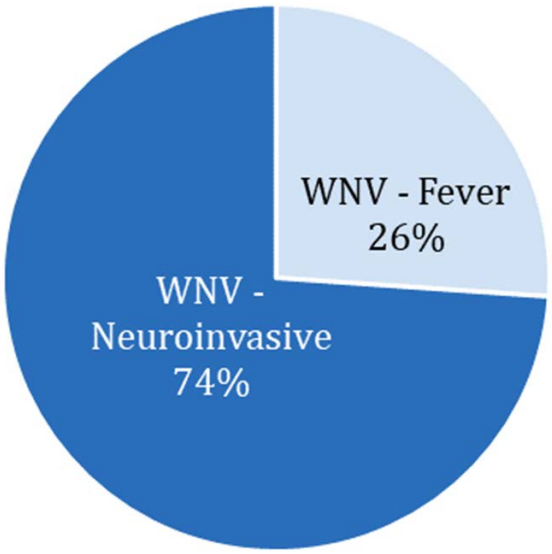
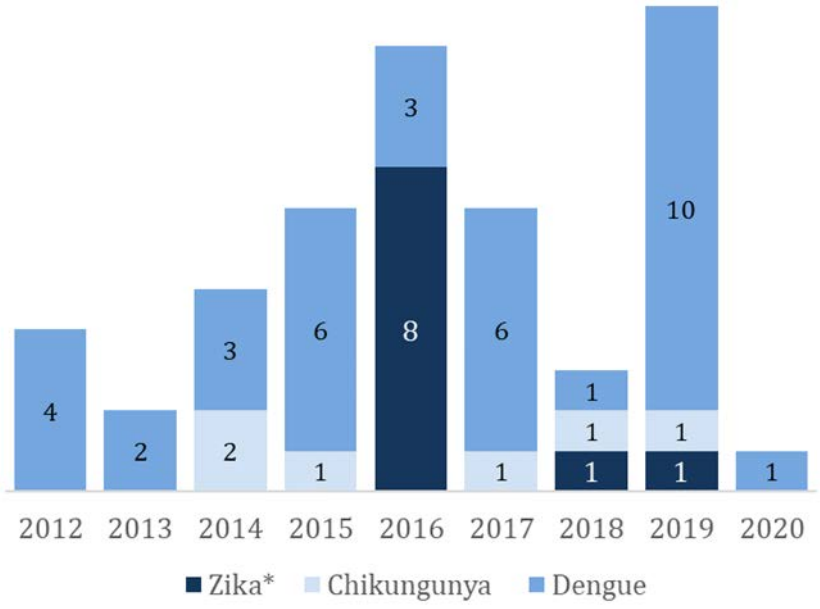


FIGURE 48: Trend in number of infections transmitted by the *Aedes* species mosquitos, 2012-2020[1]



**Zika became reportable in 2016*

Source: 1. California Reportable Disease Information Exchange (CalREDIE)

West Nile virus: West Nile virus (WNV) is the leading cause of mosquito-borne disease in the continental United States. Most people infected with WNV do not feel sick. About one in five develop a fever and other symptoms. About one in 150 persons infected get severe (neuroinvasive) disease. Despite being rare, severe cases are more likely to be diagnosed and reported; the number of WNV fever (non-neuroinvasive) cases is generally under-diagnosed and therefore under-reported. Therefore, a large percentage of reported WNV cases are neuroinvasive [Figure 47].

Aedes species mosquitos: *Aedes* aegypti mosquitoes are the main type of mosquito that spreads chickungunya, dengue, yellow fever and Zika viruses as they prefer to feed on humans. They are not native to California and were not yet found in the County in 2020. All of the cases of chickungunya, dengue and Zika among County residents from 2012-2020 were associated with travel outside the County [Figure 48]. There were no cases of yellow fever during this period.

CHRONIC DISEASE

Alzheimer's Disease

Alzheimer's disease is a progressive disease beginning with mild memory loss possibly leading to loss of the ability to carry on a conversation and respond to the environment. It involves parts of the brain that control thought, memory, and language. Alzheimer's is the most common type of dementia in the United States, with an estimated five million Americans living with the disease. Age is the best-known risk factor for Alzheimer's, with symptoms typically appearing after age 60. Researchers are studying whether education, diet and the environment play a role in developing Alzheimer's. Physical, mental, and social activities may reduce the risk of the disease.

FIGURE 49: Trend in age-adjusted Alzheimer's disease death rate, 2011-2020[2]

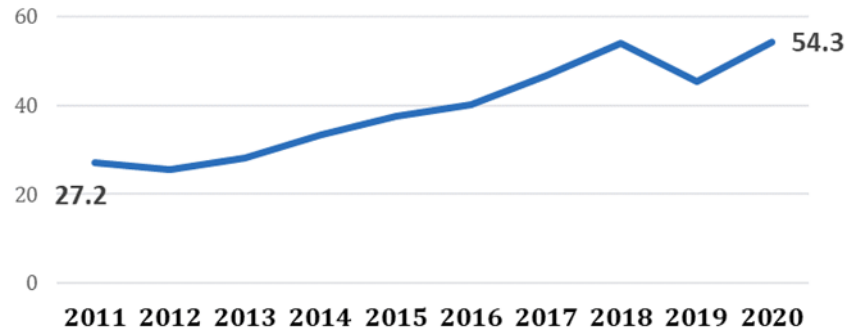
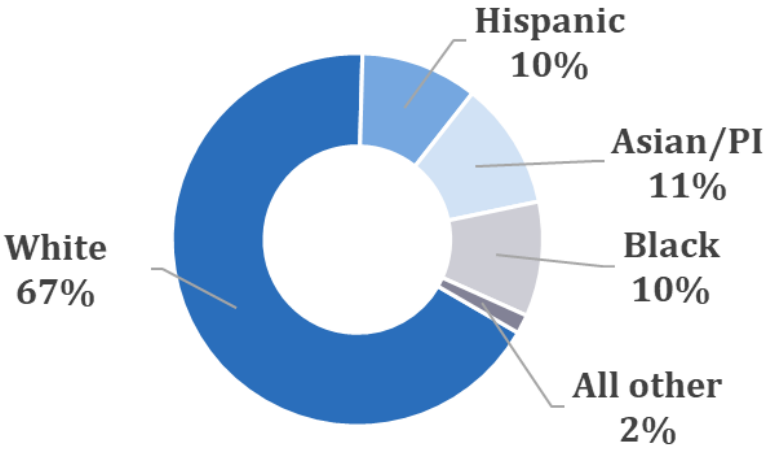


FIGURE 50: Alzheimer's disease deaths by race/ethnicity, 2020[2]



Sources: 1. Vital Records Business Intelligence System

ALZHEIMER'S DISEASE

Trend: Deaths due to Alzheimer's disease increased greatly during the ten-year period from 2011 to 2020. The age-adjusted rate of death increased 99.6% from 27.2 in 2011 to 54.3 in 2020 [Figure 49].

Race/ethnicity: Whites made up the majority of deaths due to Alzheimer's and are disproportionately affected by the disease compared to all other racial/ethnic groups [Figure 50]. Hispanics have less than half the expected proportion of Alzheimer's deaths given the County population.

FIGURE 51: Proportion of Alzheimer's disease emergency department visits by sex, 2020[1]

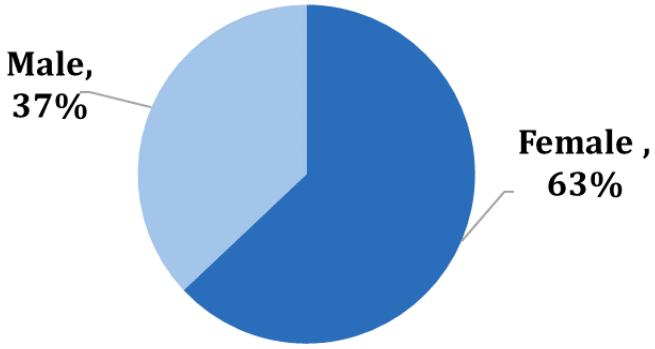


FIGURE 52: Number of Alzheimer's emergency department visits by age group, 2020[1]

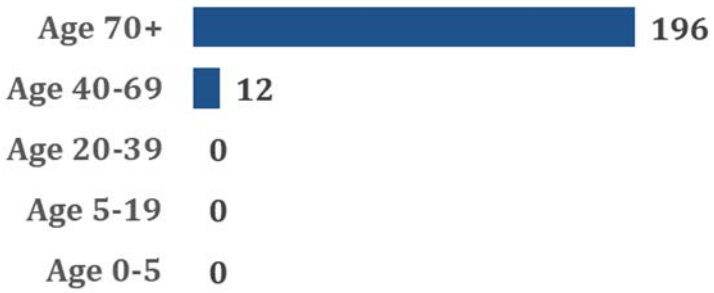
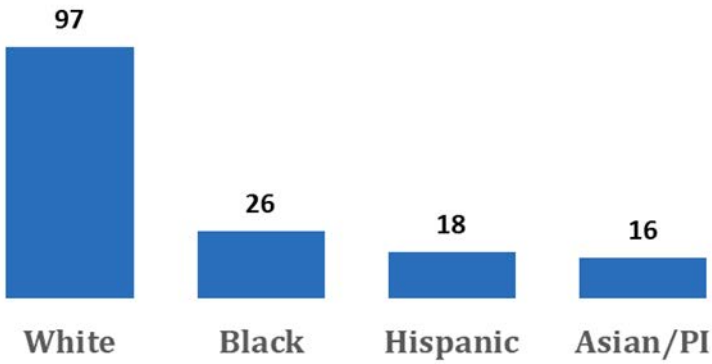


FIGURE 53: Number of Alzheimer's disease emergency department visits by race/ethnicity, 2020[1]



Source: 1. California Department of Public Health Office of Health Care Access and Information, Emergency Department Data 2020

ALZHEIMER'S DISEASE

Emergency Department Visits: There were a total of 164 emergency department (ED) visits due to Alzheimer's disease which did not result in a hospital admission in the County in 2020.

Sex: Nearly two-thirds of all Alzheimer's ED visits in the County were among females in 2020 [Figure 51].

Age group: Most (88.4%) Alzheimer's ED visits in the County were among persons age 70 and older in 2020 [Figure 52]. Not surprisingly, there were no Alzheimer's ED visits among those age less than 40.

Race/ethnicity: Nearly two-thirds of all Alzheimer's ED visits in the County were among Whites in 2020 [Figure 53]. Blacks, Hispanics and Asian/Pacific Islanders accounted for about one-third of Alzheimer's ED visits. The racial/ethnic breakdown of 2020 Alzheimer's ED visits is similar to the pattern seen in 2020 deaths.

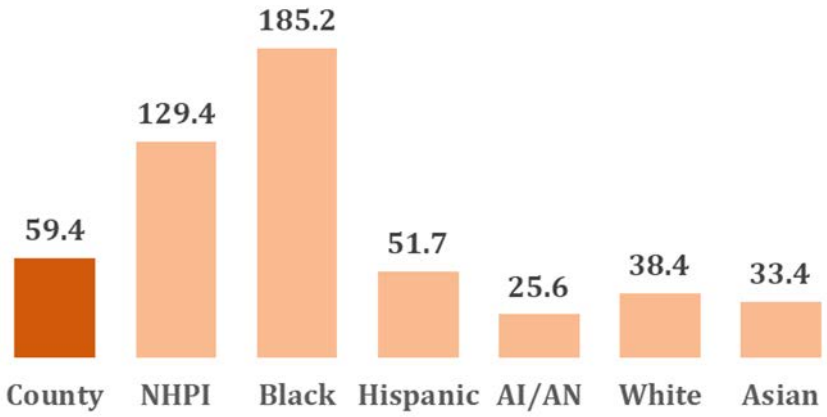
Asthma

Asthma is a chronic disease of the lungs that affects 25 million people in the United States, including six million children. It causes repeated episodes of wheezing, breathlessness, chest tightness, and nighttime or early morning coughing. In an asthma attack, the airways become inflamed, making breathing difficult. The exact causes of asthma are unknown in most cases. Asthma can be controlled by taking medicine and avoiding triggers in the environment that can cause an attack. Asthma can result in frequent emergency department (ED) visits, hospitalizations, and premature death without proper management.

TABLE 5: Estimated asthma prevalence by age group, County vs. State, 2019-2020[1]

	County	State
Lifetime asthma prevalence (Age 18+)	18.6%	16.2%
Lifetime asthma prevalence (Age 0-17)	8.1%	11.9%
Active asthma prevalence (All ages)	7.6%	7.4%
Active asthma prevalence (Age 18+)	10.6%	9.1%

FIGURE 54: Age-adjusted emergency department visits by race/ethnicity, 2019[1]



Source: 1. California Breathing County Asthma Dashboard https://www.cdph.ca.gov/Programs/CCDPHP/DEODC/EHIB/CPE/Pages/CaliforniaBreathingCountyAsthmaProfiles.aspx

ASTHMA

Prevalence: The estimated lifetime asthma prevalence and active asthma prevalence for all ages were higher in the County compared to the State in 2019-2020 [Table 5]. However, the estimated childhood (age 0 to 17) lifetime and active asthma prevalence were lower in the County compared to the State.

***Demographics*:** The rate of asthma ED visits among Blacks was nearly five times the rate of asthma ED visits among Whites in 2020 [Figure 54]. Young children had the highest rate of asthma ED visits in 2020 compared to all other age groups [data not shown].

Cancer

Cancer is a collection of related diseases. In all types of cancer, abnormal cells divide without control and can invade other tissues. Cancer can start almost anywhere in the human body. Many cancers (but not all) form solid tumors, which are masses of tissue. Cancerous tumors can be malignant, with means they can spread into, or invade, nearby tissues. As these tumors grow, they may also break off and travel to distant places in the body through the blood and lymph systems and form new tumors. About 38.4% of men and women will be diagnosed with cancer at some point during their lifetimes.

FIGURE 55: Trend in cancer (all sites) crude death rates per 100,000, 2011-2020[1]

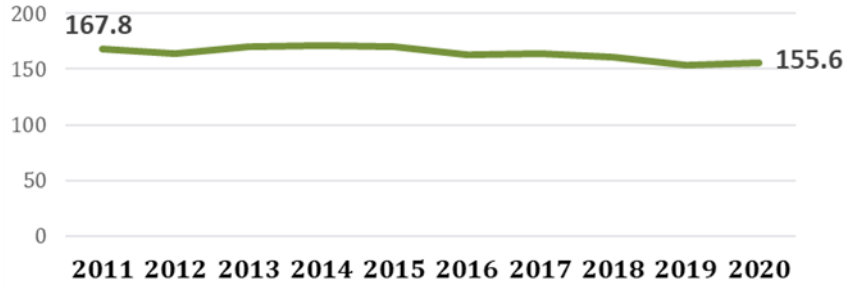


FIGURE 56: Proportion of Cancer (all sites) deaths by race/ethnicity, 2020[1]

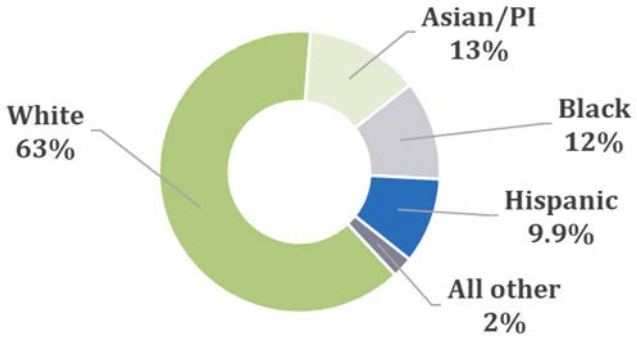


TABLE 6: Age-adjusted death rates by sex and cancer site, 2020[1]

Site of cancer	Female	Male
Lung and bronchus	29.3	39.2
Breast - female	22.0	---
Prostate	---	21.1
Colorectal	14.0	16.4
Leukemia	6.1	7.4
Lymphoma	6.0	8.4

Sources: 1. Vital Records Business Intelligence System

CANCER

Death trend: The age-adjusted cancer (all sites) death rate per 100,000 population decreased by 7.3% from 167.8 per 100,000 population in 2011 to 155.6 in 2020 [Figure 55].

Race/ethnicity: Nearly two-thirds of deaths due to cancer (all sites) were among Whites in 2020 [Figure 56]. The proportion of cancer deaths among Hispanics (9.9%) was lower than expected given the overall Hispanic population.

Site of disease by sex: Death rates by site of disease varied somewhat by sex in 2020 [Table 6]. Lung and bronchus cancer was the deadliest site of disease for both females and males. The second most deadly cancer for females was breast cancer, as opposed to prostate cancer for males. Colorectal, leukemia and lymphoma were in the top five most deadly cancers for both sexes.

Cardiovascular Disease

Cardiovascular diseases include heart disease and stroke. The term 'heart disease' refers to several types of heart conditions and is the leading cause of death in the United States. The most common type of heart disease is coronary artery disease, which can lead to heart attack. A stroke, sometimes called a brain attack, occurs when something blocks blood supply to part of the brain or when a blood vessel in the brain bursts. A stroke can cause lasting brain damage, long-term disability or even death. Healthy lifestyle changes – diet, exercise, no smoking, limited alcohol, and reduced stress – can greatly reduce the risk for cardiovascular diseases.

FIGURE 57: Trend in age-adjusted heart disease and stroke death rates, 2011-2020[1]

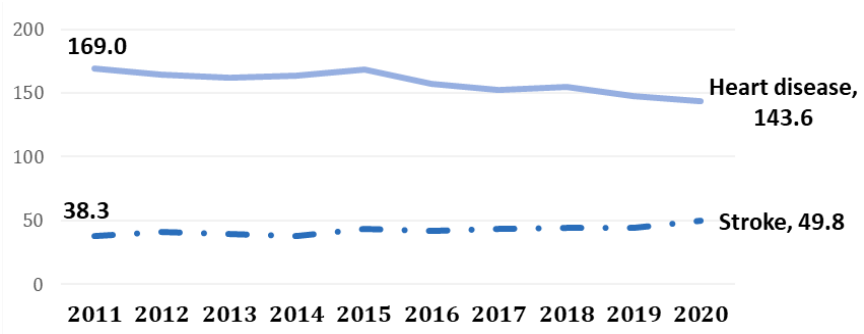
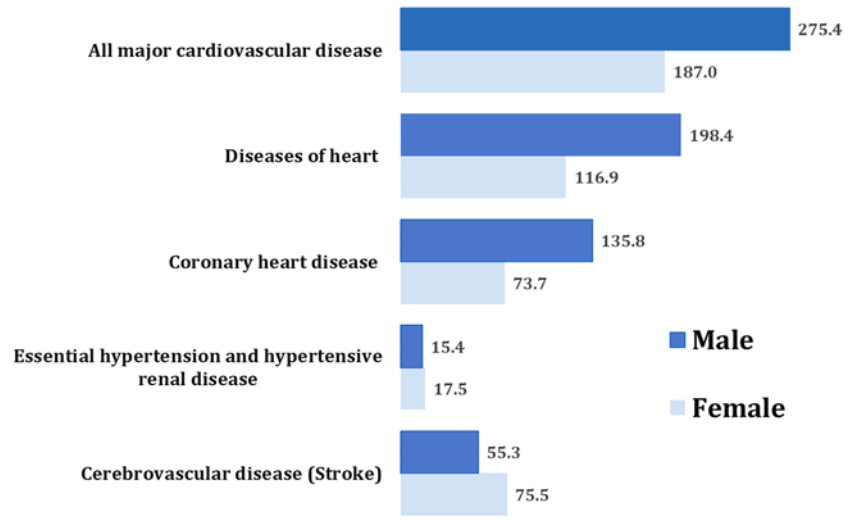


FIGURE 58: Age-adjusted major cardiovascular disease death rates overall and by subcategory by sex, 2020[1]



Sources: 1. Vital Records Business Intelligence System

CARDIOVASCULAR DISEASES

Trends: The age-adjusted heart disease rate decreased by 15.0% from 169.0 deaths per 100,000 population in 2011 to 143.6 in 2020 [Figure 57]. There was a much lower death rate due to stroke across all years, but the rate increased (+23.1%) from 38.3 in 2011 to 49.8 in 2020.

Cardiovascular disease subcategory by sex: Males had higher death rates of cardiovascular disease overall and in the most common subcategories in 2020 [Figure 58]. However, females had higher rates of death due to stroke than males.

Diabetes Mellitus

Diabetes mellitus is a chronic health condition that affects how the body turns food into energy. Most food eaten is turned into glucose (sugar) and released it into the bloodstream. When blood sugar goes up, it signals the pancreas to release insulin so that body's cells can use it for energy. Type 1 diabetes is thought to be an autoimmune reaction that stops the body from making insulin. Type 2 diabetes is when the body doesn't use insulin well and can't keep blood sugar at normal levels. Diabetes can be managed by maintaining a healthy weight, eating healthy food, being active and taking medicine as needed. Uncontrolled diabetes can lead to serious health problems, such as heart disease, vision loss and kidney disease.

TABLE 7: Estimated diabetes mellitus prevalence (all ages), County vs. State, 2020[1]

	County	State
Ever diagnosed with diabetes	8.1%	10.9%

FIGURE 59: Estimated diabetes mellitus prevalence (all ages) by select race/ethnicity, 2011-2020 pooled data[1]

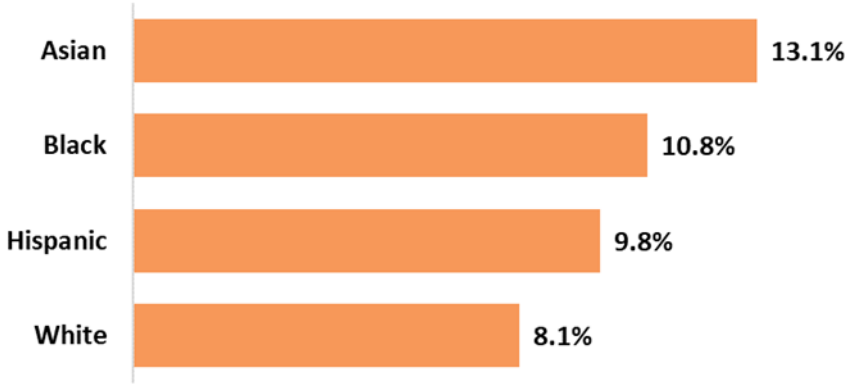
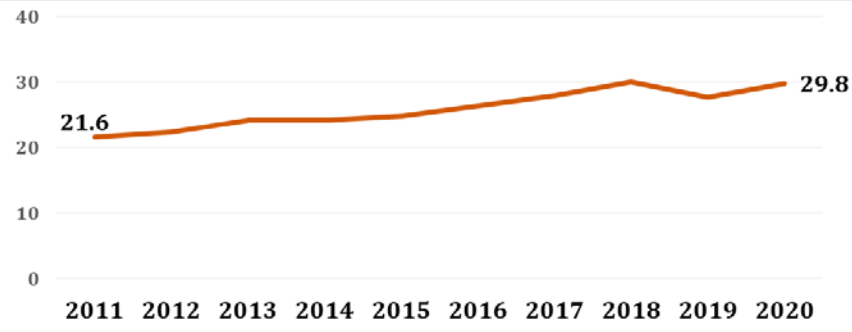


FIGURE 60: Trend in age-adjusted diabetes mellitus death rates, 2011-2020[2]



Sources: 1. California Health Interview Survey; 2. Vital Records Business Intelligence System

DIABETES MELLITUS

Prevalence: Less than one in ten persons in the County are estimated to have ever been diagnosed with diabetes [Table 7]. This is lower than the State overall.

Race/ethnicity: Asians had the highest estimated proportion of population with diabetes compared to other racial/ethnic groups for combined survey data from years 2011 to 2020 [Figure 59]. Estimates for Pacific Islander and American Indian or Alaskan Native groups were not stable due to small survey numbers.

Death trend: The death rate due to diabetes increased 38.0% from 21.6 per 100,000 population in 2011 to 29.8 in 2020 [Figure 60].

Obesity

Obesity is a national epidemic and a major contributor to some of the leading causes of death in the United States, including heart disease, stroke, diabetes, and some types of cancer. Body mass index (BMI) is used as a screening tool for adult overweight and obesity. A high BMI can be an indicator of high body fatness. Centers for Disease Control and Prevention (CDC) Growth charts are an indicator to measure the size and growth patterns of children and teens in the United States. There is no single or simple solution to the obesity epidemic. Policy makers, state and local organizations, schools, and individuals all must work together to create an environment that supports a healthy lifestyle and healthy choices.

FIGURE 61: Trend in age-adjusted obesity death rates, 2011-2012[2]

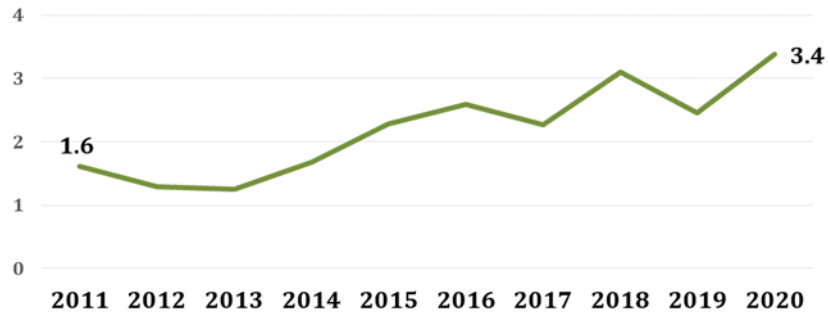
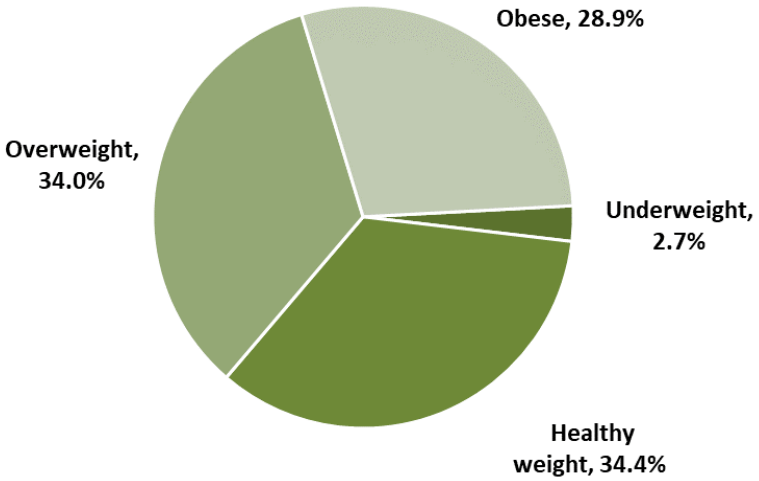


FIGURE 62: Estimated distribution of adult body mass inventory (BMI) category, 2016-2020 pooled data[2]



Sources: 1. Vital Records Business Intelligence System; 2. California Health Interview Survey

OBESITY

Death trend: The death rate due to obesity increased 112.5% from 1.6 per 100,000 in 2011 to 3.4 in 2020 [Figure 61]. Although deaths with obesity listed as the underlying cause of death on death certificates were relatively low, obesity is a contributing factor to many leading causes of death.

Adult body mass index (BMI): Only about one-third of adults surveyed from 2016 to 2020 in the County had a healthy BMI (BMI of 18.5 to less than 25) [Figure 62]. The majority (62.9%) were overweight or obese.

Oral Health

Oral health affects the ability to speak, smile, eat and show emotions. It also affects self-esteem and attendance at work or school. Oral diseases, which range from cavities to gum disease to oral cancer, cause pain and disability for millions of Americans. Oral health has been linked with other chronic diseases, like diabetes and heart disease. It has also been linked with risky behaviors like using tobacco and eating or drinking foods and beverages high in sugar. Cavities (tooth decay) are one of the most common chronic diseases in the United States, with 80% of people having at least one cavity by age 34. Public health strategies such as water fluoridation and school sealant programs have been proven to prevent cavities.

FIGURE 63: Oral Health-related emergency department visit rates per 10,000 population by age group[1] 2020[2]

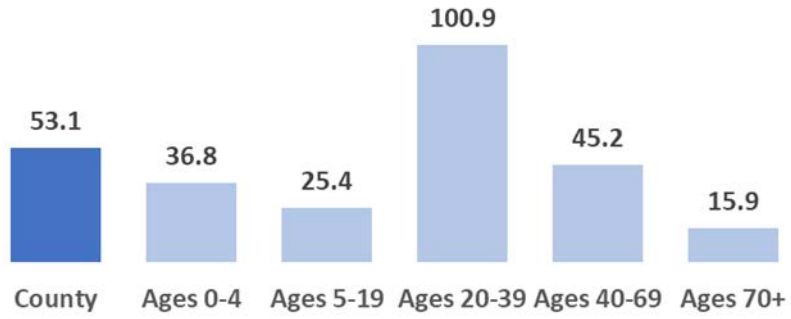
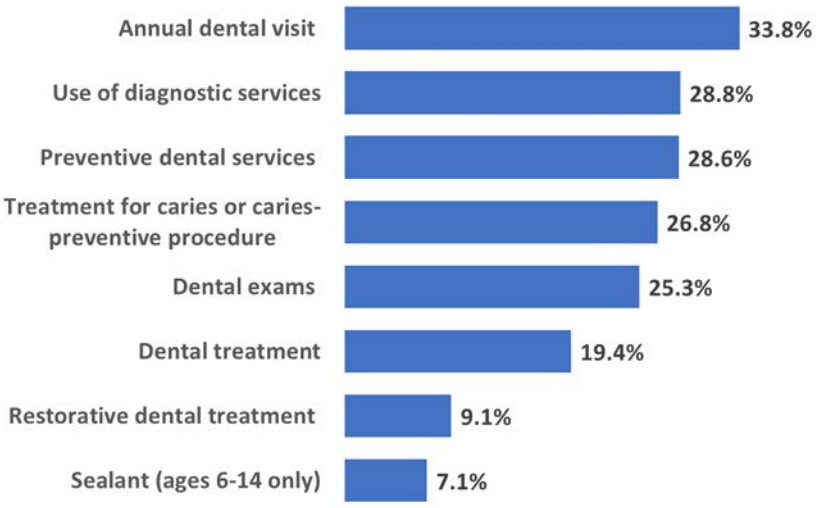


FIGURE 64: Denti-Cal dental services utilization, 2020[1]



Sources: 1. California Department of Healthcare Access and Information

ORAL HEALTH

Emergency department (ED) visit by age: The rates of oral health-related ED visits varied by age group in 2020, with the highest rates among young adults age 20 to 39 and children age less than 5 [Figure 63].

Denti-Cal utilization: The most common Denti-Cal services utilization in 2020 was annual dental visit [Figure 64]. Utilization of services, such as sealant, were likely lower than prior years due to COVID-19 related school closures and lockdowns.

Tobacco Use

Tobacco use leads to disease and disability and harms nearly every organ in the body. Smoking means inhaling, exhaling, burning, or carrying any lighted or heated cigar, cigarette, or pipe, or any other lighted or heated tobacco or plant product intended for inhalation, whether natural or synthetic. Smoking includes the use of an electronic smoking device that creates an aerosol or a vapor. It causes cancers, heart disease, stroke and chronic obstructive pulmonary disease. It also increased the risk for tuberculosis and problems of the immune system. Children who are exposed to secondhand smoke are at increased risk for sudden infant death syndrome, acute respiratory infections, more severe asthma, and other health effects.

FIGURE 65: Estimated adult smoking status, 2020[1]

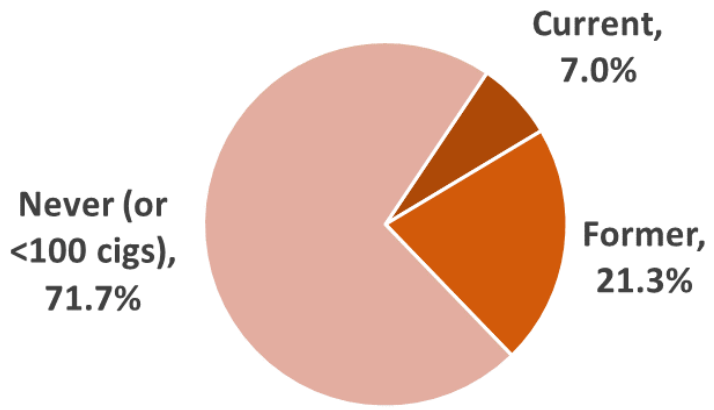
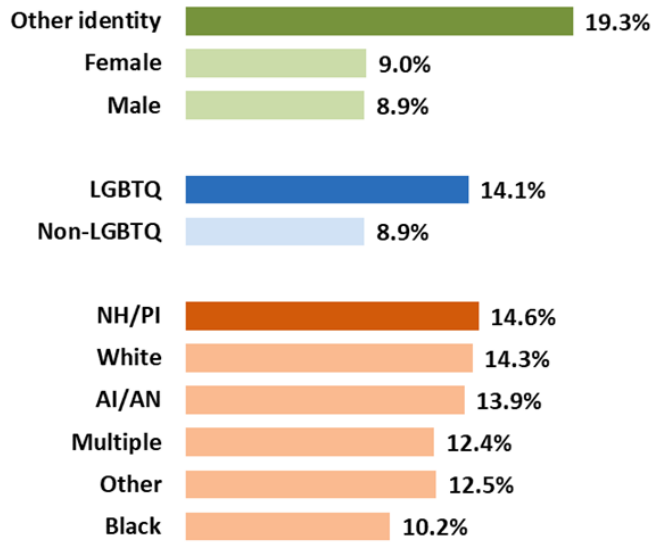


FIGURE 66: Current use of at least one tobacco product by gender, sexual orientation and race/ethnicity, California high school students, 2019-20 academic year[2]



Sources: 1. California Health Interview Survey; 2. Statewide California Student Tobacco Survey 2019-20

TOBACCO USE

Adult smoking status: Less than one in ten County adults were estimated to be current smokers in 2020 [Figure 65]. About one-fifth were estimated to be former smokers and over two thirds were estimated to be never smokers.

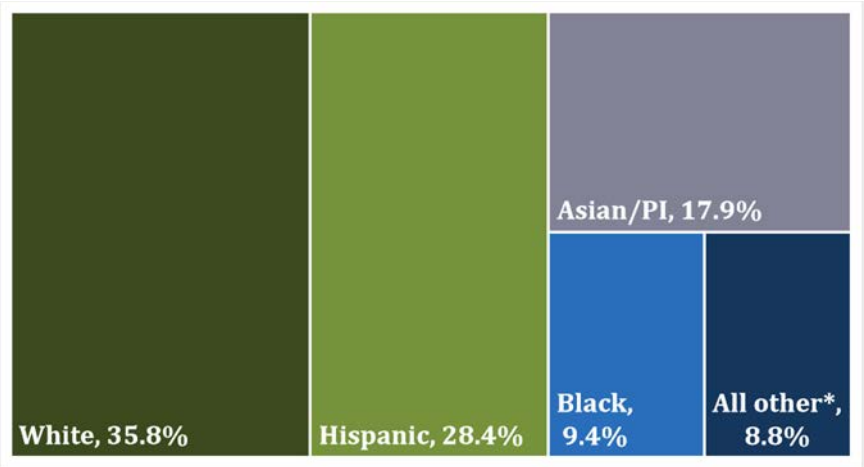
California (CA) high school tobacco use: Self-reported use of at least one tobacco product among CA high school students varied by demographics in the 2019-20 academic year [Figure 66]. Gender non-binary, LGBTQ and Native Hawaiian or other Pacific Islander students had the highest prevalence of tobacco use.

MATERNAL CHILD HEALTH

Maternal Characteristics

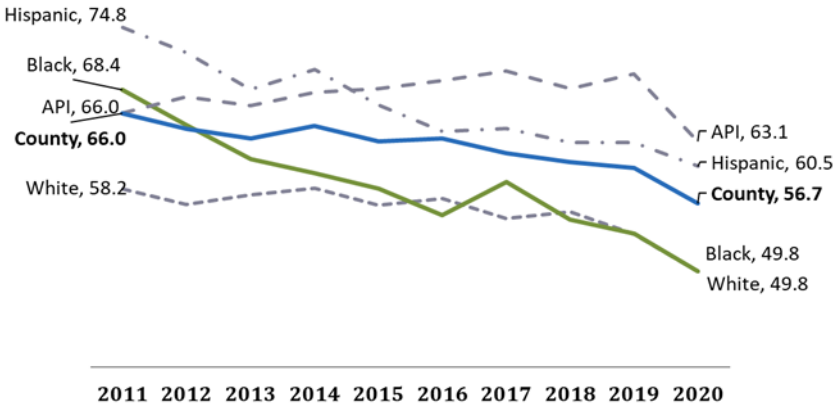
Maternal characteristics, such as maternal race/ethnicity and maternal age, are important for developing targeted public health strategies to prevent adverse birth outcomes and address disparities in maternal and child health.

FIGURE 67: Proportion of total births by maternal race/ethnicity, 2020[1]



**All other includes multi-race and American Indian/Alaskan Native*

FIGURE 68: Trend in fertility rates by select maternal race/ethnicity, 2011-2020[1]



Sources: 1. Vital Records Business Intelligence System

MATERNAL CHARACTERISTICS

Total births: There were a total of 17,978 babies born to Sacramento County women in 2020. This was a 5.4% decrease from the prior year, which may be partially due to the COVID-19 pandemic.

Maternal race/ethnicity: White mothers accounted for the highest proportion of births in 2020 [Figure 67]. However, the percent of births to White mothers was less than the proportion of overall population that was White.

Fertility rates: A fertility rate is the number of live births per 1,000 women age 15 to 44. The overall fertility rate for the County decreased by 14.1% from 66.0 in 2011 to 56.7 in 2020 [Figure 68]. The most dramatic decline in fertility rate from 2011 to 2020 was among Black mothers (-27.2%).

FIGURE 69: Proportion of births by maternal age group, 2020[1]

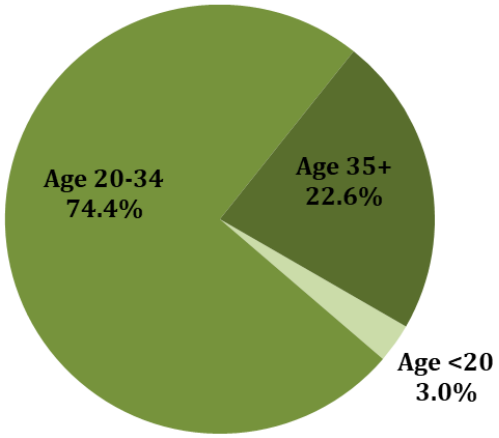


FIGURE 70: Trend in teen (age 15-19) birth rate, 2011-2020[1]

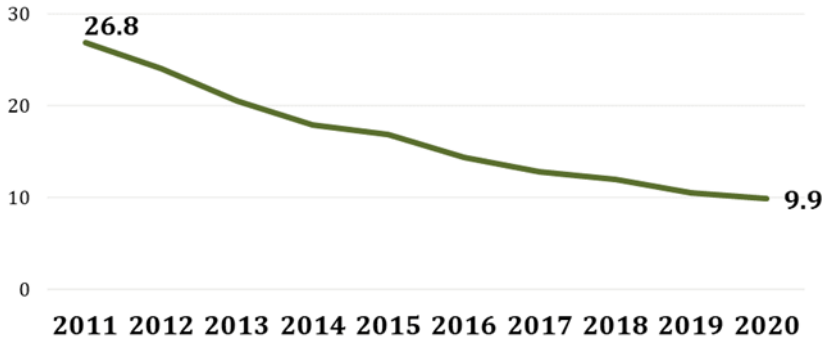
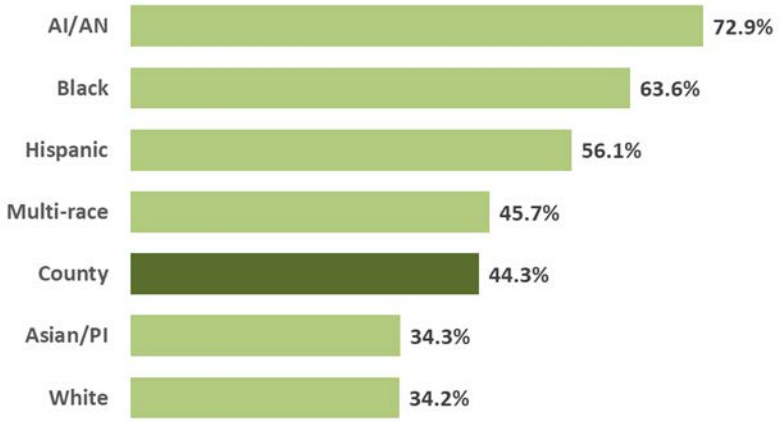


FIGURE 71: Medicaid as anticipated source of payment for delivery by maternal race/ethnicity, 2020[1]



Sources: 1. Vital Records Business Intelligence System

MATERNAL CHARACTERISTICS

Maternal Age: Nearly two thirds of births in the County in 2020 were to mothers age 20 to 34 [Figure 69]. About one in five were born to mothers who are considered advanced maternal age (age 35+). Less than 5% of births in the County were born to teen mothers.

Teen birth rate: The teen birth rate has steadily declined over time in the County [Figure 70]. The rate decreased by 170.7% from 26.8 births per 1,000 females age 15 to 19 in 2011 to 9.9 in 2020. These declines were seen for all racial/ethnic groups [data not shown].

Medicaid: Nearly 45% of all women in the County who gave birth in 2020 had Medicaid as an anticipated source of delivery payment [Figure 71]. Medicaid is sometimes used as a proxy for poverty status. There were clear differences between White mothers and non-White mothers in terms of level of poverty using this indicator.

Prenatal Behaviors

Prenatal behaviors play a large role in the health of mother and baby. The quality, quantity, and timing of prenatal care influence birth outcomes. The risk of low birth weight (LBW) is reduced for women who initiate care during the first trimester (first three months) of pregnancy. Substance use during pregnancy can also affect birth outcomes. Smoking during pregnancy doubles the risk of LBW and is a factor in 20-40% of LBW infants in the United States.[1] Prenatal behaviors are dependent upon both individual choices and the social environment; not all women have the same opportunities or ability to exert control over their prenatal situation.

FIGURE 72: Early entry into prenatal care by select maternal race/ethnicity, 2020[1]

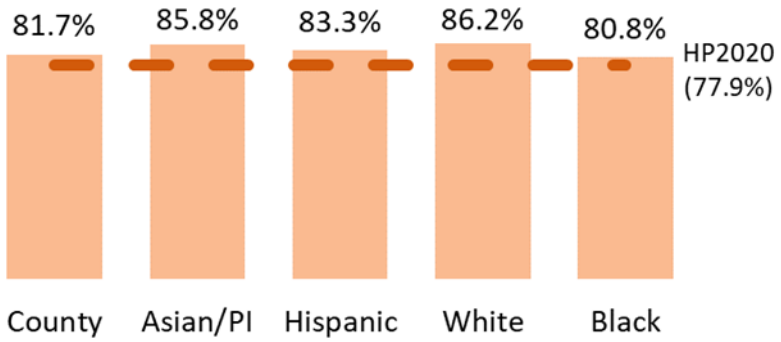
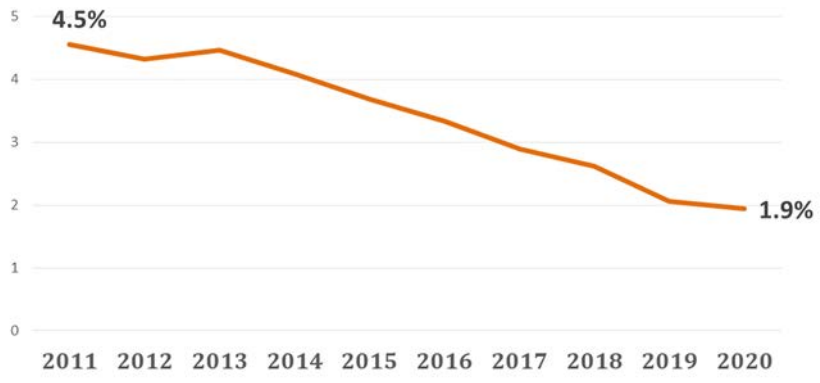


FIGURE 73: Trend in tobacco use anytime during pregnancy, 2011-2020[2]



Sources: 1. Vital Records Business Intelligence System

PRENATAL BEHAVIORS

Early prenatal care: One healthy people 2020 (HP2020) objective is to increase the proportion of pregnant women who receive prenatal care beginning in the first trimester nationally to 77.9%. The County overall and all listed racial/ethnic group met this objective in 2020 [Figure 72].

Tobacco use during pregnancy: The proportion of women who reported any tobacco use during pregnancy decreased by 136.8% from 4.5% in 2011 to 1.9% in 2020 [Figure 73]. Tobacco use during pregnancy may be under-reported.

Birth Outcomes

Healthy birth and maternal outcomes are the goal of every delivery. Preterm birth (PTB) is when a baby is born too early (before 37 weeks of pregnancy). Low birth weight (LBW) is when a baby is born less than 2,500 grams (~5.5 lbs.) and very low birth weight (VLBW) is less than 1,500 grams (~3.3 lbs.). The earlier and smaller a baby is born, the higher the risk of death or serious disability. Cesarean birth is associated with higher maternal morbidity than vaginal birth. Obstetric deaths are those resulting from complications of pregnancy, and/or interventions, omissions, or incorrect treatment. Maternal death has a broader definition and includes deaths from complications of pregnancy up to 42 days after birth or end of pregnancy. Late maternal death is death of a mother up to one year after end of pregnancy, due to direct or indirect obstetric causes.

FIGURE 74: Trend in proportion of births that are delivered preterm, 2011-2020[1]

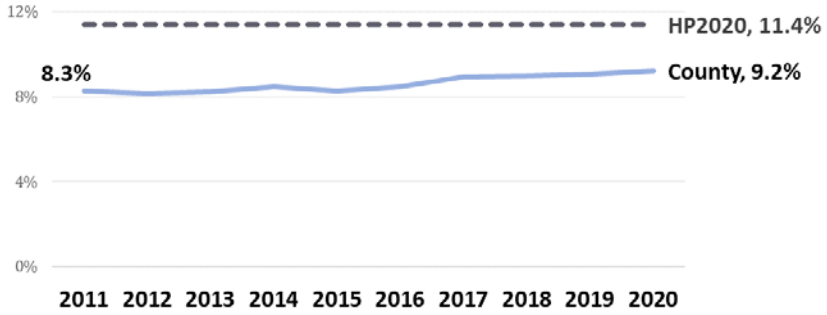
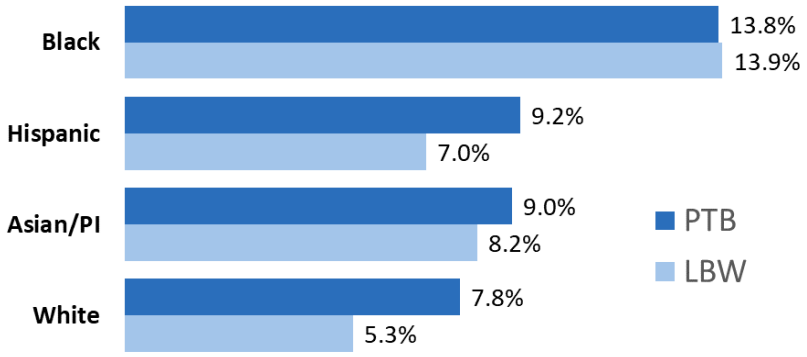


FIGURE 75: Preterm birth and low birth weight by select maternal race/ethnicity, 2020[1]



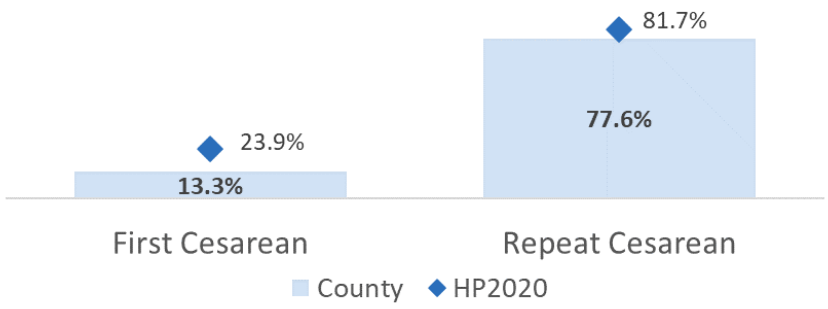
Sources: 1. Vital Records Business Intelligence System

BIRTH OUTCOMES

Preterm birth: The County overall has consistently met the HP2020 target for preterm birth (PTB) of under 11.4% [Figure 74]. The proportion of births that were preterm in the County increased by 10.8% from 8.3% in 2011 to 9.2% in 2020.

Disparities in PTB and LBW: There were distinct racial/ethnic disparities in PTB and LBW [Figure 75]. Black and Hispanic mothers had the highest proportion of babies born too early whereas Black and Asian/Pacific Islander mothers had the highest proportion born with LBW.

FIGURE 76: Proportion of low-risk* women with a first cesarean delivery and repeat cesarean delivery, 2020[1]



**Low risk is defined as a singleton, term pregnancy with baby in the vertex position*

FIGURE 77: Infant death rates by race/ethnicity, 2020[1]

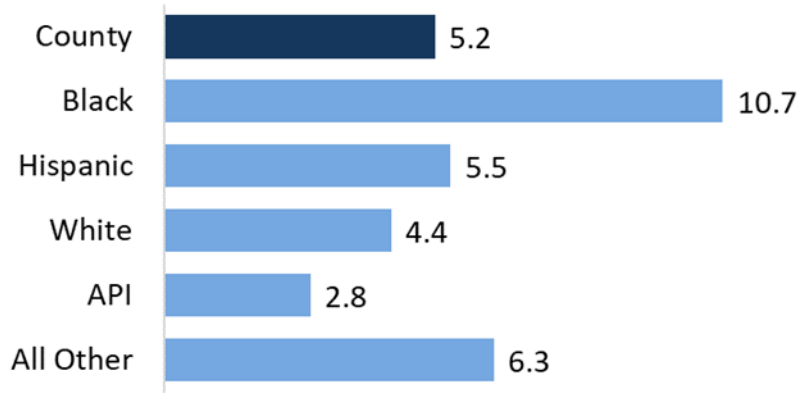
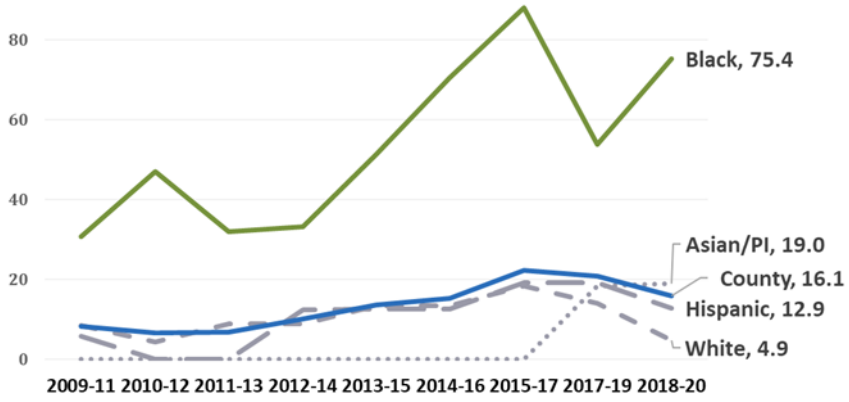


FIGURE 78: Trend in obstetric deaths per 100,000 live births by maternal race/ethnicity, 2011-2020 three-year rolling average[1]



Sources: 1. Vital Records Business Intelligence System

BIRTH OUTCOMES

Cesarean delivery: The County overall met the HP2020 targets for no more than 23.9% of low-risk mothers having a first cesarean delivery and no more than 81.7% of low-risk mothers with a prior cesarean having a repeat cesarean [Figure 76]. However, cesarean delivery varied drastically by delivery hospital or birthing center [data not shown].

Infant deaths: Infant death rate is the number of deaths among children less than one year old per 1,000 live births. The County overall met the Healthy People 2020 (HP2020) objective of no more than six infant death per 1,000 live births [Figure 77]. Black infants died at higher rates than the HP2020 objective.

Obstetric deaths: Obstetric deaths are those for which pregnancy and/or childbirth were the underlying cause of death. There was a total of 29 obstetric deaths in the County from 2010 to 2020, 11 (37.9%) of whom were Black women. Black women have been increasingly disproportionally affected by obstetric deaths [Figure 78].

INJURY

Poisonings

Substance use can result in fatal and non-fatal overdoses (i.e., poisonings). Drug overdoses occur when an individual consumes enough of a drug (whether it is prescription, illicit or over the counter) to cause harmful effects. An effective public health response includes education on risks and encourages harm reduction practices. Substance use disorders are treatable diseases, yet stigma about substance use disorders contribute to the evolving epidemic.

FIGURE 79: Trend in poisoning death rates per 100,000, County vs. State, 2016-2020[1]

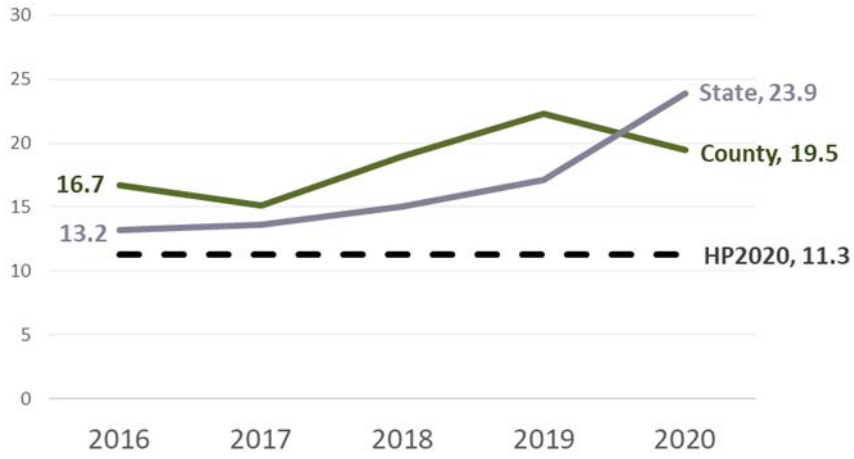
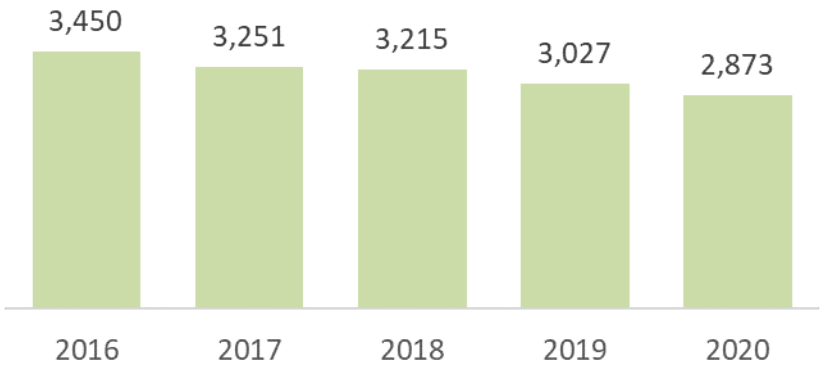


FIGURE 80: Trend in number of poisoning emergency department visits, 2016-2020



Sources: 1. California Department of Public Health EpiCenter https://skylab4.cdph.ca.gov/epicenter/

POISONINGS

Poisoning is a leading cause of death in the United States. In 2020 there were 91,799 drug overdose death in the US and 305 in the County.

Trends: Poisoning death rates increased in both the County and State from 2016 to 2020 [Figure 79]. The State rate surpassed the County rate for the first time in 2020. Both the County and State did not meet the Healthy People 2020 goal of no more than 11.3 poisoning deaths per 100,000. The number of poisoning emergency department visits in the County decreased in 2020 despite death rates increasing [Figure 80]. Issues with access to care and isolation during the COVID-19 pandemic may have contributed to this phenomenon.

FIGURE 81: Injury intent of drug-poisoning emergency department visits vs. poisoning deaths, 2016-2020 combined[1]

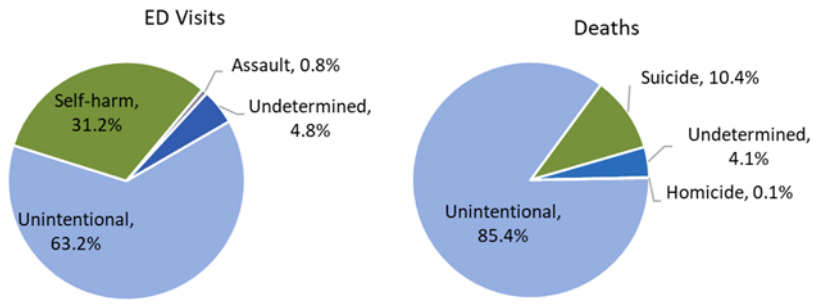


FIGURE 82: Proportion of poisoning emergency department visits and deaths by sex, 2016-2020 combined[1]

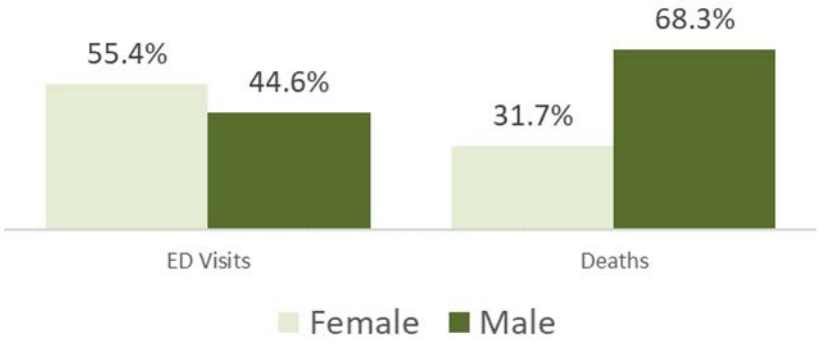
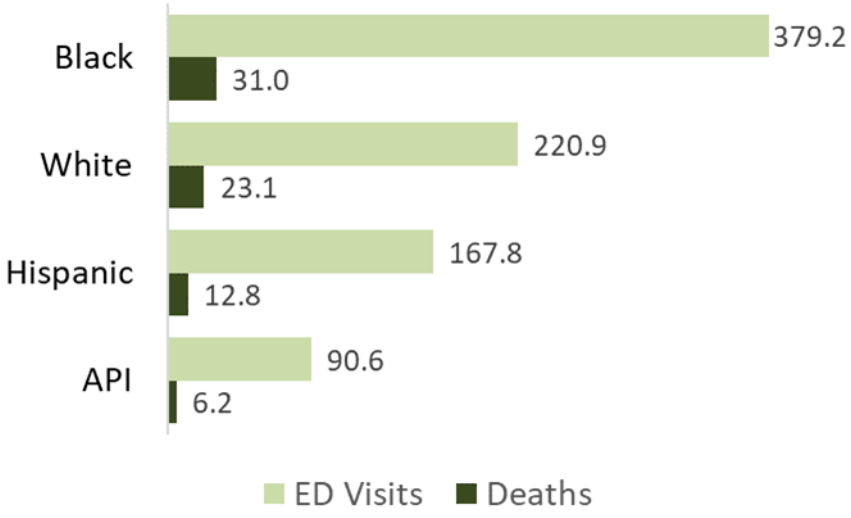


FIGURE 83: Poisoning emergency department visit and death rates per 100,000 by select race/ethnicity, 2016-2020 combined[1]



Sources: 1. California Department of Public Health EpiCenter https://skylab4.cdph.ca.gov/epicenter/

POISONINGS

Injury intent: A larger percent of poisoning deaths were unintentional compared to emergency department (ED) visits from 2016 to 2020 [Figure 81]. ED visits were three times more likely to be a result of self-harm compared to deaths.

Sex: Poisoning injury ED visits were more common among females than males from 2016 to 2020 [Figure 82]. However, over two-thirds of poisoning deaths during this time were male.

Race/ethnicity: There were racial disparities in rates of poisoning injury ED visits and deaths in the County [Figure 83]. Blacks, followed by Whites, had the highest rates from 2016 to 2020. Some racial/ethnic groups are not displayed due to small numbers. Disparities in poisoning injuries have increased over time nationwide. Differences in access to substance use care and treatment may continue to widen these disparities.

FIGURE 84: Age-adjusted opioid-related overdose death rates per 100,000 population, County vs. State, 2011-2020[1]

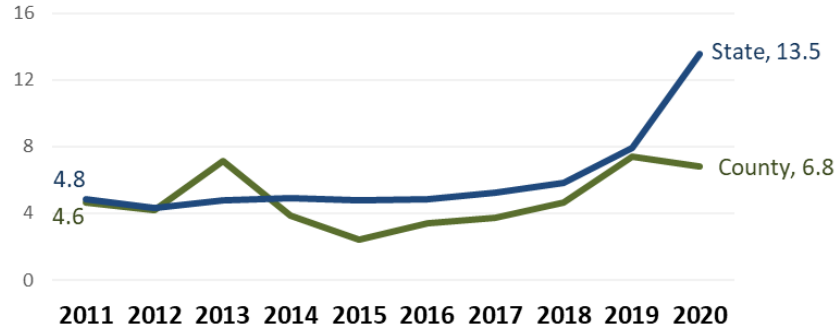


FIGURE 85: Trend in number of fentanyl death, 2011-2020[1]

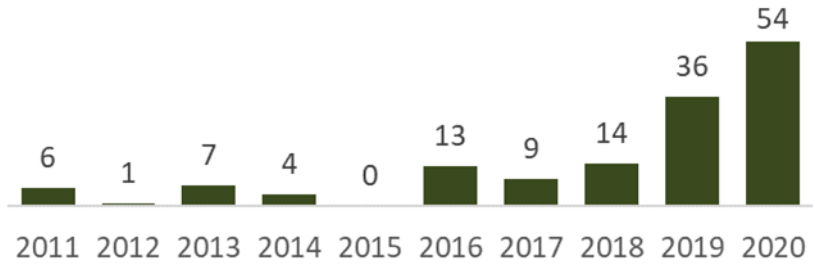


FIGURE 86: Opioid prescriptions by sex, 2020[1]

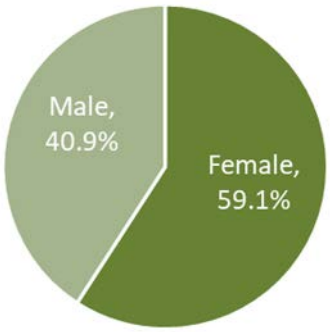
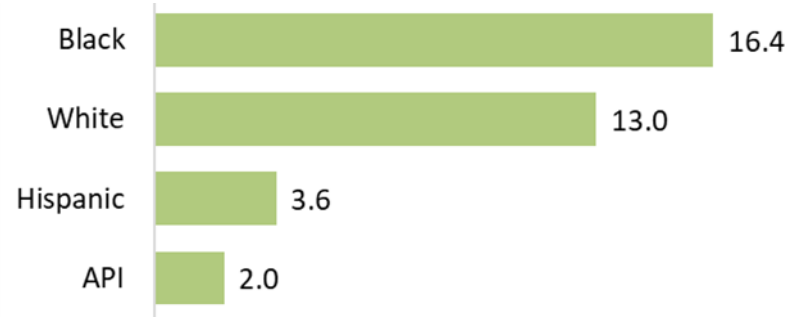


FIGURE 87: Opioid-related hospitalization rates per 10,000 by select race/ ethnicity, 2020[1]



Sources: 1. California Overdose Surveillance Dashboard https://skylab.cdph.ca.gov/ODdash/?tab=CTY

OPIOIDS

Opioid overdose trends: State and County opioid overdose death rates were similar over time except for 2020 [Figure 84]. The State death rate in 2020 was more than twice that of the County. Fentanyl deaths in the County increased by 800% from six in 2011 to 54 in 2020 [Figure 85]. Opioid death rates may be influenced by localized clusters, toxicology testing, and provider death certificate reporting.

Opioid prescriptions by sex: There were over 700,000 opioid prescriptions written to County residents in 2020, with females receiving about two thirds of these prescriptions [Figure 86]. The number of opioid prescriptions has decreased over time in the County, with over 300,000 fewer prescriptions written in 2020 compared to 2017.

Opioids and race/ethnicity: Like total poisoning deaths, Blacks had the highest rate of opioid overdose deaths in the County in 2020, followed by Whites and then Hispanics [Figure 87]. Some racial/ethnic groups are not displayed due to small numbers.

Unintentional Injuries

Unintentional injuries including drowning, falls and traffic collisions are often preventable with safety measures. Unintentional injuries resulted in 748 deaths, 9,685 hospitalizations, and 87,256 emergency department visits in the County in 2020. Males accounted for two-thirds of unintentional injury deaths in the County from 2016 to 2020.

FIGURE 88: Drowning/submersion deaths, hospitalizations, and emergency department visits by sex, 2016-2020

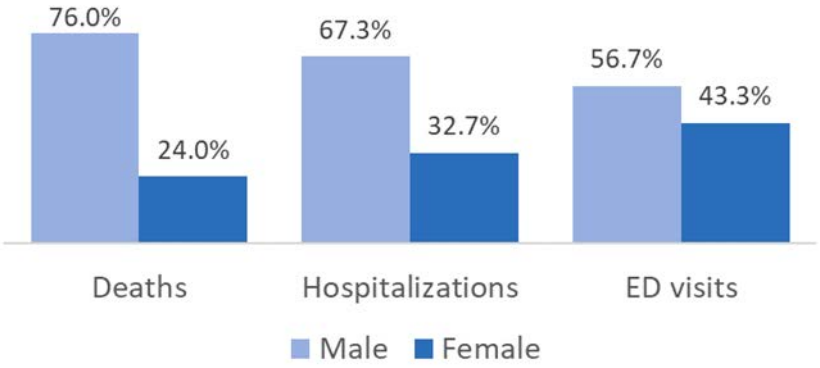


FIGURE 89: Drowning deaths by year, County vs. State[1]

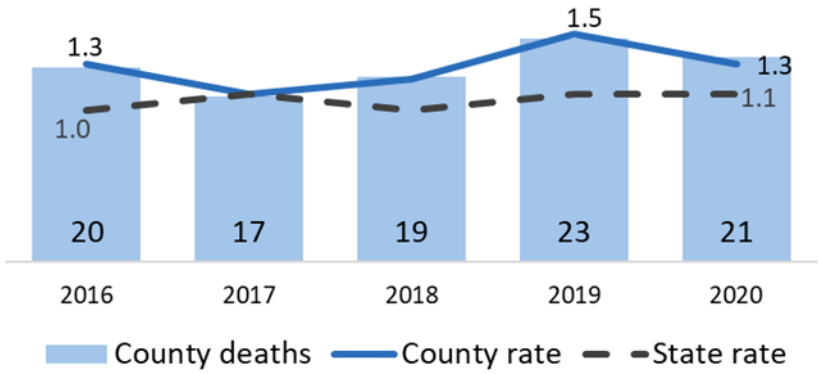
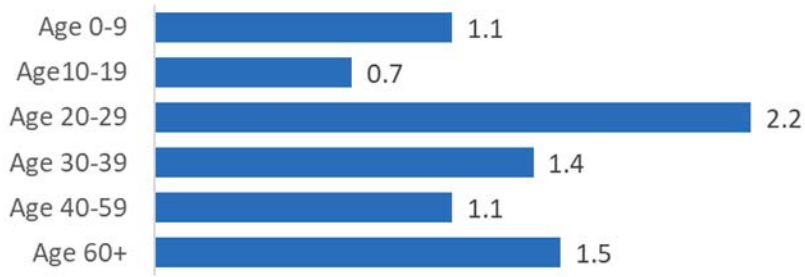


FIGURE 90: Drowning death rates by age group, 2016-2020[1]



Sources: 1. California Department of Public Health EpiCenter https://skylab4.cdph.ca.gov/epicenter/

DROWINGS

Drowning is a leading cause of death for children. Risk factors for drowning include inability to swim, risky swim behaviors, alcohol, and other drug use. Drowning injuries can cause brain damage and other serious outcomes.

Sex: Males are disproportionately affected by drowning/ submersion injures [Figure 88]. Notably, males accounted for over three quarters of drowning deaths from 2016 to 2020.

Trends: Figure 89 shows drowning deaths and rates by year. Although rates of drowning are relatively low, they were higher in the County compared to the State overall.

Age: Persons in age group 20 to 29 had the highest drowning death rate in the County from 2016 to 2020 [Figure 90]. Nationwide, children age 1 to 4 have the highest rates of drowning death.

FIGURE 91: Trend in fall death rates, County vs. State, 2016-2020

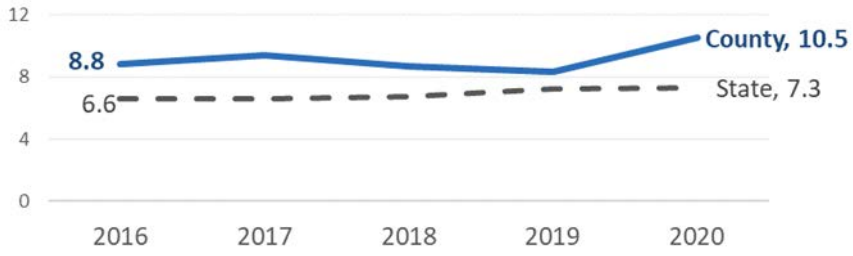


FIGURE 92: Number of fall-related emergency department visits, 2016-2020

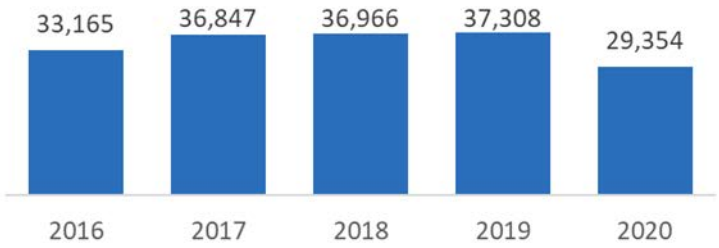


FIGURE 93: Fall deaths by age group, 2016-2020 combined

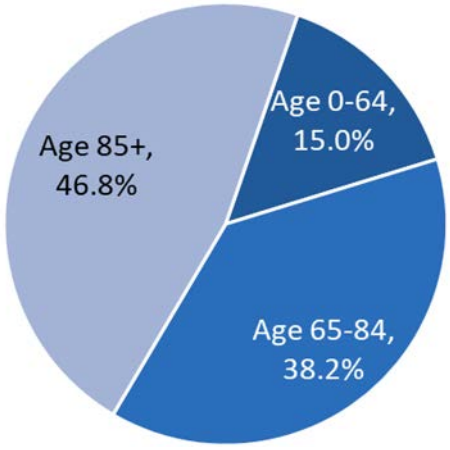
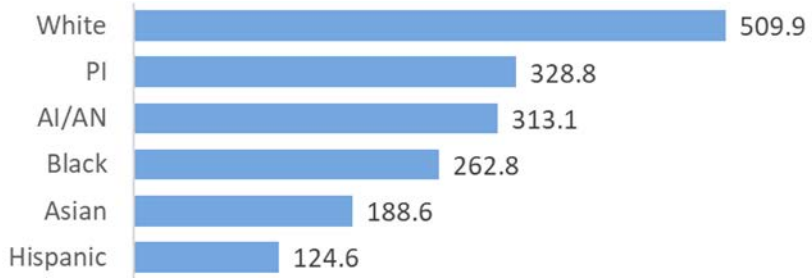


FIGURE 94: Fall-related hospitalization rates per 100,000 by race/ethnicity, 2020



Sources: 1. California Department of Public Health EpiCenter https://skylab4.cdph.ca.gov/epicenter/

FALLS

Falls are a leading injury-related cause of death for older adults. Fall risks include medication, poor strength, and poor balance.

Trends: Death rates due to falls were higher in the County compared to the State [Figure 91]. Deaths rates due to falls increased in 2020. However, the number of fall-related emergency department (ED) visits declined in 2020 [Figure 92]. The COVID-19 pandemic may have contributed to this phenomenon.

Age: The majority (85%) of fall deaths occurred among County residents age 65 and older [Figure 93]. Nearly half occurred among those age 85 and older.

Race/ethnicity: Whites had the highest rates of fall-related hospitalization in the County in 2020 [Figure 94]. Hispanics had the lowest fall-related hospitalization rates. These disparities were similar for deaths and ED visits [data not shown].

FIGURE 95: Trend in number of traffic collisions, 2016-2020[1]

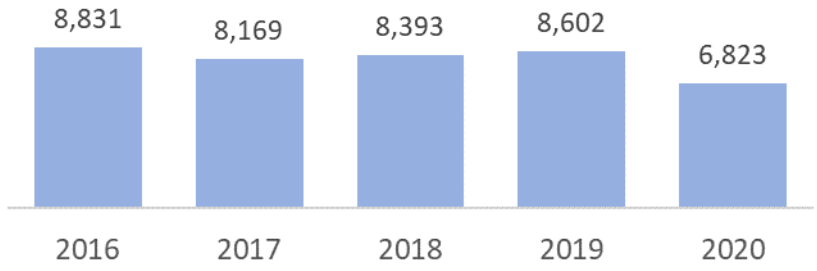


FIGURE 96: Trend in proportion of traffic collisions that were fatal, 2016-2020[1]

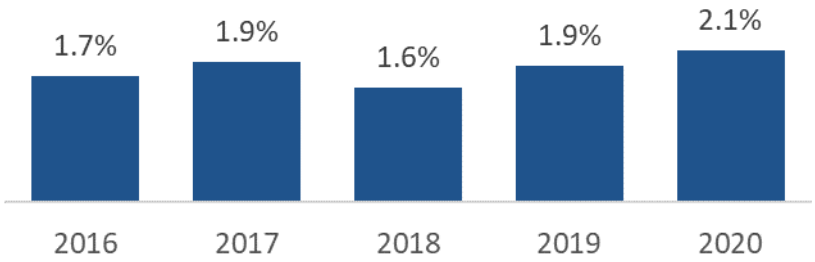


FIGURE 97: Fatal traffic collisions by collision type, 2016-2020 combined[1]

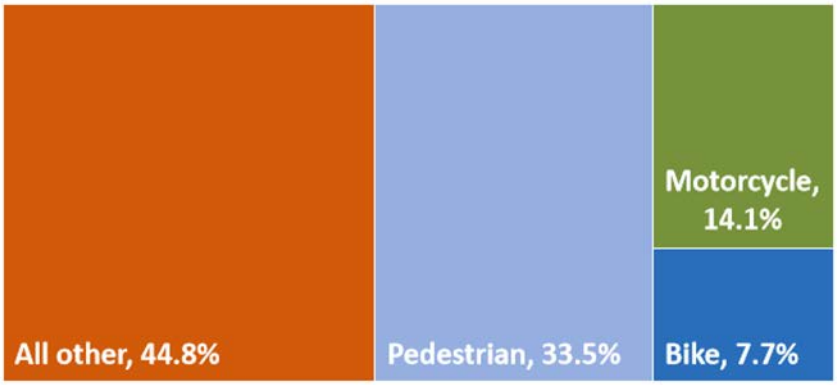


TABLE 8: Traffic collisions by location, 2016-2020 combined[1]

Location	Total collisions	Percent Fatal
Unincorporated	17,679	2.3%
Sacramento	16,423	1.5%
Elk Grove	2,603	1.1%
Citrus Heights	1,584	1.1%
Rancho Cordova	1,475	1.2%
Folsom	1,183	2.2%
Galt	307	3.3%
Isleton	7	N/A*

**Data not shown due to small numbers*

Sources: 1. UC Berkely Transportation Information Management System

TRAFFIC COLLISIONS

Traffic collision injuries and deaths are preventable. Factors including improper seat belt use, impaired driving, and distracted driving contribute to traffic collision injuries and deaths.

Trends: The number of traffic collisions in the County was relatively consistent until a sharp decrease in the first year of the COVID-19 pandemic [Figure 95]. However, more of the collisions in 2020 were fatal [Figure 96]. Over 20% of fatal collisions involved alcohol from 2016 to 2020, and 30% of non-fatal collisions involved speeding.

Collision type: Over half of fatal traffic collisions in the County from 2016 to 2020 involved either pedestrians, motorcycles or bicycles [Figure 97]. Pedestrians were involved in about a third of fatal collisions despite only making up 6.4% of total collisions.

Location: Over 80% of total collisions in the County from 2016 to 2020 occurred in either unincorporated areas of the County or the city of Sacramento [Table 8]. Galt, unincorporated County, and Folsom had the highest proportion of fatal collisions.

Violence

Violence can have long-lasting harmful effects on individuals, families, and communities. Violence has increasingly been recognized as a public health problem requiring public health solutions.

FIGURE 98: Homicide rates per 100,000 by select victim race/ethnicity, 2011-2020[1]

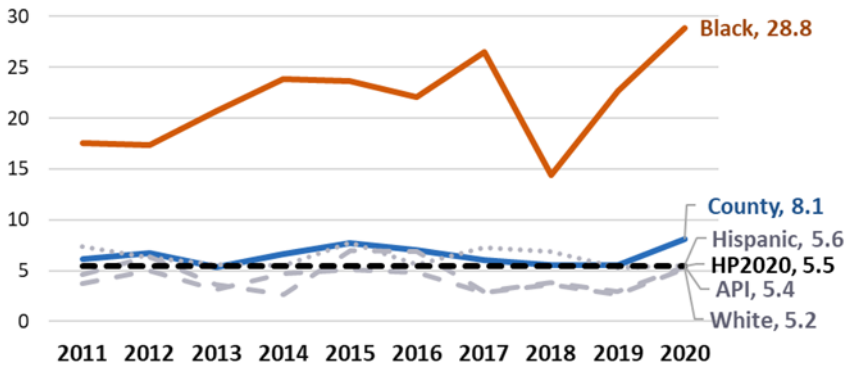


FIGURE 99: Homicides and homicide rates per 100,000 by victim age group, 2018-2020[1]

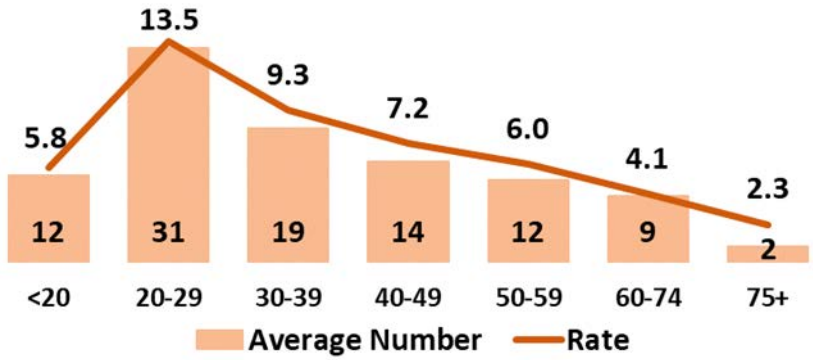


TABLE 9: Homicides by mechanism and victim's sex, 2011-2020[2]

Mechanism	Female	Male	Total
Firearms	49.4%	69.9%	66.2%
Sharp object	13.1%	9.9%	10.5%
Suffocation/hanging	8.5%	1.1%	2.5%
Other	29.0%	19.0%	20.8%

Sources: 1. Vital Records Business Intelligence System

HOMICIDE

Homicide is the act of one human killing another, regardless of perpetrator intent or legal category of homicide (e.g., manslaughter). There were 971 homicides in the County from 2011 to 2020, 127 of which occurred in 2020.

Trends & race/ethnicity: The County homicide rate increased 32.6% from 6.1 per 100,000 population in 2011 to 8.1 in 2020 [Figure 98]. Blacks were much more likely than other groups to be victims of homicide. In 2020, the rate among Blacks increased 65.0% from 17.5 in 2011 to 28.8 in 2020.

Age: Young adults age 20 to 29 had the highest number and rate of homicide victimhood during years 2018 to 2020 [Figure 99].

Mechanism and sex: Firearms were the most common mechanism of homicide in 2020 in the County, especially among male victims [Table 9].

FIGURE 100: Suicide rates per 100,000 by select race/ethnicity, 2011-2020[1]

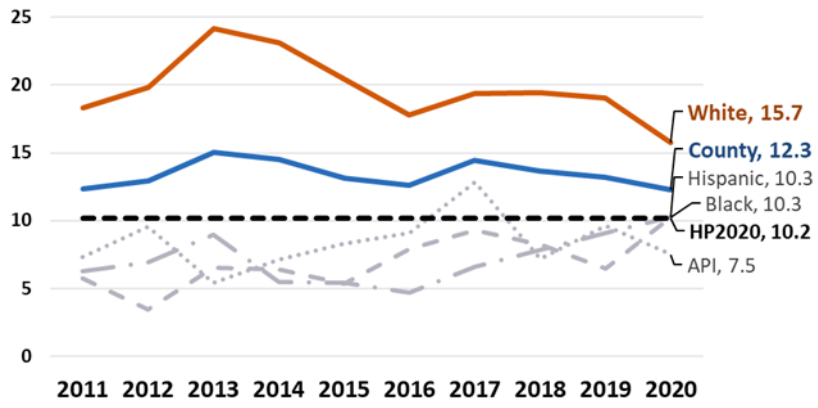


FIGURE 101: Suicides and suicide rates per 100,000 by age group 2018-2020[1]

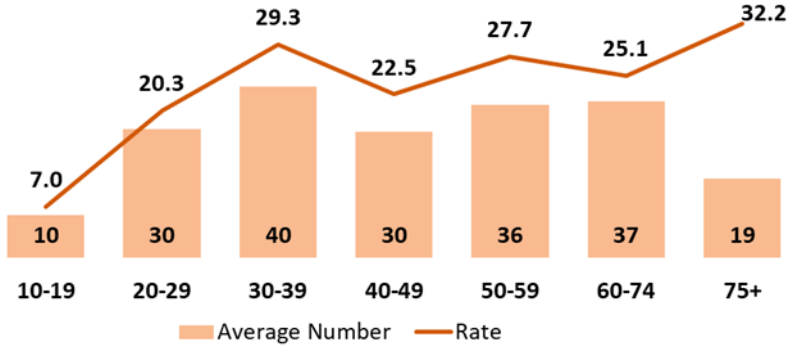


TABLE 10: Suicides by mechanism and victim's sex, 2011-2020[2]

Mechanism	Female	Male	Total
Firearms	15.5%	46.2%	38.9%
Suffocation/hanging	29.6%	31.6%	31.1%
Poisoning	39.6%	10.2%	17.2%
Other	15.3%	12.0%	12.8%

Sources: 1. Vital Records Business Intelligence System

SUICIDE

The causes of suicide are complex and determined by multiple factors. Suicide prevention focuses on promoting resilience and reducing risk factors.

Trends & race/ethnicity: There were a total of 2,008 suicide deaths in the County from 2011 to 2020, 192 of which occurred in 2020. Whites consistently had the highest rates of suicide compared to other groups [Figure 100]. In 2020, Whites, Hispanics and Blacks were above (i.e., did not meet) the Healthy People 2020 goal of no more than 10.2 suicide deaths per 100,000 population.

Age group: Suicides disproportionately affected older adults in the County in 2018 to 2020 with the highest rates among those age 75 and older [Figure 101]. The highest number of suicide deaths were among age group 30 to 39.

Mechanism and sex: The mechanism of suicide varied by sex in the County, with males most likely to use firearms and females most likely using poisoning [Table 10].

FIGURE 102: Trend in firearm-related death rates per 100,000, County vs. State, 2016-2020[1]

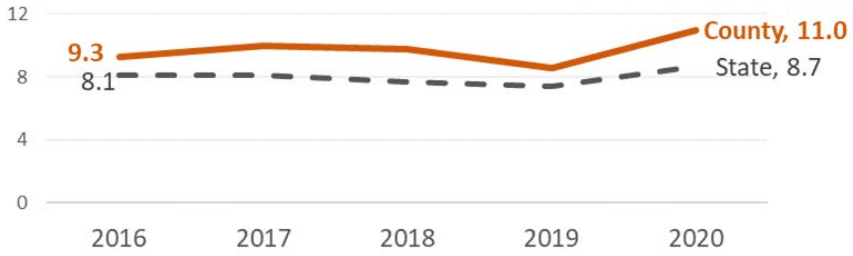


FIGURE 103: Trend in number of firearm-related emergency department visits by sex, 2016-2020[1]

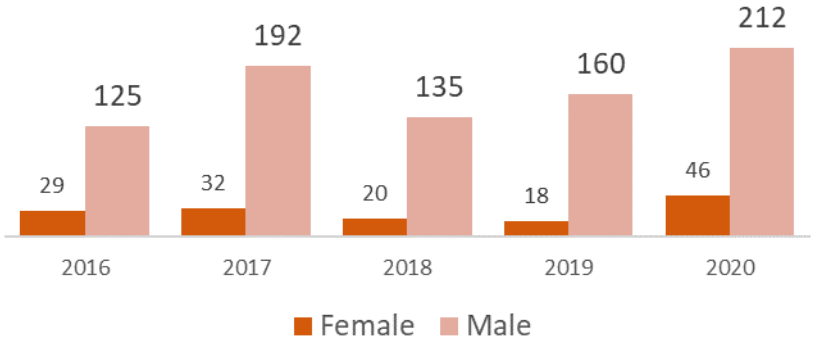


FIGURE 104: Firearms-related injury emergency department visit rates per 100,000 by age group, 2020[1]

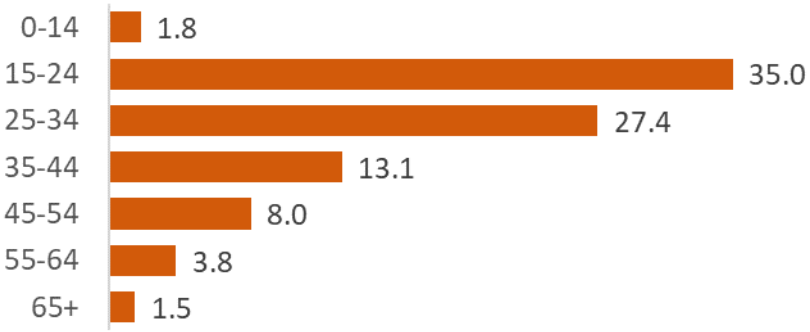


TABLE 11: Firearm-related emergency department visit rates per 100,000 by sex and select race/ethnicity, 2016-2020 combined[1]

	Male	Female	Total
Black	94.7	17.3	55.4
Hispanic	22.7	2.9	12.9
White	9.2	1.7	5.4
API	7.1	N/A*	4.1

Sources: 1. California Department of Public Health EpiCenter https://skylab4.cdph.ca.gov/epicenter/

FIREARMS

Firearm violence is a public health concern that impacts the health and safety of communities. Important gaps remain in knowledge of the problem and how to prevent it.

Trends: The County had a higher rate of firearm-related death rates per 100,000 population than the State overall from 2016 to 2020 [Figure 102]. The County rate increased 18.3% from 9.3 in 2016 to 11.0 in 2020. The number of firearm-related emergency department (ED) visits varied by year, with peaks in 2017 and 2020 [Figure 103]. Males consistently had higher numbers of firearm-related injury ED visits compared to females.

Age group: Youth age 15 to 24, followed by young adults age 25 to 34, had the highest rates of firearm-related injury ED visits in 2020 [Figure 104]. Older adults age 65 and older and children age 14 and younger were the least likely to be victims of firearm injuries.

Race/ethnicity: Black and Hispanic males in the County were disproportionately victims of firearm-related injuries from 2016 to 2020 [Table 11].

MORTALITY

Mortality (i.e., death) data provide a valuable measure for assessing community health status. They provide a snapshot of a community's health problems, patterns, and trends over time. Mortality data can be used to help inform public health plans and policies to prevent or reduce premature death, improve quality of life, and address health inequities.

FIGURE 105: Overall age-adjusted death rates per 10,000 population by sex, 2011-2020[1]

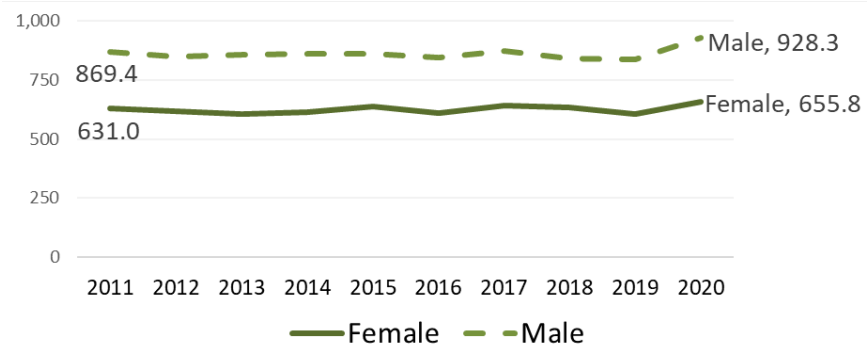


FIGURE 106: Age adjusted overall death rates of large Counties (>1 million population), 2020[2]

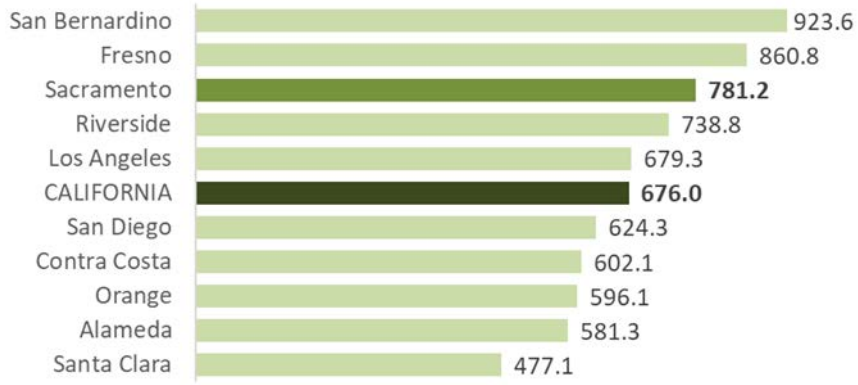
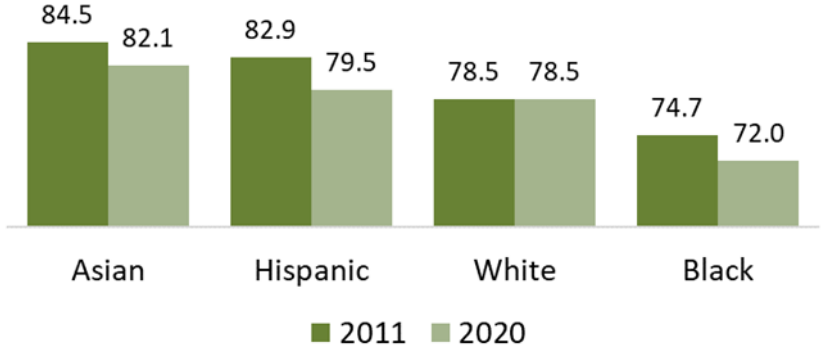


FIGURE 107: Life expectancy by select race/ethnicity, 2011 vs. 2020[2]



Sources: 1. Vital Records Business Intelligence System; 2. California Community Burden of Disease Engine https://skylab.cdph.ca.gov/communityBurden/

MORTALITY

Death rates: Age-adjusted death rates control for the effects of differences in population age distributions. The age-adjusted County death rates were consistently higher for males compared to females from 2011 to 2020 [Figure 105]. Rates increased from 2011 to 2020 for both males (+6.8%) and females (+3.9%). Among large Counties with a population of at least one million, Sacramento County had the third highest death rate in 2020 [Figure 106].

Life expectancy: Life expectancy refers to the number of years a person can expect to live. Life expectancy varied by racial/ethnic group, with the longest life expectancy among Asians and the shortest among Blacks [Figure 107]. There were decreases in life expectancy from 2011 to 2020 for Hispanics (-4.1%), Blacks (-3.6%), and Asians (-2.8%).

TABLE 12: Top 10 leading causes of death by sex, 2020[1]

Female	Rank	Male
Cancer	1	Heart Disease
Heart Disease	2	Cancer
Alzheimer	3	Accidents
Stroke	4	COVID-19
COVID-19	5	Stroke
Accidents	6	Diabetes
Chronic Lower Respiratory	7	Alzheimer
Diabetes	8	Chronic Lower Respiratory
Hypertension	9	Suicide
Influenza Pneumonia	10	Liver Cirrhosis

TABLE 13: Top 5 leading causes of premature death (age <75) and years of potential life lost, 2020[1]

Rank	Cause	Years of Life Lost
1	Cancer	17,594
2	Heart Disease	12,404
3	Accidents	21,080
4	COVID-19	5,450
5	Diabetes	3,825

TABLE 14: Top 3 leading causes of death by age group, 2020[1]

Age	Cause 1	Cause 2	Cause 3
0-14	Accidents	Cancer	Homicide
15-24	Accidents	Homicide	Suicide
25-44	Accidents	Cancer	Suicide
45-64	Cancer	Heart Disease	Accidents
65-74	Cancer	Heart Disease	COVID-19
75+	Heart Disease	Cancer	Alzheimer

Sources: 1. Vital Records Business Intelligence System

MORTALITY

Leading causes of death: The leading causes of death in the County in 2020 varied by sex [Table 12]. Cancer and heart disease were in the top two for females and males. Alzheimer's was the third leading cause for females, whereas accidents were third for males. During the first year of the COVID-19 pandemic, the virus already ranked within the top five leading causes of death for both sexes. Suicide and liver cirrhosis made the top ten for males but not for females.

Premature deaths: Deaths under age 75 are considered premature deaths in the United States (though some use under age 65). COVID-19 was the fourth leading cause of premature death in 2020 [Table 13]. Unlike prior years, only one of the top causes was due to non-natural manners of death (accidents). Years of potential life lost (YPLL) is another way to measure the impact of premature death.

Age group: Leading causes of death varied by age group in the County in 2020 [Table 14]. Risk of death for many chronic health conditions increase with age and were the top causes of death in the older age groups. Non-natural manners of death constituted a higher proportion among younger persons.

TECHNICAL NOTES

Data analysis and display

Data were analyzed using Statistical Analysis Software (SAS) 9.2. Maps were created in ESRI ArcGIS 10.4. All other figures were created in Microsoft Office Excel, and tables were created within Microsoft Office Word. Figures and Tables generally display data for Sacramento County residents unless otherwise specified (e.g., State statistics).

Data sources

Multiple primary and secondary data sources were used in this report. The two most frequently used in-house data sources in this report were birth and death certificate data from the California Vital Records Business Intelligence System and reportable disease conditions from the California Reportable Disease Information Exchange (CalREDIE) system. Data sources that are derived from survey data (e.g., California Health Interview Survey) are estimates that may not be representative of the entire County. Data sources are denoted throughout the report.

Rate calculations

Rates are generally expressed in this report as the number of cases per 100,000 population, unless otherwise noted. Overall death rates are number of deaths per 10,000 population, with cause-specific deaths generally displayed per 100,000 population. Emergency department visits are expressed as number of incidents (not individuals) per 10,000. Rates are crude rates unless labeled as age-adjusted rates. Age-adjusted rates are rates that would have existed if the population under analysis had the same age distribution as the 'standard population.' The standard population used for age adjusting in this report is the United States 2000 population. Population denominators used to calculate rates were from the California Department of Finance population estimates or population projections.

Race/ethnicity data

Race and ethnicity categories used for tabulation in this report follow the Office of Management and Budget's (OMB) Standards for the Classification of Federal Data on Race and Ethnicity. Persons of Hispanic or Latino ethnicity are categorized as Hispanic/Latino regardless of race. 'Hispanic' in this report indicates Hispanic/Latino ethnicity. Non-Hispanic/non-Latino race categories include American Indian or Alaskan Native ('AI/AN'), Asian, Black or African American ('Black'), Native Hawaiian or Other Pacific Islander ('NHPI') and White. Previous standards combined the Asian and Native Hawaiian or other Pacific Islander race categories as Asian or Pacific Islander ('API'). This report uses the API category not so much for continuity with legacy data but due to frequent small numbers for health conditions of interest in the NHPI category that would lead to unstable rates and to protect individual privacy. Asian and NHPI subcategories were not explored in this report for similar reasons.

Sex, gender, and sexual orientation data

Sex designations in this report were generally based on reported sex at birth. 'Gender' in this report refers to a person's reported gender identity. Data on gender identity and sexual orientation were not available for most data sources but were included if available and robust enough to protect individual privacy (e.g., HIV data).

Community Context Assessment 2022

Sacramento County Public Health

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INTRODUCTION

Purpose and Background

The 2022 Sacramento County Community Context Assessment (CCA) focuses on individuals who live, work, play and/or worship in Sacramento County. It aims to gather insights and concerns regarding the quality of life and health of our communities. This assessment was designed based upon the Mobilizing for Action through Planning and Partnership (MAPP) framework. MAPP framework is a strategic, community-driven planning process developed by the National Association for County and City Health Officials (NACCHO) to improve community health by improving the efficiency, effectiveness, and performance of local public health systems. CCA is one part of the MAPP planning process. The information obtained in CCA will be used to inform a Community Health Improvement Plan (CHIP). At the time of publication, the NACCHO MAPP 2.0 framework was released, but at the time of survey distribution, the original NACCHO MAPP framework was still in place. The Community Themes and Strengths Assessment (CTSA) of the original MAPP process was updated to be the CCA in MAPP 2.0. Therefore, we refer to this report as the Sacramento County CCA but the survey itself as CTSA to reflect the language used during the data collection process.

Acknowledgments

This CCA was developed based on collaboration between the Sacramento County Public Health (SCPH) Accreditation, Epidemiology, and Health and Racial Equity programs. We specifically acknowledge Health Program Manager Dr. Gurleen Roberts for her contributions to survey tool development and Human Services Program Planner Megan Sheffield for editing and content support. We would like to express appreciation to the SCPH staff, community partners, Senior Public Information Officer Samantha Mott, and Health Program Coordinator Christopher Holden-Counts for assistance ensuring widespread distribution of the survey.

This CSTE is dedicated to members of our vibrant Sacramento County community. SCPH relied on the help of community members to provide honest and thorough feedback on the health of our community to make this report possible.

Finally, this CSTE acknowledges the need for long-term investment in and with our community to optimize the health and wellbeing of all individuals who live, work, play and/or worship in Sacramento County.

METHODS

Survey Design

CTSA was a cross-sectional survey, meaning that data was collected during a specific time from many different individuals. The survey was created in the Qualtrics online survey platform. The survey was open to all community members who were at least 12 years old. Participants self-identified as community members if they lived, worked, played, and/or worshipped in Sacramento County.

CTSA began with a disclosure statement describing the nature and structure of the survey. The disclosure statement specified requirements for participation and asked for participant consent. Following self-attestation and consent, CTSA consisted of 37 questions spanning four sections. Question response options in the online survey were randomized to minimize bias in answer selection. CTSA disclosure statement and questions are included in Appendix A.

Section 1 ("What does a healthy community look like?") included Questions 1-7 and asked participants to rank the importance of certain health-related topics and issues to their community's health. Section 2 ("Is our community healthy?") included Questions 8-16 and asked participants for their opinions regarding the quality of life, healthcare system, economic opportunity, and other characteristics of the County. Section 3 ("How engaged is our community?") included Questions 17-23 and asked participants for their opinions regarding civic engagement and norms in the County. Section 4 ("How do you fit into our community?") included Questions 24-37 and asked for demographic information such as gender identity, race/ethnicity, and age.

Recruitment And Participation

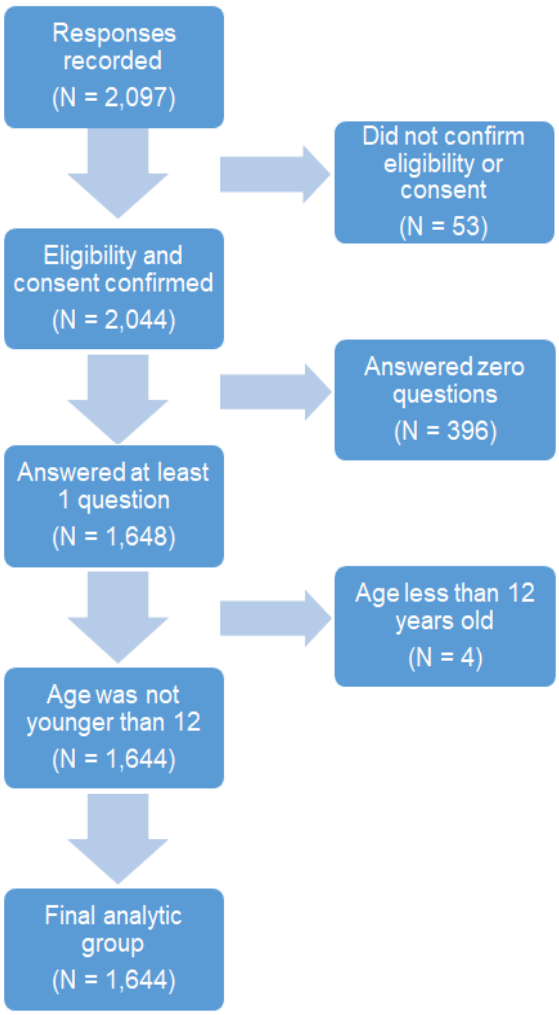
The survey was first published in English only with limited social media advertisement on April 1, 2022, as part of National Public Health Week. It was re-launched in September 2022 in twelve languages, including English, Arabic, simplified Chinese, Dari, Farsi, Hmong, Pashto, Punjabi, Russian, Spanish, Tagalog, and Vietnamese. The survey was closed after September 30, 2022. Survey respondents were recruited through word-of-mouth from community partners and organizations, and other public health networks. SCPH contracted with Runyon Saltzman, Inc. (RSE) to promote CTSA throughout the County for the timespan September 6, 2022, to September 30, 2022, via Facebook and Instagram social media campaigns. These social media campaigns were published in eight languages (English, Arabic, simplified Chinese, Pashto, Spanish, Punjabi, Russian, and Tagalog) to reach as many potential respondents as possible.

CTSA received a total of 2,097 responses. Out of these, 453 responses (21.6%) were excluded from final analysis because either they did not consent, meet age requirement, or answer at least one survey question following consent. More specifically, 53 responses were excluded

because the respondent answered "No, I do not consent to participate in this survey, or I am not at least 12 years old." Four responses were excluded because the respondent gave consent but reported an age of less than 12 at the end of the survey. Another 396 responses were excluded because respondents gave consent to participate but did not answer any additional survey questions.

The final analytic group consisted of 1,644 responses, or 78.4% of all recorded responses (Figure 1). Approximately 65% of the 1,644 analyzed responses completed all the questions in the survey.

FIGURE 1: CSTA response eligibility chart



Analysis

Statistical Analysis Software (SAS) 9.4, Microsoft Excel, and Qualtrics Text iQ software programs were used to analyze and display CTSA survey data.

Ranking Questions

CTSA Questions 1-7 asked respondents to rank health issues. Respondents' rankings can be thought of as votes in an election for the most important issue, and thus respondent votes can be counted using a ranked choice voting procedure. In one round of voting, votes for respondents' most important issue are counted. The issue with the fewest number of votes is removed. In the next round of voting, votes from respondents who selected the issue with the lowest number of votes as their top choice would then be moved to the next preferred issue that has not been excluded from the voting process yet. The process then repeats, and rounds of voting are conducted until one issue has received more than half of all votes. The relative importance of each issue to voters can be ordered based on the order in which the issues are removed from voting.

Counting votes with this ranked choice voting procedure provides some benefits over counting votes for the top issue only once. First, this procedure allows participants to have a say in the final results even if their top choice is not selected. Second, this procedure can also elevate certain issues that may not necessarily be the most important but are nonetheless still

considered relatively important by many voters. Finally, this procedure can help identify groups of voters who tend to rate the same issues as important.

Other Quantitative Questions

Quantitative data is information that can be counted and measured. Questions that resulted in quantitative response information were analyzed using simple counts and percentage calculations. Population comparison data in this report came from California Department of Finance or American Community Survey data.

Qualitative Questions

Qualitative data is information that cannot easily be counted or measured. The free text responses in the CTSA were qualitative data. Qualtrics Text iQ was used to analyze free text responses for themes and sentiment.

RESULTS

"What does a healthy community look like?"

The CTSA explored what the participants felt Sacramento County needed in 2022 to be a healthy community. Questions 1-7 asked participants to rank the importance of certain health-related topics and issues to their community's health. For most questions, a clear consensus on the most important issues did not emerge. There were instead large varieties in respondents' rankings across issues. Complete breakdowns of responses for Questions 1-7 are included in Appendix B.

Respondents were most concerned about infectious diseases, and specifically vaccine-preventable diseases. The timing of the survey with the third year of the COVID-19 pandemic likely influenced responses. Participants ranked social determinants of health (e.g., jobs and education) of high importance. Equity, diversity, and inclusion issues (e.g., racism, LGBTQ+ rights) was an important topic among non-White respondents.

TABLE 1: Health-related topic rankings

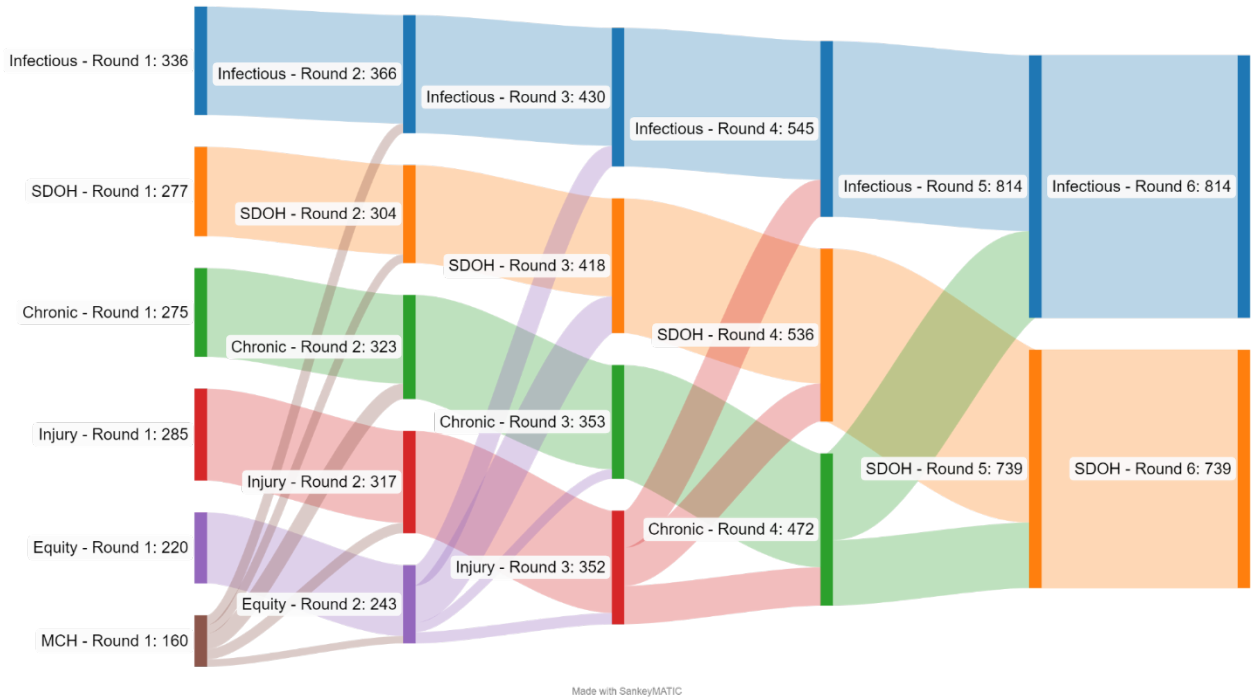
Rank	Health-Related Topic
1	Infectious disease
2	Social determinants of health
3	Chronic disease
4	Injuries
5	Equity, diversity, and inclusion
6	Maternal child health

*Participants ranked **infectious diseases** the most important health-related topic for a healthy community in 2022.*

General Health-Related Topics

Participants ranked the importance of six health-related topics to their community's health. Table 1 shows the order in which they were ranked, with Rank 1 indicating the most important. Figure 2 shows the ranked choice voting process for health-based topics. In round 1, maternal child health (MCH) had the fewest number of votes for the most important issue, so it was dropped from the next round. The 160 respondents who picked MCH as their top issue were then moved to their next preferred issue for round 2: 48 went to chronic diseases, 32 went to injury, 30 went to infectious diseases, 27 went to SDOH and 23 went to equity, diversity, and inclusion (equity). In round 2, equity had the fewest number of votes and was dropped. Most of the 243 respondents who picked equity as their top issue were moved to SDOH as their next top issue for round 3. This suggests that respondents who considered equity highly important also considered SDOH to be highly important as well. In round 4, chronic diseases received the fewest votes. The 472 voters who had chronic diseases as their top choice were spread about evenly to the remaining two topics. By round 5, infectious diseases received over half of the total votes.

FIGURE 2: Health-related topics Sankey chart (N = 1,553)



Sankey chart of ranked choice voting procedure for six health-related topics: Infectious diseases (Infectious), injuries (Injury), social determinants of health (SDOH), chronic diseases (Chronic), diversity, equity, and inclusion (DEI), and maternal child health (MCH)

Infectious Disease

Participants ranked the importance of four categories of infectious disease. Table 2 shows the order in which they were ranked, with Rank 1 indicating the most important.

TABLE 2: Infectious disease rankings

Rank	Infectious Disease
1	Vaccine-preventable disease
2	Food and water-borne disease
3	Sexually transmitted disease
4	Vector-borne disease

*Participants overwhelmingly ranked **vaccine-preventable diseases**, such as COVID-19, influenza and measles, the most important infectious disease grouping.*

More than half of respondents (52.5%) picked vaccine-preventable diseases (VPDs) as their most important infectious disease issue. Therefore, additional rounds of voting were not needed. Following VPDs, respondents picked foodborne waterborne diseases (30.0%), sexually transmitted diseases (11.4%), and then 6.0% for vector-borne diseases (Appendix B). A Sankey chart was not generated to display the voting rounds for infectious diseases since there was only a single round.

Social Determinants of Health

Participants ranked the importance of six categories of social determinants of health (SDOH). Table 3 shows the order in which they were ranked, with Rank 1 indicating the most important.

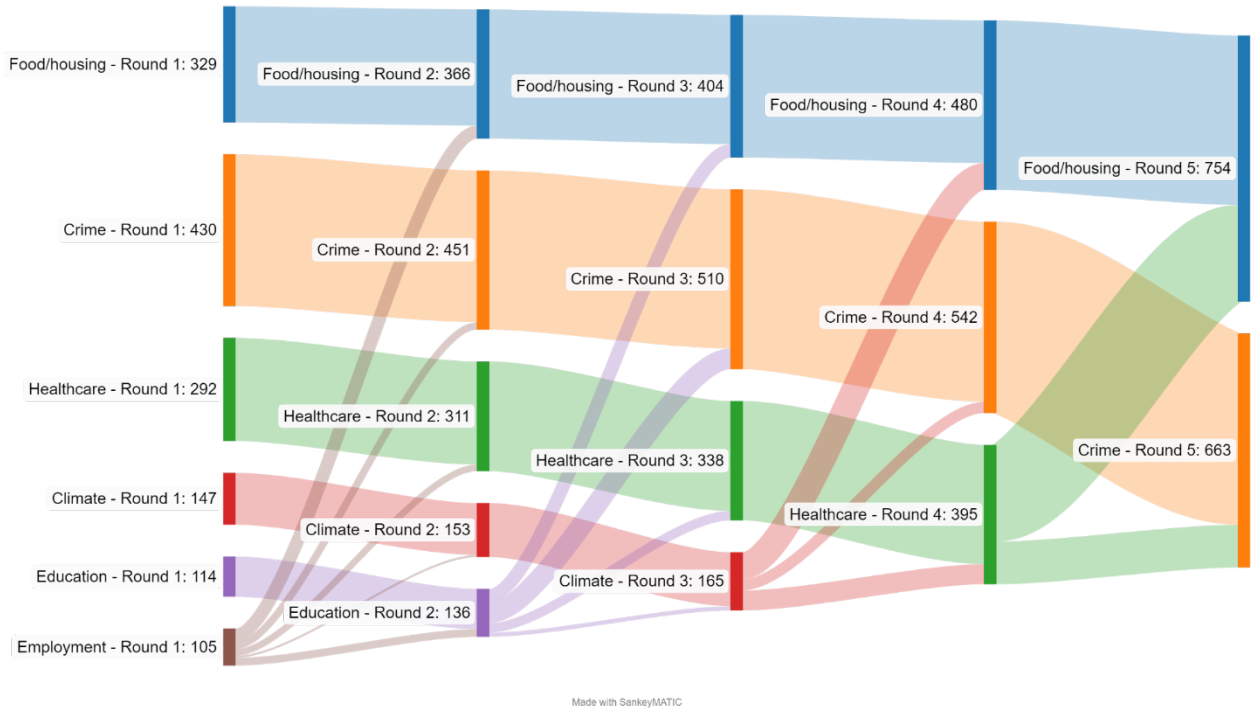
TABLE 3: Social determinants of health rankings

Rank	Social Determinant of Health
1	Food and housing security
2	Crime and safety
3	Healthcare access
4	Climate change and the environment
5	Education and literacy
6	Employment and economic opportunity

*The community ranked **food and housing security** the most important social determinant of health.*

Figure 3 shows the ranked choice voting process for SDOH issues. In round 1, employment and economic opportunity received the fewest votes. The 105 voters who picked employment as their most important issue were spread about evenly across the remaining issues, except for climate change. In round 2, education and literacy received the fewest number of votes and was dropped from the next rounds. In round 3, climate change received the fewest number of votes and was dropped. In round 4, healthcare access received the fewest votes. The majority of the 395 voters who selected healthcare access as their top issue were moved to food and housing security. This suggests that respondents who rated healthcare access as highly important also tended to rate food and housing security as highly important. By round 5, food and housing security overtook crime and safety as the SDOH with the most votes.

FIGURE 3: Social determinants of health Sankey chart (N = 1,417)



Sankey chart of ranked choice voting procedure for six SDOH issues: food and housing security (Food/housing), crime and safety (Crime), access to health care (including mental health care) (Healthcare), climate change and the environment (Climate), education and literacy (Education), and employment and economic opportunity (Employment)

Chronic Disease

Participants ranked the importance of seven categories of chronic disease. Table 4 shows the order in which they were ranked, with Rank 1 indicating the most important.

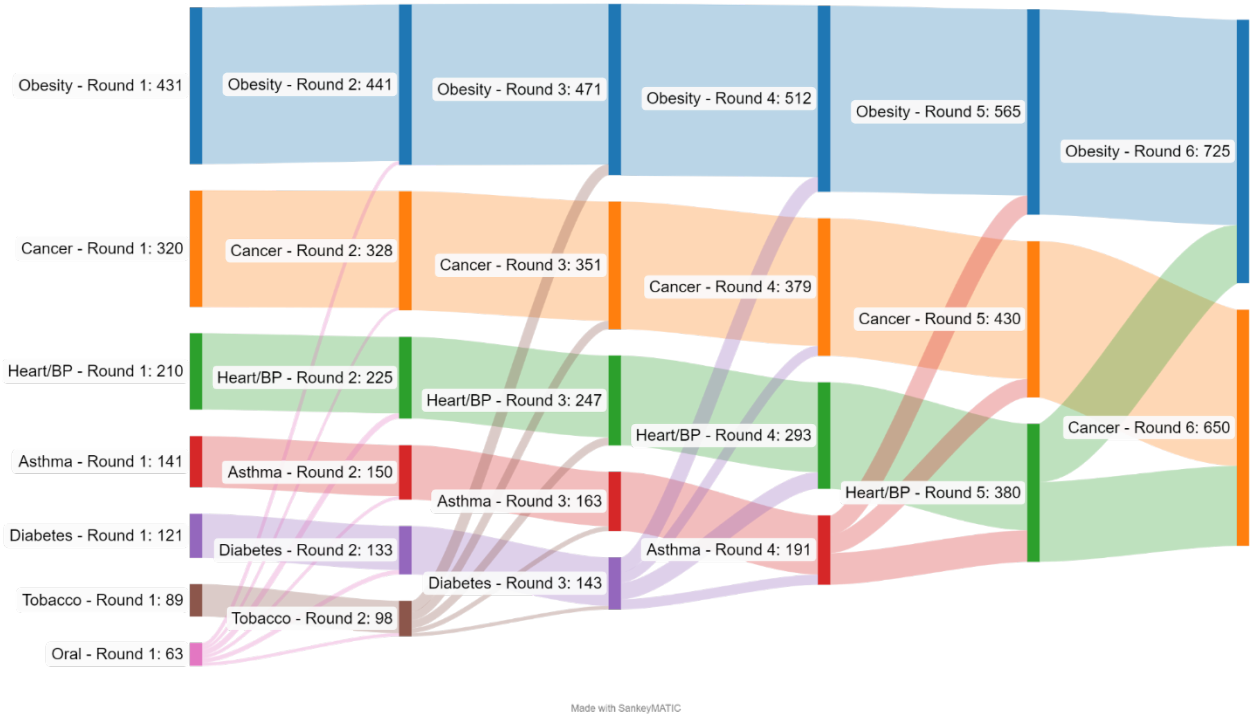
TABLE 4: Chronic disease rankings

Rank	Chronic Disease
1	Obesity
2	Cancer
3	Heart disease and hypertension
4	Asthma and other chronic respiratory diseases
5	Diabetes
6	Tobacco use
7	Oral health

*The community ranked **obesity** the most important chronic disease.*

Figure 4 shows the ranked choice voting process for chronic disease issues. In round 1, oral health received the least votes. The 63 voters who picked oral health as their most important issue were spread about evenly to the remaining issues. In round 2, tobacco use received the least votes. The 98 voters who selected tobacco use as their most important issue were spread about evenly to the remaining issues. In round 3, diabetes received the fewest number of votes. Among the 143 voters who selected diabetes as their top issue, the majority were evenly spread between obesity and heart disease and hypertension. The minority of those voters were spread between cancer and asthma. In round 4, asthma and other chronic respiratory diseases got the least votes. Among the 191 voters who selected asthma as their most important issue, there was a slight preference for heart disease and hypertension as their next choice. In round 5, heart disease and hypertension dropped. More votes for this issue were moved to cancer over obesity. However, in round 6 obesity received the most votes.

FIGURE 4: Chronic disease Sankey chart (N = 1,375)



Sankey chart of ranked choice voting procedure for seven chronic disease issues: oral health (Oral), tobacco use (Tobacco), diabetes (Diabetes), asthma and other chronic respiratory diseases (Asthma), heart disease and hypertension (Heart/BP), cancer, (Cancer), and obesity (Obesity)

Injury

Participants ranked the importance of four categories of injury. Table 5 shows the order in which they were ranked, with 1 indicating the most important.

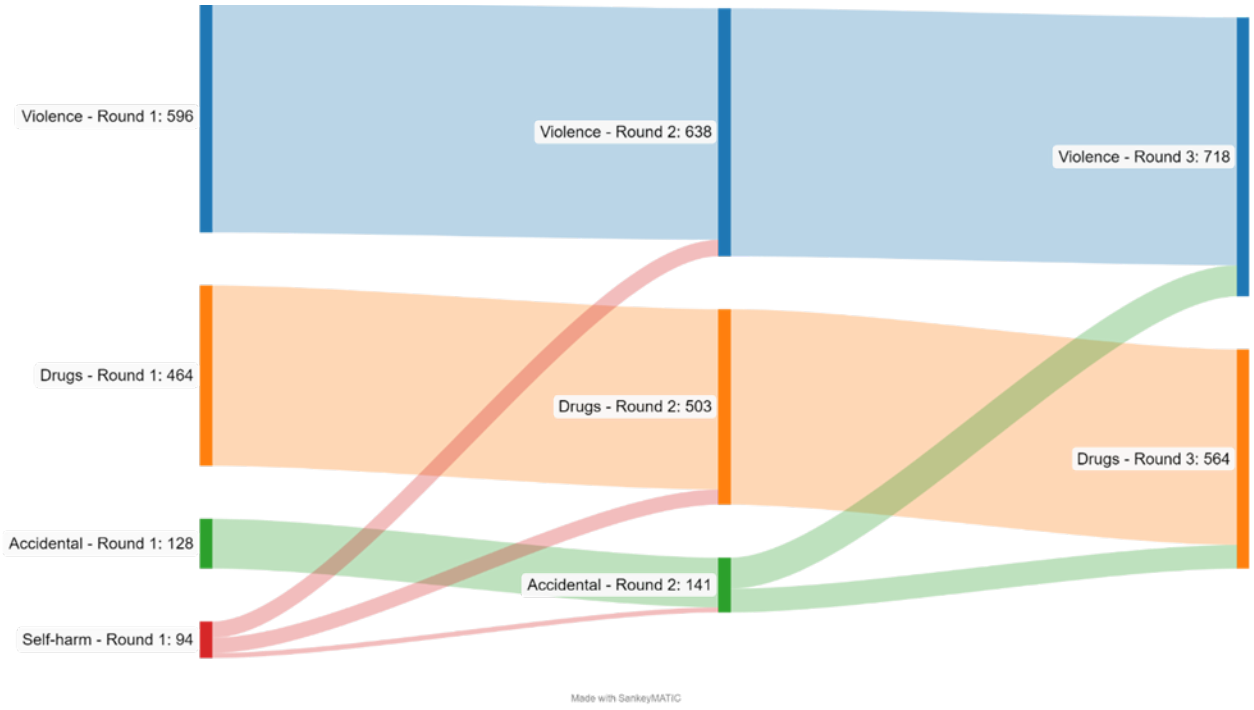
TABLE 5: Injury rankings

Rank	Injury
1	Violence
2	Drug/substance misuse
3	Accidental injuries
4	Self-harm

*The community ranked **violence** the most important injury topic.*

Figure 5 shows the ranked choice voting process for injury issues. In round 1, self-harm received the fewest number of votes for the most important issue. In round 2, accidental injuries received the fewest votes. Round 3 ended with violence receiving the most votes.

FIGURE 5: Injury Sankey chart (N=1,282)



Sankey chart of ranked choice voting procedure for four injury issues: violence like assault and homicide (Violence), drugs/substance misuse like alcohol or opioids and overdose (Drugs), accidental injuries like drowning and traffic collisions (Accidental), and self-harm like suicide and cutting (Self-harm)

Equity, Diversity, and Inclusion

Participants ranked the importance of seven equity, diversity, and inclusion issues. Table 6 shows the order in which they were ranked, with 1 indicating the most important.

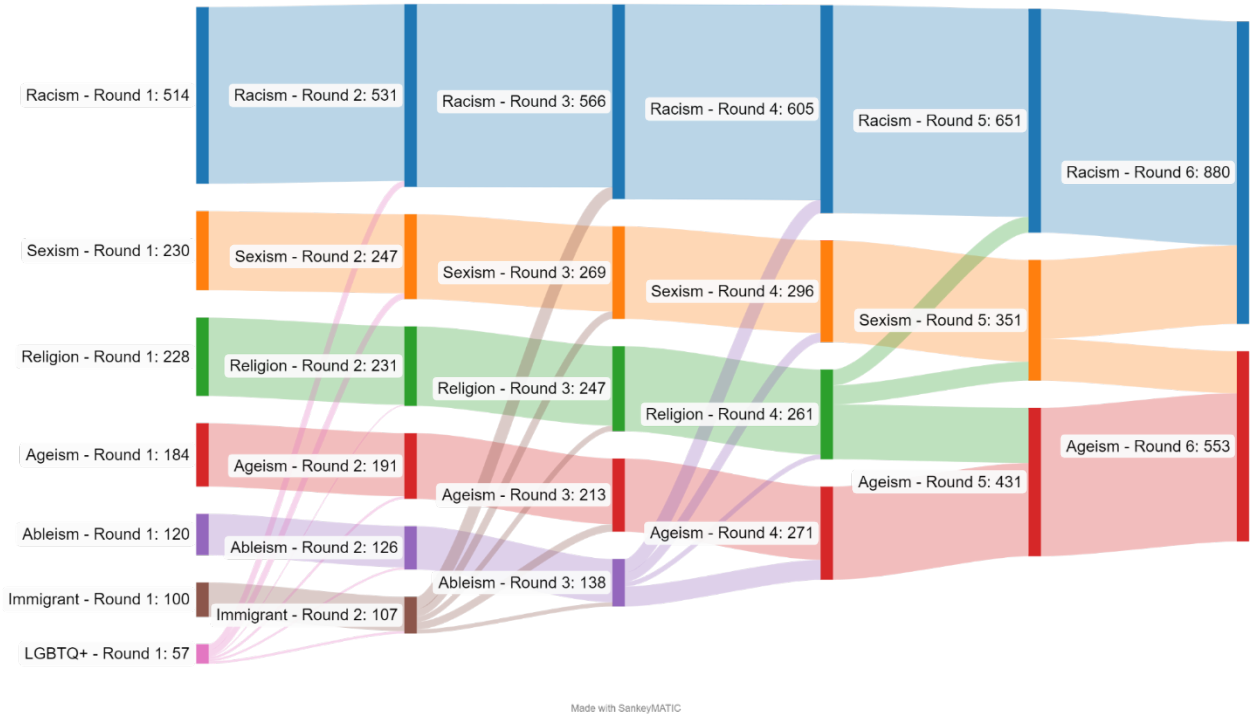
TABLE 6: Diversity, equity, and inclusion rankings

Rank	Equity issue
1	Racism
2	Ageism
3	Sexism
4	Religious discrimination
5	Ableism
6	Immigrant discrimination
7	LGBTQ+ discrimination

*The community ranked **racism** the most important diversity, equity and inclusion issue.*

Figure 6 shows the ranked choice voting process for equity issues. In round 1, LGBTQ+ discrimination and rights had the fewest number of votes for the most important issue. Therefore LGBTQ+ was dropped from the next rounds. More than half of the 57 respondents who selected LGBTQ+ as their most important issue were moved to racism or sexism as their second choice. In round 2, immigration had the fewest number of votes and was dropped. The 107 respondents who selected immigration as their top choice were spread about evenly across the remaining five equity issues. In round 3, ableism received the fewest votes and was dropped. Fifty-eight voters who selected ableism as their top issue were moved to ageism, 39 voters to racism, 27 voters to sexism, and 14 voters to religion. In round 4, religion was dropped as the issue with the fewest votes. About three-fifths of voters who chose religion as their most important issue were moved to ageism. This suggests that voters who rated religion as highly important also tended to rate ageism as highly important. In round 5, sexism was dropped as the issue with the fewest votes. About two-thirds of voters who chose sexism as their most important issue were moved to racism. This suggests that voters who rated sexism as highly important also tended to rate racism as highly important. In round 6, racism received more than half of all votes.

FIGURE 6: Equity, diversity, and inclusion Sankey chart (N = 1,433)



Sankey chart of ranked choice voting procedure for seven equity, diversity, and inclusion issues: Racism and racial justice (Racism), ageism (discrimination based on age) (Ageism), sexism and women's rights (Sexism), religious discrimination and freedom (Religion), ableism (discrimination based on disability) (Ableism), immigrant discrimination and rights (Immigrant), and LGBTQ+ discrimination and rights (LGBTQ+)

Maternal Child Health

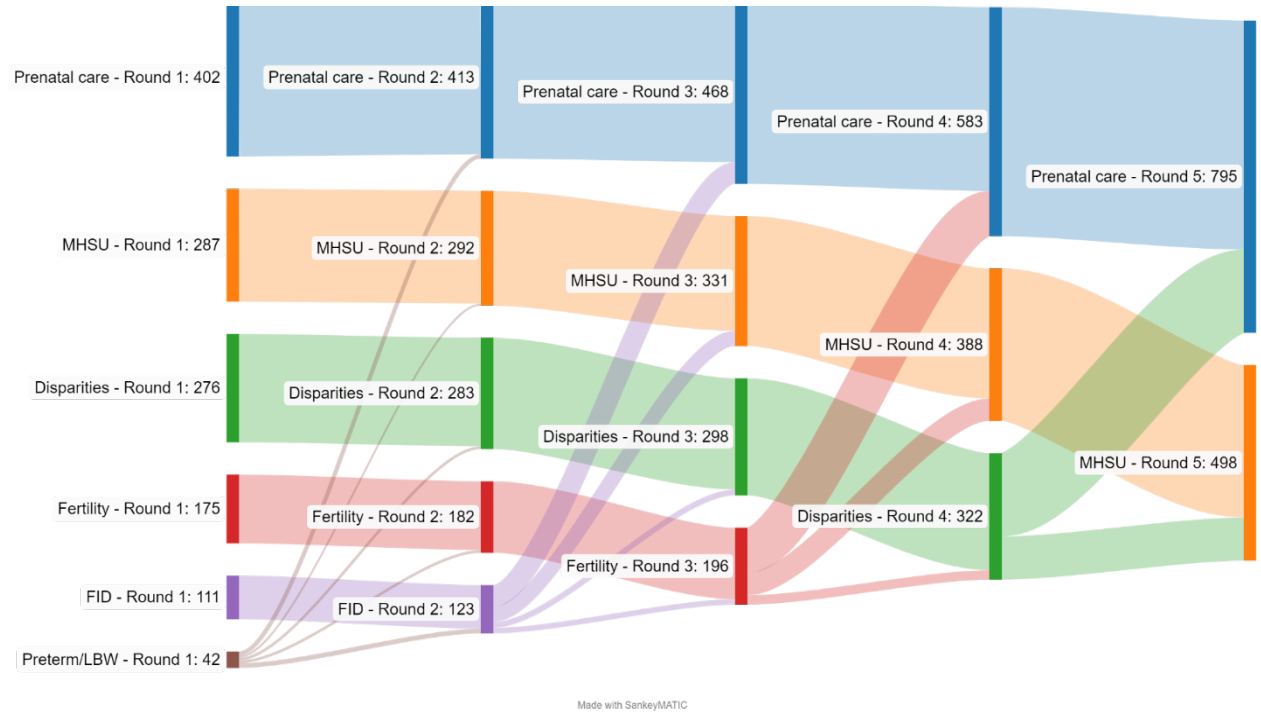
Participants ranked the importance of six maternal child health categories. Table 7 shows the order in which they were ranked, with 1 indicating the most important.

TABLE 7: Maternal child health topic rankings

Rank	Maternal child health topic
1	Prenatal care
2	Maternal mental health & substance use
3	Racial disparities in birth outcomes
4	Fertility & family planning
5	Fetal & infant death
6	Preterm birth & low birth weight

*The community ranked **prenatal care** the most important maternal child health topic.*

FIGURE 7: Maternal child health Sankey chart (N=1,293)



Sankey chart of ranked choice voting procedure for six maternal child health issues: preterm birth and low birth-weight babies (Preterm/LBW), fetal and infant death (FID), fertility and family planning (Fertility), racial disparities in birth outcomes (Disparities), maternal mental health and substance use (MHSU), and prenatal care access and quality (Prenatal care)

Figure 7 shows the ranked choice voting process for MCH issues. In round 1, preterm birth and low birth-weight babies received the fewest number of votes for the most important issue. Therefore, preterm birth and low birth weight was dropped from subsequent rounds. Roughly half of the 42 votes for this issue being most important was moved to fetal and infant death or prenatal care, and the other half was allocated to the remaining three issues. In round 2, fetal and infant death received the fewest number of votes for most important issue and was dropped from subsequent rounds. The 123 voters who selected this issue generally preferred prenatal care or maternal mental health and substance use as their next top issue. In round 3, fertility and family planning received the fewest number of votes and was dropped from subsequent rounds. Over half (115) of the 196 voters who selected this issue were moved to prenatal care, indicating that participants who rated fertility and family planning as highly important tended to also rate prenatal care as highly important. In round 4, racial disparities in birth outcomes received the fewest number of votes and was dropped from subsequent rounds. About two-thirds (212) of the 322 votes for this issue were moved to prenatal care, indicating that participants who rated racial disparities in birth outcomes as highly important tended to also rate prenatal care as highly important. In round 5, prenatal care had the most votes for the most important MCH issue.

Comparisons

New patterns emerged when responses on health-related topics (as in Figure 2) were grouped by certain demographics. Notably, non-Hispanic White respondents tended to rank equity as a less important health-related topic compared to respondents of other racial and ethnic groups. Equity was the fifth most important health-related topic among non-Hispanic White respondents compared to the 2nd most important among respondents of other racial and ethnic groups (Table 8).

TABLE 8: Health topic rankings, non-Hispanic White respondents vs. all other racial and ethnic groups

Rank (1= most important)	White (N = 590)	All other groups (N = 277)
1	Infectious diseases	Infectious diseases
2	SDOH	Equity
3	Injury	Injury
4	Chronic diseases	SDOH
5	Equity	Chronic diseases
6	MCH	MCH

Additionally, there was a major difference in the ranking of injury (which included violence and substance use) as a health-related topic depending on the poverty level of where respondents lived (Table 9). Respondents who lived in a zip code with the same or less poverty as the County overall ranked injury as more important than those who lived in a zip code with higher poverty.

TABLE 9: Health topic rankings, respondents living in zip codes with the same or less poverty vs. higher poverty than the County overall

Rank (1= most important)	Lower poverty (N = 687)	Higher poverty (N = 335)
1	Infectious diseases	Infectious diseases
2	SDOH	SDOH
3	Injury	Chronic diseases
4	Chronic diseases	Equity
5	Equity	Injury
6	MCH	MCH

"Is our community healthy?"

There were 1,337 participants who rated their community's health in Question 10. Less than half of all respondents rated their community's health as very healthy or somewhat healthy. Specifically, 3% of respondents answered very healthy, 41% answered somewhat healthy, 42% answered somewhat unhealthy, and 15% answered very unhealthy (Figure 8).

FIGURE 8: Perception of community's health (N=1,337)

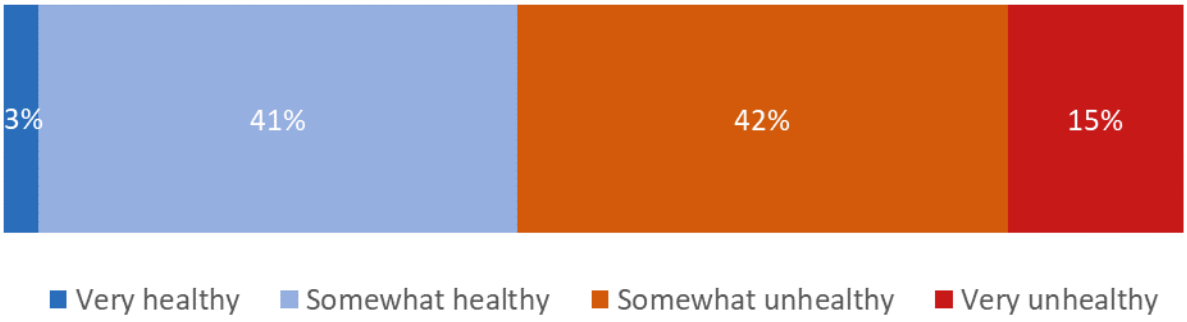
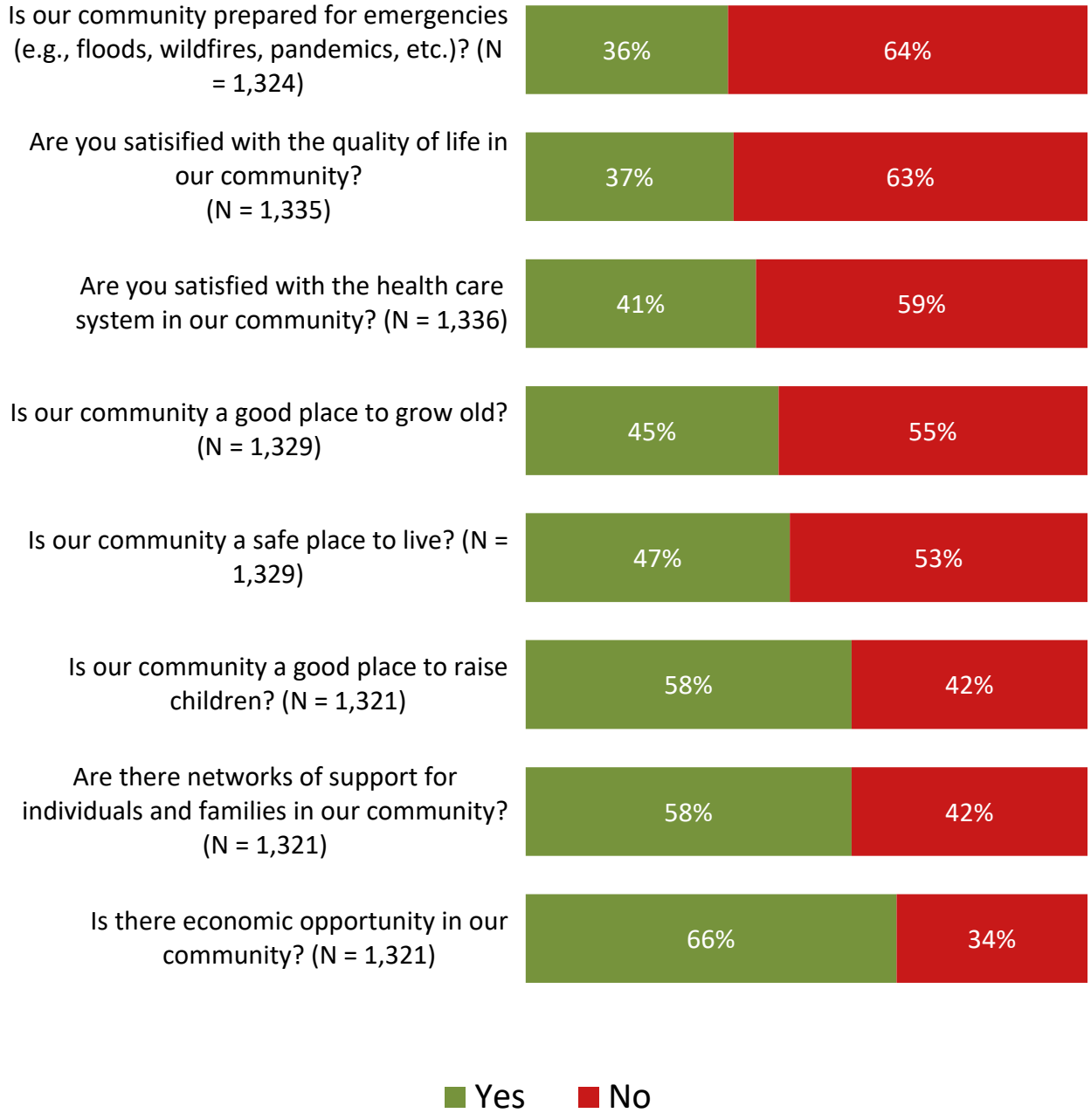


Figure 9 shows the results of Questions 8, 9, and 11-16. For five out of eight questions, more than half of respondents answered negatively. Specifically, 64% of respondents believed the County is not prepared for emergencies like floods, wildfires, or pandemics, 63% were not satisfied with the quality of life in our community, 59% were not satisfied with the health care system in the County, 55% believed the County is not a good place to grow old in, and 53% believed the County is not a safe place to live in. For the remaining three Yes-No questions, more than half of respondents answered positively. Specifically, 58% of respondents believed our community is a good place to raise children in, 58% believed there are networks of support for County members and their families, and 66% believed there is economic opportunity in the County.

FIGURE 9: Perception of community health metrics

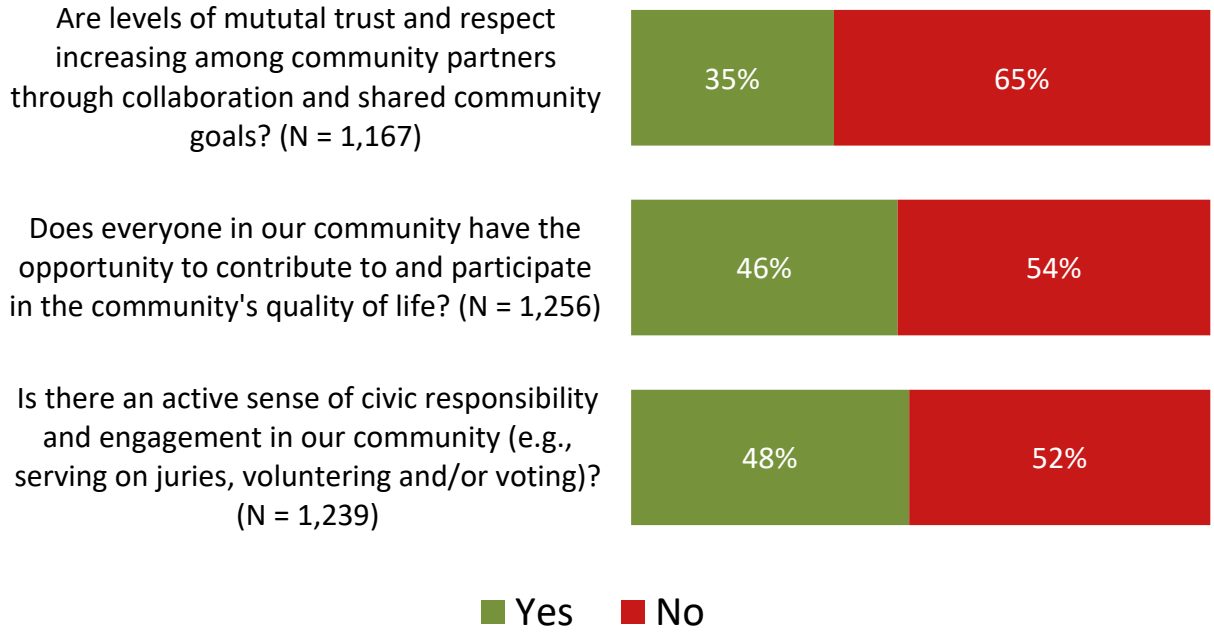


"How engaged is our community?

Civic Engagement

Figure 10 displays the results of Questions 17, 19, and 21. For all three of these questions, less than half of respondents answered positively. Specifically, 65% of respondents believed levels of mutual trust and respect have not increased among community partners through collaboration and shared community goals, 54% believed everyone does not have the opportunity to contribute to and participate in the community's quality of life, and 52% believed there is not an active sense of civic responsibility and engagement in the County through voting, volunteering, serving on juries, and other activities.

FIGURE 10: Civic engagement metrics



Community Pride

There were 925 participants who answered Question 18 which asked, "What is the one thing that makes you most proud of our community?" Figure 11 displays the 50 most common words from responses. Responses frequently mentioned the community's people and diversity, the outdoors, and green spaces available in the County. However, many respondents also said 'nothing' in response to this question.

FIGURE 11: Common themes around community pride

"Open spaces, and so many outdoor trails for walking, riding, whatever. "

"All the trees, love the trees"

"The diversity of the people that live here"

"The helpfulness and kindness of the people in the community"

"Nothing presently"

Community Involvement

There were 897 participants who answered Question 20 which asked, "What would excite you enough to become more involved in improving our community?" Figure 12 shows the 50 most common words from responses. Common responses included seeing tangible changes and addressing homelessness.

FIGURE 12: Common themes around improving community involvement

"More safe public spaces, parks, libraries, safe walkable trails"

"Feeling I could make a difference"

"Seeing results"

"True commitment to housing the homeless"

Community Priorities

There were 900 participants who answered Question 22 which asked, "What actions, policies or funding priorities would you support to build a healthier community?" Figure 13 displays the 50 most common words from responses. Common answers included homelessness, housing, and health services.

FIGURE 13: Common themes around community priorities

"Homelessness, mental health, crime"

"More affordable health care and services"

"Helping the homeless"

Additional Comments

There were 658 people that answered Question 23 which asked, “Do you have any additional brief comments about the health of the community?” Figure 14 displays the 50 most common words from responses. Common answers mentioned homelessness and housing, mental health services, cleanliness of County streets, and safety.

FIGURE 14: Common themes among open comments regarding community health

> “I love Sacramento County, and I love my neighborhood and my community institutions. And yet, its so incredibly obvious that many people in Sacramento struggling and in pain. I don't care whether folks' circumstances are their "fault", I just want to help them get better instead of blame them for their misfortunes, give them little or no support/services, and then expect them to help themselves. I'm sad but I'm also angry that the government keeps failing to help so many people in Sacramento, and I'm angry that there are places in Sacramento that no longer feel safe because the government won't help folks who need it.”

"How do you fit into our community?"

Out of 1,219 respondents who answered Question 24 about their individual health, almost all (85%) respondents rated their health as either somewhat healthy or very healthy (Figure 15). The remaining 15% of respondents rated their health as either somewhat unhealthy or very unhealthy. These results contrast greatly with respondents' assessments of their community's health, which most respondents considered unhealthy (Figure 8).

FIGURE 15: Self-rated health (N = 1,219)

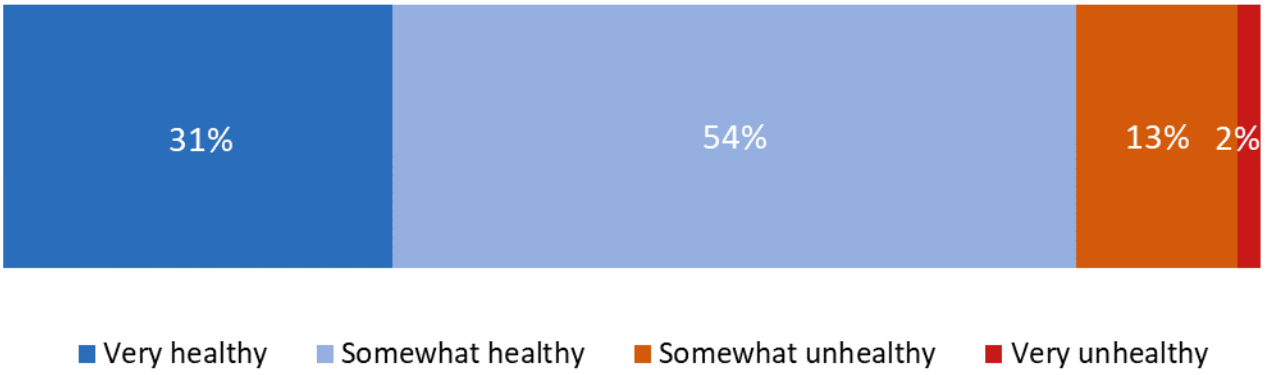
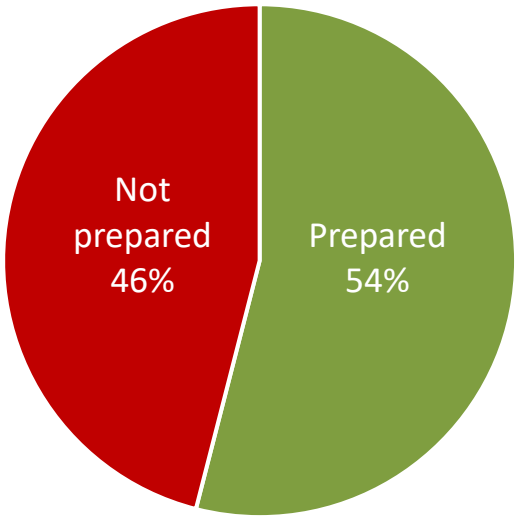


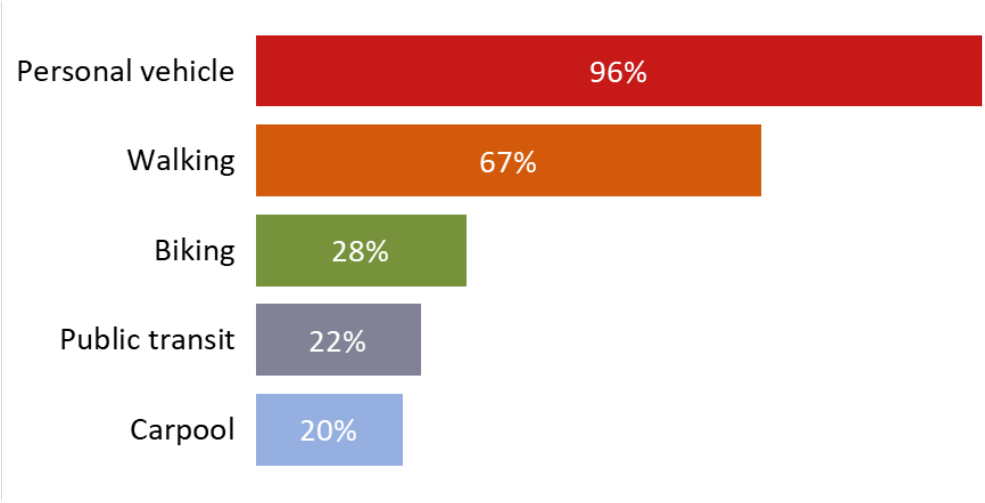
FIGURE 16: Self-rated preparedness for emergencies (N = 1,216)



Out of 1,216 respondents who answered Question 25 about emergency preparedness, slightly more than half reported being prepared for an emergency (Figure 16). These results contrast greatly with respondents' assessment of their community's emergency preparedness, which most respondents considered insufficient (Figure 9).

There were 1,217 respondents who reported the modes of transportation they used in the past year for Question 26. Respondents could select multiple modes of transportation. Ninety-six percent of respondents used a personal vehicle, 67% of respondents walked, 28% of respondents rode a bicycle, 22% of respondents rode public transportation, and 20% of respondents carpooled (Figure 17).

FIGURE 17: Transportation used in the past year (N = 1,217)

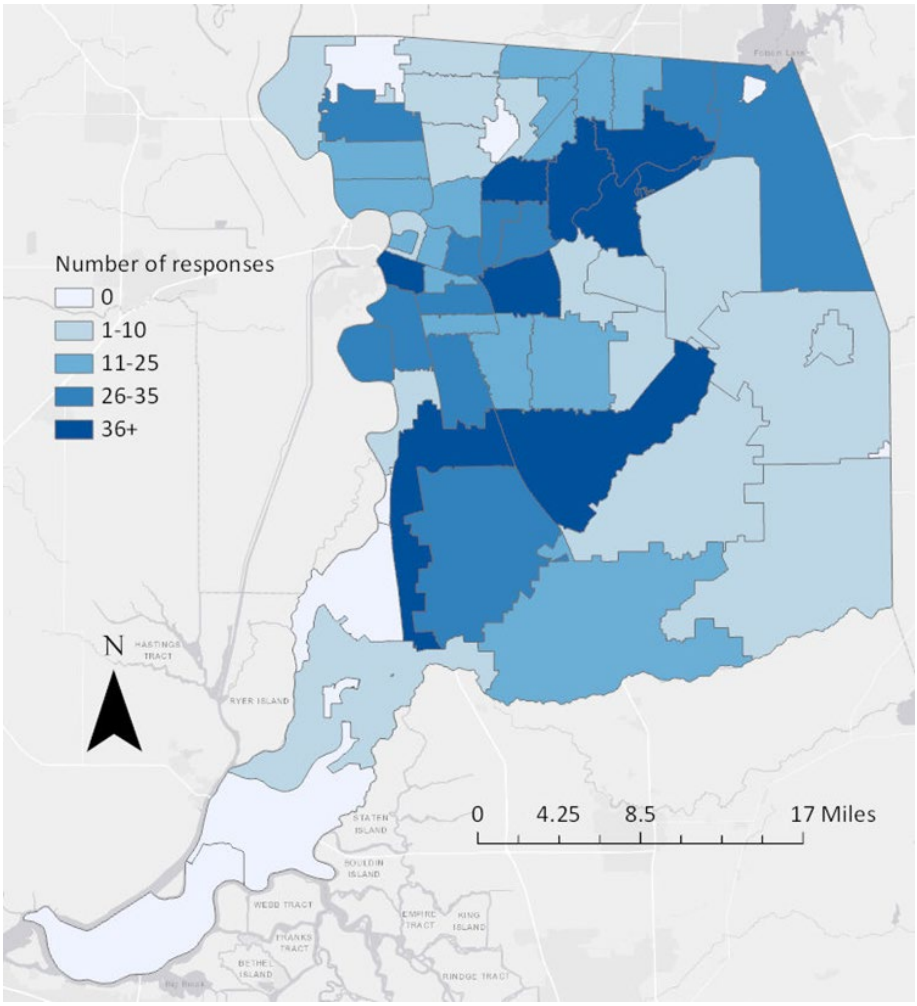


Out of 1,058 respondents who answered Question 28 length of community membership in the County, over half reported being members for at least 20 years (Figure 18). Nearly one quarter of respondents reported being a community member for between one to ten years.

FIGURE 18: Length of membership in Sacramento County community (N = 1,058)

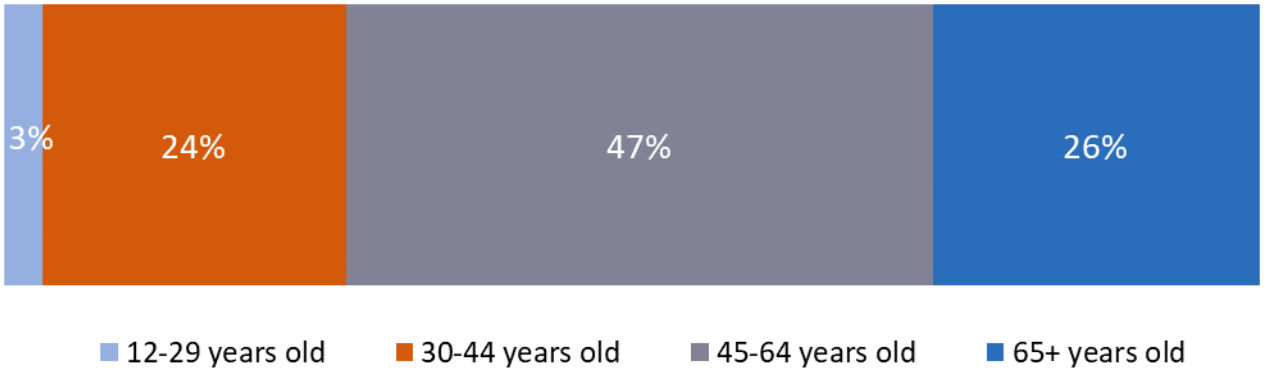
There were 1,005 respondents who provided their zip code of residence in Question 27. About 85% of the 61 zip codes within Sacramento County had at least one response (Figure 19). The zip codes with the greatest number of responses (at least 36 responses) were 95608, 95628, 95758, 95624, 95670, 95818, 95826 and 95821. This roughly corresponds to the northeast area of the County including Fair Oaks, Carmichael, Rancho Cordova and Arden Arcade, and the Elk Grove and Oak Park areas of South Sacramento. The zip codes in which no participants reported residing in were 94571, 95615, 95639, 95640, 95641, 95652, 95671, 95680 and 95836. These areas roughly correspond to rural areas in the most southwestern and southeastern areas of the County, Mcclellen Park area, Folsom prison area, and the area just east of the Sacramento metropolitan airport.

FIGURE 19: Number of survey responses by zip code of residence (N = 1,005)



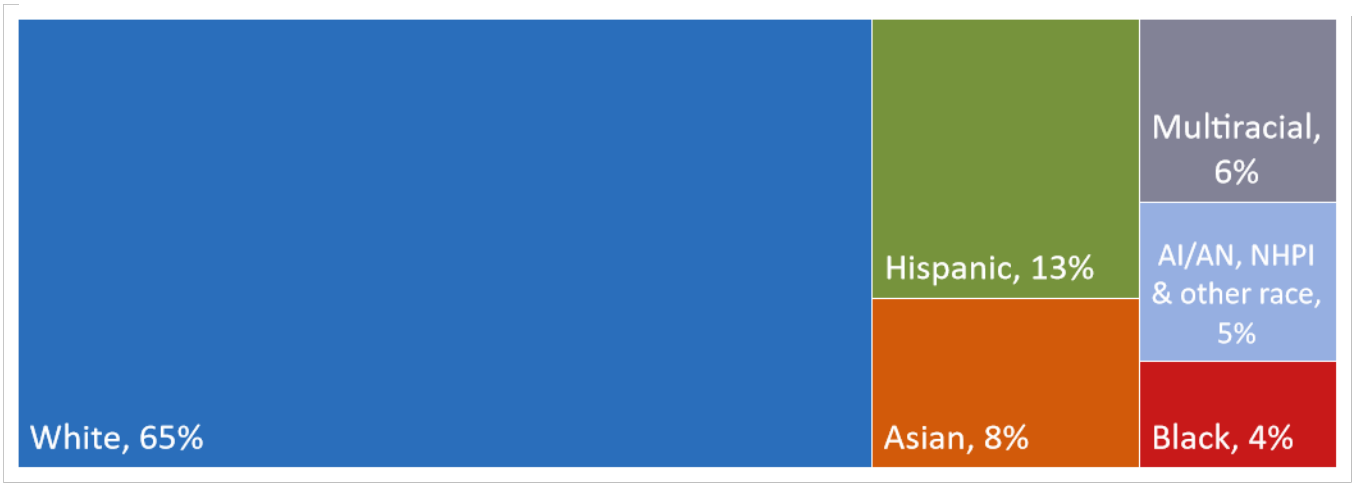
Out of 1,039 respondents who provided their age for Question 29, three percent reported being between 12 and 29 years old. About a quarter (24%) were between 30 and 44 years old, just under half (47%) between 45 and 64 years old, and about a quarter (26%) age 65 or older (Figure 20). The youngest was 14 years old, and the oldest was 111 years old. The average age was 54.4 years old. Nearly three-fourths of the 1,039 participants who answered Question 29 were at least 45 years old when they completed CTSA.

FIGURE 20: Survey respondents by age group (N = 1,039)



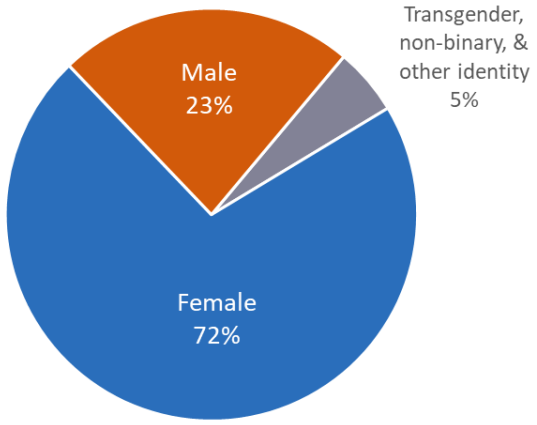
There were 929 respondents who provided both their race and ethnicity in Questions 30 and 31. Just under two-thirds (65%) were non-Hispanic White and just over one-third (35%) were non-White (Figure 21). When compared with the overall County population, Blacks, Hispanics, and Asians were underrepresented among respondents.

FIGURE 21: Survey respondents by race/ethnicity (N = 929)



Out of 1,066 respondents who provided their gender in Question 32, nearly three-fourths of respondents were cis-gender females (Figure 22). Just under a quarter (23%) were cis-gender male, and the remaining of 5% of respondents reported being transgender, non-binary, or a gender identity other than options provided. Responses for transgender, non-binary and other gender identity were aggregated into a single category in Figure 22 due to the small number of responses for each category individually.

FIGURE 22: Survey respondents by gender identity (N = 1,066)

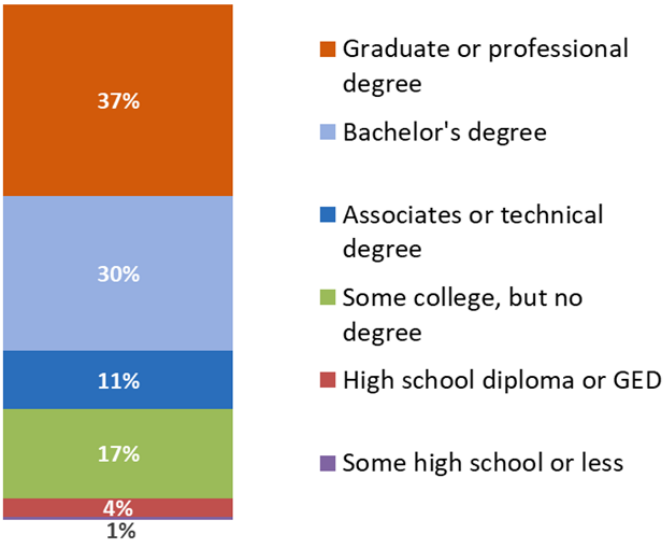


There were 935 respondents who provided their sexual orientation in Question 33. Over four-fifths (82%) of respondents were heterosexual/straight, and 18% were a sexual orientation other than heterosexual/straight (Figure 23). Specifically, 6% of respondents reported being homosexual/lesbian/gay, 4% reported being bisexual and 8% reported being asexual, pan-sexual or an orientation other than the options provided. These three choices were aggregated into a single category in Figure 23 due to the small number of responses for each category individually.

FIGURE 23: Survey respondents by sexual orientation (N = 935)

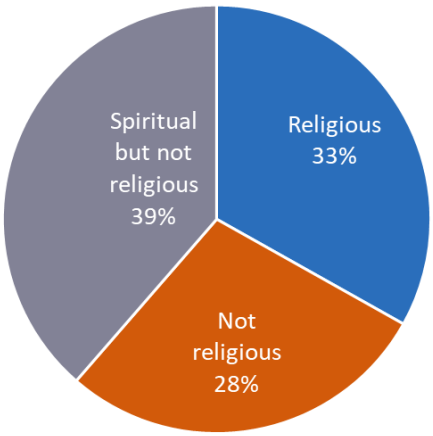
Out of 1,023 respondents who provided their highest completed level of education in Question 34, about two-thirds (67%) had a bachelor's degree or higher (Figure 24). Specifically, 30% had a bachelor's degree, and 37% had a graduate or professional degree. Eleven percent had an Associates or technical degree, and 17% had some college or education without a degree. Five percent of respondents had a high school diploma, GED, or only some high school education with no diploma.

FIGURE 24: Survey respondents by education level (N = 1,023)



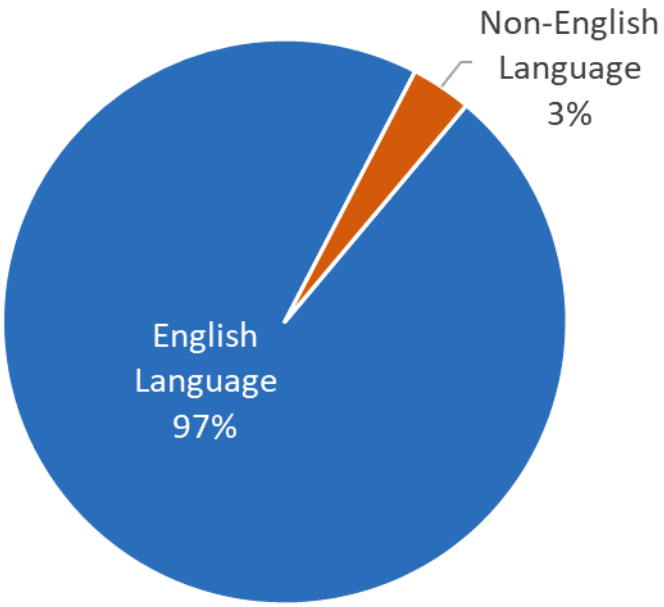
Out of 1,005 respondents who provided their religiosity in Question 35, one-third of respondents were religious, 28% were not religious, and 39% were spiritual but not religious (Figure 25).

FIGURE 25: Survey respondents by religiosity (N = 1,005)



Survey language was recorded for all 1,644 respondents analyzed in the report. Three percent of respondents answered CTSA in a language other than English, and the most common non-English languages were Russian and Pashto (Figure 26).

FIGURE 26: Survey responses by language (N = 1,644)



DISCUSSION

Findings

CTSA collected responses from members of the Sacramento County members of various ages, races and ethnicities, genders, and sexual orientations. Most County zip codes were represented by at least one participant, and a wide range of opinions were expressed through CTSA, especially in Questions 1-7 from the section "What does a healthy community look like?" and the free-response questions (Questions 18, 20, 22 and 23) in the section "How engaged is our community?"

SCPH's collaboration with RSE demonstrated the effectiveness of social media campaigns to promote community participation, especially among non-English speakers. Concurrently with the campaign, SCPH staff sent the survey to various community partners with a request to share and included a link to the survey in the County Newsletter. There were 74 non-English responses in five different non-English languages recorded, 62 of which were in September 2022 during RSE's social media campaign.

A rank-based voting procedure was implemented to determine which health topics and issues were the most important to CTSA respondents in the section "What does a healthy community look like?" After conducting this procedure, the most important issues are summarized in Table 10 below. The timing of the survey coinciding with the third year of the COVID-19 pandemic likely influenced responses. Specifically, infectious disease was ranked the most important overall health topic and vaccine-preventable diseases (including COVID-19) was ranked the most important infectious disease topic. Community perception likely would have differed prior to the pandemic. Different methods of counting and evaluating respondents' rankings could have potentially led to different issues being prioritized. Regardless of the method used, responses for Questions 1-7 demonstrate that all issues and topics mentioned in "What does a healthy community look like?" are relevant to the health of the County.

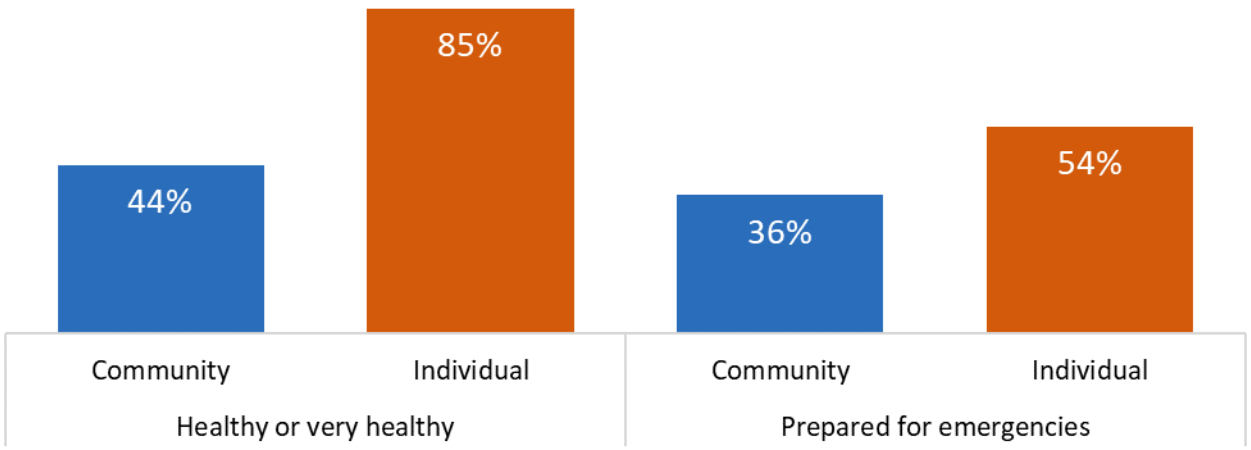
TABLE 10: Summary of issues rating most important by topic area

Topic area	Issue rated most important
Overall health	Infectious disease
Infectious disease	Vaccine preventable disease
Social determinants of health	Food and housing insecurity
Chronic Disease	Obesity
Injury	Violence
Equity, diversity, and inclusion	Racism
Maternal child health	Prenatal care

One major finding was that certain groups of CTSA participants tended to rank certain issues differently compared to the CTSA participants overall. Compared to non-Hispanic White respondents, respondents of other races and ethnicities tended to consider equity as a highly important health-related topic (Table 8). Respondents living in zip codes with lower levels of poverty also tended to rank injury as a highly important health-related topic compared to respondents living in zip codes with higher levels of poverty (Table 9).

A second major finding was the contrast between respondents' evaluation of their communities versus themselves with regards to health status and emergency preparedness (Figure 27). More than half of CTSA participants thought their communities were unhealthy (Figure 8). When asked about their own health, nearly 90% of participants thought their own health was either very or somewhat healthy (Figure 15). More than half of CTSA participants also thought their communities were not prepared for a potential emergency, but more than half of participants thought they themselves were prepared (Figures 9 and 16). There are a few possible explanations for these differences. First, CTSA participants could have overestimated their own health and preparedness. Second, participants could have underestimated their community's health and emergency preparedness. Third, healthier and more-prepared community members could have been more likely to complete CTSA. It is likely that some combination of these three possibilities contributed to this finding. For emergency preparedness, there could also be true differences in term of individual-level preparedness (e.g., having a family evacuation plan, go-bags etc.) compared to perceptions of County-level preparedness (e.g., mass evacuation plans, emergency sheltering infrastructure, etc.).

FIGURE 27: Community vs. Individual health and preparedness rankings



Limitations

There are a few limitations of the CTSA. The main limitation is the generalizability of participant responses to all members of the Sacramento County community. CTSA participants were more likely to be older, non-Hispanic White, cis-gender women with a college education or higher who were long-term County members, even though efforts were made to specifically recruit participants outside of these characteristics.

Figures 28 compares the sex, racial-ethnic, and age compositions of CTSA participants to the Sacramento County population. The County Population is from the California Department of Finance (DoF) population projections published in July 2022 for the year 2022 among people ages 12 and older. Three-quarters of cis-gender CTSA participants answered female as their biological sex and only 25% answered male as their biological sex. County residents ages 12 and older is almost evenly split between female and male. White participants constituted 65% of CTSA participants, while White County residents constituted less than half of County residents ages 12 and older. Older and middle-aged County members were over-represented in CTSA as well. Nearly 75% of CTSA participants were at least 45 years old, while that age group is closer to half of County residents ages 12 and older.

FIGURE 28: Demographic characteristics, County population vs. CTSA participants

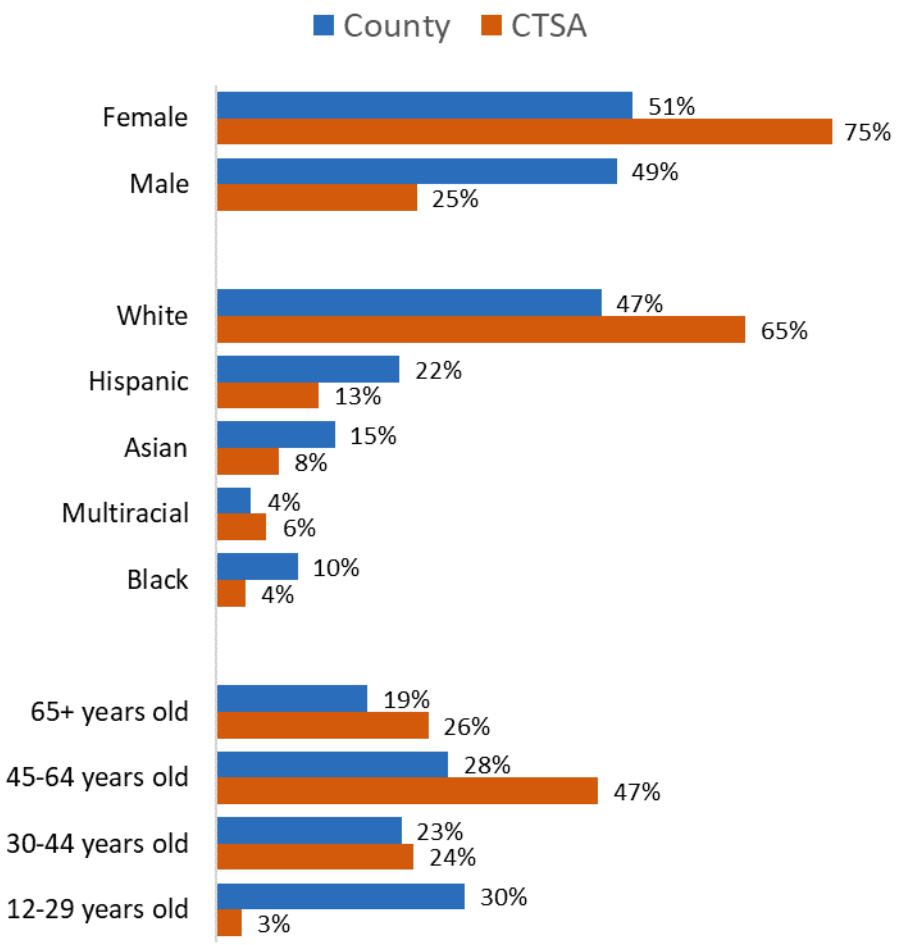
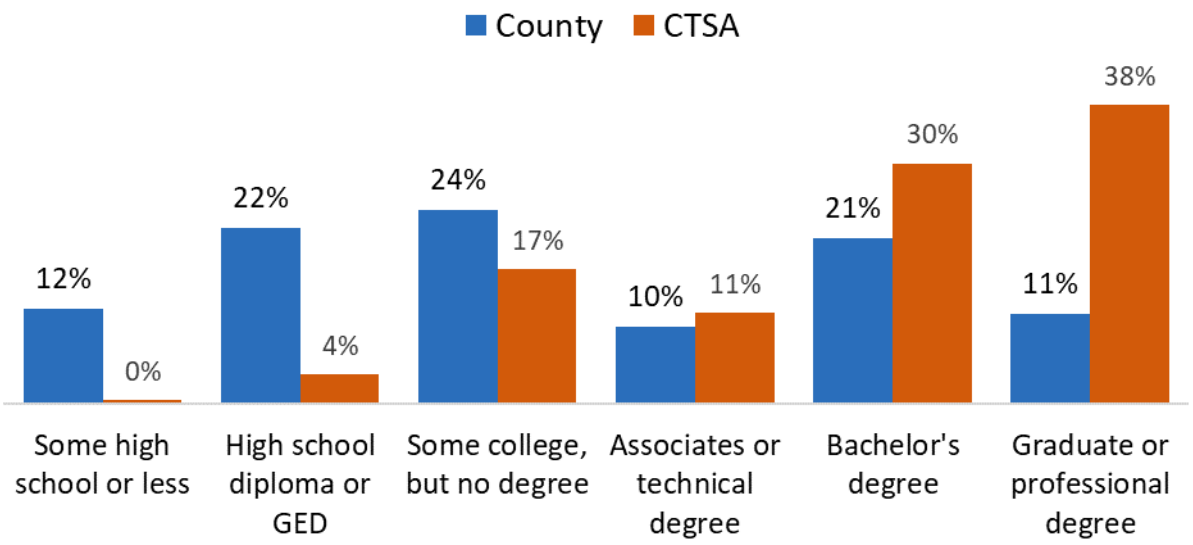


Figure 29 compares the educational attainment of CTSA participants to estimates of educational attainment in Sacramento County from the 2021 American Community Survey (ACS) 5-year estimates. The 2021 ACS data was the most recently available data at the time of this report and was limited to individuals 25 years and older. The opinions of CTSA participants

may not be indicative of the opinions of County members at large. CTSA respondents were more likely to have attained a bachelor's degree or higher compared to the County population. CTSA respondents were more than three times as likely to have a graduate or professional degree compared to all County residents. The higher average age or CTSA respondents may have been influenced by this difference despite CTSA including a wider range of ages.

FIGURE 29: Educational attainment, County population vs. CTSA participants



The second limitation of CTSA was the rate of completion. Even after excluding responses that answered zero questions, only slightly more than half of survey participants reached the end of CTSA. Additionally, many respondents chose to not disclose demographic information such as race/ethnicity and sexual orientation in the final section. These two factors complicate our ability to understand the priorities of specific subgroups among members of the Sacramento County community. It also complicates efforts to recruit specific groups for future participation in community assessments.

CONCLUSION

The 2022 CTSA survey was successfully disseminated, administered, analyzed, and interpreted. Community surveys such as the CTSA continue to be one of many valuable tools for engagement with and for Sacramento County community members. The Community Context Assessment, along with the 2020 Health Status Assessment and 2022 Community Partners Assessment, were building blocks for the overall Sacramento County Community Health Assessment and will be used to inform the Community Health Improvement Plan process. Sacramento County Public Health will continue to draw on community feedback in the pursuit of its shared vision of optimal health for those who live, work, play and worship in the County.

APPENDIX A:
CTSA Survey

Sacramento County Public Health (SCPH) values your opinion. The Community Themes and Strengths Assessment is a vital part of a community health improvement process. We are collecting community thoughts, opinions, concerns, and solutions - anything that provides insight into the issues the community feels are important. We're also interested in feedback about the quality of life and community assets in Sacramento County. Responses will inform a SCPH Community Health Improvement Plan.

There are four sections to this survey:

1. Section 1 - What does a healthy community look like?
2. Section 2 - Is our community healthy?
3. Section 3 - How engaged is our community?
4. Section 4 - How do you fit into our community?

You must be 12 years or older to participate in this survey and live, work, play or worship in Sacramento County. This survey will take about 20 minutes to complete. Your participation is voluntary and any personal information you provide will be kept secure. There are no foreseeable risks or direct benefits associated with participation in this project. If you have questions or concerns about this survey, you can contact Jamie White at epidemiology@saccounty.gov or Dr. Gurleen Roberts at robertsg@saccounty.gov. If you consent to being part of this project, please select 'yes' below.

- Yes, I consent to participate in this survey and I am at least 12 years old
- No, I do not consent to participate in this survey or I am not at least 12 years old

Section 1: This section will ask you some questions about what is needed for a healthy community. The questions in this section will ask you to rank topics. You can rank each item by clicking on it, dragging and dropping it into place.

1. Please rank the most important health-related topics from the list below that need to be addressed to improve health in our community (1 = most important). To rank, click each item and drag and drop them in the order of importance.
    - Chronic diseases (e.g., cancer, diabetes, etc.)
    - Equity, diversity and inclusion (e.g., racism, LQBTQ+ rights)
    - Other social determinants of health (e.g., jobs, education etc.)
    - Infectious diseases (e.g., COVID-19, STDs etc.)
    - Injury (e.g., accidents, violence, drug overdoses)
    - Maternal child health (e.g., infant death, prenatal care etc.)

2. Please rank the most important equity, diversity and inclusion issues from the list below that need to be addressed to improve health in our community (1 = most important). To rank, click each item and drag and drop them in the order of importance.
    - Ableism (discrimination based on disability)
    - Ageism (discrimination based on age)
    - Immigrant discrimination and rights
    - LGBTQ+ discrimination and rights
    - Racism and racial justice
    - Religious discrimination and freedom
    - Sexism and women's rights

3. Please rank the most important social determinants from the list below that need to be addressed to improve health in our community (1 = most important). To rank, click each item and drag and drop them in the order of importance.
    - Access to health care (including mental health care)
    - Climate change and the environment
    - Crime and safety
    - Education and literacy
    - Employment and economic opportunity
    - Food and housing security

4. Please rank the most important injury-related issues that need to be addressed to improve health in our community (1 = most important). To rank, click each item and drag and drop them in the order of importance.
    - Accidental injuries (e.g., drowning, traffic collisions etc.)
    - Drugs/substance misuse and overdose (e.g., alcohol, opioids etc.)
    - Self-harm (e.g., suicide, cutting etc.)
    - Violence (e.g., assault, homicide, abuse etc.)

5. Please rank the most important chronic disease issues that need to be addressed to improve health in our community (1 = most important). To rank, click each item and drag and drop them in the order of importance.
    - Asthma & other chronic respiratory diseases
    - Cancer
    - Diabetes
    - Heart disease & hypertension
    - Oral health
    - Obesity
    - Tobacco use

6. Please rank the most important infectious diseases the need to be addressed to improve health in our community (1 = most important). To rank, click each item and drag and drop them in the order of importance.
    - Food & water-borne diseases (e.g., E. coli, salmonella etc.)
    - Sexually transmitted diseases (e.g., HIV, syphilis etc.)
    - Vaccine-preventable disease (e.g., COVID-19, influenza, measles etc.)
    - Vector-borne diseases (e.g., Zika virus, West Nile virus etc.)

7. Please rank the most important maternal-child health issues the need to be addressed to improve health in our community (1 = most important). To rank, click each item and drag and drop them in the order of importance.
    - Fetal and infant death
    - Fertility and family planning
    - Maternal mental health and substance use
    - Preterm birth and low birth-weight babies
    - Prenatal care access and quality
    - Racial disparities in birth outcomes

Section 2: This section will ask you some questions about the health of our community.

8. Are you satisfied with the quality of life in our community?
    - Yes
    - No

9. Are you satisfied with the health care system in our community?
    - Yes
    - No

10. How would you describe the health of our community?
    - Very healthy
    - Somewhat healthy
    - Somewhat unhealthy
    - Very unhealthy

11. Is our community a good place to raise children?
    - Yes
    - No

12. Is our community a good place to grow old?
    - Yes
    - No

13. Is there economic opportunity in our community?
    - Yes
    - No

14. Is our community a safe place to live?
    - Yes
    - No

15. Are there networks of support for individuals and families in our community?
    - Yes
    - No

16. Is our community prepared for emergencies (e.g., floods, wildfires, pandemics, etc.)
    - Yes
    - No

Section 3: This section will ask you some questions about community engagement.

17. Is there an active sense of civic responsibility and engagement in our community (e.g., serving on juries, volunteering and/or voting)?
    - Yes
    - No

18. What is the one thing that makes you most proud of our community?

19. Does everyone in our community have the opportunity to contribute to and participate in the community's quality of life?
    - Yes
    - No

20. What would excite you enough to become more involved in improving our community?

21. Are levels of mutual trust and respect increasing among community partners through collaboration and shared community goals?
    - Yes
    - No

22. What actions, policies or funding priorities would you support to build a healthier community?

23. Do you have any additional brief comments about the health of our community?

Section 4: This section will ask you some questions about you as an individual.

24. How would you describe your individual health?
    - Very healthy
    - Somewhat healthy
    - Somewhat unhealthy
    - Very unhealthy

25. Are you and your household prepared for an emergency (e.g., have evacuation plan, emergency bag etc.)?
    - Yes
    - No

26. Which forms of transportation have you used in the past year (please select all that apply)?
    - Biking
    - Carpool
    - Personal vehicle
    - Public transportation (e.g., bus, train etc.)
    - Walking
27. What zip code do you currently live in?

28. How many years have you been a member of the Sacramento County community (i.e., lived, worked, played or worshipped)?

29. What is your age?

30. Are you of Spanish, Hispanic or Latino origin?
    - Yes
    - No
    - Prefer not to say

31. Choose one or more races that you consider yourself to be.
    - American Indian/ Native American or Alaska Native
    - Asian
    - Black or African American
    - Native Hawaiian or other Pacific Islander
    - White
    - Other, please specify:_____
    - Prefer not to say

32. What is your gender?
    - Female, cis-gender (female since birth)
    - Male, cis-gender (male since birth)
    - Female to male transgender

- Male to female transgender
- Non-binary
- Other, please specify:_____
- Prefer not to say

33. What is your sexual orientation?
    - Asexual
    - Bisexual
    - Heterosexual (straight)
    - Homosexual (lesbian or gay)
    - Pan-sexual
    - Other, please specify:_____
    - Prefer not to say

34. What is the highest level of education you have completed?
    - Some high school or less
    - High school diploma or GED
    - Some college, but no degree
    - Associates or technical degree
    - Bachelor's degree
    - Graduate or professional degree
    - Prefer not to say

35. Do you consider yourself religious?
    - Yes
    - Spiritual but not religious
    - No
    - Prefer not to say

36. Would you be interested in an opportunity to participate in future community health meetings, interviews or other public health activities that are scheduled over the next year (through 2023)?
    - Yes
    - No

37. You indicated you were interested in participating in future events and activities. Please let us know how to best contact you.
    - If you prefer to be reached by phone or text, please enter your phone number.
    - If you prefer to be reached by email, please enter your email address.

Thank you for your participation. Your response has been recorded

APPENDIX B:

Health-related topic and issue rankings

Health-related topics (N = 1,553)

Rank	Chronic diseases	Equity, diversity, and inclusion	Infectious diseases	Injuries	Maternal child health	Other social determinants of health
1	275 (17.7%)	220 (14.2%)	336 (21.6%)	285 (18.4%)	160 (10.3%)	277 (17.8%)
2	305 (19.6%)	170 (10.9%)	259 (16.7%)	257 (16.5%)	292 (18.8%)	270 (17.4%)
3	268 (17.3%)	177 (11.4%)	236 (15.2%)	262 (16.9%)	368 (23.7%)	242 (15.6%)
4	275 (17.7%)	197 (12.7%)	251 (16.2%)	250 (16.1%)	355 (22.9%)	225 (14.5%)
5	238 (15.3%)	231 (14.9%)	313 (20.2%)	244 (15.7%)	242 (15.6%)	285 (18.4%)
6	192 (12.4%)	558 (35.9%)	158 (10.2%)	255 (16.4%)	136 (8.8%)	254 (16.4%)

Rank	Asthma and other chronic respiratory diseases	Cancer	Diabetes	Heart disease and hypertension	Obesity	Oral health	Tobacco use
1	141 (10.3%)	320 (23.3%)	121 (8.8%)	210 (15.3%)	431 (31.3%)	63 (4.6%)	89 (6.5%)
2	143 (10.4%)	190 (13.8%)	279 (20.3%)	385 (28.0%)	182 (13.2%)	82 (6.0%)	114 (8.3%)
3	202 (14.7%)	186 (13.5%)	304 (22.1%)	318 (23.1%)	184 (13.4%)	93 (6.8%)	88 (6.4%)
4	233 (16.9%)	186 (13.5%)	313 (22.8%)	222 (16.1%)	165 (12.0%)	157 (11.4%)	99 (7.2%)
5	311 (22.6%)	210 (15.3%)	189 (13.7%)	129 (9.4%)	160 (11.6%)	227 (16.5%)	149 (10.8%)
6	218 (15.9%)	176 (12.8%)	105 (7.6%)	76 (5.5%)	132 (9.6%)	396 (28.8%)	272 (19.8%)
7	127 (9.2%)	107 (7.8%)	64 (4.7%)	35 (2.5%)	121 (8.8%)	357 (26.0%)	564 (41.0%)

Chronic diseases (N = 1,375)

Equity, diversity and inclusion (N = 1,433)

Rank	Ableism	Ageism	Immigrant discrimination and rights	LGBTQ+ discrimination and rights	Racism and social justice	Religious discrimination and freedom	Sexism and women's rights
1	120 (8.4%)	184 (12.8%)	100 (7.0%)	57 (4.0%)	514 (35.9%)	228 (15.9%)	230 (16.1%)
2	199 (13.9%)	247 (17.2%)	182 (12.7%)	170 (11.9%)	229 (16.0%)	105 (7.3%)	301 (21.0%)
3	264 (18.4%)	199 (13.9%)	178 (12.4%)	209 (14.6%)	161 (11.2%)	127 (8.9%)	295 (20.6%)
4	235 (16.4%)	193 (13.5%)	264 (18.4%)	223 (15.6%)	148 (10.3%)	124 (8.7%)	246 (17.2%)
5	260 (18.1%)	215 (15.0%)	264 (18.4%)	191 (13.3%)	150 (10.5%)	146 (10.2%)	207 (14.4%)
6	236 (16.5%)	252 (17.6%)	268 (18.7%)	234 (16.3%)	152 (10.6%)	185 (12.9%)	106 (7.4%)
7	119 (8.3%)	143 (10.0%)	177 (12.4%)	349 (24.4%)	79 (5.5%)	518 (36.1%)	48 (3.3%)

Infectious disease issues (N = 1,241)

Rank	Food & water-borne diseases	Sexually transmitted diseases	Vaccine-preventable diseases	Vector-borne diseases
1	372 (30.0%)	142 (11.4%)	652 (52.5%)	75 (6.0%)
2	427 (34.4%)	286 (23.0%)	188 (15.1%)	340 (27.4%)
3	325 (26.2%)	378 (30.5%)	172 (13.9%)	366 (29.5%)
4	117 (9.4%)	435 (35.1%)	229 (18.5%)	460 (37.1%)

Injury issues (N = 1,282)

Rank	Accidental injuries	Drugs/substance misuse and overdose	Self-harm	Violence
1	127 (9.9%)	464 (36.2%)	94 (7.3%)	596 (46.5%)
2	222 (17.3%)	437 (34.1%)	203 (15.8%)	420 (32.8%)
3	396 (30.9%)	260 (20.3%)	439 (34.2%)	187 (14.6%)
4	537 (41.9%)	121 (9.4%)	546 (42.6%)	78 (6.1%)

Maternal child health issues (N = 1,293)

Rank	Fertility and family planning	Fetal and infant death	Maternal mental health and substance use	Prenatal care access and quality	Preterm and low birth-weight babies	Racial disparities in birth outcomes
1	175 (13.5%)	111 (8.6%)	287 (22.2%)	402 (31.1%)	42 (3.2%)	276 (21.3%)
2	124 (9.6%)	151 (11.7%)	293 (22.7%)	423 (32.7%)	131 (10.1%)	171 (13.2%)
3	129 (10.0%)	254 (19.6%)	274 (21.2%)	225 (17.4%)	254 (19.6%)	157 (12.1%)
4	151 (11.7%)	267 (20.6%)	217 (16.8%)	137 (10.6%)	364 (28.2%)	157 (12.1%)
5	238 (18.4%)	318 (24.6%)	156 (12.1%)	76 (5.9%)	334 (25.8%)	171 (13.2%)
6	476 (36.8%)	192 (14.8%)	66 (5.1%)	30 (2.3%)	168 (13.0%)	361 (27.9%)

Other social determinants of health issues (N = 1,417)

Rank	Climate change and the environment	Crime and safety	Education and literacy	Employment and economic opportunity	Food and housing security	Healthcare and mental healthcare access
1	147 (10.4%)	430 (30.3%)	114 (8.0%)	105 (7.4%)	329 (23.2%)	292 (20.6%)
2	111 (7.8%)	192 (13.5%)	236 (16.7%)	221 (15.6%)	337 (23.8%)	320 (22.6%)
3	116 (8.2%)	165 (11.6%)	273 (19.3%)	322 (22.7%)	240 (16.9%)	301 (21.2%)
4	156 (11.0%)	161 (11.4%)	304 (21.5%)	321 (22.7%)	226 (15.9%)	249 (17.6%)
5	180 (12.7%)	196 (13.8%)	342 (24.1%)	280 (19.8%)	225 (15.9%)	194 (13.7%)
6	707 (49.9%)	273 (19.3%)	148 (10.4%)	168 (11.9%)	60 (4.2%)	61 (4.3%)

Community Partner Assessment 2022

Publication date: October 6, 2023

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ASSESSMENT OVERVIEW

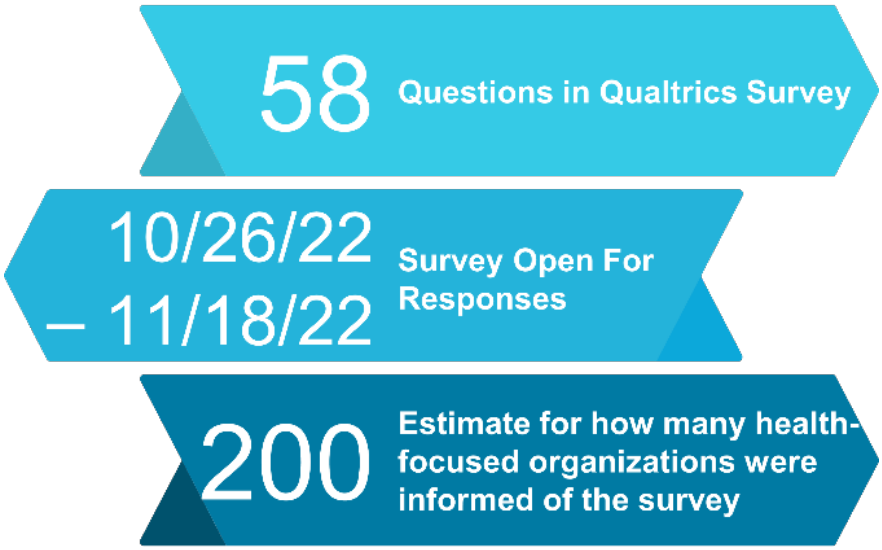
Sacramento County Public Health (SCPH) used the National Association of County and City Health Officials (NACCHO) Mobilizing for Action through Planning and Partnerships (MAPP) framework to inform the Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) process. The MAPP framework was most recently updated in November 2020, and emphasizes the integral role of broad stakeholders and community engagement; the need for policy, systems, and environmental change; and alignment of community resources toward shared goals in addition to a "community owned, systems thinking approach that looks at the rapidly changing landscape of public health" (NACCHO, 2020).

Following the current MAPP framework, the 2022 Community Partners Assessment (CPA) replaced the Local Public Health System Assessment (LPHSA), previously conducted by SCPH in 2016 (SCPH, 2016). The purpose of the CPA was for SCPH and its community partners to look critically within their systems and processes, reflect on their role in the community's health and well-being, and understand the degree to which they are addressing or perpetuating health inequities ranging from the individual to the systemic and structural levels (NACCHO, 2020). This CPA helps identify the range of public health-related actions currently being taken and potential actions that could be taken to address health inequity ranging from the individual to the systemic and structural levels.

As demonstrated by the public health systems graphic below by Oregon Health Authority – the public encounters opportunities to interact with public health and its partners on a regular basis. By improving public health systems, it will make it easier for all Sacramento County residents to live healthier lives and do the things they love.

METHODOLOGY

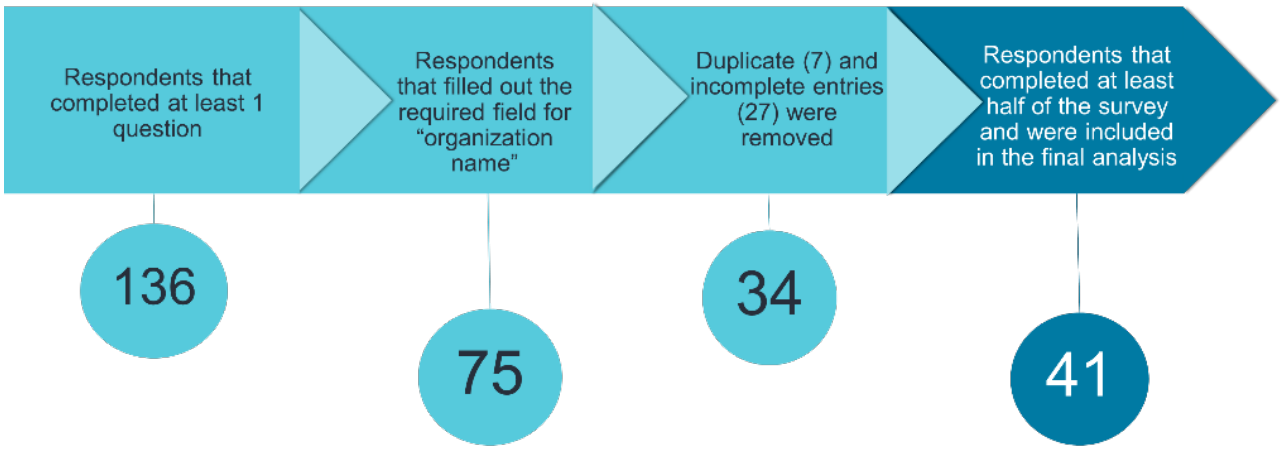
SCPH adapted a community partner survey tool originally designed by NACCHO and Human Impact Partners. The final version of SCPH's 58-question survey was administered as an electronic survey utilizing the Qualtrics platform. The target audience of this survey included any organization working to improve health in Sacramento County and was designed to be filled out by one representative per organization. The full survey tool is available in Appendix A.



The survey was open for responses from October 26, 2022, to November 18, 2022. SCPH sent out the survey request via email in late October 2022 to SCPH staff, and the staff then emailed the various public health-related coalitions and tasks forces which they lead or participate in. Organizations who received the survey then forwarded the survey to other public health-related networks comprised of multiple organizations. Some County staff also directly emailed organizations to inform them of the survey. Overall, SCPH estimates over 200 organizations were informed of the survey through this outreach process.

Final Responses Included

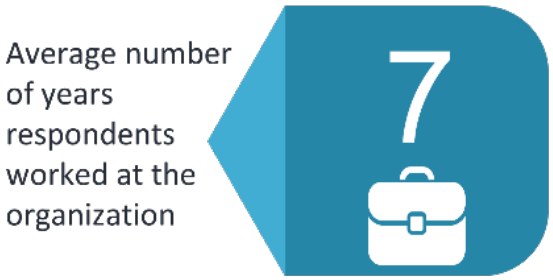
SCPH applied two rules for surveys to be included in the analysis. An organization name and respondents must have completed at least half of the survey. Of the 136 respondents that answered at least one question, 41 organizations were included in the analysis with the survey completion time ranging between 30 to 50 minutes.



RESULTS AND DISCUSSION

About the Organizations

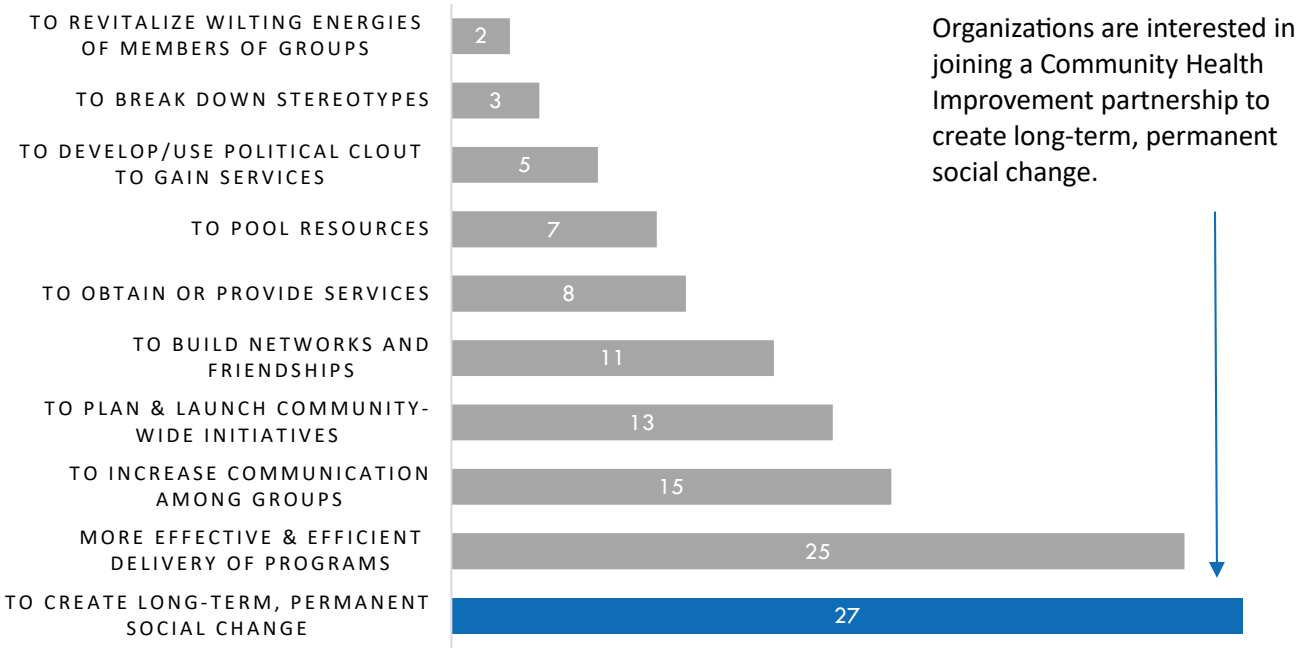
A variety of organizations completed the survey (see Appendix B) including non-profits (26), other (8, including school districts, church, health plans, etc.), grassroots community (4), public and private hospitals/clinics (4).



Organizations were generally connected to a coalition or partnership (31) like the Greater Sacramento Smoke and Tobacco Free Coalition, StopFalls Sacramento, Live Well South Sac, Youth Violence Prevention Collective, and many others. Organizations that noted participation in "community-led decision-making processes around policies, actions or programs" was lower (24).

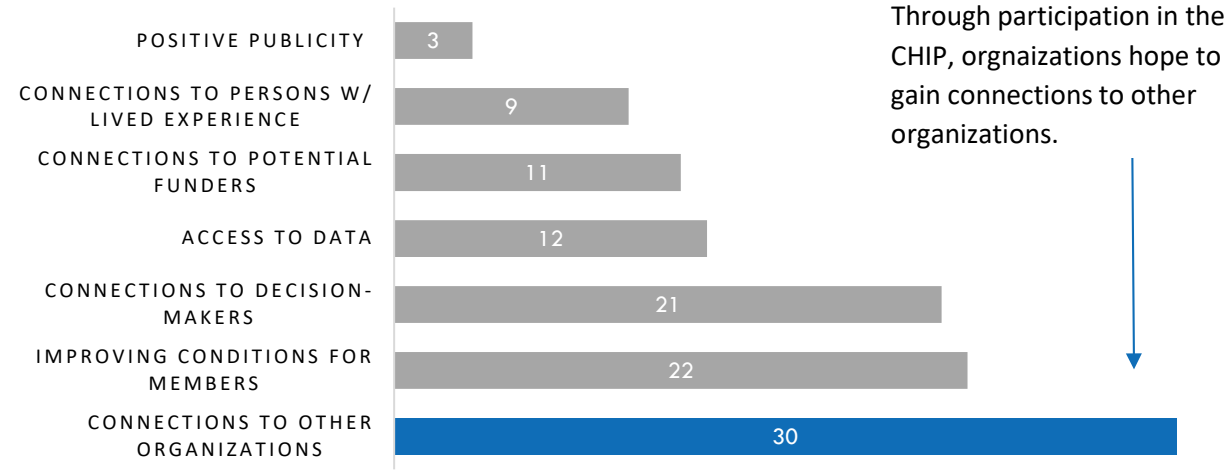
When asked about why organizations were interested in joining the CHIP partnership (see Figure 1), "to create long-term, permanent social change" (27) was the most popular response, followed by "more effective and efficient delivery of programs and eliminate duplication of efforts" (25) and "increase communication among groups" (15). SCPH did not have a formal CHIP previously and hopes this survey will be the first step in engaging community organizations in the upcoming CHIP process.

FIGURE 1: Why are organizations interested in joining a Community Health Improvement Partnership?



Overall, what organizations hope to gain from participating in the CHIP (see Figure 2) are connections to other organizations (30), improving conditions for members/constituents (22), and connections to decision-makers (21).

FIGURE 2: What does the organization hope to gain from participating in the CHIP?



Organizations reported they can contribute resources to the CHIP process activities, including staff time for meetings and activities (24), staff time for community engagement (22), and relationship building with other organizations to advance the CHIP (22).

Generally, organizations served all racial/ethnic groups and gender/sexual identities but reported focusing on a variety of priority populations, including but not limited to, Black families, recently resettled populations (Afghans, Ukrainians, etc.), low-income persons, persons who are/were justice-involved, unhoused persons, etc. There were a wide variety of reported languages spoken in the organizations with additional language line services (up to 200 languages) available at some organizations.

In order to "reach/engage/work" with the target community they serve, organizations ensure they "work closely" (31), "support leadership development" (28), or "hire staff" (27) with target populations.

For most organizations, respondents reported that the higher the position level at the organization, the less it reflects the demographics of the community served (see Figure 3).

FIGURE 3: Does this staff position level reflect the demographics of the community served?

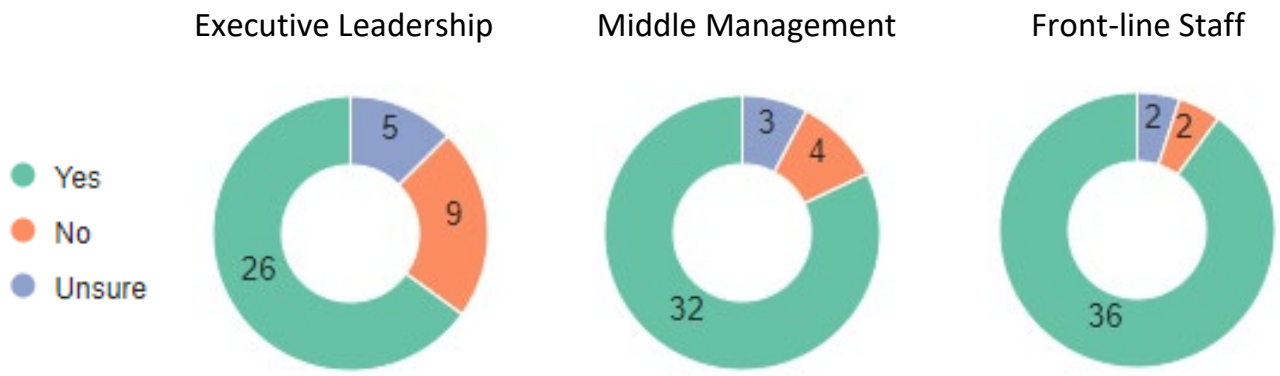


FIGURE 4: Which of the following categories does your organization work on/with?

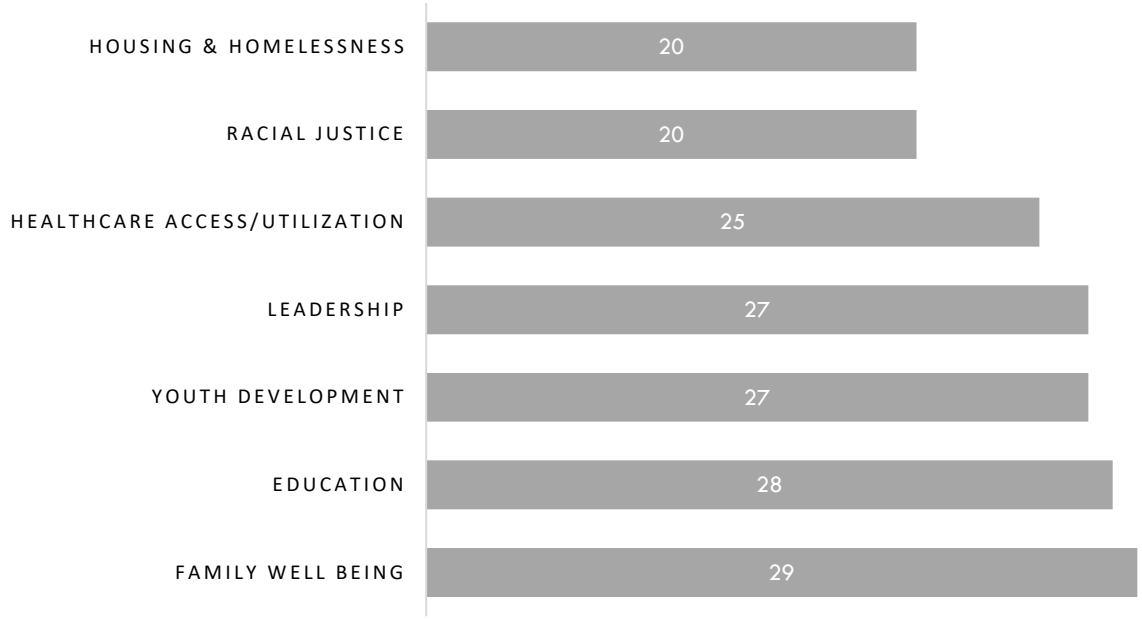
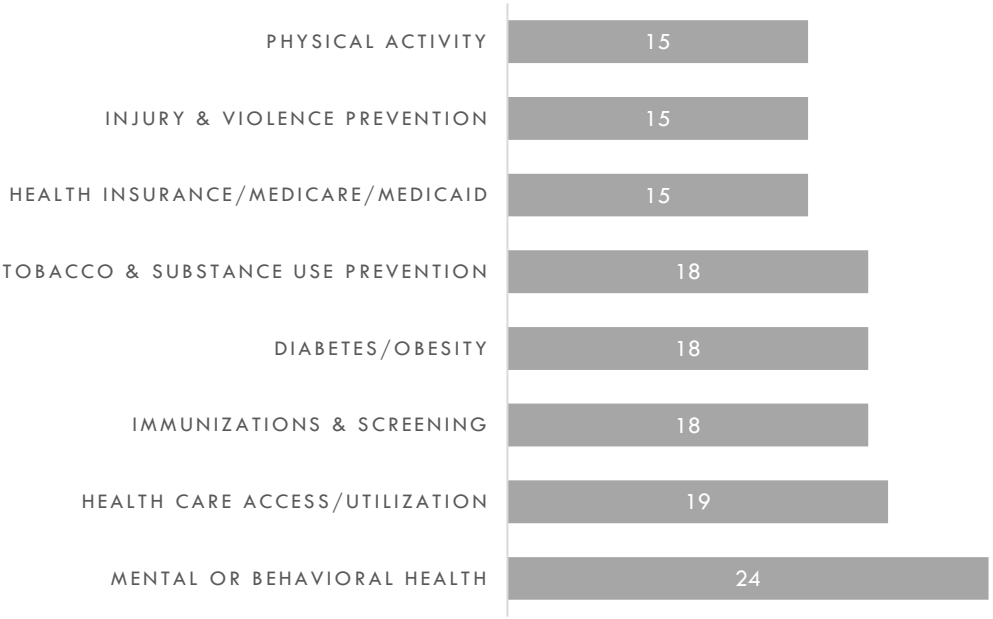


FIGURE 5: Which of the following health topics does your organization work on?



Health Equity in Organizations

Organizations incorporated various health equity-centered staffing, missions, and practices into their work (see Table 1).

TABLE 1: Organizational responses for how much internal equity staffing they have.

STATEMENT	AGREE	DISAGREE	UNSURE
We have at least one individual dedicated to addressing diversity, equity and inclusion in our organization. (N = 39)	30 (76.9%)	5 (12.8%)	4 (10.3%)
We have at least one individual dedicated to addressing inequities in our organization (N = 39).	28 (71.8%)	4 (10.3%)	7 (17.9%)
We have a team dedicated to advancing equity/addressing inequities in our organization (N= 39).	28 (71.8%)	7 (17.9%)	4 (10.3%)
Advancing equity/addressing inequities is included in all or most staff job requirements (N = 39).	26 (66.7%)	4 (10.3%)	9 (23.1%)
Advancing equity/addressing inequities is included in almost none or no staff job requirements (N = 39).	14 (35.9%)	16 (44.4%)	9 (23.1%)

Incorporating equity into staff positions was also strong and varied from the executive director being the lead, to a student services director focusing on diversity, equity, and inclusion (DEI), to grassroots organizations who do not use job titles but take shared responsibility to center "equity and justice." Organizations also shared additional comments about their commitment to and practice of equity by stating, "It's how we do business," centering Black inequity, using data to align health equity strategies.

> "This organization demonstrates the most commitment to equity [they] have ever worked at…and is continually evaluating for areas where we can improve ."

Organizational Accountability

Figures 6 and 7 demonstrate questions that asked about their organizational accountability and who their organizations are accountable to.

FIGURE 6: Do you have an advisory board of community members, stakeholders, youth, or others who are impacted by your organization?

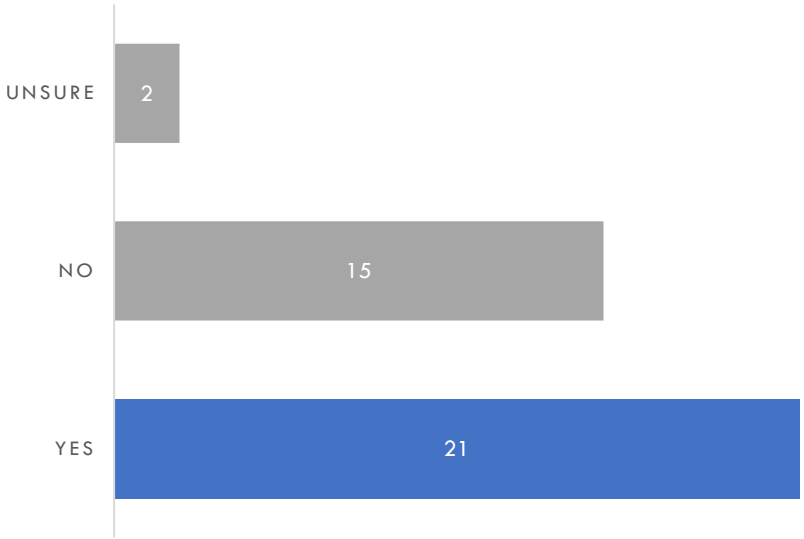
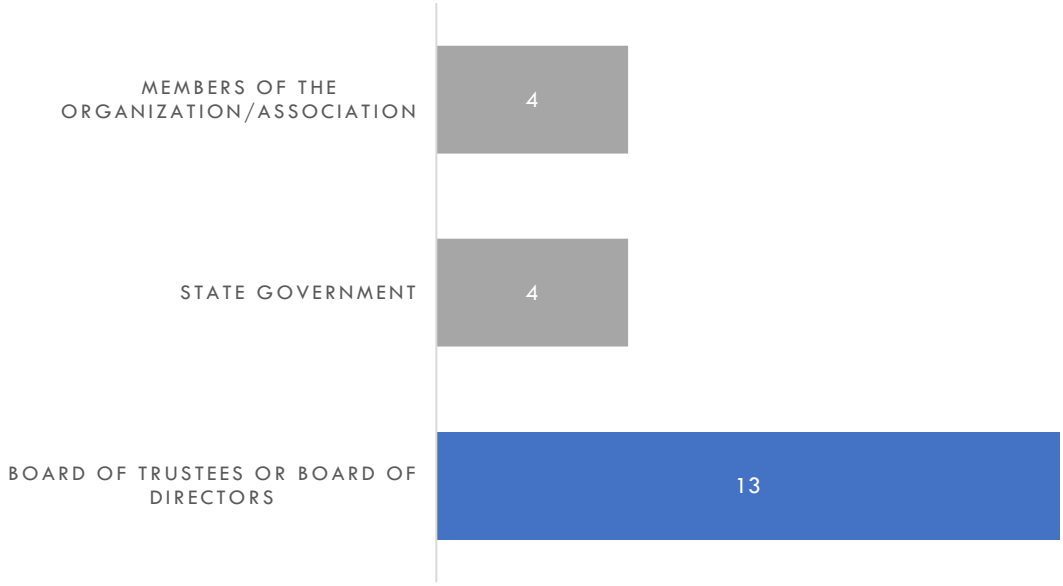


FIGURE 7: Who does your organization report to?

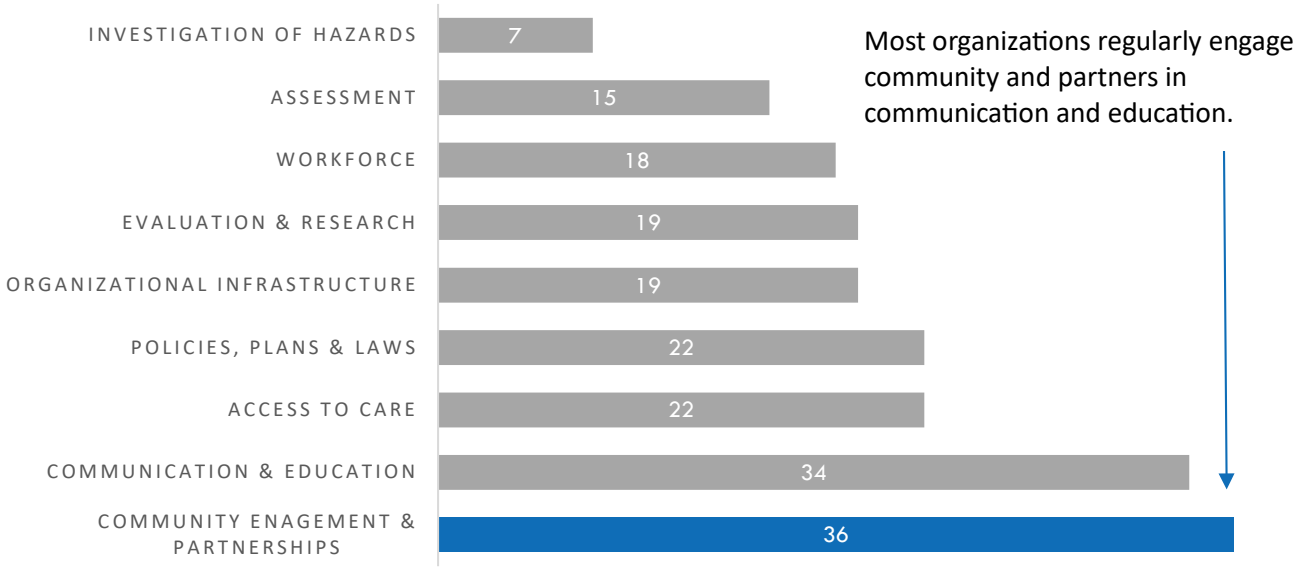


The most common method for organizations to report back to those they are accountable to was publicly available written reports (21), public reports to a decision-making body (12), and private reports to decision-making body (9). Public town hall meetings (8) and town hall meetings for organizational affiliates (7) were the next most popular set of responses.

Organizational Capacities

This next section explores the organizational capacities of survey respondents. The following figure illustrates the variety of activities regularly conducted by organizations that align with the 10 Essential Public Health Services (see Figure 8). Community engagement and partnerships (36) and communication and engagement (34) were by far the most commonly selected choices.

FIGURE 8: Which of the following 10 Essential Public Health Services does your organization regularly do?



When asked if organizations "have enough staff/funding/support to do [their] work," organizations said no (20), often citing limited and/or inconsistent funding.

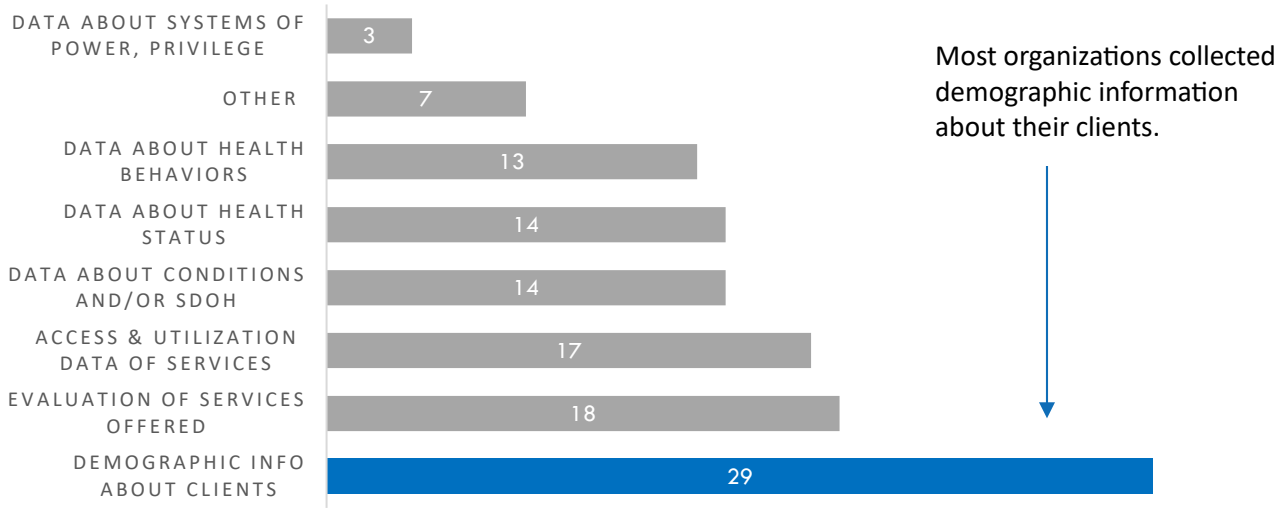
After being asked, "Which of the following strategies does your organization use to do your work?" organizations listed a variety of strategies: communications (27), leadership development (24), research and policy analysis (24), and social services (24) were the most popular. Alliance and coalition building (20), organizing (18), advocacy and grassroots lobbying (17) and healing (16) were also popular strategies that organizations used in their work. In a follow-up question, organizations were asked if there were any capacities they would like to grow. Organizations responded with "movement building," strengthening partnerships with each other, and training.

Specific Capacities to Support Community Health Improvement

Data and Assessments

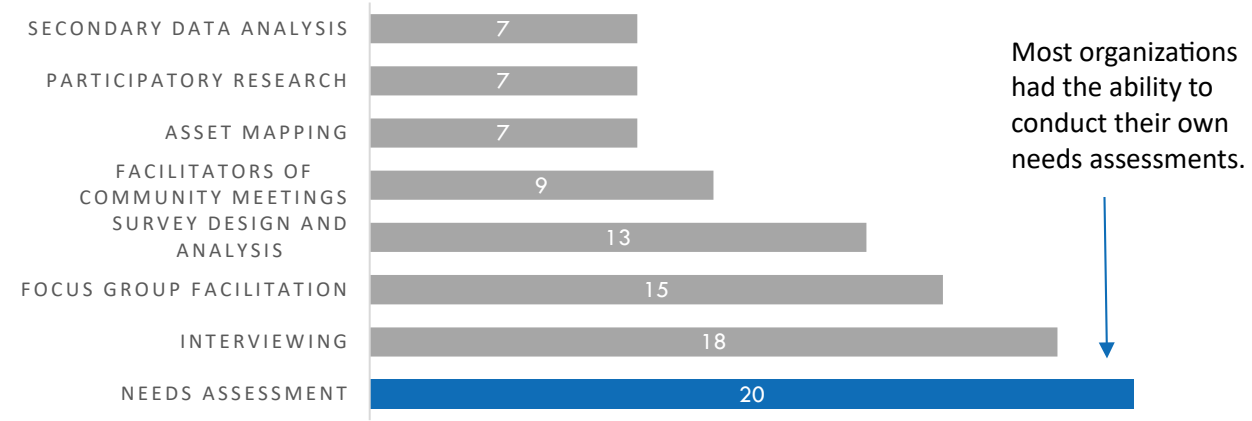
Overall, roughly half of the organizations (17) conduct assessments (e.g., of basic needs, community health, neighborhood). When asked about the data organizations collect (see Figure 9), "demographic information about clients" (29) was the most popular. "Evaluation or quality improvement information about services offered" (18) and "access and utilization data about services provided and to whom" (17) were the next most popular responses. "Data about systems of power, privilege and oppression" (3) was the least popular response.

FIGURE 9: What data does your organization collect?



Furthermore, 15 organizations stated they can share some of the data they collect with the CHIP coalition, while 17 were unsure. Organizations also collect data using several methods—surveys (26), interviews (20), focus groups (18) and feedback forms (16) were some of the most popular. Organizations also listed a variety of data skills they have (see Figure 10).

FIGURE 10: What data skills does your organization have?



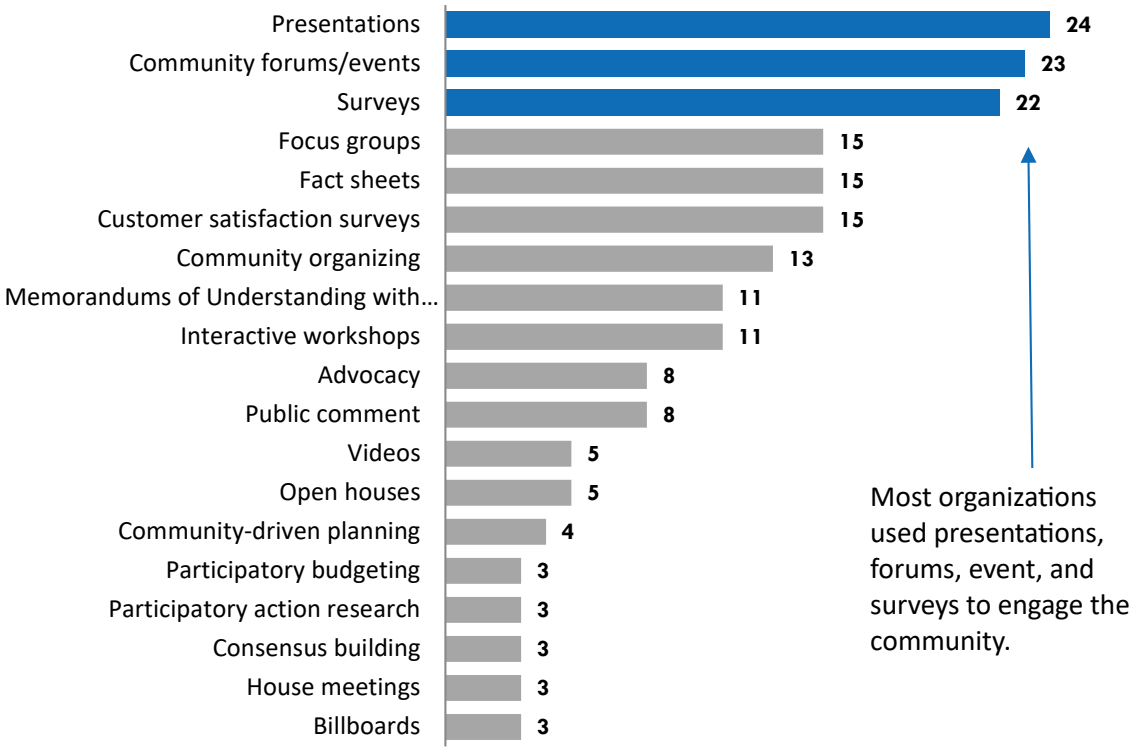
When asked about whether organizations analyze data with a health equity focus, not sure (15), yes (12), and no (9) were the reported responses.

Community Engagement

Organizations were asked about the type of community engagement practice they conduct most often. Inform (16) and involve (11) were the most popular with collaborate being the third most popular option.

The figure below shows community engagement methods that organizations used most often (see Figure 11). Presentations (24), community forums/events (23), and surveys (22) were the most popular methods to engage with community.

FIGURE 11: What type of community engagement practices does your organization do the most often?

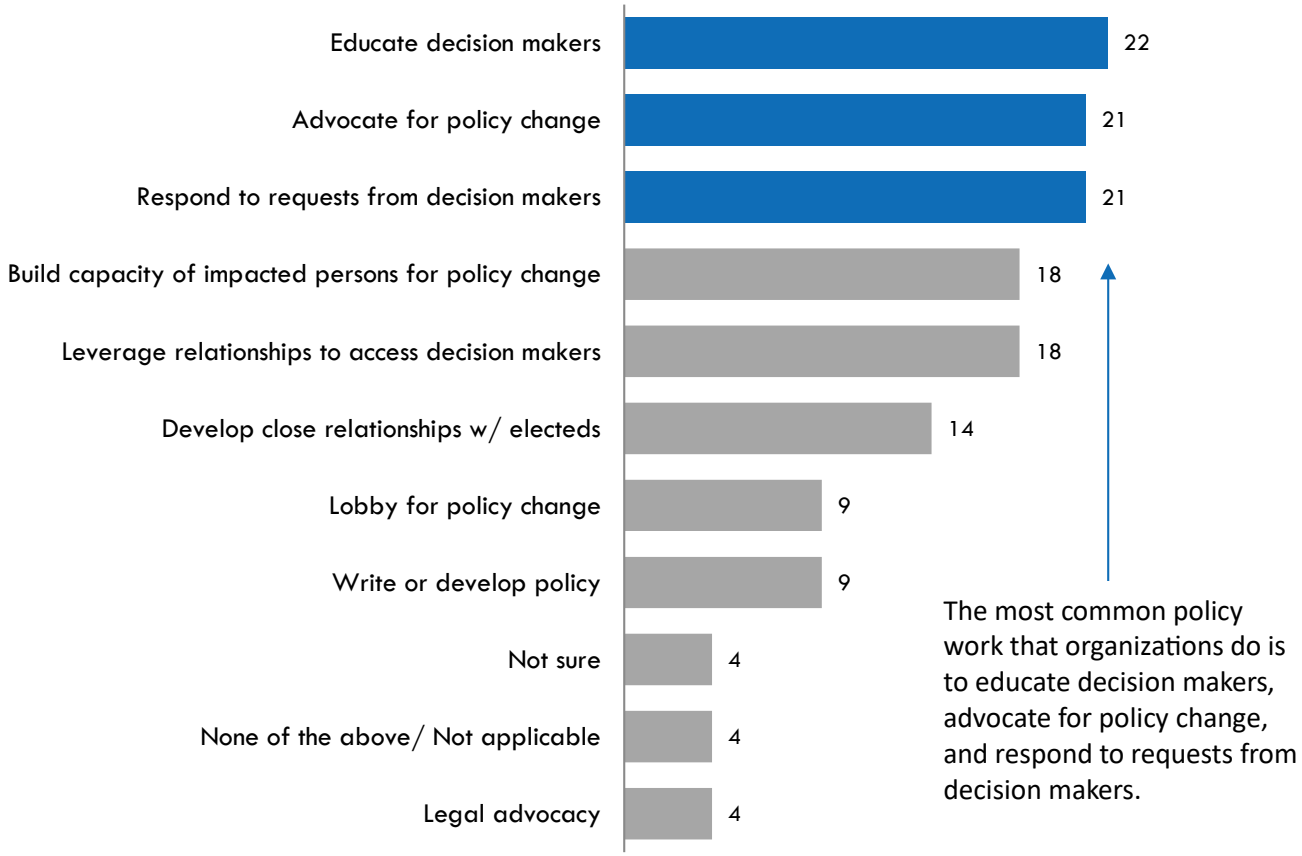


When hosting community meetings, organizations were asked which features were also included. Virtual ways to participate (18) and food/snacks were the most common, followed by interpretation/translation to other languages (13).

Policy/Advocacy and Communications

Organizations perform a variety of policy/advocacy work. Educate decision makers (22), advocate for policy change (21) and respond to requests from decision makers (21) were the most popular responses (see Figure 12).

FIGURE 12: What policy/advocacy work does your organization do?



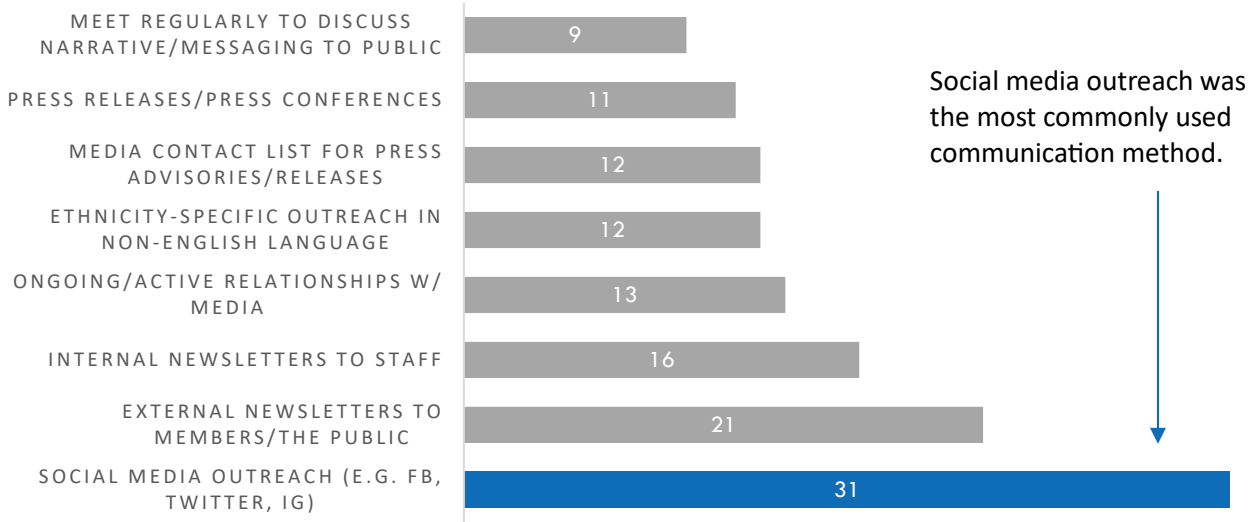
Organizations were asked whether they agree, disagree, or were unsure about the following statements about communication (see Table 2).

TABLE 2: Organizational responses for their communication practices.

STATEMENT	STRONGLY AGREE	DISAGREE	UNSURE
Our organization has a strong presence in local earned media (print/radio/TV) (N = 37).	10 (27.0%)	16 (43.2%)	11 (29.7%)
Our organization has a strong communications infrastructure and capacity (N = 37).	20 (54.0%)	9 (24.3%)	8 (21.6%)
Our organization has a clear communications strategy (N = 37).	22 (59.5%)	8 (21.6%)	7 (18.9%)
Our organization has good relationships with other organizations who can help disseminate information (N = 37).	30 (81.1%)	2 (5.4%)	5 (13.5%)
Our organization has a clear equity lens that we use for our external communications and engagement work (N = 37).	24 (64.9%)	2 (5.4%)	11 (29.7%)

Social media (31) was by far the most popular communication method used by organizations, followed by newsletters to members/the public (21), and newsletters to staff (16) (see Figure 13).

FIGURE 13: What communications work does your organization do the most often?



Regarding the frequency of translation of publicly available materials, organizations reported most of our publicly available materials are translated (19) and few of our publicly available materials are translated (9). Three organizations stated that all of their publicly available materials were translated.

LIMITATIONS AND RECOMMENDATIONS

There were several limitations to SCPH's CPA. This was SCPH's first time administering the CPA, and there were no existing evidenced-based or best practices available for SCPH to adapt. Due to time constraints, SCPH's CPA was based on a draft survey developed by NACCHO. If time was not an issue, SCPH could have utilized NACCHO's final survey and guidelines published in December 2022. The completion rate of the CPA was low despite the relatively large number of responses. Lengthening the duration of the survey response period beyond three weeks would have likely increased the number of completed surveys.

Other factors that may have contributed to a lower survey participation rate is that the survey period was during Halloween, the 2022 federal, state, and local elections, and Veteran's Day, all while large in-person community events were resuming after two years of virtual events due to the Covid-19 pandemic. In addition, the high number of questions asked on the survey also likely contributed to a low survey completion rate. However, SCPH did not want to deviate too much from NACCHO's draft survey, and shortening the survey may have resulted in a loss of important information from the CBO's.

Lastly, there is selection bias as the coalitions and work groups who first received the survey are networks with which SCPH already maintains existing relationships. There are likely other public health- and human services-related coalitions and networks who may not have had the opportunity to complete the survey.

CONCLUSION

Overall, Sacramento County organizations individually demonstrated a wide breadth and depth of existing knowledge, organizational capacity, equity practices, and policy/advocacy and communications. The opportunity to engage in the SCPH CHIP process provides a promising pathway to create long-term, permanent social change and more effective and efficient delivery of programs and eliminate duplication of efforts. Largely, respondents demonstrated a willingness to increase communication among groups, build collective capacity via training and policy/advocacy, and work together to implement collective change in communities. As organizations adjust from the last three years of Covid-19 and general social unrest, the CHIP process offers a promising opportunity to create sustainable and healthy change.

APPENDIX A:

SURVEY TOOL

Sacramento County Public Health (SCPH) needs your organization's input. This 58-question survey (est. time is 30-40 mins) is part of the Community Health Assessment (CHA) and Community Health Improvement Planning (CHIP) process for the County of Sacramento. The CHIP process is a long-term effort to improve the health of a community. Your survey responses, along with other responses, will be used to develop the CHA and help identify our CHIP priorities for improving health in Sacramento County. We intend to list the names of the organizations who complete the survey, but all results will be shared in summary form in the CHA report.

There are three sections to this survey:

A. About Your Organization
B. Organizational Capacities
C. Specific Capacities to Support Community Health Improvement

This survey builds on a draft developed for the National Association of County and City Health Officials (NACCHO) and the Mobilizing for Action through Planning and Partnerships (MAPP), a community-driven strategic planning process for improving community health. Please reach out to Tim at 916-591-6352 (phone and text preferred) or choit@saccounty.gov for any and all questions or feedback.

SECTION A: ABOUT YOUR ORGANIZATION

Q1 What is the full name of your organization?

Q2 Which best describes your position or role in your organization?

Administrative staff
- Front line staff
- Supervisor (not senior management)
- Senior management level/unit or program lead
- Leadership team
- Community member
- Community leader
- Other (please specify):

Q3 How long have you been working at your organization (in years)?

Q4 Have you ever participated in a community health improvement planning (CHIP) process?
- Yes
- No
- Not sure

Q5 Have you ever participated in community-led decision-making process around policies, actions or programs?
- Yes. If so, which ones:
- No
- Not sure

Q6 Have you ever participated in a multi-sector coalition or partnership?
- Yes. If so, which ones:
- No
- Not sure

Q7 What type of organization are you? (check all that apply)
- County Health Department
- State Health Department
- Other City Government Agency
- Other County Government Agency
- Other State Government Agency
- Regional Government Agency
- Tribal institution
- Private hospital
- Public hospital
- Private clinic
- Public clinic
- Non-profit organization
- Grassroots community (please specify):
- Neighborhood association

- Business improvement district
- Foundation/philanthropy
- For-profit organization / private business
- Faith-based organization
- Academic partner
- Advocacy organization
- Other (please specify):

Q8 Which of the following describes your interest in joining a community health improvement partnership (Check up to 3 responses):

- To bring about more effective and efficient delivery of programs and eliminate any unnecessary duplication of effort
- To pool resources
- To increase communication among groups
- To break down stereotypes
- To build networks and friendships
- To revitalize wilting energies of members of groups who are trying to do too much alone
- To plan and launch community-wide initiatives on a variety of issues
- To develop and use political clout to gain services or other benefits for the community
- To create long-term, permanent social change
- To obtain or provide services
- Not interested in joining a community health improvement planning process at this time
- Other (please specify):

Q9 What does your organization hope to gain by participating in the Community Health Improvement Planning (CHIP) process? How will participation help support your work? (Check up to 3 responses)

- Access to data
- Connections to Communities with Lived Experience
- Connections to Other Organizations
- Connections to Decision-Makers
- Connections to Potential Funders
- Positive publicity (e.g. our organization supports community health)
- Helps achieve requirements for public health accreditation
- Helps achieve requirements for IRS non-profit tax status
- Helps achieve requirements for Federally Qualified Health Center (FQHC) status
- Helps achieve other requirements
- Improving conditions for members/constituents
- Other (please specify):

Q10 (OPTIONAL) Any comments or notes about your organization's interest in participating in the Community Health Improvement Planning(CHIP) process?

Q11 What are your organization's most valuable resources and strongest assets (for example, things that make your organization great)?

Q12 What resources can your organization contribute to support the Community Health Improvement Planning (CHIP) process activities (check all that apply)?

- Funding to support assessment activities (e.g. data collection, analysis)
- Funding to support community engagement (e.g. stipends, gift cards)
- Food for community meetings
- Childcare for community meetings
- Policy/advocacy skills
- Media connections
- Social media capacities
- Physical space to hold meetings
- Technology to support virtual meetings
- Staff time to support community engagement and involvement
- Staff time to support interpretation and translation
- Lending interpretation equipment for use during meetings

- Staff time to support relationship building between the Community Health Improvement Process (CHIP) staff and other organizations (e.g. intros to govt agencies, organizers, etc)
- Staff time to support focus group facilitation or interviews
- Staff time to help analyze quantitative data
- Staff time to help analyze qualitative data
- Staff time to participate in the Community Health Improvement Process (CHIP)meetings and activities
- Staff time to help plan the Community Health Improvement Process (CHIP)meetings and activities
- Staff time to help facilitate the Community Health Improvement Process (CHIP)meetings and activities
- Staff time to help implement the Community Health Improvement Process (CHIP)priorities
- Note-taking support during qualitative data collection
- Staff time to transcribe meeting notes/recordings
- Other (please specify):

Q13 (OPTIONAL) Any comments or notes about the items above and/or other ways your organization can support the Community Health Improvement Process (CHIP)?

Q14 Who are the racial/ethnic populations your organization works with? (check all that apply)

- Black/African American
- African
- Native American/Indigenous/Alaska Native
- Latinx/Hispanic
- Asian
- Asian American
- Pacific Islander/Native Hawaiian
- Middle Eastern/North African
- White/European
- Other (please specify):

Q15 What are the gender/sex identities of the populations your organization works with? (check all that apply)

- Women
- Men
- Nonbinary
- Transgender
- Other:

Q16 What other population groups does your organization work with? Consider groups by race/ethnicity, gender, sexual orientation, socioeconomic status, education, disability, immigration status, religion, insurance status, housing status, occupation, age, neighborhood, and involvement in the criminal legal system.

Q17 What priority populations do you serve?

Q18 What do you do to reach/engage/work with your clientele or community? (check all that apply)

- We hire staff from specific racial/ethnic groups that mirror our target populations
- We hire staff/interpreters who speak the language/s of our target populations
- We support leadership development in our target populations
- We have leadership who speak the language/s of our target populations
- Our organization is physically located in neighborhood(s) of our target populations
- We receive many clients from our target populations
- We receive many referrals from our target populations
- We work closely with community organizations from our target populations
- We have done extensive outreach to our target populations
- Other (please specify):

Q19-Q21 How does staff position at your organization reflect the demographics of the community you serve?

	Yes	No	Unsure
Does the executive leadership of your organization reflect the demographics of the community you serve?	○	○	○
Does the middle management of your organization reflect the demographics of the community you serve?	○	○	○
Does the administrative (front-line) staff and others in your organization reflect the demographics of the community you serve	○	○	○

Q22 What languages do staff at your organization speak?
Q23 What language(s) are your public meetings conducted in?
Q24 Any comments or notes about your organization and the demographics of the community you serve?
Q25 Please rank how much your organization focuses on each topic.

	A lot	A little	Not at all	Not sure
Economic Stability: The connection between the financial resources people have - income, cost of living, and socioeconomic status - and their health. This includes key issues such as poverty, employment, food security, and housing stability.	○	○	○	○
Education Access & Services: The connection of education to health and wellbeing. This includes key issues such as graduating from high school, educational attainment in general, language and literacy, and early childhood education and development.	○	○	○	○
Health Care Access & Quality: The connection between people's access to and understanding of health services and their own health. This includes key issues such as access to healthcare, access to primary care, health insurance coverage, and health literacy.	○	○	○	○
Neighborhood & Built Environment: The connection between where a person lives - housing, neighborhood, and environment - and their health and wellbeing. This includes topics like quality of housing, access to transportation, availability of healthy foods, air and water quality, and public safety.	○	○	○	○
Social and Community Context: The connection between characteristics of the contexts within which people live, learn, work, and play, and their health and wellbeing. This includes topics like cohesion within a community, civic participation, discrimination, conditions in the workplace, and incarceration.	○	○	○	○

Q26 Which of the following categories does your organization work on/with? (Check all that apply)

- ○ Arts and culture
- ○ Businesses and for-profit organization
- ○ Criminal legal system
- ○ Disability justice
- ○ Early childhood development / childcare
- ○ Education
- ○ Community economic development
- ○ Economic security
- ○ Environmental justice / climate change
- ○ Faith communities
- ○ Family well-being
- ○ Financial institutions (e.g. banks, credit

- unions)
- Food access and affordability (e.g., food bank)
- Food service / restaurants
- Gender discrimination / equity
- Government accountability
- Health care access / utilization
- Housing and homelessness
- Human services
- Immigration
- Jobs / labor conditions / wages & income
- Land use planning / development
- LGBTQIA+ discrimination / equity
- Parks, recreation and open space
- Public safety / violence prevention
- Racial justice
- Seniors / elder care
- Transit and transportation
- Utilities
- Veterans issues
- Youth development and leadership
- Other (please specify):

Q27 Which of the following health topics does your organization work on? (Check all that apply)

- Asthma
- Cancer
- Cardiovascular diseases
- Dental/oral health
- Diabetes/Obesity
- Immunizations + Screenings
- Infectious diseases
- Injury and violence prevention
- HIV / STD prevention
- Environmental health
- Health care access / utilization
- Health insurance / Medicare/Medicaid
- Maternal and child health
- Mental or Behavioral Health (including PTSD, anxiety, trauma)
- Physical activity
- Safe streets and planning
- Tobacco and Substance Use and Prevention
- WIC / CalFresh (aka food stamps)
- None of the above/Not applicable
- Other (please specify):

Q28 If your organization has a shared written definition of equity or health equity, please copy and paste that below.

Q29 Please select whether you agree/disagree/unsure for each of the following statements:

	Agree	Disagree	Unsure
We have at least one individual dedicated to addressing diversity, equity and inclusion in our organization.	○	○	○
We have at least one individual dedicated to addressing inequities in our organization.	○	○	○
We have a team dedicated to advancing equity/addressing inequities in our organization.	○	○	○
Advancing equity/addressing inequities is included in all or most staff job requirements	○	○	○
Advancing equity/addressing inequities is included in almost none or no staff job requirements.	○	○	○

Q30 Please list some of the staff positions working to address equity and describe what type of equity-focused work they do.

Q31 Please share any comments/notes or questions about your organization's commitment to and practice of equity.

Q32 Does your organization have an advisory board of community members, stakeholders, youth or others who are impacted by your organization?

- Yes. If YES, what is that advisory board and what powers/authority/responsibility do they have?
- No
- Unsure

Q33 Who is your organization accountable to?

(By accountable we mean who your organization MUST report to because they determine or oversee your funding as an organization, determine your priorities, etc. Framed another way, this could be considered who has power over your organization's decision-making - for example city government agencies may be accountable to the Mayor or City Council, a business may be accountable to its shareholders, and an organizing group may be accountable to its members).

- Governor or other Elected Executive Official
- City Council, Board of Supervisors, or other Elected Legislative Officials
- State government
- Federal government
- Foundation
- Community Members
- Members of the Organization/Association
- Customers/Clients
- Board of Trustees
- Shareholders
- Voters
- Voting members
- Other Government Agencies
- Other (please specify):

Q34 How does your organization report back to those they are accountable to? (select all that apply)

- Private (not publicly available) written reports
- Publicly available written reports
- Private reports to decision-making body
- Public reports to decision-making body
- Town hall meetings for organizational affiliates (e.g., shareholders, members of the organization)
- Public town hall meetings - for all who may be interested
- Other (please specify):

SECTION B: ORGANIZATIONAL CAPACITIES

As discussed in this survey introduction, one of the goals of this assessment is to help describe how each of your organizations contribute to our local public health system. Your organization - and you yourself - are an integral part of our community's local public health system, even if you do not work in public health or health care (to recap, public health is more than health care, and health outcomes are shaped by behaviors, access to care, living and working conditions, institutions, policies, systems, cultural norms, social inequities, and the environment). Organizations working to improve the well-being of individuals, families, and communities through improving housing, education, childcare, workforce development, or other conditions have an impact on the public's health. One way to understand, assess, and improve upon our local public health system is to name how your organizational capacities and activities align with the 10 Essential Public Health Services (EPHS). The ten statements below describe types of activities that are needed for the public health system (e.g., assessment, communication, community engagement, etc.). For more information about the 10 EPHS, visit https://www.cdc.gov/publichealthgateway/publichealthservices/essentialhealthservices.html.

Q35 Please select whether your organization regularly does the following activities. (check all that apply).

- ASSESSMENT: My organization conducts assessments of living and working conditions and community needs and assets.
- INVESTIGATION OF HAZARDS: My organization investigates, diagnoses, and addresses health problems and hazards affecting the population.
- COMMUNICATION + EDUCATION: My organization works to communicate effectively to inform and educate people about health or well-being, factors that influence well-being and how to improve it.

- COMMUNITY ENGAGEMENT + PARTNERSHIPS: My organization works to strengthen, support, and mobilize communities and partnerships to improve health and well-being.
- POLICIES, PLANS, LAWS: My organization works to create, champion, and implement policies, plans, and laws that impact health and well-being.
- LEGAL AND REGULATORY AUTHORITY: My organization has legal or regulatory authority to protect health and well-being and/or leverages or utilizes legal and regulatory actions to improve and protect the public's health and well-being.
- ACCESS TO CARE: My organization provides health care and/or social services to individuals and/or works to ensure equitable access and an effective system of care and services.
- WORKFORCE: My organization supports workforce development and can help build and support a diverse and skilled workforce.
- EVALUATION AND RESEARCH: My organization conducts evaluation, research and/or continuous quality improvement and can help improve or innovate functions.
- ORGANIZATIONAL INFRASTRUCTURE: My organization is helping build and maintain a strong organizational infrastructure for health and well-being.
- None of the above/ Not applicable
- NOT SURE

Q36 Are there any other core competencies or strengths not included on the list above that your organization does that you would like to mention?

Q37 Of all of the activities and capacities listed above (including the ones you added), which do you identify as your organization's 1-3 core competencies or strengths?

Q38 Does your organization have sufficient capacity to meet the needs of your clients/members? E.g., do you have enough staff/funding/support to do your work?

- Yes
- No (please explain):
- Unsure (please clarify):

Q39 Which of the following strategies does your organization use to do your work? (check all that apply)

- Research and policy analysis: Gathering and analyzing data to create credibility and inform policies, projects, programs, or coalitions
- Social services: Providing services that reach clients and meet their needs
- Organizing: Involving people in efforts to change their circumstances by altering the underlying structures, decision-making processes, policies, and priorities that produce inequities.
- Communications: Messaging that resonates with communities, connects them to an issue, and/or inspires them to take action.
- Leadership development: Equipping leaders with the skills, knowledge, and experiences to play a greater role within their organization or movement.
- Litigation: Leveraging legal resources to reach outcomes that further long-term goals.
- Advocacy and grassroots lobbying: Targeting public officials either by directly speaking to them or mobilizing constituents to influence legislative or executive policy decisions.
- Alliance and coalition building: Building collaboration among groups with shared values and interest.
- Arts and culture: Nurturing the multiple skills of an individual through the arts and encouraging connection through shared experiences.
- Campaigns: Employing a series of organized actions that address a specific purpose, policy, or change.
- Healing: Addressing personal and community trauma and how they connect to larger social and economic inequalities.
- Inside-outside strategies: Coordinating support from organizations on the "outside" with a team of like-minded lawmakers on the "inside" to achieve common goals.
- Integrated voter engagement: Connecting organizing and voter engagement strategies to build a strong

base over multiple election cycles.
- Movement building: Scaling up from single organizations and issues to long-term initiatives, perspectives, and narratives that seek systems change.
- Narrative change: Harnessing arts and expression to replace dominant assumptions about a community or issue with dignified narratives and values.
- Other (please specify):

Q40 One of the goals of the Community Health Improvement Planning (CHIP) process is to help build the collective capacity of our network and connect partners to help build their capacities. Are there any capacities that you would like to grow as an organization (e.g. anything that was referenced above in this section)?

SECTION C: SPECIFIC CAPACITIES TO SUPPORT COMMUNITY HEALTH IMPROVEMENT

The following questions ask about your organization's experience collecting data, engaging community members, advocating for policy change, and communicating with the public. Please let us know if your organization regularly does each of the following tasks and whether your organization might be able to support the Community Health Improvement Planning (CHIP) process by doing that task. Following the set of questions is space for any comments, notes or questions you may have.

Q41 Does your organization conduct assessments (e.g., of basic needs, community health, neighborhood, etc.)?
- Yes. Please describe what they assess:
- No. If no, please skip Q42.
- Not sure

Q42 Can you share the assessments you described above with the Community Health Improvement Plan (CHIP) coalition?
- Yes
- No
- Not sure

Q43 What data (including, but not limited to, qualitative and qualitative data) does your organization collect? (check all that apply)
- Demographic info about clients or members
- Access and utilization data about services provided and to whom
- Evaluation or quality improvement info about services offered
- Data about health status
- Data about health behaviors
- Data about conditions and/or social determinants of health
- Data about systems of power, privilege, and oppression
- We don't collect data
- None of the above/ Not applicable
- Other (please specify):

Q44 Can you share any of that data with the Community Health Improvement Plan (CHIP) coalition?
- Yes
- No
- Not sure

Q45 How does your organization collect data? (check all that apply)
- Surveys
- Focus groups
- Interviews
- Feedback forms
- Photovoice or other participatory research
- Notes from community meetings
- Videos
- Secondary data sources
- Other (please specify):

Q46 What data skills does your organization have? (check all that apply)
- Survey design and analysis
- Secondary data analysis
- Needs assessment
- Focus group facilitation
- Interviewing
- Detailed note-taking or transcription

- Participatory research
- Facilitators of community or town hall meetings
- Asset mapping
- Mapping/visualization skills
- Other quantitative or qualitative method (please specify):

Q47 Does your organization analyze data with a health equity focus? If yes or not sure, please describe:

- Yes
- No
- Not sure

Q48 Any comments or notes about how your organization could support data collection and analysis in the Community Health Improvement Process (CHIP) process?

Q49 What type of community engagement practices does your organization do the most often (Check one): (we will explore this more deeply in the CPA partner discussion.)

- Provide the community with relevant information
- Gather input from the community
- community needs and assets are integrated into process and inform planning
- Ensure community capacity to play a leadership role in implementation of decisions
- Foster democratic participation and equity through community-driven decision-making. Bridge divide between community and governance.
- Not Sure

Q50 Which of the following methods of community engagement does your organization use most often? (Check all that apply):

- Customer satisfaction surveys
- Fact sheets
- Open houses
- Presentations
- Billboards
- Videos
- Public comment
- Focus groups
- Community forums/events
- Surveys
- Community organizing
- Advocacy
- House meetings
- Interactive workshops
- Polling
- Memorandums of Understanding with community-based organizations
- Citizen Advisory Committees
- Open planning forums with resident polling
- Community-driven planning
- Consensus building
- Participatory action research
- Participatory budgeting
- Cooperatives
- Other (please specify):

Q51 When you host community meetings, do you regularly offer: (check all that apply)

- Stipends or gift cards for participation
- Interpretation/Translation to other languages including sign language
- Food/snacks
- Transportation vouchers if needed
- Childcare if needed
- Visual materials for low literacy populations
- Virtual ways to participate
- None of the above/ Not applicable
- Other (please specify):

Q52 Any comments or notes about how your organization could support community engagement in the Community Health Improvement Planning (CHIP) process?

Q53 What policy/advocacy work does your organization do? (check all that apply)

- Develop close relationships with elected officials
- Educate decision makers
- Respond to requests from decision makers
- Leverage relationships to access decision makers
- Write or develop policy
- Advocate for policy change
- Build capacity of impacted individuals/communities to advocate for

policy change
- Lobby for policy change
- Mobilize public opinion on policies via media/communications
- Contribute to political campaigns/PACs
- Voter outreach and education
- Legal advocacy
- None of the above/ Not applicable
- Not sure
- Other (please specify):

Q54 Please share whether you agree, disagree, or are unsure about the following statements about communication.

	Agree	Disagree	Unsure
Our organization has a strong presence in local earned media (print/radio/TV).	○	○	○
Our organization has a strong communications infrastructure and capacity.	○	○	○
Our organization has a clear communications strategy.	○	○	○
Our organization has good relationships with other organizations who can help disseminate information.	○	○	○
Our organization has a clear equity lens that we use for our external communications and engagement work.	○	○	○

Q55 What communications work does your organization do the most often? (check all that apply)
- Internal newsletters to staff
- External newsletters to members/the public
- Ongoing and active relationships with local journalists and earned media organizations
- Media contact list for press advisories/releases
- Social media outreach (e.g. on Facebook, Twitter, Instagram)
- Ethnicity-specific outreach in non-English language
- Press releases/press conferences
- Meet regularly to discuss what narrative + messaging we are putting out publicly
- Not sure
- None of the above/ Not applicable
- Other (please specify):

Q56 If your organization has publicly available materials, are they translated into other languages?
- All of our publicly available materials are translated into other languages
- Most of our publicly available materials are translated into other languages (e.g. when conducting outreach to various populations and/or when hosting events for various populations)
- Few of our publicly available materials are translated into other languages (e.g. only when requested)
- None of our publicly available materials are translated into other languages
- Not applicable (we do not have any publicly available materials)
- Not sure

Q57 Do you have any comments or notes about how your organization could support policy, advocacy, or communications in the Community Health Improvement Planning (CHIP) process?

Q58 Do you have any questions or comments about the Community Health Improvement Process (CHIP) and our next steps together to improve community health

APPENDIX B

ORGANIZATIONS WHO COMPLETED THE COMMUNITY PARTNERS ASSESSMENT SURVEY

Organization Name (n = 41) *Italics* - participated in LPHSA (2016)	**Organization Type**	**Organization Name (n = 41)** *Italics* - participated in LPHSA (2016)	**Organization Type**
Aetna Better Health of California, Inc.	Other (Medi-Cal Managed Care Plan)	*La Familia Counseling Center*	Non-profit organization
Africa House Sacramento	Non-profit organization	Natomas Charter School	Academic partner
Anthem	Other (Health Plan)	NorCal Resist	Non-profit organization
Asian Resources, Inc. (ARI)	Non-profit organization	One Community Health	Public clinic, Non-profit organization
Breathe California Sacramento Region	Non-profit organization	Philippine National Day Association	Non-profit organization
California Pan Ethnic Health Network	Non-profit organization	Public Health Advocates	Non-profit organization
California Youth Advocacy Network	Non-profit organization	Pucci's Pharmacy	Private clinic
Center for Wellness and Nutrition	Non-profit organization	Refugees Enrichment and Development Assoc.	Non-profit organization
Center for Workers' Rights	Non-profit organization	Sacramento Children's Home	Non-profit organization
Citrus Heights Police Department	Other City Government Agency	*Sacramento City Unified School District*	Academic partner
Community Lead Advocacy Program	Grassroots community	Sacramento County Behavioral Health Services	County Health Department
Decarcerate Sacramento	Grassroots community	*Sacramento County Public Health*	County Health Department
Education, Training, and Research and Associates	Non-profit organization	Sacramento Self Help Housing	Non-profit organization
Folsom Cordova Unified School District	Other (Public School District)	Safe Kids Greater Sacramento	Public hospital
Galt Joint Union High School District	Other (Public School District)	South Sacramento Christian Center	Non-profit organization, Other (Church)
Health Education Council	Non-profit organization	Folsom Cordova Community Partnership	Non-profit organization
HeartLand Child and Family Services	Non-profit organization	Tooth Fairies of California	Non-profit organization
Hmong Youth and Parents United	Non-profit organization	*Valley Vision*	Non-profit organization
Justice2Jobs Coalition	Grassroots community	Vision y Compromiso	Non-profit organization, Grassroots community
Kaiser Permanente	Other (HMO)	WellSpace Health	Private clinic, Non-profit organization
		Wind Youth Services	Non-profit organization

APPENDIX C

REFERENCES

National Association for County and City Health Officials (NACCHO). (2020). *MAPP Evolution Blueprint Executive Summary*. Retrieved on October 15, 2022 from https://www.naccho.org/uploads/full-width-images/MAPP-Evolution-Blueprint-Executive-Summary-V3-FINAL.pdf

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