SACRAMENTO COUNTY

PUBLIC HEALTH

Promote • Prevent • Protect

ANNUAL REPORT 2025-26

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SACRAMENTO COUNTY PUBLIC HEALTH
Promote • Prevent • Protect

Accredited Health Department
PHAB
Advancing Public Health Performance
Public Health Accreditation Board

About SCPH

SACRAMENTO COUNTY PUBLIC HEALTH

MISSION

To promote, protect, and champion conditions for optimal health and well-being in partnership with our diverse communities.

VISION

All people thrive in healthy communities.

CORE VALUES

EQUITY	We implement equitable strategies at all levels to dismantle systemic barriers, address inequities, and eliminate health disparities, creating pathways for everyone to achieve optimal health and well-being.
COLLABORATION	We work hand in hand with partners and communities, valuing diverse voices, fostering trust, and aspiring to share power to improve health.
INTEGRITY	We are transparent and accountable for providing efficient and quality services.
COMPASSION	We treat all with kindness, dignity, and respect as we seek to uplift one another's humanity.
INNOVATION	We embrace creativity, curiosity, and continuous improvement by seeking bold solutions that push us beyond our comfort zones.

GUIDING STATEMENT

Our vision rests largely on understanding social determinants of health, such as

- access to high-quality education,
- income and wealth,
- a healthy environment, and
- language and literacy skills.

These factors determine access to safe and healthy housing, neighborhoods, green spaces, transportation, nutritious foods, quality health care, social and emotional support, and inclusion. Historic legacies, structures, and systems continue to drive inequalities and exclude many groups from full and equitable access to these fundamental building blocks for health. Meaningful progress will require shifting toward a more equitable allocation of resources and opportunities within and across our communities.

Introduction

A MESSAGE FROM THE HEALTH OFFICER

September 18, 2026

Dear Sacramento County Board of Supervisors,

It is an honor to introduce this year's Sacramento County Public Health (SCPH) Annual Report. Since joining SCPH as the Health Officer and Public Health Division Director in June 2026, I have been inspired by the dedication of our staff and their commitment to improving the health and well-being of the communities we serve.

Sacramento County is a dynamic and growing community, and our public health work touches nearly every aspect of County residents' lives. Every day, SCPH advances our mission and vision by preventing disease, promoting health, reducing disparities, and working alongside our partners to create healthier communities.

The stories highlighted in this report demonstrate the breadth and impact of that work. When a disruption to CalFresh benefits threatened food security for thousands of residents, SCPH worked with other County departments, food banks, and other partners to identify areas of greatest need, coordinate resources, and provide clear, multilingual information.

During the 2026 measles outbreak, staff from across seven SCPH programs worked together to rapidly identify cases and exposures to effectively contain the outbreak to protect our community.

Our Public Health Laboratory introduced advanced DNA sequencing technology to identify drug-resistant tuberculosis in as little as two days, helping patients receive effective treatment weeks sooner, and strengthening our capacity to respond to infectious disease threats across the region.

These examples reflect just a portion of the work happening across SCPH. I am excited to be part of this dedicated team and look forward to building on its strong foundation.

Sincerely,

Phuong Luu, MD, MHS, FACP
Health Officer &
Public Health Division Director

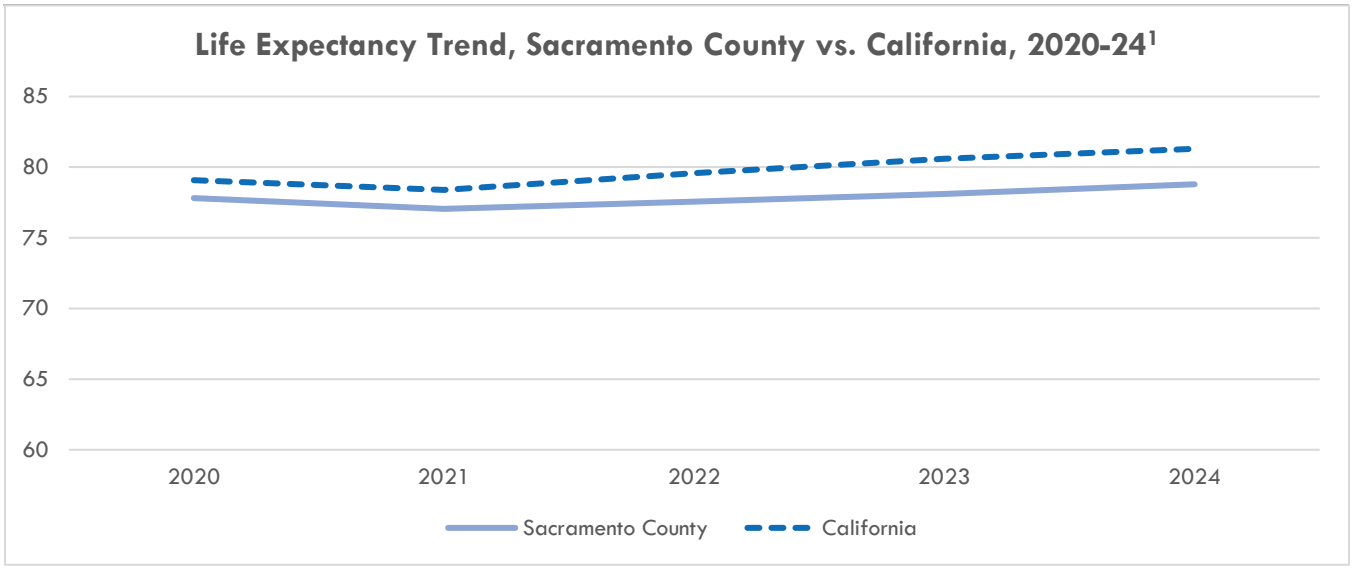
The Health of Sacramento County

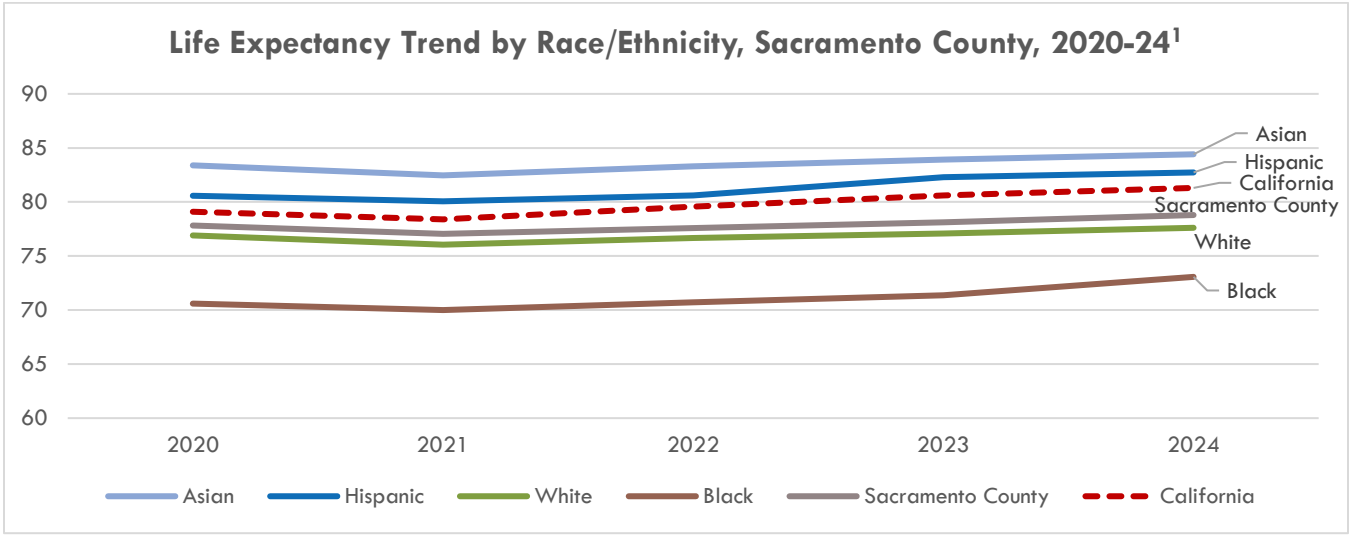
A SNAPSHOT OF SACRAMENTO COUNTY HEALTH DATA

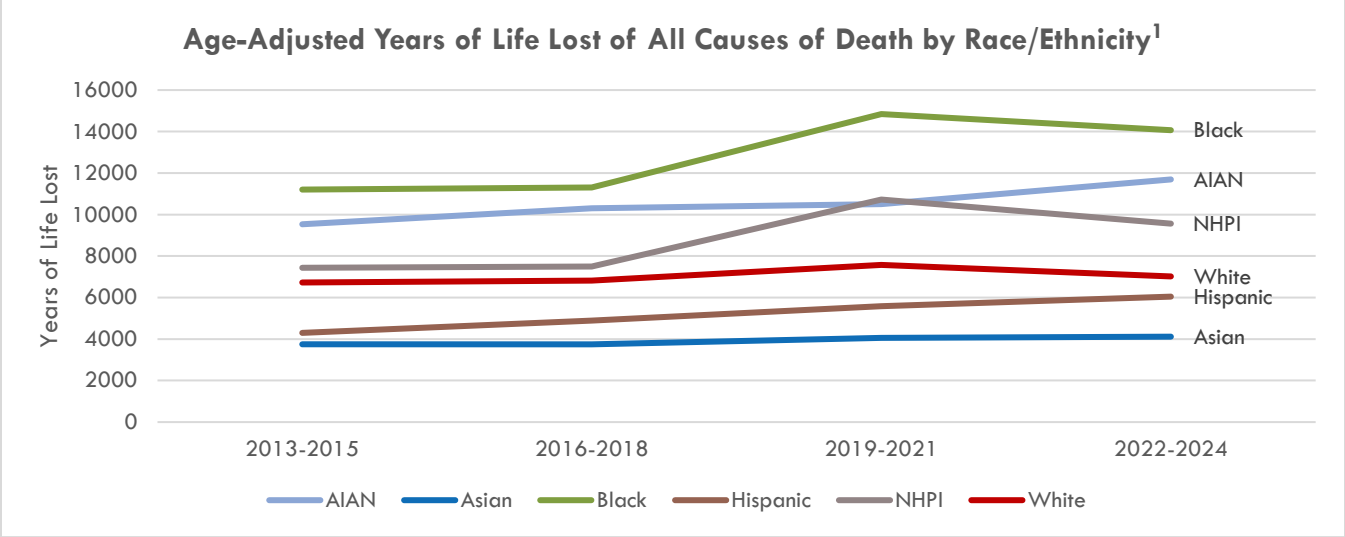
HOW HEALTHY ARE WE?

Jurisdiction	Life Expectancy[1] (2024)	Premature Mortality[1] (2024)	Infant Mortality[1] (2023)
Sacramento County	78.8 years	6,660.6 YPPL	4.6 per 1,000
California	81.3 years	5,707.4 YPPL	4.1 per 1,000

*YPLL = Years of Potential Life Lost per 100,000. Estimates the average years a person would have lived if they had not died prematurely; a larger YPLL indicates a higher societal burden of premature, preventable deaths.







Leading Causes of Death by Sex, 2024[2]

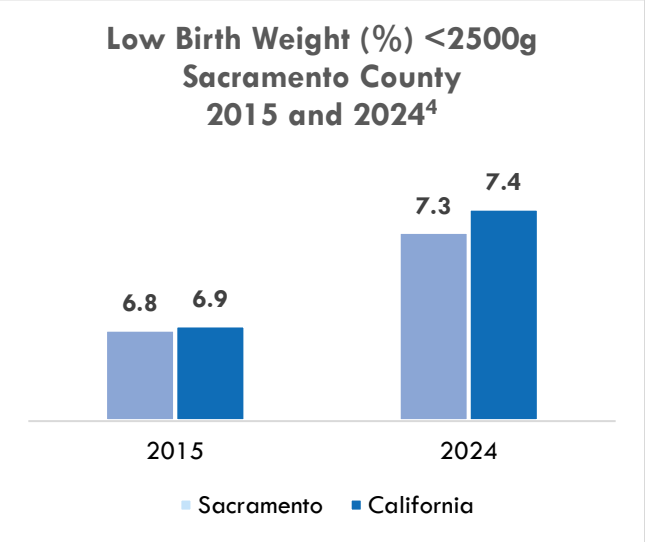
Female		Rank	Male	
Sacramento County	California		Sacramento County	California
Cancer	Cancer	1	Heart Disease	Heart Disease
Heart Disease	Heart Disease	2	Cancer	Cancer
Stroke	Alzheimer's Disease	3	Accidents	Accidents
Alzheimer's Disease	Stroke	4	Stroke	Stroke
Chronic Lower Respiratory Diseases	Chronic Lower Respiratory Diseases	5	Diabetes	Diabetes
Accidents	Accidents	6	Chronic Lower Respiratory Diseases	Chronic Lower Respiratory Diseases
Diabetes	Diabetes	7	Alzheimer's Disease	Alzheimer's disease
Hypertension	Hypertension	8	Suicide	Liver/Cirrhosis
Influenza/Pneumonia	Influenza/Pneumonia	9	Liver/Cirrhosis	Suicide
Chronic kidney disease	Liver/Cirrhosis	10	Hypertension	Hypertension

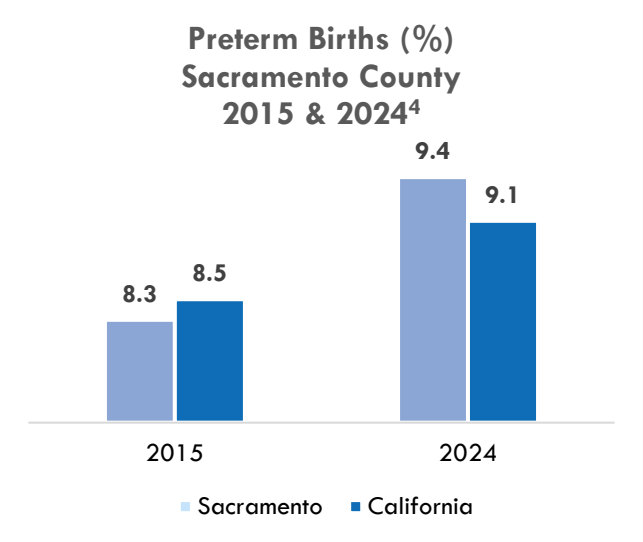
CHRONIC DISEASE

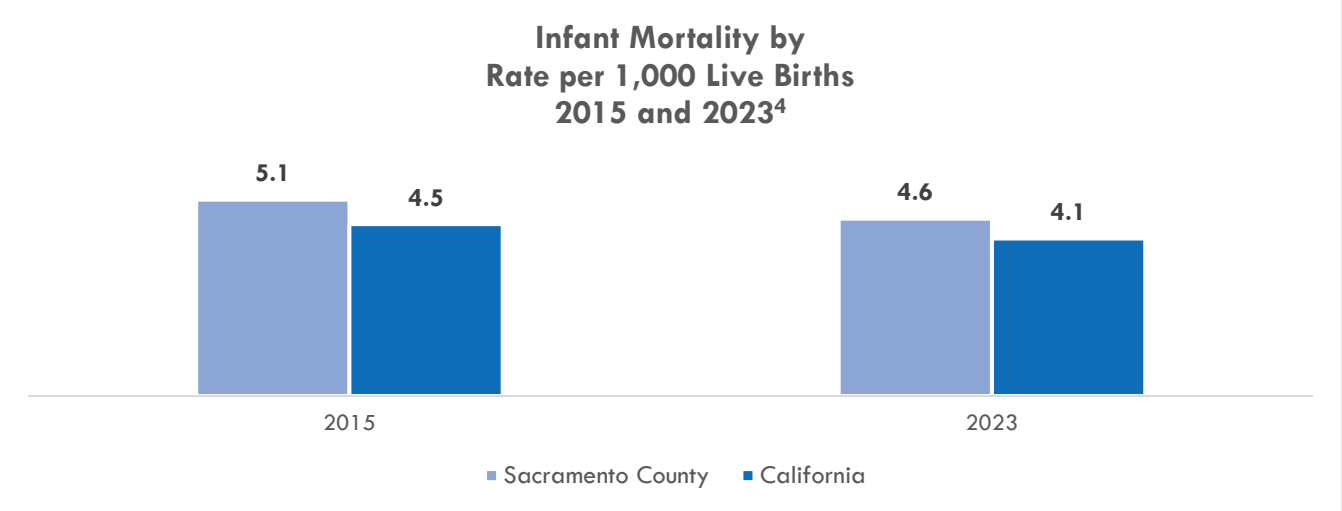
Jurisdiction	Obesity[3]	Diabetes[3]	Heart Disease[1]	Cancer/Neoplasms[1]
Sacramento County	31.6%	12.1%	224.7 *	151.3 *
California	27.8%	12.4%	190.5 *	130.3 *

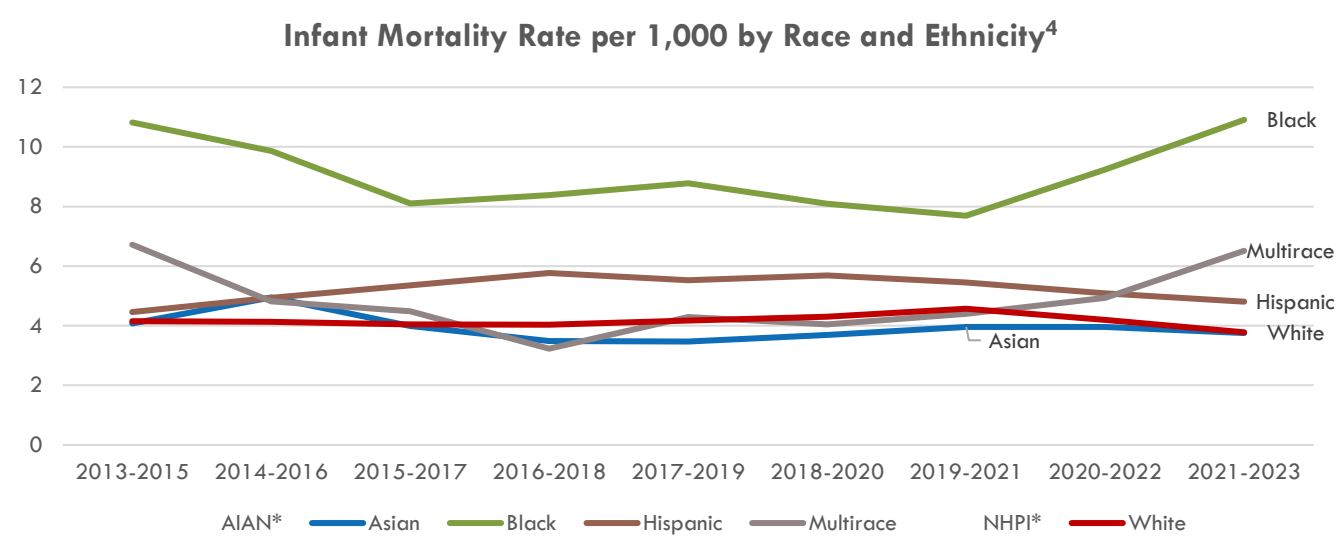
*Per 100,000 deaths. All data from 2024.

MATERNAL & CHILD HEALTH

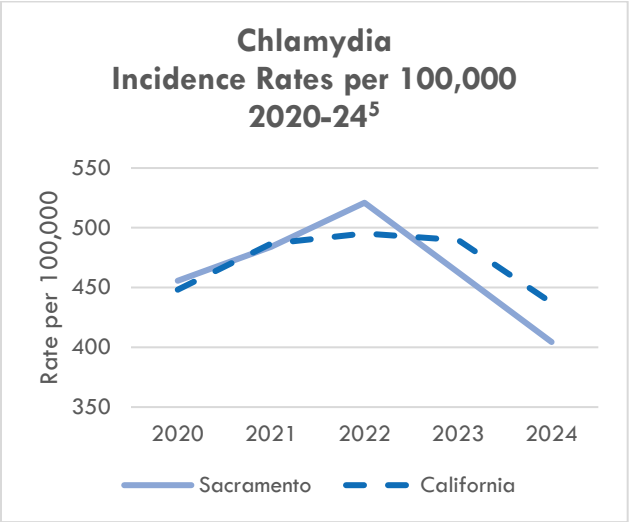


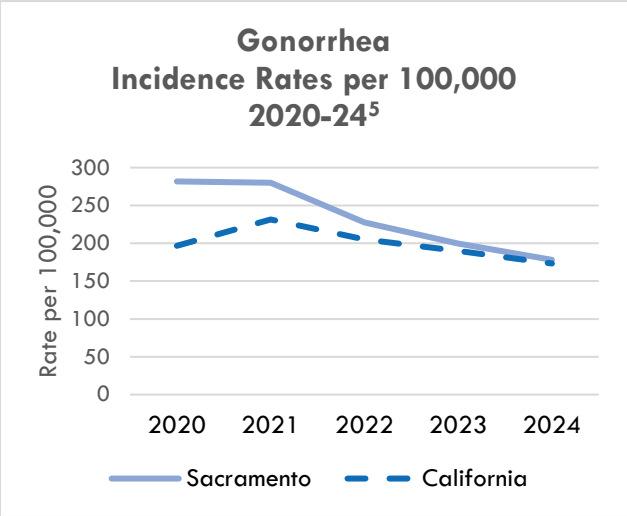


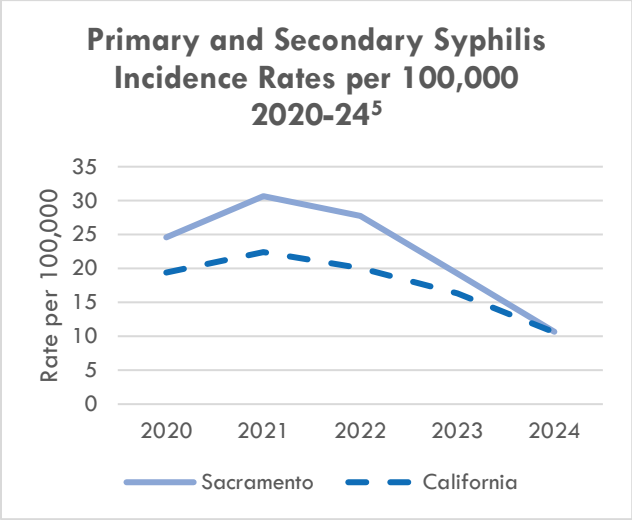


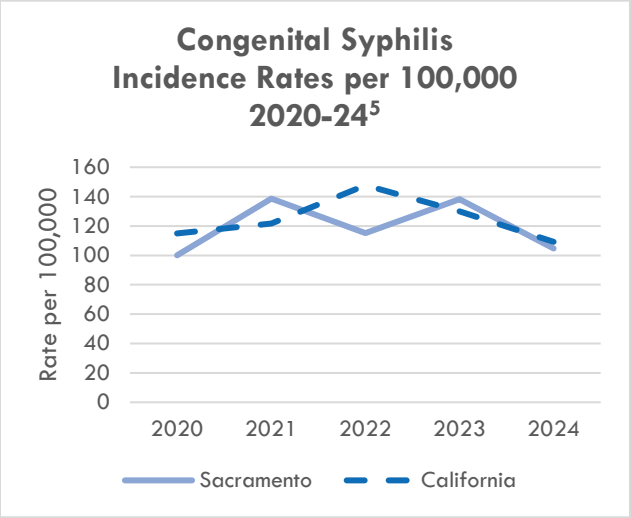


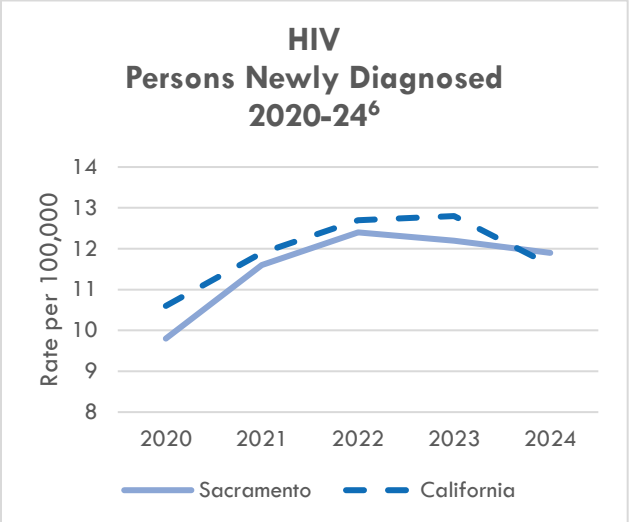
COMMUNICABLE DISEASE

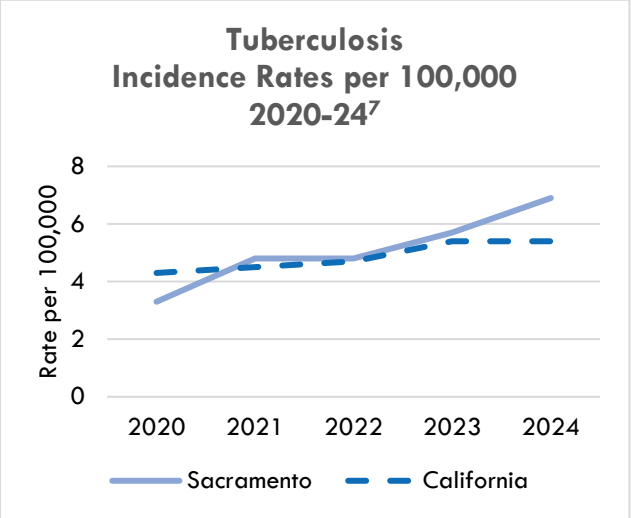












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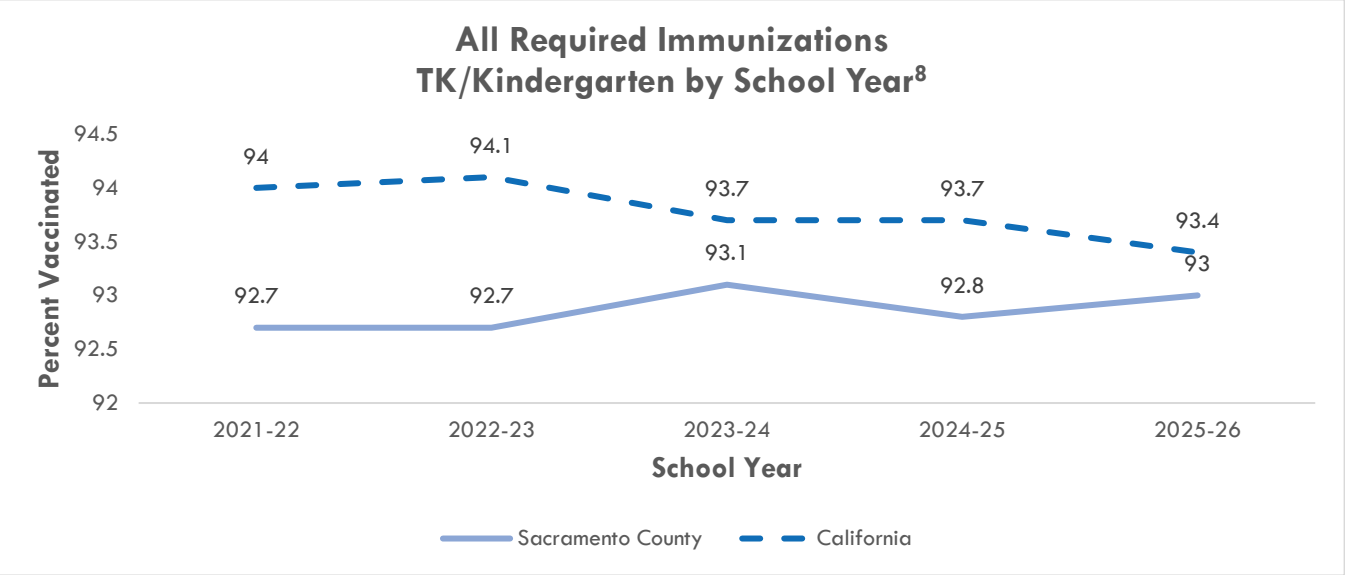
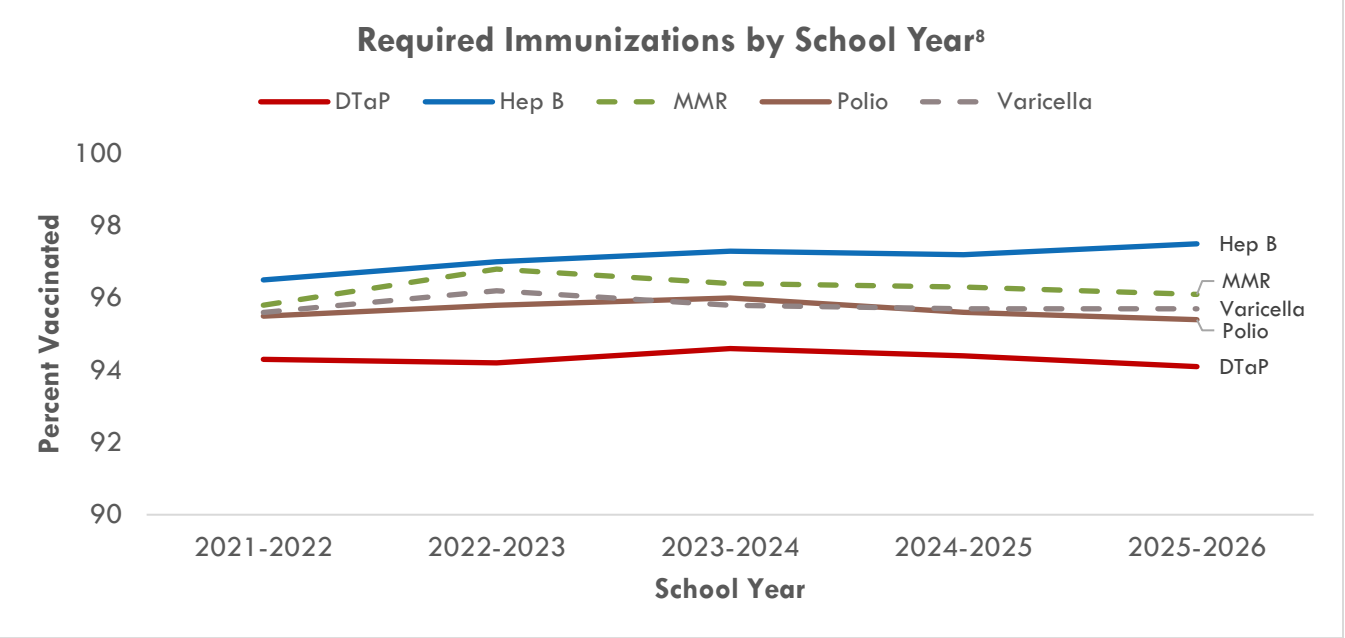
IMMUNIZATIONS





Data Sources:

1. California Community Burden of Disease (CCB)
2. California Department of Public Health (CDPH), *Death Profiles by County*, CalHHS Open Data Portal
3. 2024 California Health Interview Survey
4. CDPH Infant Mortality Dashboard, Last Modified March 2026
5. CDPH STD Control Branch
6. CDPH HIV Surveillance Report, 2024
7. CDPH Tuberculosis Control Branch (TBCB)
8. California Immunizations Registry (CAIR) Hub

Events That Shaped 2025-26

THREE STORIES THAT MATTERED

COORDINATED RESPONSE TO CALFRESH BENEFIT DISRUPTION

In late 2025, when a federal government shutdown threatened to delay CalFresh (SNAP) food benefits for approximately 270,000 Sacramento County residents, the Department of Health Services (DHS) moved quickly to support the community. Working with the Office of Emergency Services (OES), the Department of Human Assistance, Sacramento Food Bank and Family Services, community-based organizations, city partners, and school and fire districts, SCPH's Public Health Emergency Preparedness program led the DHS response to coordinate information sharing and resource planning across the county.

To guide the response, the Epidemiology program created heat maps that showed which neighborhoods would be most affected if food benefits were delayed. These maps highlighted areas with high numbers of CalFresh users and helped partners understand where food shortages and increased demand on food banks were most likely. The maps were shared with County leadership and community partners to support planning and outreach efforts.

Throughout the disruption, SCPH supported virtual coordination through the Department Operations Center. Staff connected with food banks, tracked community needs, and worked with partners to support residents who were homebound or had no caregivers. In collaboration with OES, SCPH also supported accurate public messaging through the Joint Information Center, ensuring residents received clear updates and multilingual information.

This coordinated effort helped reduce confusion, strengthened partnerships, and ensured that Sacramento County was better prepared to meet community food needs during the CalFresh disruption. SCPH's work demonstrated the importance of early communication, strong partnerships, and accessible public information during a food security emergency.

SPRING 2026 MEASLES OUTBREAK CONTAINED

A measles outbreak in Sacramento County and Placer County began in early 2026 following the identification of an unvaccinated child who had recently traveled from an area experiencing a large, ongoing outbreak in another state. Throughout March and April 2026, SCPH implemented a multifaceted response to contain the spread of this highly contagious virus.

Public Health Nurses (PHNs) in the Communicable Disease Control (CD) program conducted rapid case investigations and contact tracing interviews to identify individuals who may have been exposed. Significant exposure events occurred at urgent care centers, pediatric clinics, emergency departments, and educational enrichment programs for school-aged children. In total, these included approximately 300 health care-related exposures and 150 exposures associated with enrichment programs.

PHNs promptly assessed exposed individuals, initiated symptom monitoring and quarantine recommendations, and coordinated post-exposure prophylaxis (PEP) for high-risk contacts within recommended timeframes. PHNs also conducted in-home visits to test symptomatic individuals for measles, reducing the potential for additional exposures in health care settings while supporting rapid identification of new cases. Close coordination between the CD program and the Public Health Lab enabled timely specimen processing and reporting of laboratory results, allowing response activities to be adjusted as new information became available.

The response also prioritized culturally appropriate outreach and community engagement. SCPH staff partnered with trusted community leaders and organizations in the most affected communities to help share prevention messages and increase awareness. Staff also worked directly with health care and educational facilities to provide guidance, share resources, and assess preparedness for potential exposures.

The outbreak resulted in 13 confirmed cases in Sacramento County (and 8 confirmed cases in Placer County), several of which occurred among household contacts who were already under quarantine. Ninety-two percent of cases occurred among unvaccinated or under-vaccinated individuals. The outbreak was declared over on May 29, 2026, after two incubation periods had passed since the last date of exposure without evidence of new cases. The successful response required close collaboration across seven different SCPH programs, in addition to collaboration with Placer County, other counties with exposed residents, the California Department of Public Health, and health care partners throughout the county.

TB DRUG RESISTANCE TESTING IN DAYS, NOT WEEKS

The Sacramento County Public Health Laboratory (Lab) expanded its ability to detect and treat tuberculosis (TB) by introducing Deeplex, an advanced DNA sequencing test that identifies drug-resistant TB in as little as two days. Traditional testing can take several weeks, requiring medical providers to begin treatment before knowing which medications will be most effective. Faster results help patients receive the right treatment sooner and reduce the spread of disease in the community.

The SCPH Lab spent nearly a year validating the new technology after expanding its DNA sequencing capabilities during the COVID-19 pandemic. Today, the SCPH Lab is one of only a few public health laboratories in California offering this advanced level of TB testing, strengthening its ability to respond to serious infectious disease threats, and serving a leader in the public health laboratory realm.

As a regional public health laboratory, SCPH Lab also provides specialized testing and outbreak support to neighboring counties. The addition of this new capacity further strengthens these partnerships while creating opportunities to apply DNA sequencing technology to other infectious diseases in the future, helping protect the health of communities across Northern California.

SCPH Budget & Workforce

2025-26 SCPH BUDGET: **$104,154,716**

Funding Sources:

$57,170,213 Federal Government

$18,923,578 State of California

$14,367,298 County of Sacramento

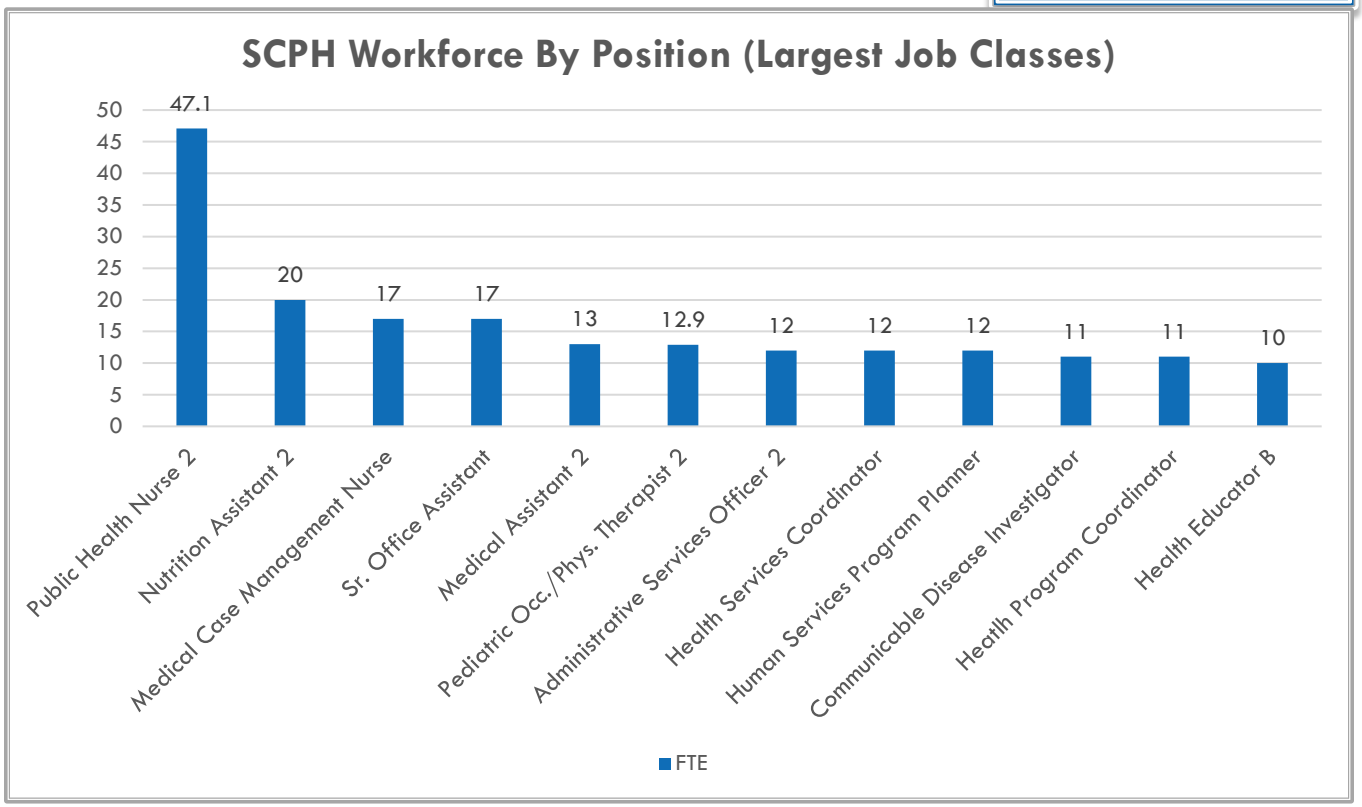
$5,016,903 Social Services & Public Health Realignment

$4,158,852 Miscellaneous

$2,797,557 Fees

$1,720,315 Tobacco Tax

356.6 FTE
Full Time Equivalents



Dr. Phuong Luu
Health Officer &
Public Health
Division Director

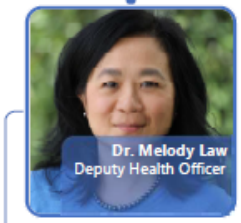
Nick Mori
Special Projects

Wakmana Sherzai
ASO I

Prevention & Health Services

Lynnan Svensson
Nursing Division Manager
Director of Nursing

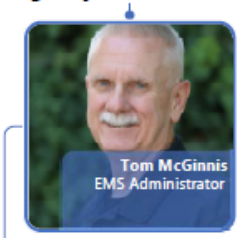
- **Rachel Allen**, Nurse Manager
  - Child Protective Services Nursing
    - Emergency Response & Informal Supervision
    - Health Care Program for Children in Foster Care
    - Supportive Health Interventions through Nursing Empowerment (SHINE)
  - Immunization Assistance
  - Senior & Adult Services Nursing
    - Adult Protective Services
    - In-Home Supportive Services
- **Melanie Capiccioni**, Nurse Manager
  - Chest Clinic/Tuberculosis Control
  - Communicable Disease Control
- **Leesa Hooks**, Nurse Manager
  - Childhood Lead Poisoning Prevention
  - Maternal, Child, & Adolescent Health
  - Oral Health
    - African American Perinatal Health
    - Black Infant Health
    - Community Nursing
    - Nurse Family Partnership
- **Vanessa Stacholy**, Program Manager
  - California Children's Services



Dr. Melody Law
Deputy Health Officer

- **Staci Syas**, Program Manager
  - Sexual Health Promotion
  - Sexual Health Clinic

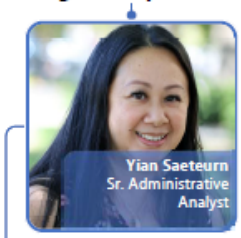
Emergency Medical Services



Tom McGinnis
EMS Administrator

- Emergency Medical Services

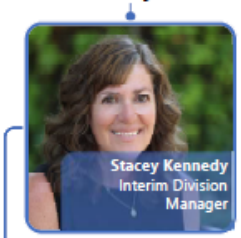
Budget & Operations



Yian Saeteurn
Sr. Administrative
Analyst

- **Nicole Brandner**, ASO III
  - Budget
- **Alden Avila Hunter**, ASO III
  - Operations

Community Health



Stacey Kennedy
Interim Division
Manager

- **Nolana Mymka**, Program Manager
  - Emergency Preparedness
  - Epidemiology
  - Vital Records
- **Stacey Kennedy**, Program Manager
  - Workforce Development
- **Dr. Mark Pandori**, Laboratory Director
  - Public Health Laboratory
- **Dr. Gurleen Roberts**, Program Manager
  - Accreditation
  - Health & Racial Equity
  - Health Education
    - Child Passenger Safety
    - Tobacco Education & Prevention
- **Amelia Schendel**, Program Manager
  - Women, Infants, & Children

SACRAMENTO COUNTY
PUBLIC HEALTH
Promote • Prevent • Protect

Organizational Chart

September 1, 2026

Budget & Operations

Budget & Operations

ABOUT THE PROGRAM

The Budget and Operations team provides essential support that keeps SCPH programs operating efficiently and effectively. The team manages County and grant budgets, contracts, Board letters, purchasing, personnel matters, facilities, and medical billing, helping programs maintain the resources and infrastructure needed to serve the community.

WHAT WE DID

PHOTO: The Budget & Operations team during Public Health Week.

The Budget and Operations team provided essential financial and administrative support across SCPH. The team prepared 63 Board letters, executed and/or monitored 289 contracts, processed 2,044 vendor and subcontractor invoices, and reviewed and approved 230 grant claims. Through these activities, the team supported program operations, maintained critical administrative processes, and helped ensure that Public Health resources were managed efficiently and in accordance with County, state, and federal requirements.

HIGHLIGHTS & OUTCOMES

The team successfully launched the County-Based Medi-Cal Administrative Activities (CMAA) program across seven Public Health programs, encompassing 80 staff members. This new reimbursement opportunity positions SCPH to claim federal funds for eligible program activities and strengthen the long-term financial sustainability of Public Health services. As the program expands, CMAA funding can provide additional resources to support staffing, services, and program activities.

289 Contracts

85 Memoranda of Understanding

69 Subcontractors

Community Health

Accreditation

ABOUT THE PROGRAM

The Accreditation Unit coordinates division-wide efforts to maintain accreditation with the Public Health Accreditation Board (PHAB) by supporting quality improvement (QI), performance management, workforce development, strategic planning, and organizational accountability. The program strengthens the infrastructure needed to deliver high-quality public health services.

Annual Budget
- $322,623

State Funding
- 100%

Full Time Equivalents (FTE)
- 1.5

WHAT WE DID

SCPH submitted its first post-accreditation annual report to PHAB and completed its 2025–2029 Strategic Plan. The team implemented staff training, with 94 managers and supervisors completing QI 101 and 93 completing Equity-Focused QI training. Four QI projects were completed, with three additional projects underway. SCPH also advanced Results-Based Accountability (RBA), training staff, developing five division scorecards, and initiating "Turn the Curve" conversations focused on key community health indicators. Five *Focus on the Future* meetings supported leadership development, communication, and strategic alignment. Accreditation staff also led grant development and the implementation of a new electronic health record system.

HIGHLIGHTS & OUTCOMES

All QI projects completed during the year met their stated aims, demonstrating measurable progress from staff-led improvement efforts. QI initiatives improved workforce engagement, streamlined administrative processes, strengthened documentation and continuity of care, and supported better client experiences. RBA is also shifting performance management toward a clear question: "Is anyone better off?" Five community health indicators, including infant mortality rate, TB case rate, syphilis among women of childbearing age, out of hospital cardiac arrest rate, and kindergarten vaccination rate, now provide a shared framework for identifying disparities, coordinating action, and improving outcomes for Sacramento County residents.

Sharing the Wealth: SCPH provided accreditation technical assistance to five health departments across two states, sharing lessons learned and practical strategies to strengthen PHAB accreditation readiness and continuous improvement.

87% Of SCPH managers trained on QI

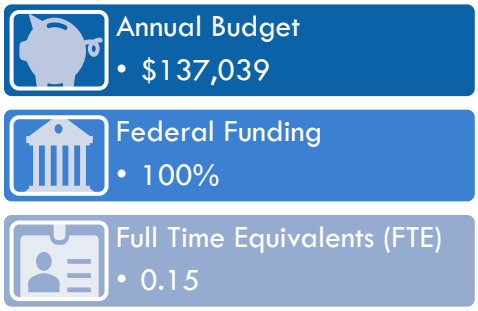
4 QI projects completed

100% Of QI projects met their stated aim

Child Passenger Safety

ABOUT THE PROGRAM

SCPH subcontracts with the Dignity Health Mercy San Juan Car Seat Program to provide child passenger safety education and outreach for parents and caregivers, helping reduce injuries and fatalities among children involved in motor vehicle crashes. Funded by the CA Office of Traffic Safety, the program prioritizes underserved populations, including refugee and non-English-speaking families.



WHAT WE DID

The Child Passenger Safety program expanded access to car seats and safety education for Sacramento County families, distributing 287 child safety seats at no cost. The program also provided 365 individual car seat fitting appointments, giving parents and caregivers hands-on guidance to ensure seats were properly installed and used. In addition, 32 child passenger safety classes were conducted, reaching 293 parents and community educators. Through a combination of direct services, individualized support, and community education, the program strengthened caregivers' knowledge and skills to help keep children safe while traveling.

HIGHLIGHTS & OUTCOMES

The program helped families build the knowledge and confidence needed to protect children from preventable injuries in motor vehicle crashes. Eighty-seven percent of parents reported increased knowledge of child passenger safety after participating in classes. This education is particularly important because an estimated 75% of child safety seats are installed incorrectly, potentially reducing their effectiveness. By providing free car seats, hands-on fitting assistance, and practical education, the program helps address barriers to proper child restraint use. Properly installed child safety seats can reduce the risk of crash-related death by 71% for infants and 54% for children ages 1 to 4, reinforcing the program's potential to save lives.

A Safe Start for Twins: A first-time father arrived in Sacramento in 2025 with his five-month-old twins, facing the challenges of adjusting to a new country, learning U.S. car seat laws, and affording essential safety equipment. The program provided hands-on car seat safety education and two car seats, giving him the knowledge and resources to safely transport his children as his family began a new chapter in Sacramento County.

Epidemiology

ABOUT THE PROGRAM

The Epidemiology Program helps turn data into action. Through disease surveillance, data analysis, dashboards, mapping, and program evaluation, the team provides the information needed to identify health trends, respond to emerging threats, and improve the health of Sacramento County residents.

- **Annual Budget**
  - $1,657,893
- **Federal Funding**
  - 44%
- **State Funding**
  - 23%
- **County Funding**
  - 20%
- **Managed Care Plans**
  - 8%
- **Fees**
  - 5%
- **Full Time Equivalents (FTE)**
  - 6.0

WHAT WE DID

Epidemiology completed 113 projects and data requests, providing analysis, surveillance, visualization, mapping, and decision support across SCPH. Work included 31 new data analyses, 16 dashboards and visualizations, 14 Qualtrics survey projects, four mapping projects, three presentations, two formal reports, media support, surveillance reporting, and specialized epidemiologic requests. Staff supported outbreak investigations, disease surveillance, health disparity analyses, program evaluation, grant applications, community health planning, and performance measurement.

PHOTO: The Epidemiology Team.

HIGHLIGHTS & OUTCOMES

Interactive dashboards and surveillance reporting enabled SCPH to monitor trends and respond to emerging concerns, while epidemiologic analyses supported outbreak investigations and targeted interventions. GIS mapping advanced emergency preparedness and community planning by making geographic patterns easier to understand. Qualtrics surveys and evaluation tools captured community and client perspectives to guide program improvements. Analyses supporting grants, strategic planning, and performance measurement strengthened accountability and resource decisions. Together, these services improved SCPH's ability to identify disparities, evaluate outcomes, anticipate needs, and direct resources where they are needed most.

113 Data projects

16 Dashboards & visualizations

14 Qualtrics survey projects

Food Systems

ABOUT THE PROGRAM

Food system initiatives work focusing on strengthening food security, advancing coordinated food system planning, and supporting compliance with statewide regulations related to edible food recovery.

Annual Budget
- $2,053,254*

Full Time Equivalents (FTE)
- 0.5

*Carryover funds from initial funding cycle (FY2023-24) contributed by all CFAA jurisdictions (County & 6 cities). Most of these funds were distributed to the community through grants.

WHAT WE DID

The Capital Food Access Alliance (CFAA), a partnership with six cities in the county, awarded $199,000 in Equipment Grants to 12 organizations for refrigeration, transportation, storage, and other food recovery equipment. An additional $1.5 million in Capacity Expansion Project Grants supported 10 large-scale projects involving 19 food recovery organizations and partners. Projects advanced transportation logistics, Tier 2 prepared food recovery, repackaging kitchens and innovative recovery models. The Sacramento Safety Net Alliance launched in October 2025 to unite County departments and community partners around a shared goal: strengthening food access, reducing duplication, and connecting residents to resources with greater dignity and resilience. A cross-sector Steering Committee now guides this collaborative effort, bringing together public health, human services, health care, food systems, and community organizations to maximize the impact of available resources.

PHOTO: Produce boxes ready for distribution.

HIGHLIGHTS & OUTCOMES

CFAA investments expanded organizations' ability to safely recover, store, transport, and distribute larger quantities of surplus food to community members experiencing food insecurity. Grantees reported improvements across their entire food recovery systems, from pickup and warehouse operations to distribution. Six of 16 grantees launched new pilot programs, including mobile food pantries, school-based recovery, and shared transportation models.

From Surplus to Support: Todo Un Poco's pilot recovered 14,253 pounds of edible food and provided 13,445 prepared meals. Capital Compassion expanded transportation and repackaging capacity while launching a mobile food pantry, demonstrating how strategic investments can simultaneously reduce food waste, strengthen food access, and build sustainable community infrastructure.

Health & Racial Equity

ABOUT THE PROGRAM

The Health & Racial Equity (HRE) Unit works alongside communities, partners, and public health staff to improve health outcomes by strengthening organizational capacity, fostering meaningful community engagement, and supporting policies and practices that are culturally responsive and accessible. Through collaboration and systems improvement, the program helps reduce barriers to health and well-being across Sacramento County.

Annual Budget
- $3,188,497

Federal Funding
- 40%

State Funding
- 55%

Managed Care Plans
- 5%

Full Time Equivalents (FTE)
- 5.0

WHAT WE DID

HRE expanded community partnerships, leadership development, and workforce capacity through a range of initiatives. Community Wellness Hubs connected residents to prevention and behavioral health services while supporting peer-led wellness programming and training 38 Medi-Cal Peer Support Specialists. The Parent Leader Training Institute, a First 5 initiative, engaged 40 parents and caregivers in English and Spanish cohorts. HRE partnered with 25 organizations to advance strategies addressing mental health, food access, housing, and economic stability. HRE also hosted a 108-hour Community Health Worker practicum, co-hosted the T.H.R.I.V.E. Summit for approximately 300 participants, launched a trauma-informed learning cohort, and conducted its annual staff capacity assessment.

PHOTO: HRE Conference poster presentation.

HIGHLIGHTS & OUTCOMES

Community Wellness Hubs reached more than 3,000 residents and expanded prevention, behavioral health, and peer support. Sacramento County's first neighborhood-level eviction dashboard launched, visualizing 9,624 writs of possession to inform prevention efforts. Parent leaders expanded civic engagement and leadership pathways, while the T.H.R.I.V.E. Summit strengthened relationships across County departments and community organizations. Internally, trauma-informed training increased staff readiness to apply supportive practices, while workforce assessment data provided leadership with actionable insights to guide improvement.

"The HRE team is forward thinking, strategic, and dedicated to bringing the agency and program work to a higher level." **- SCPH Manager**

Nutrition Education & Active Living

ABOUT THE PROGRAM

Annual Budget
- $973,340

Federal Funding
- 100%

Full Time Equivalents (FTE)
- 1.2

The Nutrition Education and Active Living (NEAL) Program served as Sacramento County's local implementer of the CDPH CalFresh Healthy Living Program from 2012–2026. The program aimed to improve the health and well-being of CalFresh-eligible individuals and communities by supporting policy, systems, and environmental changes that promote healthy eating, food access, and physical activity. Following federal budget cuts, the program was discontinued and officially concluded on April 30, 2026.

PHOTO: HEC Schools Food Distribution.

WHAT WE DID

NEAL-funded community partners delivered nutrition education and promoted healthier food environments. Sacramento Food Bank and Family Services reached more than 8,900 individuals with nutrition education and resources, while Health Education Council (HEC) provided nutrition education to more than 850 students and adults. HEC also continued to convene the Afghan mother's group and transitioned Team Nutrition to Twin Rivers Unified School District using a train-the-trainer model. Civic Thread advanced equitable active transportation and launched a GIS map featuring more than 450 walk audit recommendations. Partners also strengthened sustainability through resource libraries, training, and updated pantry procedures.

HIGHLIGHTS & OUTCOMES

Despite an unexpected federal funding sunset, partners prioritized sustainability while continuing to deliver meaningful benefits to Sacramento County residents. HEC's culturally responsive Afghan mothers' workshops increased participants' confidence in choosing healthy foods, adapting traditional recipes, and supporting children's participation in school meals while fostering connection and reducing isolation. Its train-the-trainer approach will allow Team Nutrition to continue in 30 classrooms beyond grant funding. SFBFS exceeded education goals while helping partner pantries strengthen their operations and client experience. Civic Thread's 450+ walk audit recommendations created a lasting advocacy tool, supporting safer, more equitable opportunities for residents to walk and be active.

"I learned how to choose healthy food in America when joining these classes as well as how much physical activity can reduce my chances for chronic disease, from now on I have more knowledge to teach my children to eat better and live healthier." **-Afghan Moms participant**

Public Health Emergency Preparedness

ABOUT THE PROGRAM

Public Health Emergency Preparedness (PHEP) focuses on preparedness and response efforts through plan development, resource management, and training related to public health and medical emergencies.

- **Annual Budget**
  - $2,159,355
- **Federal Funding**
  - 95%
- **State Funding**
  - 5%
- **Full Time Equivalents (FTE)**
  - 5.5

WHAT WE DID

PHEP strengthened Sacramento County's readiness for disasters, disease outbreaks, and other large-scale emergencies through planning, training, exercises, and partnerships. PHEP expanded Incident Command System capabilities, conducted department-wide Department Operations Center training and a tabletop exercise, and supported real-world response, including activation during the fall 2025 CalFresh disruption. The program also convened quarterly preparedness meetings with health care, emergency management, and community partners; advanced emergency communications and accessibility; strengthened Cities Readiness Initiative capabilities; and enhanced Public Health Laboratory readiness through specialized testing and Laboratory Response Network activities.

PHOTO: The PHEP Team.

HIGHLIGHTS & OUTCOMES

Preparedness investments strengthened Sacramento County's ability to coordinate a rapid, effective response while maintaining critical services during emergencies. The 2026 Medical Response and Surge Exercise brought together more than 70 health care and emergency response partners, including all 10 acute care hospitals, to practice responding to a simulated 6.8-magnitude earthquake. Participants tested patient tracking, communication, resource coordination, and hospital surge capacity while identifying gaps before a real disaster. PHEP's broader partnerships and exercises also strengthened regional relationships and whole-community preparedness, helping ensure residents, including those with access and functional needs, can receive timely, coordinated support when emergencies occur.

Don't Flock with Bird Flu: PHEP partnered with Communicable Disease Control on a media campaign to remind Sacramento County residents "Don't Flock with Bird Flu!" to educate residents on how to protect themselves from Bird Flu.

Public Health Laboratory

ABOUT THE PROGRAM

The Public Health Laboratory (Lab) performs laboratory tests for rabies and various human infectious diseases along with genomic intelligence and consultation to clinics and laboratories in Sacramento County and five nearby counties.

- **Annual Budget**
  - $2,886,380
- **Federal Funding**
  - 20%
- **State Funding**
  - 7%
- **County Funding**
  - 64%
- **Fees**
  - 9%
- **Full Time Equivalents (FTE)**
  - 19.0

WHAT WE DID

The SCPH Lab performed 79,456 tests for approximately 34,138 clients, supporting disease diagnosis, surveillance, and treatment. The SCPH Lab expanded its capabilities by adding three new testing services, including genomic sequencing for bacteria and fungi and drug-susceptibility testing for tuberculosis that can shorten diagnostic timelines by weeks. Staff also trained future laboratory professionals, including Public Health Microbiology trainees and six UC Davis and Sacramento State clinical laboratory science students. Lab staff shared their expertise nationally through a presentation at the American Association for Bioanalysis meeting, further advancing public health laboratory practice.

PHOTO: SCPH Lab and CD staff.

HIGHLIGHTS & OUTCOMES

The SCPH Lab delivered timely, reliable results that supported the health of more than 34,000 clients, with more than 95% of tests meeting turnaround-time expectations. Quality and accuracy remained strong: the Lab completed 60 proficiency exams without a single failure and received zero deficiencies during its CMS/Laboratory Field Services audit. Advanced genomic sequencing also helped a local hospital rapidly identify a C. auris outbreak, supporting efforts to understand and contain its spread. New tuberculosis drug-susceptibility testing has the potential to save weeks in diagnosis, enabling patients with drug-resistant TB to receive appropriate treatment sooner.

79,456 Tests performed

34,138 Clients served

3 New lab testing services added

Stop Stigma Sacramento

ABOUT THE PROGRAM

Annual Budget
- $368,161

State Funding
- 100%

Full Time Equivalents (FTE)
- 1.8

The Stop Stigma Sacramento Speakers Bureau (SSSSB) is part of the "Mental Illness: It's not always what you think" project, which aims to reduce stigma and discrimination, promote mental health and wellness, and inspire hope for people and families living with mental illness. SSSSB seeks to reduce stigma and discrimination through first-hand stories shared by everyday people in Sacramento County who are living with, or supporting someone else living with, mental illness. The project transitioned to the Division of Behavioral Health Services on July 1, 2026.

WHAT WE DID

SSSSB hosted 44 local speaking events and participated in 32 tabling events, providing 194 hours of direct community engagement. Speakers shared their personal experiences 74 times, representing 18.5 hours of lived-experience storytelling. SSSSB maintained 40 active speakers throughout the year and held three orientation and training sessions for prospective speakers, welcoming three new members.

PHOTO: SSSSB staff & speakers.

HIGHLIGHTS & OUTCOMES

SSSSB helped make mental health conversations more visible, relatable, and culturally responsive across Sacramento County. Speakers' willingness to share personal experiences created opportunities for community members to see mental health through the lens of lived experience, helping reduce shame and encourage more open dialogue. Attendees and community partners expressed gratitude for the speakers' vulnerability, strength, and cultural competence. SSSSB also demonstrated strong sustainability, achieving a 97.2% speaker retention rate while adding three new active speakers. Together, these efforts strengthened a growing network of community advocates working to normalize conversations about mental health and create a more supportive community.

"Words fall short to express my gratitude. The honesty, vulnerability, and authenticity of each segment of your session was unlike anything we have experienced before. Thank you SO much for bringing truth to power and for highlighting your lived experiences and bringing us so thoughtfully into the folds of your inner worlds." **- American Medical Student Association**

Tobacco Education & Prevention

ABOUT THE PROGRAM

The Tobacco Education & Prevention Program (TEPP) leads tobacco prevention efforts in Sacramento County. TEPP works to reduce tobacco access, use, and exposure through policy initiatives, cessation support, and collaboration with the Greater Sacramento Smoke & Tobacco Free Coalition and other community partners.

Annual Budget
- $1,456,627

State Funding
- 100%

Full Time Equivalents (FTE)
- 4.4

WHAT WE DID

TEPP distributed 927 tobacco quit kits tailored to smoking, vaping, and other tobacco use, available in English, Spanish, Russian, and Arabic. Staff conducted 214 secondhand smoke public opinion polls, 96 tobacco retail observations, and 52 outdoor observations examining tobacco use, litter, and signage. Through the Wellness Without Walls (W3) pilot, 49 unhoused individuals received tobacco cessation services through a partnership with UC Davis. TEPP also hosted a Behavioral Health Regional Training to strengthen providers' ability to address tobacco use directly with their clients.

PHOTO: The Behavioral Health Regional Training.

HIGHLIGHTS & OUTCOMES

These efforts expanded access to cessation support while strengthening community and provider capacity to reduce tobacco use. Quit kits provided practical, accessible resources for individuals seeking to quit, while the W3 pilot connected unhoused residents with tailored cessation services. The Behavioral Health Regional Training produced particularly strong results: 100% of respondents said they planned to address tobacco use directly in their work, compared with 78% before training. Provider confidence also increased substantially, with 98% reporting confidence in treating tobacco use, up from 65% before training.

From Training to Action: A Behavioral Health Regional Training sparked action beyond the classroom. Following the training, Sacramento County's 30 substance use treatment clinics received tobacco quit kits. This expanded access to cessation resources and helped providers integrate tobacco treatment into behavioral health services, creating new opportunities for clients to quit and improve their health.

Vital Records

ABOUT THE PROGRAM

The Office of Vital Records registers all births, deaths, and fetal deaths that occur in Sacramento County. They issue birth and death certified certificates, disposition permits for burial and cremation, and medical marijuana identification cards.

Annual Budget
- $1,530,000

Fees
- 100%

Full Time Equivalents (FTE)
- 8.0

WHAT WE DID

Vital Records served as a critical link between residents, health care providers, hospitals, funeral homes, and government agencies by maintaining accurate records of significant life events. Staff registered 15,426 births, 15,394 deaths, and 110 fetal deaths and issued more than 80,000 certified copies of birth, death, and fetal death records. The program also issued 142 Medical Marijuana Identification Cards and managed certificate-fee disbursements to support six state and local programs. Through careful record management and coordination with community partners, Vital Records maintained the integrity and accessibility of essential public records.

PHOTO: The Vital Records Team.

HIGHLIGHTS & OUTCOMES

Vital Records' work helped families and institutions navigate some of life's most important moments with reliable documentation and responsive service. Accurate records supported access to benefits, health care, estate and financial matters, legal processes, and other essential services. Certificate fees also generated more than $571,000 in dedicated funding, supporting child protection, DNA testing, indigent burial assistance, umbilical cord blood collection, peace officer training, and vehicle registration improvements. By combining accurate recordkeeping with compassionate service and strategic stewardship of resources, the program supported both individual residents and broader systems that contribute to community well-being.

80,000+ Certified copies of records issued

$571,000 Disbursed to community programs

142 Medical Marijuana cards issued

Workforce Development

ABOUT THE PROGRAM

The Workforce Development program strengthens staff capacity and engagement through multiple initiatives to support employee growth and development, organizational change management, and a more connected, well-equipped public health workforce across the division.

Annual Budget
- $9,106,173*

Federal Funding
- 100%

Full Time Equivalents (FTE)
- 4.0

*These funds support an additional 20 FTEs in multiple programs across SCPH.

WHAT WE DID

Workforce Development strengthened staff learning, leadership, recognition, and professional growth across SCPH. The team completed 44 translation projects across 16 languages, supported 46 staff through mentorship, and delivered six training sessions informed by employee feedback. Three SCPH 101 sessions and a refreshed new employee welcome strengthened onboarding, while 44 staff received professional development support. The team also coordinated four joint internship and volunteer onboarding sessions, approved 12 Team Recognition Awards, and honored 28 employees through the SCPH Shout-Outs Program. Cross-divisional efforts also advanced CalAIM implementation, policy review, workforce classification, and standardized referral processes.

PHOTO: The 2026 mentorship cohort.

HIGHLIGHTS & OUTCOMES

Workforce investments contributed to a stronger, more connected, and increasingly engaged SCPH workforce. Overall employee engagement reached 83% in 2026, up from 80% in 2023 and ten points above the external benchmark, while 88% of staff reported feeling supported in learning and development. The mentorship program earned a 9.0/10 satisfaction rating, with 95% of participants recommending it; mentors also reported stronger coaching, listening, and leadership skills. The Policy Review Team brought diverse perspectives into agency-wide policies, helping ensure their potential workforce impacts are considered. CalAIM partnerships and the new referral platform also strengthened coordination between SCPH programs and health care partners, improving pathways to services.

"Mentoring has been incredibly rewarding. It's given me the opportunity to build meaningful relationships, share what I've learned, and see junior staff grow with confidence." **-Mentor**

Women, Infants, & Children (WIC)

ABOUT THE PROGRAM

WIC is a supplemental nutrition program that supports healthy pregnancies and promotes optimal health and growth for children from birth through age five. WIC provides nutrition and health education, breastfeeding support, nutritious foods, and referrals to health care and other community resources.

- **Annual Budget**
  - $8,239,420
- **Federal Funding**
  - 82%
- **First 5**
  - 5%
- **County Funding**
  - 12%*
- **Full Time Equivalents (FTE)**
  - 44.8

*A portion of which comes from other County departments or divisions.

WHAT WE DID

In a single month this spring, WIC served 24,131 participants, providing families with nutritious foods, nutrition education, breastfeeding support, and referrals to health care and community resources and 14,287 families redeemed an average of $126.49 in benefits. WIC provided advanced lactation care and support to 1,737 families last year. The program also provided ongoing breastfeeding education and counseling through lactation consultants and peer counselors, helping families make informed feeding choices. Staff connected participants with community partners and health care providers for urgent needs and supported continued access to WIC benefits as children transitioned beyond infancy.

PHOTO: WIC summer event.

HIGHLIGHTS & OUTCOMES

More than half of WIC infants (51.6%) received breastmilk, while those receiving lactation consultant support had higher rates of both exclusive breastfeeding (33.9% vs. 25.6%) and breastfeeding in any amount (63.6% vs. 47.9%). Participant satisfaction with breastfeeding and lactation services was overwhelmingly positive, with most respondents rating services excellent or very good. Ninety percent of infants remained enrolled through 13 months, continuing access to nutrition support. Just 1.4% of families had unissued benefits, below the statewide average of 2.1%, reflecting strong engagement and continuity of services.

"The WIC lactation consultation program has been the most valuable resource for my family. During a painful and overwhelming start to breastfeeding, WIC's compassionate lactation consultants provided immediate support, expert guidance, and essential pumping supplies that truly protected my baby's health and my own well-being." **-WIC Mother**

Emergency Medical Services

Emergency Medical Services

ABOUT THE PROGRAM

The Sacramento County Emergency Medical Services Agency (SCEMSA) is the local EMS agency responsible for planning, implementing, and evaluating Sacramento County's emergency medical services system. SCEMSA works collaboratively with EMS providers, hospitals, fire agencies, and community partners to oversee system coordination, quality improvement, policy development, and innovative programs that improve patient care and outcomes throughout Sacramento County.

- Annual Budget
  - 4,253,251
- Federal Funding
  - 4%
- County Funding
  - 32%
- Fees
  - 64%
- Full Time Equivalents (FTE)
  - 12.0

WHAT WE DID

SCEMSA strengthened Sacramento County's emergency medical services system through extensive stakeholder engagement, quality improvement, policy development, and provider support. The team conducted more than 20 stakeholder meetings and 15 workgroup sessions, reviewed cases and incidents, and coordinated with partner agencies and facilities. SCEMSA also developed and implemented more than 80 policies and protocols while providing ongoing technical assistance to EMS providers and system partners. In addition, the agency issued 2,600 certifications and accreditations, helping maintain a qualified and prepared EMS workforce.

HIGHLIGHTS & OUTCOMES

SCEMSA advanced several initiatives that strengthen emergency response and improve access to appropriate care. A standardized countywide Multi-Casualty Incident (MCI) Plan improved coordination, resource management, and patient tracking during large-scale emergencies. The pre-hospital whole blood program expanded access to early, potentially lifesaving treatment for critically injured patients. The Triage to Alternate Destination (TAD) Program created additional pathways to behavioral health and urgent care services for eligible patients, helping connect residents to the right level of care while preserving emergency department capacity.

Preparing for the Unthinkable: SCEMSA staff attended the California EMS Authority Statewide full-scale emergency preparedness exercise. Staff observed and supported the mass casualty drill which simulated a severe disaster scenario requiring state and regional agencies to handle overwhelming casualties, patient tracking, and medical evacuations.

- 20 — Stakeholder meetings
- 2,600 — Certifications & accreditations issued
- 80 — Policies & protocols implemented

Prevention & Health Services

African American Perinatal Health

ABOUT THE PROGRAM

The African American Perinatal Health (AAPH) program provides culturally responsive home visitation, case management, and care coordination to African American women throughout pregnancy and during their infant's first year of life. Public Health Nurses address health care needs alongside social factors such as housing, income, employment, education, and safety.

Annual Budget
- $483,022

County Funding
- 100%

Full Time Equivalents (FTE)
- 2.0

WHAT WE DID

AAPH served more than 200 pregnant and postpartum clients and received 218 referrals, a 15% increase from the previous fiscal year. Public Health Nurses provided culturally responsive, trauma-informed home visiting; care coordination; developmental screening; and health education. Nurses maintained partnerships with Sacramento Food Bank & Family Services to provide monthly diapers, WIC to coordinate joint home visits and breastfeeding support, and the SCPH Sexual Health Promotion Unit to provide specialized services for pregnant clients and infants affected by syphilis. AAPH nurses also participated in multidisciplinary Black Child Legacy Campaign meetings to coordinate care and community resources.

HIGHLIGHTS & OUTCOMES

All enrolled pregnant clients established prenatal care with an obstetrics provider, and 99% of infants and children were connected to a primary care provider. Among children eligible for developmental assessment, 92% were assessed, with those needing additional support linked to follow-up resources. AAPH maintained 85% client retention and engagement through culturally responsive, trauma-informed care. In addition, 93% of postpartum clients initiated breastfeeding, and 100% of clients identified as needing mental health services were connected to appropriate referrals.

"When my baby was born unexpectedly in an ambulance and rushed to the NICU because he couldn't breathe on his own, I was scared and overwhelmed. My AAPH nurse took the time to explain my baby's condition and answer my questions....Having someone who truly listened, educated, and supported me during one of the hardest moments of my life made all the difference. I am so grateful for the AAPH program and my PHN." **-AAPH client**

200+ Clients served

99% Of infants & children were connected to a primary care provider

100% Of clients needing mental health referrals received one

Black Infant Health

ABOUT THE PROGRAM

The Black Infant Health (BIH) Program is a culturally affirming, empowerment-focused initiative that supports Black pregnant and postpartum women through group sessions and one-on-one guidance. BIH helps participants build life skills, reduce stress, strengthen social support, and improve health outcomes for themselves and their babies.

- Annual Budget
  - $1,942,678
- Federal Funding
  - 16%
- State Funding
  - 84%
- Full Time Equivalents (FTE)
  - 3.8

WHAT WE DID

BIH served 426 mothers and facilitated 10 prenatal and 8 postpartum groups. Staff completed baseline assessments with 95% of participants to identify individual strengths and needs and tailor services accordingly. BIH strengthened community outreach through partnerships with clinics, health systems, WIC, and community organizations. BIH also collaborated with Health Net to promote program enrollment and participated in the statewide Black Joy Parade and a UC Davis research project focused on culturally responsive tobacco and cannabis education and support for Black families.

PHOTO: Proud BIH graduate and her baby.

HIGHLIGHTS & OUTCOMES

BIH exceeded the State's participant service target, achieving 105.9% of the 80% goal and ranking among the top two sites statewide. Participant feedback demonstrated meaningful benefits: 74 survey respondents reported increased knowledge for birth and infant care, stronger social connections, and improved ability to manage stress and maintain stable housing. Partnerships expanded access to breastfeeding education, lactation support, and other resources in trusted community settings. The program's research partnership is also helping inform more meaningful and culturally responsive approaches to tobacco and cannabis prevention and cessation, supporting healthier pregnancies and infants.

A Community of Support: A BIH participant shared that weekly postpartum groups provided a meaningful mental health break, connection with other mothers, and practical stress-management tools. She also expressed deep gratitude for receiving diapers in the sizes her family needed, highlighting how consistent, compassionate support made a meaningful difference for her and her children.

California Children's Services

ABOUT THE PROGRAM

California Children's Services (CCS) has been part of SCPH since 1927, providing children and young adults under age 21 with access to specialized medical care. The program provides diagnostic and treatment services, medical case management, and physical and occupational therapy for children with CCS-eligible medical conditions.

- Annual Budget
  - $13,445,731
- Federal Funding
  - 43%
- State Funding
  - 41%
- County Funding
  - 16%
- Full Time Equivalents (FTE)
  - 66.7

WHAT WE DID

CCS managed care for 8,148 active clients this year. Health Services Coordinators and Medical Case Management Nurses provided ongoing case management, while three Medical Therapy Units (MTUs) delivered physical and occupational therapy to 912 clients. The Bowling Green MTU completed a year-long modernization project, including a temporary relocation during construction.

PHOTO: Members of the Starr King MTU Team.

HIGHLIGHTS & OUTCOMES

CCS maintained access to essential services for children and young adults with complex medical needs, even during a major facility renovation. The updated Bowling Green MTU now offers improved accessibility, additional treatment space, and a dedicated waiting area, creating a better experience for clients and families. The program's new CMAA reimbursement process is expected to provide additional resources that can support future service capacity and staffing. Client feedback remained largely positive, with an overall satisfaction rating of 3.7 out of 5. Survey responses are also helping CCS identify opportunities to improve responsiveness and connect families with resources they need.

Back to School, Safely: When a child's wheelchair brake malfunctioned, preventing him from safely riding the school bus, the CCS Medical Therapy Unit responded immediately. Staff coordinated with the equipment vendor, who repaired the wheelchair the same day. The quick response restored the child's ability to safely return to school and his daily routine.

Chest Clinic/Tuberculosis Control

ABOUT THE PROGRAM

The Chest Clinic/Tuberculosis Control Program combats the spread of tuberculosis (TB) by providing testing, treatment, case management, and community surveillance. The program guides patients with suspected or confirmed tuberculosis disease from evaluation and diagnosis through treatment completion, including medication delivery and direct observation of each dose taken, patient assessments and testing in the home and in clinic, and care for exposed contacts.

- Annual Budget
  - $4,520,556
- Federal Funding
  - 5%
- State Funding
  - 5%
- County Funding
  - 84%
- Fees
  - 6%
- Full Time Equivalents (FTE)
  - 19.0

WHAT WE DID

The Chest Clinic/TB Control program provided comprehensive evaluation, treatment, and case management for patients with TB across the region. The program case-managed 120 patients with active TB in Sacramento County, along with patients in Placer, Sutter, Yolo, and Yuba counties. Chest Clinic physicians and a nurse practitioner completed 3,396 patient visits and evaluated 266 people arriving in Sacramento County from countries outside the U.S. For patients receiving TB treatment, Public Health Nurses provided individualized case management, home visits, medication monitoring, and support to address treatment barriers. The program also provided $112,868 in food, transportation, and isolation housing assistance.

HIGHLIGHTS & OUTCOMES

The program helped protect patients and the broader community by supporting successful TB treatment and preventing transmission. Of eligible TB contacts, 96% completed latent TB treatment to prevent development of active disease, compared with 65% statewide. The program identified and conducted outreach to 100% of contacts exposed to infectious TB cases, reaching 311 individuals compared with 89% statewide. With the highest number of active cases since 2015 (120), nurses helped patients navigate lengthy treatment, manage side effects, maintain isolation when needed, and overcome barriers to care. These efforts helped patients complete treatment while reducing the risk of further spread in the community.

120 Active TB patients received treatment and case management

3,396 Patient visits

100% Of contacts exposed to infectious TB cases received outreach

Child Protective Services Nursing

ABOUT THE PROGRAM

Child Protective Services (CPS) Nursing encompasses Emergency Response (ER) & Informal Supervision (IS), Health Care Program for Children in Foster Care (HCPCFC), and Supportive Health Interventions through Nursing Empowerment (SHINE), all of which work to advance the health, safety, and wellbeing of vulnerable children and youth through nursing assessment, case management, health education, and care coordination across medical and social service systems, ensuring timely access to comprehensive health care.

Annual Budget
- $7,138,765*

Federal Funding
- 71%

State Funding
- 29%

Full Time Equivalents (FTE)
- 29.8**

* Funding also provided via the Dept. of Child, Family, & Adult Services (DCFAS)

** Includes both DHS & DCFAS employees

WHAT WE DID

Public Health Nurses (PHNs) provided care coordination, health assessments, developmental screenings, and referrals to children and youth involved in the foster care and probation systems. The IS program received 120 referrals and provided direct services to 185 children, achieving 100% on-time contact. HCPCFC Permanency PHNs served more than 700 children and youth in out-of-home placement, completing health and education documentation and implementing new state performance measures. Specialized PHNs coordinated care for 222 foster youth receiving psychotropic medications, maintained 94 Health and Education Passports for youth in probation, and trained Social Workers on safe medication monitoring. The SHINE home visiting program served 123 foster/resource parents and children.

PHOTO: SHINE PHNs.

HIGHLIGHTS & OUTCOMES

These programs helped children and youth in foster care and probation receive timely, coordinated health care despite significant barriers to access. PHNs maintained more than 90% timeliness for required medical record reviews and nursing care plans, while probation PHNs achieved 100% timely completion of Health and Education Passports, supporting continuity of care as youth move between placements and services. SHINE generated more than 75 referrals to medical, dental, behavioral health, and insurance resources. Caregiver feedback demonstrated the value of this support, with 91% reporting extreme satisfaction and 100% saying home visits were helpful and meaningful in navigating the health care system.

Childhood Lead Poisoning Prevention

ABOUT THE PROGRAM

The Childhood Lead Poisoning Prevention Program (CLPPP) mission is to prevent and reduce the harmful effects of lead poisoning among Sacramento County's children under six years of age, as well as other high-risk older children through public awareness, education, collaboration, and partnerships.

Annual Budget
- $2,174,717

State Funding
- 100%

Full Time Equivalents (FTE)
- 7.55

WHAT WE DID IN FY25-26

CLPPP expanded outreach, education, and case management to reduce lead exposure and support affected families. Staff distributed more than 15,000 educational materials, engaged 944 families through community events and outreach, and reached nearly 33,000 people through a spring media campaign. The program also trained medical providers, community partners, and code enforcement staff while conducting 41 lead hazard investigations. Comprehensive case management, education, developmental screening, and follow-up services ensured children and families received timely support and resources.

PHOTO: Spring 2026 media campaign.

HIGHLIGHTS & OUTCOMES

CLPPP strengthened care coordination and improved outcomes for children through enhanced case management and stronger provider engagement. A revised provider reminder letter increased provider responses by 200%, improving follow-up for children needing blood lead testing. The program provided timely services for 100% of state-assigned cases, achieved 100% family satisfaction with Public Health Nurse services, and prevented many potential cases from escalating through early intervention. In addition, 98% of investigated properties were cleared of lead hazards, while workforce and provider training increased knowledge and strengthened the community's capacity to prevent childhood lead exposure.

"Having a Public Health Nurse involved helped me understand what the lab results meant and what I needed to do next for my child's health." **-CLPPP client**

Communicable Disease Control

ABOUT THE PROGRAM

Communicable Disease Control (CD) stops the spread of disease in the community by responding to more than 90 types of diseases and conditions of public health concern, investigating the source, following up on exposed contacts, coordinating laboratory testing, educating the community, providing technical guidance on prevention and control measures, and assisting in outbreak investigations.

- **Annual Budget**
  - $2,370,538
- **State Funding**
  - 34%
- **County Funding**
  - 66%
- **Full Time Equivalents (FTE)**
  - 11.5

WHAT WE DID

CD investigated 2,953 disease reports covering 96 reportable diseases and conditions. Staff conducted case investigations, contact tracing, and disease monitoring, including responses to measles, hantavirus, Ebola, multidrug-resistant organisms (MDROs), rabies exposures, and poisonous wild mushroom illnesses. The program collaborated with health care providers, schools, public health agencies, and community partners, delivered targeted trainings, conducted skilled nursing facility site visits, and developed multilingual educational materials to strengthen disease prevention and outbreak preparedness.

PHOTO: CD and Animal Care Services staff.

HIGHLIGHTS & OUTCOMES

CD successfully contained a local measles outbreak through rapid case investigation, monitoring of more than 100 exposed individuals, and coordinated action with health care providers and community partners. Proactive monitoring of travelers, infection prevention efforts in health care facilities, and expanded education on rabies and poisonous mushrooms reduced the risk of disease transmission and illness. These coordinated public health actions strengthened regional preparedness, improved infection prevention practices, and helped protect Sacramento County residents from infectious diseases.

- **2,953** Disease reports investigated
- **96** Different diseases investigated
- **100+** Measles-exposed individuals monitored

Community Nursing

ABOUT THE PROGRAM

The Community Nursing Program deploys Public Health Nurses (PHNs) to provide in-home assessments, education, and interventions to support high-risk children and families in underinvested communities. By addressing medical, social, and environmental needs directly where people live, it aims to improve health outcomes and reduce disparities.

- Annual Budget
  - $2,900,414
- Federal Funding
  - 51%
- State Funding
  - 49%
- Full Time Equivalents (FTE)
  - 9.0

WHAT WE DID

Community Nursing provided intensive home visiting and family support services to 645 families, serving 1,281 individuals through 739 home visits. Staff conducted screenings for perinatal mood and anxiety disorders, child development, and alcohol and other drug (AOD) concerns, making 979 referrals to health care, behavioral health, developmental, and social service providers. Families received education, care coordination, and ongoing support to connect them with services that promote healthy pregnancies, child development, and family well-being.

HIGHLIGHTS & OUTCOMES

Early screening and timely referrals helped connect families with the care they needed. All women identified with possible perinatal mood or anxiety disorders, all children with developmental delays, and all caregivers reporting AOD concerns were referred for appropriate services. Families demonstrated strong engagement, with 899 reported follow-throughs on recommended referrals, including primary care, obstetric, behavioral health, developmental, and social services. These efforts strengthened access to care, supported early intervention, and improved outcomes for children and families.

Connecting A Familiy: A recently immigrated single father struggled to care for his three daughters while navigating language barriers, financial hardship, and an unfamiliar health care system. A CN Public Health Nurse coordinated pediatric care, connected the children to required immunizations, and secured specialized daycare for the youngest daughter with complex medical needs. As a result, the older siblings were able to return to school, the father could continue working, and the family gained the tools and confidence to successfully access health care, education, and community resources.

1,281 Individuals served through home visits

100% Of clients received tailored service referrals

739 Home visits

HIV Care Services

ABOUT THE PROGRAM

The HIV Care Services Program provides essential medical care, support services, and coordinated systems of care for people living with HIV who lack adequate health insurance or other resources.

- Annual Budget
  - $8,766,649
- Federal Funding
  - 85%
- State Funding
  - 15%
- Full Time Equivalents (FTE)
  - 7.0

WHAT WE DID

The program provided coordinated medical and supportive services through a network of nine community-based organizations, serving 2,283 unduplicated clients, including 274 people new to the program. The program completed a competitive Ryan White Part A and B funding process, adding a new service provider and establishing three new service categories this year. Through Ending the HIV Epidemic (EHE) funding, the program also expanded partnerships with community organizations and County programs to better serve older adults. These efforts broadened access to HIV services, strengthened the local continuum of care, and supported targeted outreach to communities disproportionately affected by HIV.

HIGHLIGHTS & OUTCOMES

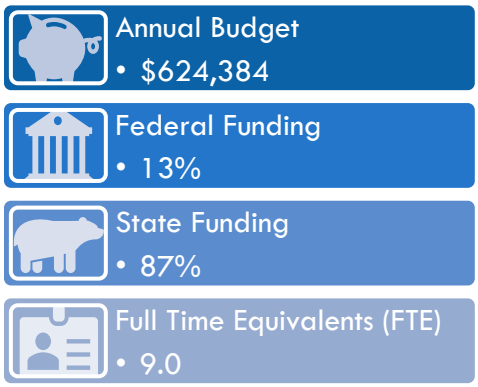
The program helped 89.31% of clients achieve viral suppression, supporting better health outcomes while reducing the likelihood of HIV transmission. Client enrollment grew from 2,187 to 2,283, demonstrating continued engagement and reach. Outreach and services were particularly successful in connecting and retaining populations disproportionately affected by HIV, including African American and Hispanic communities. EHE funding expanded access for older adults living with HIV, creating opportunities to address isolation, stigma, and unique aging-related needs. The program's broader eligibility through EHE funding enabled more people in the Sacramento region to access HIV services, regardless of income or residency requirements.

A Path to Stability: After more than 60 days hospitalized following a new HIV diagnosis, a patient faced medical, housing, and personal challenges. Upon discharge, coordinated case management secured emergency lodging and continued housing support, allowing the patient to focus on recovery and reconnect with care. Today, the patient remains engaged in medical treatment while working toward long-term housing stability and improved well-being.

- **2,283** — HIV-positive clients served
- **89.31%** — Viral suppression rate
- **9** — Funded organizations serving the community

HIV/STD Surveillance & HEART

ABOUT THE PROGRAM



HIV/STD Surveillance aims to accurately detect, report, monitor, and prevent HIV/STD cases in Sacramento County by providing education, treatment recommendations, efficient and enhanced case management, patient outreach, and coordination to improve health outcomes for cases and exposed contacts. The HIV Early Action Response Team (HEART) is a multidisciplinary team composed of members from each program of the Sexual Health Promotion Unit, whose focus is to provide comprehensive disease response and care to those living with HIV in Sacramento County.

WHAT WE DID

Program staff investigated 2,571 syphilis incidents, including 68 congenital syphilis cases, as well as 62 pregnant chlamydia cases, 18 pregnant gonorrhea cases, and 344 HIV incidents. Staff completed 1,444 chlamydia and gonorrhea surveys and referred 25 pregnant patients with syphilis to Maternal, Child, and Adolescent Health (MCAH) for enhanced case management. Surveillance staff prioritized rapid follow-up, assigning 91% of high-priority syphilis cases within two business days. The program also strengthened treatment verification, partner notification, and linkage to medical care and supportive resources through collaboration with health care providers, MCAH, and community organizations.

HIGHLIGHTS & OUTCOMES

Surveillance and case investigation efforts helped connect residents to timely treatment and care while reducing the spread and impact of sexually transmitted infections. Ninety-five percent of primary and secondary syphilis cases were closed with verified treatment, while 74% of pregnant syphilis cases had verified treatment. Reported congenital syphilis cases declined 27%, from 18 to 13, supporting healthier starts for newborns. HIV linkage efforts also contributed to 83% of people living with HIV in Sacramento County being in care, compared with 76% statewide. Together, these efforts strengthened early intervention, treatment, and continuity of care across the community.

Partners in Prevention: SHPU partnered with MCAH and Sunburst Projects to provide enhanced case management and practical support, including transportation, housing, home visits, and other services, to pregnant individuals with syphilis. Since the collaboration began in 2022, congenital syphilis cases have declined 38%.

HIV/STI Prevention & W3

ABOUT THE PROGRAM

The HIV/STI Prevention Program provides community based STI/HIV education, prevention, testing and linkage/reengagement to care services in partnership with community-based organizations serving people most at risk for HIV and STI acquisition and transmission. Wellness Without Walls (W3) provides mobile primary and STI health services among populations, including the unhoused, who have barriers accessing services in other health care settings.

- Annual Budget
  - $1,855,175
- Federal Funding
  - 57%
- State Funding
  - 43%
- Full Time Equivalents (FTE)
  - 10.0

WHAT WE DID

The HIV/STI Prevention Program expanded access to HIV and STI prevention, testing, and linkage services through County staff and community-based partners. Partners distributed 70,433 external condoms, 3,303 internal condoms, 4,724 dental dams, and 39,618 units of lubricant. Together, they conducted 10,284 HIV, HCV, syphilis, gonorrhea, and chlamydia tests across Sacramento County, including services through the W3 mobile clinic. The program also strengthened its community network by adding Sierra Foothills AIDS Foundation as a testing partner and Golden Rule Services as a PrEP provider, expanding opportunities for prevention and care among populations at increased risk.

HIGHLIGHTS & OUTCOMES

Prevention and linkage efforts helped more people access testing, prevention, and HIV care. The Linkage to Care Coordinator engaged 13 people newly diagnosed with HIV and successfully connected 10 to care, while all newly diagnosed clients were contacted within 24 hours. Targeted outreach also helped 42 people living with HIV re-engage in care. Of 271 people screened for PrEP, 240 were eligible, 234 were referred to prescribers, and 177 initiated PrEP. These efforts strengthened pathways to prevention and treatment while addressing barriers such as transportation, insurance, and navigating complex health care systems.

Connecting Prevention to Care: A client concerned about HIV exposure after his partner lost insurance was confirmed HIV-negative and quickly connected to PrEP, receiving his first injections within a week. His partner was also connected to Ryan White services to maintain uninterrupted HIV treatment.

- 10,284 — STI tests performed
- 177 — Patients initiated PrEP
- 73,736 — Condoms distributed

Immunization Assistance

ABOUT THE PROGRAM

The Immunization Assistance Program (IAP) works to improve community health by increasing access to recommended vaccines, reducing barriers to immunization, and promoting vaccine coverage for Sacramento County residents. Through partnerships with schools, health care providers, and community organizations, IAP supports immunization education, provider outreach, quality improvement, outbreak response, and disease prevention efforts to reduce the burden of vaccine-preventable illness.

- Annual Budget
  - $1,660,227
- Federal Funding
  - 24%
- State Funding
  - 62%
- County Funding
  - 14%
- Full Time Equivalents (FTE)
  - 8.8

WHAT WE DID

IAP expanded access to vaccines, bringing services directly into communities where barriers to care can be greatest. Partnerships with schools, health care providers, community organizations, and emergency response agencies supported vaccination for children, unhoused residents, older adults, young adults, and 62 farm workers. During the Spring 2026 measles outbreak, staff provided post-exposure prophylaxis and supported disease-control efforts, helping prevent further transmission. Mobile and school-based clinics also helped students meet immunization requirements and remain in school.

PHOTO: The IAP Team.

HIGHLIGHTS & OUTCOMES

IAP completed immunization reporting and assessments for 758 schools and maintained communication with schools through 1,265 emails and phone contacts. Across 81 community clinics, IAP served 1,386 patients and administered 2,816 vaccine doses through safety-net, school-based, flu, unhoused pediatric, HPV, and special clinics. Staff also conducted perinatal hepatitis B outreach, provided provider and community education, and supported HPV vaccination initiatives. Patient feedback reflected strong service quality, with 100% of surveyed patients reporting extreme satisfaction, having all their questions answered, and receiving information about their vaccines.

"I bring my grandbabies here because you all are the best." **-IAP client**

Nurse Family Partnership

ABOUT THE PROGRAM

The Nurse-Family Partnership (NFP) is a proven, community-driven health program backed by 45 years of research, demonstrating remarkable improvements in the well-being and futures of parents and their children, especially those facing social and economic challenges. The program features both the traditional NFP model and the newly introduced NFPx initiative, which expands eligibility to reach more families within the community.

- Annual Budget
  - $4,519,482
- Federal Funding
  - 28%
- State Funding
  - 72%
- Full Time Equivalents (FTE)
  - 11.4

WHAT WE DID

NFP provided intensive, nurse-led home visitation and support to 299 pregnant individuals and their families, with 75 babies born during the year. Public Health Nurses completed more than 2,250 home visits, bringing clinical care, health education, and parenting support directly to families' homes.

PHOTO: NFP graduation celebration.

The program received more than 330 referrals and made over 3,000 referrals to external health care, social service, and community resources to address families' needs. In addition, 54 participants completed the NFP program, a 2.5-year intervention designed to support families throughout pregnancy and their children's early years.

HIGHLIGHTS & OUTCOMES

NFP expanded access by opening enrollment to all pregnant individuals, regardless of parity or gestation. More than 30 families who previously would not have qualified were enrolled through this expansion. Families experienced strong health outcomes, with 97% of newborns achieving a healthy birth weight and 95% born full-term. More than 90% of pregnant participants began prenatal care in the first trimester, while 99% of infants and children were connected to a primary care provider. All enrolled infants received developmental screening at 10 months, and over 97% of participants initiated breastfeeding following the birth of their infant.

"It truly takes a village, and you were a central part of our village the last 2.5 years. Even in some of my darkest moments in pregnancy, I knew you were looking out for me and baby… You were empathetic, optimistic, helpful and so kind the whole time." **-NFP client**

Oral Health

ABOUT THE PROGRAM

The Oral Health Program works to promote oral health through collaboration, education, prevention, and advocacy. The program strives to reduce health disparities and improve quality of life by addressing the social, environmental, and behavioral factors that influence oral health.

Annual Budget
- $728,984

State Funding
- 100%

Full Time Equivalents (FTE)
- 2.6

WHAT WE DID

PHOTO: Oral Health Program staff at a school assembly.

The Oral Health Program expanded oral health education, prevention, and care coordination through community outreach and partnerships. Staff attended 10 community events, engaged 2,161 families, and delivered 22 trainings to 353 participants. The program distributed 3,324 oral health kits and reached 17 providers with the Oral Health Champion Toolkit. Staff provided early prevention programming to 70 preschool classrooms and connected five school districts with school-based dental providers. The program also hosted the three-session Kindergarten Oral Health Assessment (KOHA) Success Series with 102 statewide participants and launched a remote KOHA tele-dentistry pilot in partnership with California Northstate University.

HIGHLIGHTS & OUTCOMES

The Oral Health Program expanded access to preventive services and strengthened systems that connect children and families to dental care. County KOHA reporting increased from 55% to 67.6%, nearly double the 35% state benchmark, helping more students receive screenings and referrals. Two school districts expanded access through remote KOHA screenings, reaching children who might otherwise lack dental assessments. The Dental Provider Resource Map made it easier for families to find Medi-Cal-accepting dentists. Training also strengthened providers' ability to integrate oral health into primary care, while community education helped children and families build healthier daily habits.

3,324 Oral health kits distributed

2,161 Families engaged

70 Preschool classes reached

Perinatal Equity Initiative

ABOUT THE PROGRAM

Annual Budget
- $664,016

State Funding
- 100%

Full Time Equivalents (FTE)
- 1.3

The Perinatal Equity Initiative (PEI) is a community-driven effort to reduce racial disparities in infant mortality by connecting Black families with meaningful support and resources. Although infant mortality is declining statewide, Black infants continue to experience mortality rates two to four times higher than other groups. PEI complements the Black Infant Health Program by strengthening community partnerships, expanding support, and improving health outcomes for Black families.

PHOTO: Statewide PEI meeting in Sacramento.

WHAT WE DID

Through the Perinatal Equity Initiative, Black Fathers Inc. served more than 65 fathers during the first three quarters of FY 2025-26 and hosted 15 Funky Fresh Friday events focused on supporting fathers and families. The initiative also awarded $27,846 in midwifery scholarships to support students pursuing midwifery education and training. Four Community Advisory Board meetings brought together community leaders, health care providers, stakeholders, and families to discuss maternal and infant health priorities. The Black Fathers Inc. team also presented at the 27th International Families & Fathers Conference in Los Angeles.

HIGHLIGHTS & OUTCOMES

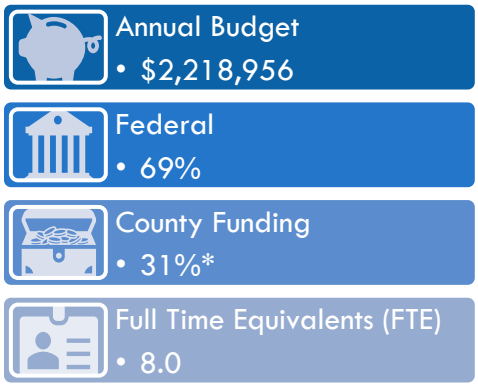
PEI strengthened support for Black fathers and families during pregnancy and the postpartum period. Ninety percent of surveyed fathers reported satisfaction with the fatherhood program, and all fathers who completed the program reported feeling more confident and prepared for their role during childbirth and postpartum. Participants also received connections to employment and job training opportunities, supporting economic stability. The UnequalBirth.com awareness campaign reached audiences effectively, with organic search users demonstrating a 75% engagement rate. The midwifery scholarship program also helped expand the future maternal health workforce by reducing financial barriers for students pursuing midwifery careers.

Advancing Midwifery: Sacramento County partnered with Alameda and Santa Clara Counties to participate in strategic panel discussions aimed at expanding access to midwifery care. These cross-county collaborations strengthen collective awareness of birth disparities and drive coordinated action toward meaningful change.

Senior & Adult Services Nursing

ABOUT THE PROGRAM

Senior and Adult Services (SAS) Nursing works to improve the well-being of Adult Protective Services (APS) and In Home Supportive Services (IHSS) clients through health assessments, expert consultation, collaboration with partners, and management of preventive care and specialized health care for seniors and disabled adults in our community.



* Dept. of Child, Family, & Adult Services

WHAT WE DID

SAS Nursing received 1,280 IHSS referrals and 238 APS referrals, including 164 home visit referrals. Public Health Nurses (PHNs) also provided 1,478 consultations for IHSS and 574 consultations for APS, developing individualized care plans based on each client's needs and circumstances. To strengthen the skills and knowledge of partners and staff, PHNs also conducted 17 professional development training sessions. PHNs initiated contact within seven days of receiving a referral.

HIGHLIGHTS & OUTCOMES

SAS Nursing helped vulnerable adults remain safely in their homes while addressing health and safety needs that could otherwise lead to more restrictive care. Among active APS cases successfully closed following referrals, 85% of clients achieved stable living situations and were able to avoid placement in a skilled nursing facility. PHNs effectively addressed the needs of 99% of IHSS recipients served, helping clients access appropriate support and resources. Through timely assessments, individualized care plans, and coordination with IHSS and APS partners, PHNs helped improve clients' ability to remain safely and independently in their homes.

Connecting Care and Support: APS and Public Health Nursing worked together to support an older adult living alone with complex medical needs, no income or medical coverage, and significant barriers to care. Through thoughtful coordination with health care and community partners, the team helped connect the individual to needed medical services and CalAIM supports, ultimately facilitating placement in an assisted living facility where they could receive the ongoing care and support they needed.

2,052 Consultations provided

85% Of IHSS clients achieved stable living situations

99% Of IHSS recipients had their needs met

Sexual Health Clinic

ABOUT THE PROGRAM

The Sexual Health Clinic (SHC) provides comprehensive, inclusive, evidence-based and client-centered STI/HIV and family planning care in a safe and non-judgmental space.

- **Annual Budget**
  - $2,939,000
- **Federal Funding**
  - 95%
- **County Funding**
  - 5%
- **Full Time Equivalents (FTE)**
  - 15.0

WHAT WE DID

SHC provided comprehensive sexual and reproductive health services to 1,243 patients through 3,147 visits. Clinical services included 4,779 gonorrhea/chlamydia tests, 1,607 syphilis tests, 1,828 HIV tests, and 58 mpox tests. The clinic expanded access through telehealth, introduced long-acting injectable lenacapavir for HIV prevention, and expanded Family PACT services to include long-acting reversible contraception. HIV case management, STI surveillance, mobile medicine, and partnerships with community-based organizations supported identification and linkage of individuals to medical, behavioral health, and supportive services.

PHOTO: The Sexual Health Clinic Team.

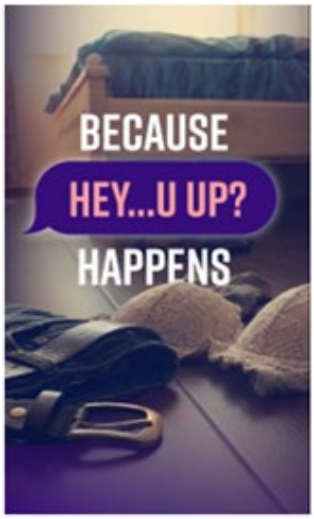
HIGHLIGHTS & OUTCOMES

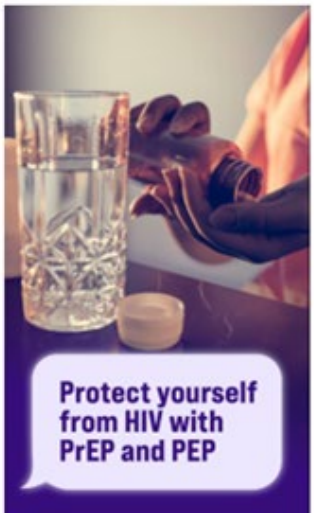
SHC expanded access to HIV care and prevention while strengthening connections to comprehensive services. The HIV caseload increased 27%, from 150 to 190 patients, reflecting improved identification and linkage to care through community partnerships and targeted outreach. Of those receiving HIV care, 83% were taking antiretroviral therapy, supporting treatment continuity and improved health outcomes. Patients also reported positive experiences, with 80% indicating they were satisfied or very satisfied with the quality of medical care. Expanded telehealth, PrEP options, and reproductive health services gave patients more choices for accessing convenient, comprehensive, and preventive care.

Expanding Access Through Telehealth: By integrating telehealth into our electronic health record, the Sexual Health Clinic expanded access to follow-up care, strengthened medication adherence, and helped prevent interruptions in treatment. This makes patient-centered care more accessible and responsive for people facing barriers to in-person visits.

Like, Share, Protect

CONNECTING WITH OUR COMMUNITY, ONE POST AT A TIME





PrEP Awareness Campaign

Four-week Meta campaign to increase awareness of PrEP and PEP services, promote accessible sexual health resources, and reach communities with historically lower PrEP utilization.

Post Copy: With migration season in swing, know the risks and how to stay safe.

Bird Flu Campaign

Public Health Emergency Preparedness (PHEP) and Communicable Disease Control partnered on a campaign to educate residents about bird flu and ways to protect themselves.

Lead Poisoning Prevention Campaign

Social media ads to raise awareness of lead poisoning prevention, promote resources for families, and connect residents with information to reduce lead exposure.

@SacCounty

@SacCountyCA

Sacramento County Public Health