February 16, 2023

TO: Legal Counsel

News Media
Salinas Californian
El Sol
Monterey County Herald
Monterey County Weekly
KION-TV
KSBW-TV/ABC Central Coast
KSMS/Entravision-TV

The next regular meeting of the **COMMUNITY ADVOCACY COMMITTEE - COMMITTEE OF THE WHOLE** of the Salinas Valley Memorial Healthcare System will be held **TUESDAY, FEBRUARY 21, 2023, AT 8:30 A.M., IN THE DOWNING RESOURCE CENTER, CEO CONFERENCE ROOM 117, IN SALINAS VALLEY MEMORIAL HOSPITAL, 450 E. ROMIE LANE, SALINAS, CALIFORNIA, OR VIA TELECONFERENCE (Visit svmh.com/virtualboardmeeting for Access Information)**.

Pursuant to SVMHS Board Resolution No. 2023-01, Assembly Bill 361, and guidance from the Monterey County Health Department in response to concerns regarding COVID-19, Board Members of Salinas Valley Memorial Healthcare System, a local health care district, are permitted to participate in this duly noticed public meeting via teleconference and certain requirements of The Brown Act are suspended.

Pete Delgado
President/Chief Executive Officer

Committee Members: Rolando Cabrera, MD, Chair; Joel Hernandez Laguna; Pete Delgado, President/CEO; Theodore Kaczmar, Jr., MD, Chief of Staff; Allen Radner, MD, CMO; Lisa Paulo, CNO; Adrienne Laurent, Chief Strategic Communications Officer; David E. Ramos, MD, Medical Staff Member; Julie Edgcomb, Community Member; Harald Barkhoff, Ph.D., Community Member

COMMUNITY ADVOCACY COMMITTEE
FEBRUARY 2023 - COMMITTEE OF THE WHOLE
SALINAS VALLEY MEMORIAL HEALTHCARE SYSTEM

TUESDAY, FEBRUARY 21, 2023, 8:30 A.M.
DOWNING RESOURCE CENTER, CEO CONFERENCE ROOM 117

Salinas Valley Memorial Healthcare System
450 E. Romie Lane, Salinas, Calfornia 93901
via Teleconference
(Visit svmh.com/virtualboardmeeting for Access Information)

Pursuant to SVMHS Board Resolution No. 2023-01, Assembly Bill 361, and guidance from the Monterey County Health Department in response to concerns regarding COVID-19, Board Members of Salinas Valley Memorial Healthcare System, a local health care district, are permitted to participate in this duly noticed public meeting via teleconference and certain requirements of The Brown Act are suspended.

AGENDA

1. Call to Order / Roll Call

2. Approve Minutes of the Community Advocacy Committee Meeting of November 15, 2022 (DELGADO)
   - Motion/Second
   - Action by Committee/Roll Call Vote

3. Consider Recommendation for Board Approval of 2022 Community Health Needs Assessment and Salinas Valley Memorial Healthcare System Implementation Strategy (DELGADO/LAURENT)
   - Staff Report
   - Committee Questions to Staff
   - Public Comment
   - Committee Discussion/Deliberation
   - Motion/Second
   - Action by Committee/Roll Call Vote

4. Blue Zones Project: California Department of Food and Agriculture Grant (LAURENT/DITULLIO)

5. Report from the Salinas Valley Memorial Hospital Service League (LAURENT/GRAHAM)

6. Report from the Salinas Valley Memorial Hospital Foundation (DELGADO/WARDWELL)

7. Public Input

   This opportunity is provided for members of the public to make a brief statement, not to exceed three (3) minutes, on issues or concerns within the jurisdiction of this District Board which are not otherwise covered under an item on this agenda.

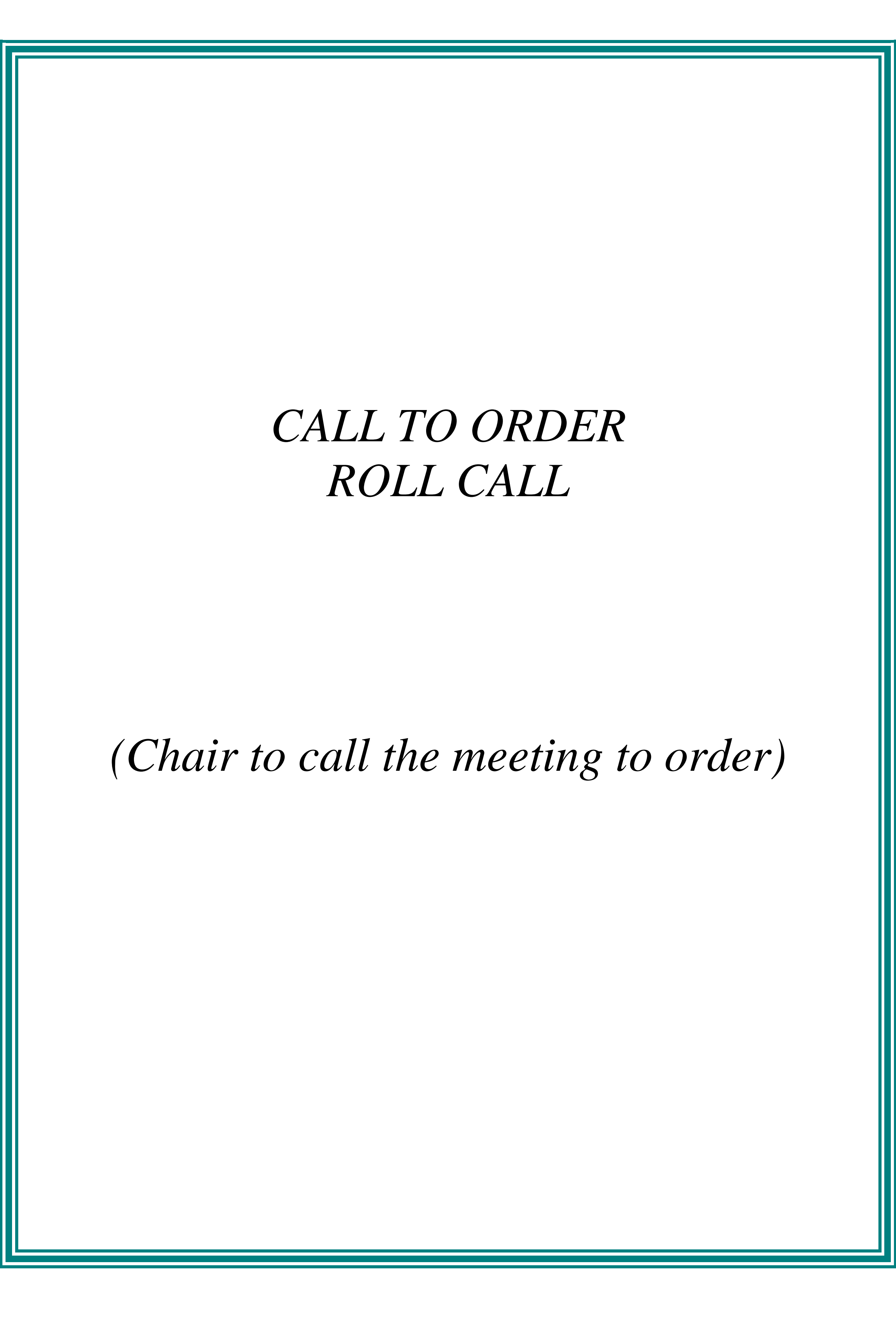
8. Adjournment

   The Community Advocacy Committee meets quarterly and the next meeting is scheduled for **Tuesday, May 23, 2023, at 8:30 a.m.**

This Committee meeting may be attended by Board Members who do not sit on this Committee. In the event that a quorum of the entire Board is present, this Committee shall act as a Committee of the Whole. In either case, any item acted upon by the Committee or the Committee of the Whole will require consideration and action by the full Board of Directors as a prerequisite to its legal enactment.

The Committee packet is available at the Committee Meeting, at www.svmh.com, and in the Human Resources Department of the District. All items appearing on the agenda are subject to action by the Committee.

Requests for a disability related modification or accommodation, including auxiliary aids or services, in order to attend or participate in a meeting should be made to the Board Clerk during regular business hours at 831-755-0741. Notification received 48 hours before the meeting will enable the District to make reasonable accommodations.



CALL TO ORDER
ROLL CALL

(Chair to call the meeting to order)

SALINAS VALLEY MEMORIAL HEALTHCARE SYSTEM
COMMUNITY ADVOCACY COMMITTEE MEETING
COMMITTEE OF THE WHOLE
MEETING MINUTES
NOVEMBER 15, 2022

Pursuant to SVMHS Board Resolution No. 2022-16, Assembly Bill 361, and guidance from the Monterey County Health Department in response to concerns regarding COVID-19, Board Members of Salinas Valley Memorial Healthcare System, a local health care district, are permitted to participate in this duly noticed public meeting via teleconference and certain requirements of The Brown Act are suspended.

The Community Advocacy Committee convened at 8:32 a.m. in the Downing Resource Center, CEO Conference Room 117.

Committee Members Present:
In person: Harald Barkhoff, Ph.D., Adrienne Laurent, Lisa Paulo, David Ramos, MD., and Regina Gage
Via teleconference: Joel Hernandez Laguna.

Committee Members Absent:
Pete Delgado, Julie Edgcomb, Theodore Kaczmar, MD, Allen Radner, MD.

Other Board Members Present, Constituting Committee of the Whole:
Victor Rey (via teleconference)

Victory Rey joined the meeting at 8:40 a.m.

A quorum was present and Chair Gage called the meeting to order at 8:32 a.m.

APPROVE MINUTES OF THE COMMUNITY ADVOCACY COMMITTEE MEETING OF AUGUST 23, 2022

Approve the minutes of the Community Advocacy Committee meeting of August 23, 2022. This information was included in the Committee packet.

No public comment.

MOTION:
Upon motion by Committee member Laurent, second by Committee member Barkoff, the minutes of March 22, 2022 of the Community Advocacy Committee were approved, as presented.

Ayes: Barkhoff, Hernandez Laguna, Laurent, Paulo, Ramos, and Chair Gage; Noes: None; Abstentions: None; Absent: Committee members: Delgado, Edgcomb, Kaczmar, and Radner, MD. Motion Carried.

MOBILE CLINIC UPDATE

Dr. Orlando Rodriguez, Mobile Health Clinic Medical Director, and Lynette Fitzgerald, Mobile Clinic Manager, provided a Mobile Clinic Update with the following highlights. The mobile clinic's current schedule is Sunday – Thursday. There was 10,345 total patient visits: 1,373 in 2020; 3,635 in 2021; and

5,337 in 2022 (YTD). Over 200 doses of the Flu Vaccine were administered in one month. The Mobile Clinic is now collaborating with Hartnell College Nursing and Health Sciences. There was a $10,000 donation to Operation Smiles to share holiday cheer with underserved families.

Committee member Hernandez Laguna thanked everyone that is making this possible and further added that it is very important to capture the data.

HONORING OUR VETERANS

Adrienne Laurent, Chief Communication Officer, reported that the hospital system will undergo a name change and ways to honor our veterans are being explored.

REPORT FROM THE SALINAS VALLEY MEMORIAL HOSPITAL SERVICE LEAGUE

Shannon Graham, MM/PA, CAVS, Director Volunteer & Health Career Services, announced that the Salinas Valley Memorial Hospital Service League is celebrating their 70th anniversary (1952-2022).
At their October 18, 2022 Fall General meeting they elected the 2023-24 Board. Twenty-two volunteers were recognized for their years of service milestones (5-25 years). Celebrated 49 hours plateaus 100-8,700 hours.

Strategic Goals
- Increase number of active & engaged volunteers
- Maintain & Increase Financial Stability
- Improve Volunteer Experience
- Grow Service Areas
- Refine & Implement Leadership Strategy

Health Career Services
The Explorer program is growing. The first meeting of the year, room was set for 20ish students and had over 30 students register. Meetings are now being scheduled in Cislini Plaza 4 to accommodate increased participation.

Health Explorers Meetings 5:30-7pm Cislini Plaza 4
- September: Margaret D'Arrigo-Martin, AIM Mental Health
- October: Student Alumni Panel
- November: Dr. Semer, Palliative Medicine and Plastic Surgery
- December: Holiday Event
- January: Blue Zones Purpose Workshop

Summer Health Institute
- Applications start February for April Selection & June-July program

REPORT FROM THE SALINAS VALLEY MEMORIAL HOSPITAL FOUNDATION

Jeff Wardwell, Chief Philanthropy Officer, and Melissa Gross, Director of Strategic Development, presented a report of the Salinas Valley Memorial Hospital Foundation. Children's Miracle Network awarded nine individual grants for pediatric medical needs. For FY 2023 Quarter 1, there was nine grants

in the amount of $8,190.62. The Grants were for generators, hearing aids, Prenatal Loss Cremations, adaptive gripping device, and special needs bodysuits.

Patient Assistance
FY 2023 Q1 242 individual Grants 20,324.65

Type of Assistance	
Equipment Treatment	40%
Gas Cards	26%
Basic Needs	24%
Food Assistance	10%

Referral Source	
SVMC	42%
SVMHS	17%
CRC	17%
Mobile Clinic	16%
Palliative	8%

Monterey County Gives! November 10 – December 31, 2022
Year-end appeal will support the expansion of behavioral health services for adults and children across Monterey County. Donations received through MCGives will receive a partial, pro-rated match.
Challenge Gifts Received $9,250

The Foundation received a $250k grant from Monterey Peninsula Foundation to improve the access to behavioral health services for Monterey County, and a $25K grant for addressing food insecurity amount patients and families.

Adopt-A-Family is new this year. Staff will nominate patient families. Donations will be solicited primarily internally. This will formalize a process that has been happening unofficially for many years across many departments.

PUBLIC INPUT

No public comment received.

ADJOURNMENT

There being no other business, the meeting was adjourned at 9:13 a.m. The Community Advocacy Committee meets quarterly.

ATTEST:

____
Joel Hernandez Laguna, Member
Community Advocacy Committee
/es

Board Paper: Community Advocacy Committee

Agenda Item:	Consider Recommendation for Board Adoption of 2022 Community Health Needs Assessment and Salinas Valley Memorial Healthcare System Implementation Strategy
Executive Sponsor:	Adrienne Laurent
Date:	February 13, 2023

Executive Summary

Salinas Valley Memorial Healthcare System in collaboration with the other three hospitals in Monterey County, the United Way, the Monterey County Health Department, and the Hospital Council of Northern California, formed the Monterey County Health Needs Collaborative. The initial purpose of this collaborative group was to complete a Community Health Needs Assessment (CHNA), which is the culmination of months of research into the pressing health needs of our community.

In addition to the CHNA, Salinas Valley Memorial Healthcare System has created an Implementation Strategy - our plan to address community health issues described in the CHNA. Both of these documents are attached.

Background/Situation/Rationale

In order to comply with IRS regulations and maintain our non-profit status, every three years Salinas Valley Memorial Healthcare System is required to document our community benefit activities in a Community Health Needs Assessment and an accompanying Implementation Strategy. While this activity fulfills the requirements of the federal government, we find its true value to be far greater. The information contained in the CHNA is vital in meeting the mission of our organization to provide quality healthcare to our patients, and to improve the health and wellbeing of our community.

Timeline/Review Process to Date:

September, 2021: First discussions with the Hospital Council regarding a collaborative approach to the CHNA, leading to the creation of the Monterey County Health Needs Collaborative
November, 2021: Engagement of PRC, healthcare research firm
January, 2022: Engagement of Actionable Insights for strategy development for Implementation Strategy
October, 2022: Public release of the Community Health Needs Assessment

Meeting our Mission, Vision, Goals

Beyond the governmental requirement to complete a CHNA and Implementation Strategy, Salinas Valley Memorial Healthcare System's strategic planning process and community funding priorities will be informed by its CHNA.

Pillar/Goal Alignment:

☐Service ☐People ☐Quality ☐Finance ☐Growth ☒Community

Financial/Quality/Safety/Regulatory Implications

This document is a requirement of the Internal Revenue Service.

Recommendation

Consider recommendation for board adoption of the 2022 CHNA and Implementation Strategy.

Attachments

Community Health Needs Assessment
Salinas Valley Memorial Implementation Strategy Report

2022 COMMUNITY HEALTH NEEDS ASSESSMENT

Salinas Valley Memorial Hospital Service Area
Monterey County, California

Sponsored by

Salinas Valley Memorial Hospital

In collaboration with

Monterey County Health Needs Collaborative

- Community Hospital of the Monterey Peninsula
- Salinas Valley Memorial Hospital
- Mee Memorial Healthcare System
- Monterey County Health Department
- Natividad
- United Way Monterey County

With coordination from

Hospital Council of Northern & Central California

© September 2022
2022-1809-02

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INTRODUCTION

PROJECT OVERVIEW

This Community Health Needs Assessment is a systematic, data-driven approach to determining the health status, behaviors, and needs of residents in the service area of Salinas Valley Memorial Hospital. Subsequently, this information may be used to inform decisions and guide efforts to improve community health and wellness.

A Community Health Needs Assessment provides information so that communities may identify issues of greatest concern and decide to commit resources to those areas, thereby making the greatest possible impact on community health status.

This report was prepared for Salinas Valley Memorial Hospital by PRC, a nationally recognized health care consulting firm with extensive experience conducting Community Health Needs Assessments in hundreds of communities across the United States since 1994. The data presented in this report was collected as part of a broader, countywide assessment sponsored by the Monterey County Health Needs Collaborative and facilitated by the Hospital Council of Northern and Central California.

> This report, as well as those produced for the county and other individual partners of the Collaborative, are available at www.healthymontereycounty.org.

Methodology

This assessment incorporates data from multiple sources, including primary research (through the PRC Community Health Survey and PRC Online Key Informant Survey), as well as secondary research (vital statistics and other existing health-related data). It also allows for trending and comparison to benchmark data at the state and national levels.

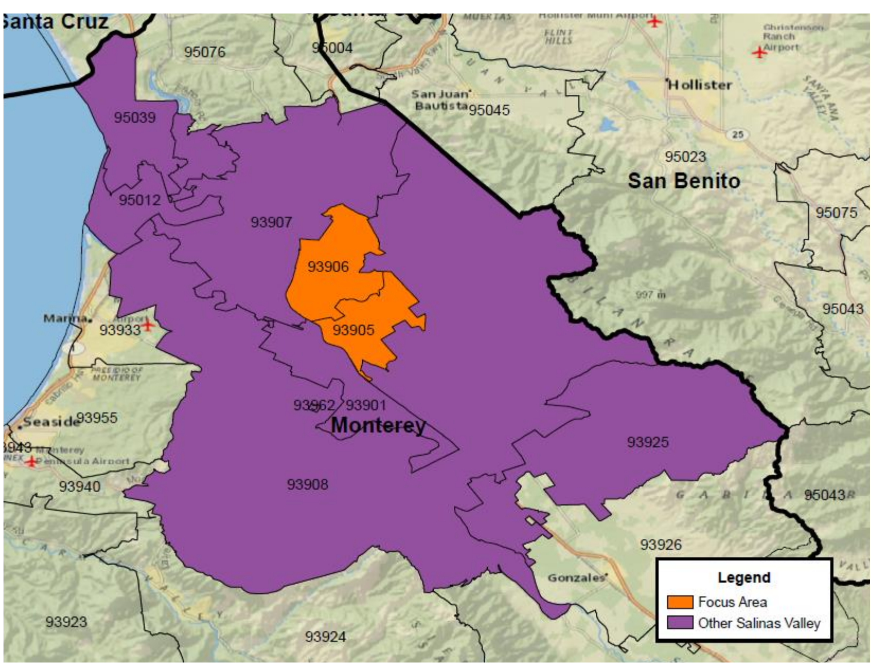
PRC Community Health Survey

Survey Instrument

The survey instrument used for this study is based largely on the Centers for Disease Control and Prevention (CDC) Behavioral Risk Factor Surveillance System (BRFSS), as well as various other public health surveys and customized questions addressing gaps in indicator data relative to health promotion and disease prevention objectives and other recognized health issues. The final survey instrument was developed by the Monterey County Health Needs Collaborative and PRC.

Community Defined for This Assessment

The study area for this report (referred to as the “SVMH Service Area” or “SVMH” in this report) is defined as each of the residential ZIP Codes comprising the service area of Salinas Valley Memorial Hospital, including 93905 and 93906 (the Focus Area), as well as 93901, 93907, 93908, 93925, 93962, 95012, and 95039 (collectively, Other Salinas Valley or Other SVHM). This community definition is illustrated in the following map.



Sample Approach & Design

A precise and carefully executed methodology is critical in asserting the validity of the results gathered in the PRC Community Health Survey. Thus, to ensure the best representation of the population surveyed, a mixed-mode methodology was implemented. This included targeted surveys conducted by PRC via telephone (landline and cell phone) or through online questionnaires, as well as a community outreach component promoted by the study sponsors through social media posting and other communications. These surveys were administered and collected between March 2 and June 15, 2022.

> **RANDOM-SAMPLE SURVEYS** (PRC) ▶ For the targeted administration, PRC administered 308 surveys at random among the various geographic strata.
>
> **COMMUNITY OUTREACH SURVEYS** (Monterey County Health Needs Collaborative) ▶ PRC also created a link to an online version of the survey, and the study sponsors promoted this link throughout the various communities in order to drive additional participation and bolster overall samples. This yielded an additional 589 surveys to the overall sample.

In all, 897 surveys were completed through these mechanisms, including 346 in the Focus Area (ZIP Codes 93905 and 93906) and 551 in the remainder of the SVMH Service Area (Other Salinas Valley/Other SVMH). Once the interviews were completed, these were weighted in proportion to the actual population distribution so as to appropriately represent the SVMH Service Area as a whole. All administration of the surveys, data collection, and data analysis was conducted by PRC.

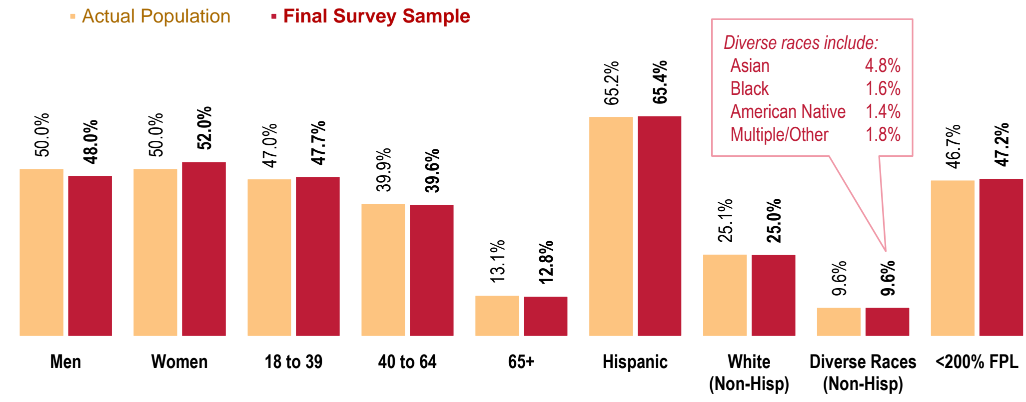
For statistical purposes, the maximum rate of error associated with a sample size of 897 respondents is ±3.3% at the 95 percent confidence level.

Sample Characteristics

To accurately represent the population studied, PRC strives to minimize bias through application of a proven telephone methodology and random-selection techniques. While this random sampling of the population produces a highly representative sample, it is a common and preferred practice to “weight” the raw data to improve this representativeness even further. This is accomplished by adjusting the results of a random sample to match the geographic distribution and demographic characteristics of the population surveyed (poststratification), so as to eliminate any naturally occurring bias.

The following chart outlines the characteristics of the service area sample for key demographic variables, compared to actual population characteristics revealed in census data. [Note that the sample consisted

solely of area residents age 18 and older; data on children were given by proxy by the person most responsible for that child's health care needs, and these children are not represented demographically in this chart.]



Sources:
- US Census Bureau, 2011-2015 American Community Survey.
- 2022 PRC Community Health Survey, PRC, Inc.

Notes:
- FPL is federal poverty level, based on guidelines established by the US Department of Health & Human Services.

The sample design and the quality control procedures used in the data collection ensure that the sample is representative. Thus, the findings may be generalized to the total population of community members in the defined area with a high degree of confidence.

INCOME & RACE/ETHNICITY

INCOME ► Poverty descriptions and segmentation used in this report are based on administrative poverty thresholds determined by the US Department of Health & Human Services. These guidelines define poverty status by household income level and number of persons in the household (e.g., the 2021 guidelines place the poverty threshold for a family of four at $26,500 annual household income or lower). In sample segmentation: "very low income" refers to community members living in a household with defined poverty status; "low income" refers to households with incomes just above the poverty level and earning up to twice (100%-199% of) the poverty threshold; and "mid/high income" refers to those households living on incomes that are twice or more (≥200% of) the federal poverty level.

RACE & ETHNICITY ► In analyzing survey results, mutually exclusive race and ethnicity categories are used. All Hispanic respondents are grouped, regardless of identity with any race group. White reflects individuals who identify as White alone without Hispanic origin. The "diverse races" category are non-Hispanic persons who identify as Black alone, American Native alone, Asian alone, or multiple or other races, without Hispanic ethnic origin.

Online Key Informant Survey

To solicit input from key informants, those individuals who have a broad interest in the health of the community, a countywide Online Key Informant Survey also was implemented as part of this process. A list of recommended participants was provided by the Monterey County Health Needs Collaborative; this list included names and contact information for physicians, public health representatives, other health professionals, social service providers, and a variety of other community leaders. Potential participants were chosen because of their ability to identify primary concerns of the populations with whom they work, as well as of the community overall.

Key informants were contacted by email, introducing the purpose of the survey and providing a link to take the survey online; reminder emails were sent as needed to increase participation. In all, 128 community leaders took part in the Online Key Informant Survey between March 17 and April 19, 2022, as outlined below:

ONLINE KEY INFORMANT SURVEY PARTICIPATION	
KEY INFORMANT TYPE	NUMBER PARTICIPATING
Physicians	23
Public Health Representatives	12
Other Health Providers	13
Social Services Providers	33
Other Community Leaders	47

Final participation included representatives of the organizations outlined below.

- Alisal Family Resource Centers
- All In Monterey
- Alliance on Aging
- Aspire Health
- Big Sur Health Center
- Blue Zones Project Monterey County
- Bright Beginnings
- Brighter Bites
- Building Healthy Communities
- Buttgereit-Pettitt & Davis Agency Inc
- California State Senate
- Cancer Patients Alliance
- Central California Alliance for Health
- Central Coast Labor Council
- Centro Binacional para el Desarrollo Indígena Oaxaqueño (CBDIO)
- City of Del Rey Oaks
- City of Gonzales
- City of Monterey
- City of Monterey Fire Department
- City of Pacific Grove
- City of Seaside
- Clinica de Salud
- Community Builders for Monterey County
- Community Foundation for Monterey County
- Community Hospital of the Monterey Peninsula
- Community Human Services
- Community Partnership for Youth
- California State University, Monterey Bay
- California State University, Monterey Bay - Bright Futures
- Cypress Healthcare Partners/Doctors on Duty
- Diora/Delicato Wines
- Eddington Funeral Services
- Farm Bureau
- Farmers insurance
- First 5 of Monterey County
- Gathering for Women
- Gonzales Adult School
- Grace Lutheran Church
- Greenfield High School
- Harmony at Home
- Hartnell College
- Hospice Giving Foundation

- Interim, Inc.
- Iron Ox
- King City
- Kobrinsky Group
- Legacy Real Estate
- Maurine Church Coburn School of Nursing
- Meals on Wheels of the Salinas Valley
- Mee Memorial Foundation
- MoGo Urgent Care
- Montage Health
- Montage Medical Group
- Monterey Bay Dental Associates
- Monterey Bay GI consultants
- Monterey Bay Independent Practice Association
- Monterey County Board of Supervisors
- Monterey County Eye Associates
- Monterey County Growers and Vintners
- Monterey County Health Department
- Monterey County Office of Education
- Monterey Peninsula College
- Monterey Peninsula Unified School District
- Mujeres en Accion
- Natividad
- Natividad Foundation
- Pinnacle Healthcare, King City
- Pinnacle Healthcare, Soledad
- Planned Parenthood Mar Monte
- Prescribe Safe Monterey County
- RotaCare
- Salinas Union High School District
- Salinas Valley Fair
- Salinas Valley Medical Clinic
- Salinas Valley Memorial Healthcare System
- Salinas Valley Memorial Hospital Foundation
- San Ardo School District
- San Lucas School District
- Santa Cruz and Monterey County
- Soledad Chamber of Commerce
- Soledad Community Health Care District
- Soledad Medical Clinic
- Soledad School District
- Sunstreet Centers, King City
- Teamsters Local 890
- The Carmel Foundation
- The Salvation Army Monterey Peninsula Corps
- United Methodist Church
- United Way Monterey County
- Visiting Nurses Association
- WIC South County
- YMCA
- YWCA

Through this process, input was gathered from several individuals whose organizations work with low-income, minority, or other medically underserved populations.

In the online survey, key informants were asked to rate the degree to which various health issues are a problem in their own community. Follow-up questions asked them to describe why they identify problem areas as such and how these might better be addressed. Results of their ratings, as well as their verbatim comments, are included throughout this report as they relate to the various other data presented.

NOTE ▶ These findings represent qualitative rather than quantitative data. The Online Key Informant Survey was designed to gather input regarding participants' opinions and perceptions of the health needs of the residents in the area.

Public Health, Vital Statistics & Other Data

A variety of existing (secondary) data sources was consulted to complement the research quality of this Community Health Needs Assessment. Data for the SVMH Service Area were obtained from the following sources (specific citations are included with the graphs throughout this report):

- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension, SparkMap (sparkmap.org)
- Centers for Disease Control & Prevention, Office of Infectious Disease, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
- Centers for Disease Control & Prevention, Office of Public Health Science Services, Center for Surveillance, Epidemiology and Laboratory Services, Division of Health Informatics and Surveillance (DHIS)
- Centers for Disease Control & Prevention, Office of Public Health Science Services, National Center for Health Statistics
- ESRI ArcGIS Map Gallery
- National Cancer Institute, State Cancer Profiles
- OpenStreetMap (OSM)
- US Census Bureau, American Community Survey
- US Census Bureau, County Business Patterns
- US Census Bureau, Decennial Census
- US Department of Agriculture, Economic Research Service
- US Department of Health & Human Services
- US Department of Health & Human Services, Health Resources and Services Administration (HRSA)
- US Department of Justice, Federal Bureau of Investigation
- US Department of Labor, Bureau of Labor Statistics

Note that secondary data reflect the entirety of Monterey County.

Benchmark Data

Trending

While trending is not available for survey data in the SVMH Service Area, historical data for secondary data indicators are included where available.

California Risk Factor Data

Statewide risk factor data are provided where available as an additional benchmark against which to compare local survey findings; these data represent the most recent *BRFSS (Behavioral Risk Factor Surveillance System) Prevalence and Trends Data* published online by the Centers for Disease Control and Prevention. State-level vital statistics are also provided for comparison of secondary data indicators.

Nationwide Risk Factor Data

Nationwide risk factor data, which are also provided in comparison charts, are taken from the *2020 PRC National Health Survey*; the methodological approach for the national study is similar to that employed in this

assessment, and these data may be generalized to the US population with a high degree of confidence. National-level vital statistics are also provided for comparison of secondary data indicators.

Healthy People 2030

Healthy People provides 10-year, measurable public health objectives — and tools to help track progress toward achieving them. Healthy People identifies public health priorities to help individuals, organizations, and communities across the United States improve health and well-being. Healthy People 2030, the initiative's fifth iteration, builds on knowledge gained over the first four decades.

Healthy People 2030's overarching goals are to:

- Attain healthy, thriving lives and well-being free of preventable disease, disability, injury, and premature death.
- Eliminate health disparities, achieve health equity, and attain health literacy to improve the health and well-being of all.
- Create social, physical, and economic environments that promote attaining the full potential for health and well-being for all.
- Promote healthy development, healthy behaviors, and well-being across all life stages.
- Engage leadership, key constituents, and the public across multiple sectors to take action and design policies that improve the health and well-being of all.

The Healthy People 2030 framework was based on recommendations made by the Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2030. After getting feedback from individuals and organizations and input from subject matter experts, the U.S. Department of Health and Human Services (HHS) approved the framework which helped guide the selection of Healthy People 2030 objectives.

Information Gaps

While this assessment is quite comprehensive, it cannot measure all possible aspects of health in the community, nor can it adequately represent all possible populations of interest. It must be recognized that these information gaps might in some ways limit the ability to assess all of the community's health needs.

For example, certain population groups — such as persons experiencing homelessness, institutionalized persons, or those who only speak a language other than English or Spanish — are not represented in the survey data. Other population groups — for example, pregnant women, undocumented residents, and members of certain racial/ethnic or immigrant groups — might not be identifiable or might not be represented in numbers sufficient for independent analyses.

In terms of content, this assessment was designed to provide a comprehensive and broad picture of the health of the overall community. However, there are certainly medical conditions that are not specifically addressed.

Public Comment

Salinas Valley Memorial Hospital made its prior Community Health Needs Assessment (CHNA) report publicly available on its website; through that mechanism, the hospital requested from the public written comments and feedback regarding the CHNA and implementation strategy. At the time of this writing, Salinas Valley Memorial Hospital had not received any written comments. However, through population surveys and key informant feedback for this assessment, input from the broader community was considered and taken into account when identifying and prioritizing the significant health needs of the community. Salinas Valley Memorial Hospital will continue to use its website as a tool to solicit public comments and ensure that these comments are considered in the development of future CHNAs.

IRS Form 990, Schedule H Compliance

For non-profit hospitals, a Community Health Needs Assessment (CHNA) also serves to satisfy certain requirements of tax reporting, pursuant to provisions of the Patient Protection & Affordable Care Act of 2010. To understand which elements of this report relate to those requested as part of hospitals' reporting on IRS Schedule H (Form 990), the following table cross-references related sections.

IRS FORM 990, SCHEDULE H (2019)	See Report Page
Part V Section B Line 3a A definition of the community served by the hospital facility	4
Part V Section B Line 3b Demographics of the community	32
Part V Section B Line 3c Existing health care facilities and resources within the community that are available to respond to the health needs of the community	137
Part V Section B Line 3d How data was obtained	4
Part V Section B Line 3e The significant health needs of the community	12
Part V Section B Line 3f Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups	Addressed Throughout
Part V Section B Line 3g The process for identifying and prioritizing community health needs and services to meet the community health needs	13
Part V Section B Line 3h The process for consulting with persons representing the community's interests	6
Part V Section B Line 3i The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)	146

SUMMARY OF FINDINGS

Significant Health Needs of the Community

The following "Areas of Opportunity" represent the significant health needs of the community, based on the information gathered through this Community Health Needs Assessment. From these data, opportunities for health improvement exist in the area with regard to the following health issues (see also the summary tables presented in the following section).

The Areas of Opportunity were determined after consideration of various criteria, including: standing in comparison with benchmark data (particularly national data); identified trends; the preponderance of significant findings within topic areas; the magnitude of the issue in terms of the number of persons affected; and the potential health impact of a given issue. These also take into account those issues of greatest concern to the community leaders (key informants) giving input to this process.

AREAS OF OPPORTUNITY IDENTIFIED THROUGH THIS ASSESSMENT	
ACCESS TO HEALTH CARE SERVICES	▪ Barriers to Access – Inconvenient Office Hours – Cost of Prescriptions – Cost of Physician Visits – Appointment Availability – Finding a Physician – Lack of Transportation – Language/Culture ▪ Skipping/Stretching Prescriptions ▪ Difficulty Accessing Children's Health Care ▪ Primary Care Physician Ratio ▪ Routine Medical Care (Adults) ▪ Low Health Literacy [Focus Area ZIP Codes] ▪ Ratings of Local Health Care
CANCER	▪ Leading Cause of Death
DIABETES	▪ Prevalence of Diabetes [Focus Area ZIP Codes] ▪ Prevalence of Borderline/Pre-Diabetes ▪ Key Informants: Diabetes ranked as a top concern. ▪ Kidney Disease Deaths
HEART DISEASE & STROKE	▪ Leading Cause of Death ▪ Heart Disease Prevalence ▪ High Blood Cholesterol Prevalence ▪ Overall Cardiovascular Risk
HOUSING	▪ Worry Over Mortgage/Rent ▪ Unhealthy or Unsafe Housing Conditions ▪ Financial Instability
INFANT HEALTH & FAMILY PLANNING	▪ Teen Births
INJURY & VIOLENCE	▪ Unintentional Injury Deaths ▪ Intimate Partner Violence

—continued on the next page—

AREAS OF OPPORTUNITY (continued)	
MENTAL HEALTH	▪ "Fair/Poor" Mental Health ▪ Diagnosed Depression ▪ Symptoms of Chronic Depression ▪ Stress ▪ Suicide Mortality ▪ Difficulty Obtaining Mental Health Services ▪ [Parents] Awareness of Children's Mental Health Services ▪ [Parents] Child Has Needed Mental Health Services [Other SVMH Area] ▪ Key Informants: Mental health ranked as a top concern.
NUTRITION, PHYSICAL ACTIVITY & WEIGHT	▪ Food Insecurity ▪ Difficulty Accessing Fresh Produce ▪ Access to Recreation/Fitness Facilities ▪ Overweight & Obesity [Adults & Children] ▪ Key Informants: Nutrition, physical activity, and weight ranked as a top concern.
ORAL HEALTH	▪ Regular Dental Care [Adults]
POTENTIALLY DISABLING CONDITIONS	▪ Multiple Chronic Conditions ▪ Activity Limitations ▪ High-Impact Chronic Pain ▪ Alzheimer's Disease Deaths ▪ Caregiving
SUBSTANCE USE	▪ Cirrhosis Disease Deaths ▪ Unintentional Drug-Related Deaths ▪ Personally Impacted by Substance Use (Self or Other's) ▪ Key Informants: Substance use ranked as a top concern.

Community Feedback on Prioritization of Health Needs

On September 15, 2022, the partners of the Monterey County Health Needs Collaborative convened an online meeting attended by 136 community leaders (representing a cross-section of community-based providers, agencies, and organizations) to evaluate, discuss, and prioritize health issues for community, based on findings of this Community Health Needs Assessment (CHNA). Professional Research Consultants, Inc. (PRC) began the meeting with a presentation of key findings from the CHNA, highlighting the significant health issues identified from the research (see Areas of Opportunity above). Following the data review, PRC answered any questions. Finally, participants were provided an overview of the prioritization exercise that followed.

In order to assign priority to the identified health needs (i.e., Areas of Opportunity), an online voting platform was used in which each participant was able to register his/her ratings using a mobile device or web browser. The participants were asked to evaluate each health issue along two criteria:

- **Scope & Severity** — The first rating was to gauge the magnitude of the problem in consideration of the following:
  - How many people are affected?
  - How does the local community data compare to state or national levels, or Healthy People 2030 targets?
  - To what degree does each health issue lead to death or disability, impair quality of life, or impact other health issues?

Ratings were entered on a scale of 1 (not very prevalent at all, with only minimal health consequences) to 10 (extremely prevalent, with very serious health consequences).

- **Ability to Impact** — A second rating was designed to measure the perceived likelihood of the hospital having a positive impact on each health issue, given available resources, competencies, spheres of influence, etc. Ratings were entered on a scale of 1 (no ability to impact) to 10 (great ability to impact).

Individuals' ratings for each criteria were averaged for each tested health issue, and then these composite criteria scores were averaged to produce an overall score. This process yielded the following prioritized list of community health needs:

1. Diabetes
2. Mental Health
3. Access to Health Care Services
4. Nutrition, Physical Activity & Weight
5. Heart Disease & Stroke
6. Substance Use
7. Housing
8. Infant Health & Family Planning
9. Injury & Violence
10. Cancer
11. Oral Health
12. Potentially Disabling Conditions

Hospital Implementation Strategy

Salinas Valley Memorial Hospital will use the information from this Community Health Needs Assessment to develop an Implementation Strategy to address the significant health needs in the community. While the hospital will likely not implement strategies for all of the health issues listed above, the results of this prioritization exercise will be used to inform the development of the hospital's action plan to guide community health improvement efforts in the coming years.

Note: An evaluation of the hospital's past activities to address the needs identified in prior CHNAs can be found as an appendix to this report.

Summary Tables: Comparisons With Benchmark Data

The following tables provide an overview of indicators in the SVMH Service Area, including comparisons between the individual communities, as well as trend data. These data are grouped by health topic.

Reading the Summary Tables

- In the following tables, SVMH Service Area results are shown in the larger, gray column.

- The columns to the left of the service area column provide comparisons between the Focus Area and the remaining ZIP Codes, identifying differences for each as "better than" (☼), "worse than" (☂), or "similar to" (☁) the opposing area.

- The columns to the right of the SVMH Service Area column provide trending (for secondary data indicators), as well as comparisons between local data and any available state and national findings, and Healthy People 2030 objectives. Again, symbols indicate whether the service area compares favorably (☼), unfavorably (☂), or comparably (☁) to these external data.

TREND SUMMARY

Trends for secondary data indicators (e.g., public health data) represent point-to-point changes between the most current reporting period and the earliest presented in this report (typically representing the span of roughly a decade).

Note that secondary data reflect the entirety of Monterey County.

Note that blank table cells signify that data are not available or are not reliable for that area and/or for that indicator.

Tip: Indicator labels beginning with a "%" symbol are taken from the PRC Community Health Survey; the remaining indicators are taken from secondary data sources.

SOCIAL DETERMINANTS	DISPARITY BETWEEN SUBAREAS: Focus Area	DISPARITY BETWEEN SUBAREAS: Other SVMH	SVMH	SVMH vs. BENCHMARKS: vs. CA	SVMH vs. BENCHMARKS: vs. US	SVMH vs. BENCHMARKS: vs. HP2030	TREND
Linguistically Isolated Population (Percent)			12.1	7.7	4.1		
Population in Poverty (Percent)			12.0	12.6	12.8	8.0	
Population Below 200% FPL (Percent)							
Children in Poverty (Percent)			18.4	16.8	17.5	8.0	
No High School Diploma (Age 25+, Percent)			27.0	16.1	11.5		
% Unable to Pay Cash for a $400 Emergency Expense	37.6	26.8	33.2		24.6		
% HH Member Lost Job, Wages, Insurance Due to Pandemic	35.0	31.3	33.5				
% Worry/Stress Over Rent/Mortgage in Past Year	49.3	45.8	47.9		32.2		
% Multi-Generational Housing	28.1	17.0	23.6				
% Share Housing Expenses With Non-Family	11.3	11.7	11.5				
% Unhealthy/Unsafe Housing Conditions	30.9	19.8	26.4		12.2		

SOCIAL DETERMINANTS (continued)	DISPARITY BETWEEN SUBAREAS		SVMH	SVMH vs. BENCHMARKS			
	Focus Area	Other SVMH		vs. CA	vs. US	vs. HP2030	TREND
% Food Insecure	48.4	37.1	43.8		34.1		

Note: Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

OVERALL HEALTH	DISPARITY BETWEEN SUBAREAS		SVMH	SVMH vs. BENCHMARKS			
	Focus Area	Other SVMH		vs. CA	vs. US	vs. HP2030	TREND
% "Fair/Poor" Overall Health	25.6	15.6	21.5	14.9	12.6		

Note: Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

ACCESS TO HEALTH CARE	DISPARITY BETWEEN SUBAREAS		SVMH	SVMH vs. BENCHMARKS			
	Focus Area	Other SVMH		vs. CA	vs. US	vs. HP2030	TREND
% [Age 18-64] Lack Health Insurance	10.9	10.0	10.6	13.2	8.7	7.9	
% Difficulty Accessing Health Care in Past Year (Composite)	68.9	70.5	69.5		35.0		
% Cost Prevented Physician Visit in Past Year	28.4	24.2	26.7	8.6	12.9		

ACCESS TO HEALTH CARE (continued)	DISPARITY BETWEEN SUBAREAS		SVMH	SVMH vs. BENCHMARKS			
	Focus Area	Other SVMH		vs. CA	vs. US	vs. HP2030	TREND
% Cost Prevented Getting Prescription in Past Year	26.2	24.7	**25.6**		12.8		
% Difficulty Getting Appointment in Past Year	50.8	56.7	**53.2**		14.5		
% Inconvenient Hrs Prevented Dr Visit in Past Year	36.2	29.0	**33.3**		12.5		
% Difficulty Finding Physician in Past Year	31.3	36.7	**33.5**		9.4		
% Transportation Hindered Dr Visit in Past Year	14.7	13.8	**14.3**		8.9		
% Language/Culture Prevented Care in Past Year	9.9	6.9	**8.7**		2.8		
% Skipped Prescription Doses to Save Costs	17.7	21.3	**19.2**		12.7		
% Difficulty Getting Child's Health Care in Past Year	16.0	13.8	**15.2**		8.0		
Primary Care Doctors per 100,000			**87.5**	98.9	102.7		
% Have a Specific Source of Ongoing Care	74.6	73.0	**73.9**		74.2	84.0	
% Have Had Routine Checkup in Past Year	57.9	59.7	**58.6**	65.6	70.5		

ACCESS TO HEALTH CARE (continued)	DISPARITY BETWEEN SUBAREAS: Focus Area	Other SVMH	SVMH	SVMH vs. BENCHMARKS: vs. CA	vs. US	vs. HP2030	TREND
% Child Has Had Checkup in Past Year	88.4	88.8	88.5		77.4		
% Two or More ER Visits in Past Year	12.0	7.6	10.2		10.1		
% Low Health Literacy	37.3	18.1	29.5		27.7		
% Rate Local Health Care "Fair/Poor"	25.7	25.0	25.5		8.0		

Note: Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

CANCER	DISPARITY BETWEEN SUBAREAS: Focus Area	Other SVMH	SVMH	SVMH vs. BENCHMARKS: vs. CA	vs. US	vs. HP2030	TREND
Cancer (Age-Adjusted Death Rate)			116.7	132.3	146.5	122.7	140.0
Lung Cancer (Age-Adjusted Death Rate)			20.1	23.7	33.4	25.1	
Prostate Cancer (Age-Adjusted Death Rate)			15.9	19.6	18.5	16.9	
Female Breast Cancer (Age-Adjusted Death Rate)			13.9	18.7	19.4	15.3	

CANCER (continued)	DISPARITY BETWEEN SUBAREAS: Focus Area	DISPARITY BETWEEN SUBAREAS: Other SVMH	SVMH	SVMH vs. BENCHMARKS: vs. CA	vs. US	vs. HP2030	TREND
Colorectal Cancer (Age-Adjusted Death Rate)			10.2	better 12.2	better 13.1	similar 8.9	
Cancer Incidence Rate (All Sites)			390.8	similar 402.4	similar 448.6		
Female Breast Cancer Incidence Rate			117.8	similar 121.8	similar 126.8		
Prostate Cancer Incidence Rate			96.4	similar 92.3	similar 106.2		
Lung Cancer Incidence Rate			34.9	better 40.3	better 57.3		
Colorectal Cancer Incidence Rate			31.5	similar 34.8	better 38.0		
% Cancer	similar 10.5	similar 9.4	10.1	similar 9.8	similar 10.0		
% [Women 50-74] Mammogram in Past 2 Years	similar 81.1	similar 89.4	85.6	better 76.3	better 76.1	better 77.1	
% [Women 21-65] Cervical Cancer Screening	similar 81.2	similar 82.9	81.9	similar 79.3	better 73.8	similar 84.3	
% [Age 50-75] Colorectal Cancer Screening	similar 78.9	similar 78.9	78.9	better 59.5	similar 77.4	better 74.4	

Note: Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

Legend: better / similar / worse

DIABETES	DISPARITY BETWEEN SUBAREAS		SVMH	SVMH vs. BENCHMARKS			
	Focus Area	Other SVMH		vs. CA	vs. US	vs. HP2030	TREND
Diabetes (Age-Adjusted Death Rate)			17.1	22.9	22.6		18.8
% Diabetes/High Blood Sugar	17.1	10.7	14.5	9.8	13.8		
% Borderline/Pre-Diabetes	22.4	17.0	20.2		9.7		
% [Non-Diabetics] Blood Sugar Tested in Past 3 Years	45.4	49.6	47.2		43.3		

Note: Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

HEART DISEASE & STROKE	DISPARITY BETWEEN SUBAREAS		SVMH	SVMH vs. BENCHMARKS			
	Focus Area	Other SVMH		vs. CA	vs. US	vs. HP2030	TREND
Diseases of the Heart (Age-Adjusted Death Rate)			109.3	140.2	164.4	127.4	125.2
% Heart Disease (Heart Attack, Angina, Coronary Disease)	7.7	10.3	8.8	5.0	6.1		
Stroke (Age-Adjusted Death Rate)			34.5	37.8	37.6	33.4	39.0
% Stroke	5.1	3.2	4.3	2.9	4.3		

HEART DISEASE & STROKE (continued)	DISPARITY BETWEEN SUBAREAS: Focus Area	Other SVMH	SVMH	SVMH vs. BENCHMARKS: vs. CA	vs. US	vs. HP2030	TREND
% Told Have High Blood Pressure	38.7	38.3	38.6	27.8	36.9	27.7	
% Told Have High Cholesterol	40.2	39.5	39.9		32.7		
% 1+ Cardiovascular Risk Factor	90.9	86.2	89.0		84.6		

Note: Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

INFANT HEALTH & FAMILY PLANNING	DISPARITY BETWEEN SUBAREAS: Focus Area	Other SVMH	SVMH	SVMH vs. BENCHMARKS: vs. CA	vs. US	vs. HP2030	TREND
No Prenatal Care in First Trimester (Percent)			18.5	17.6	22.3		29.1
Low Birthweight Births (Percent)			6.2	6.9	8.2		
Infant Death Rate			4.1	3.9	5.5	5.0	4.6
Births to Adolescents Age 15 to 19 (Rate per 1,000)			28.2	17.4	20.9		

Note: Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

INJURY & VIOLENCE	DISPARITY BETWEEN SUBAREAS		SVMH	SVMH vs. BENCHMARKS			
	Focus Area	Other SVMH	SVMH	vs. CA	vs. US	vs. HP2030	TREND
Unintentional Injury (Age-Adjusted Death Rate)			41.6	37.9	51.6	43.2	31.3
Motor Vehicle Crashes (Age-Adjusted Death Rate)			10.5	9.9	11.4	10.1	
[65+] Falls (Age-Adjusted Death Rate)			40.0	41.4	67.1	63.4	
Firearm-Related Deaths (Age-Adjusted Death Rate)			7.7	7.7	12.5	10.7	
Homicide (Age-Adjusted Death Rate)			5.0	5.1	6.1	5.5	9.5
Violent Crime Rate			424.6	440.5	416.0		
% Victim of Violent Crime in Past 5 Years	8.8	7.0	8.1		6.2		
% Victim of Intimate Partner Violence	16.6	19.2	17.7		13.7		

Note: Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

KIDNEY DISEASE	DISPARITY BETWEEN SUBAREAS: Focus Area	Other SVMH	SVMH	SVMH vs. BENCHMARKS: vs. CA	vs. US	vs. HP2030	TREND
Kidney Disease (Age-Adjusted Death Rate)			9.5	9.1	12.8		7.5
% Kidney Disease	5.0	3.2	4.3	2.8	5.0		

Note: Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

MENTAL HEALTH	DISPARITY BETWEEN SUBAREAS: Focus Area	Other SVMH	SVMH	SVMH vs. BENCHMARKS: vs. CA	vs. US	vs. HP2030	TREND
% "Fair/Poor" Mental Health	35.4	30.5	33.5		13.4		
% Diagnosed Depression	27.0	26.4	26.8	14.1	20.6		
% Symptoms of Chronic Depression (2+ Years)	55.4	48.5	52.6		30.3		
% Typical Day Is "Extremely/Very" Stressful	23.0	22.0	22.7		16.1		
Suicide (Age-Adjusted Death Rate)			9.7	10.5	13.9	12.8	8.1
Mental Health Providers per 100,000			145.1	144.3	126.0		

MENTAL HEALTH (continued)	DISPARITY BETWEEN SUBAREAS: Focus Area	DISPARITY BETWEEN SUBAREAS: Other SVMH	SVMH	SVMH vs. BENCHMARKS: vs. CA	vs. US	vs. HP2030	TREND
% Taking Rx/Receiving Mental Health Treatment	similar 16.8	similar 18.8	17.6		similar 16.8		
% Unable to Get Mental Health Services in Past Year	similar 19.6	similar 14.5	17.5		worse 7.8		
% [Age 5-17] Child Needed Mental Health Services in the Past Year	better 14.3	worse 27.2	20.0		similar 17.1		
% [Age 5-17] Child Has Taken Prescribed Meds for Mental Health	similar 9.6	similar 10.4	10.0		similar 12.5		
% [Age 5-17] Aware of Mental Health Resources for Children	similar 47.5	similar 56.7	51.4		worse 70.2		

Note: Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

Legend: better / similar / worse

NUTRITION, PHYSICAL ACTIVITY & WEIGHT	DISPARITY BETWEEN SUBAREAS: Focus Area	DISPARITY BETWEEN SUBAREAS: Other SVMH	SVMH	SVMH vs. BENCHMARKS: vs. CA	vs. US	vs. HP2030	TREND
Population With Low Food Access (Percent)			16.6	worse 13.3	better 22.2		
% "Very/Somewhat" Difficult to Buy Fresh Produce	similar 33.8	similar 29.8	32.2		worse 21.1		
% 5+ Servings of Fruits/Vegetables per Day	similar 32.2	similar 34.2	33.0		similar 32.7		

NUTRITION, PHYSICAL ACTIVITY & WEIGHT (continued)	DISPARITY BETWEEN SUBAREAS		SVMH	SVMH vs. BENCHMARKS			
	Focus Area	Other SVMH		vs. CA	vs. US	vs. HP2030	TREND
% 7+ Sugar-Sweetened Drinks in Past Week	16.6	14.1	15.6				
% No Leisure-Time Physical Activity	30.0	19.2	25.7	21.2	31.3	21.2	
% Meeting Physical Activity Guidelines	23.9	30.3	26.5	22.6	21.4	28.4	
% Child [Age 2-17] Physically Active 1+ Hours per Day	25.1	34.1	28.7		33.0		
Recreation/Fitness Facilities per 100,000			8.7	12.4	12.2		
% Overweight (BMI 25+)	75.2	72.9	74.3	64.0	61.0		
% Obese (BMI 30+)	43.9	39.1	42.0	30.3	31.3	36.0	
% Children [Age 5-17] Overweight (85th Percentile)	51.7	40.1	46.5		32.3		
% Children [Age 5-17] Obese (95th Percentile)	40.1	22.0	32.0		16.0	15.5	

Note: Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

ORAL HEALTH	DISPARITY BETWEEN SUBAREAS Focus Area	Other SVMH	SVMH	SVMH vs. BENCHMARKS vs. CA	vs. US	vs. HP2030	TREND
% Have Dental Insurance	75.2	71.4	73.7		68.7	59.8	
% [Age 18+] Dental Visit in Past Year	49.9	64.0	55.6	64.7	62.0	45.0	
% Child [Age 2-17] Dental Visit in Past Year	77.0	84.5	80.1		72.1	45.0	

Note: Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

POTENTIALLY DISABLING CONDITIONS	DISPARITY BETWEEN SUBAREAS Focus Area	Other SVMH	SVMH	SVMH vs. BENCHMARKS vs. CA	vs. US	vs. HP2030	TREND
% 3+ Chronic Conditions	43.2	37.8	41.0		32.5		
% Activity Limitations	29.1	29.7	29.3		24.0		
% With High-Impact Chronic Pain	21.6	16.8	19.7		14.1	7.0	
Alzheimer's Disease (Age-Adjusted Death Rate)			25.1	38.2	30.9		19.8
% Caregiver to a Friend/Family Member	29.5	32.5	30.7		22.6		

Note: Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

RESPIRATORY DISEASE	DISPARITY BETWEEN SUBAREAS		SVMH	SVMH vs. BENCHMARKS			
	Focus Area	Other SVMH		vs. CA	vs. US	vs. HP2030	TREND
CLRD (Age-Adjusted Death Rate)			24.1	29.3	38.1		27.8
Pneumonia/Influenza (Age-Adjusted Death Rate)			10.6	13.8	13.4		12.9
% [Age 65+] Flu Vaccine in Past Year	80.3	83.8	82.2	68.8	71.0		
% [Adult] Asthma	15.6	15.5	15.6	9.3	12.9		
% [Child 0-17] Asthma	8.4	14.0	10.5		7.8		
% COPD (Lung Disease)	7.4	5.8	6.7	5.4	6.4		
% Fully/Partially Vaccinated for COVID-19	89.6	94.6	91.6				
COVID-19 (Age-Adjusted Death Rate)			53.8	68.7	85.0		

Note: Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

SEXUAL HEALTH	DISPARITY BETWEEN SUBAREAS			SVMH vs. BENCHMARKS			
	Focus Area	Other SVMH	SVMH	vs. CA	vs. US	vs. HP2030	TREND
HIV/AIDS (Age-Adjusted Death Rate)			1.1	1.7	1.8		
HIV Prevalence Rate			206.8	395.9	372.8		174.8
Chlamydia Incidence Rate			510.4	585.3	539.9		299.9
Gonorrhea Incidence Rate			98.7	200.3	179.1		45.4

Note: Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

SUBSTANCE ABUSE	DISPARITY BETWEEN SUBAREAS			SVMH vs. BENCHMARKS			
	Focus Area	Other SVMH	SVMH	vs. CA	vs. US	vs. HP2030	TREND
Cirrhosis/Liver Disease (Age-Adjusted Death Rate)			12.4	12.8	11.9	10.9	10.3
% Excessive Drinker	21.8	23.0	22.3	18.0	27.2		
Unintentional Drug-Related Deaths (Age-Adjusted Death Rate)			15.2	15.2	21.0		9.9
% Illicit Drug Use in Past Month	3.5	2.1	2.9		2.0	12.0	

SUBSTANCE ABUSE (continued)	DISPARITY BETWEEN SUBAREAS			SVMH vs. BENCHMARKS			
	Focus Area	Other SVMH	SVMH	vs. CA	vs. US	vs. HP2030	TREND
% Used a Prescription Opioid in Past Year	6.8	8.3	7.4		12.9		
% Ever Sought Help for Alcohol or Drug Problem	4.5	2.9	3.9		5.4		
% Personally Impacted by Substance Use	43.6	50.8	46.4		35.8		

Note: Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

TOBACCO USE	DISPARITY BETWEEN SUBAREAS			SVMH vs. BENCHMARKS			
	Focus Area	Other SVMH	SVMH	vs. CA	vs. US	vs. HP2030	TREND
% Current Smoker	5.8	5.8	5.9	8.9	17.4	5.0	
% Someone Smokes at Home	10.9	7.1	9.4		14.6		
% [Household With Children] Someone Smokes in the Home	15.3	7.8	12.5		17.4		
% Currently Use Vaping Products	6.4	4.0	5.5		8.9		

Note: Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

DATA CHARTS & KEY INFORMANT INPUT

The following sections present data from multiple sources, including the population- based PRC Community Health Survey, public health and other existing data sets (secondary data), as well as qualitative input from the Online Key Informant Survey.

Data indicators from these sources are intermingled and organized by health topic. To better understand the source data for specific indicators, please refer to the footnotes accompanying each chart.

COMMUNITY CHARACTERISTICS

Population Characteristics

Land Area, Population Size & Density

Data from the US Census Bureau reveal the following statistics for our community relative to size, population, and density. [COUNTY-LEVEL DATA]

Total Population
(Estimated Population, 2016-2020)

	TOTAL POPULATION	TOTAL LAND AREA (square miles)	POPULATION DENSITY (per square mile)
Monterey County	432,977	3,281.72	132
California	39,346,023	155,858.32	252
United States	326,569,308	3,533,038.14	92

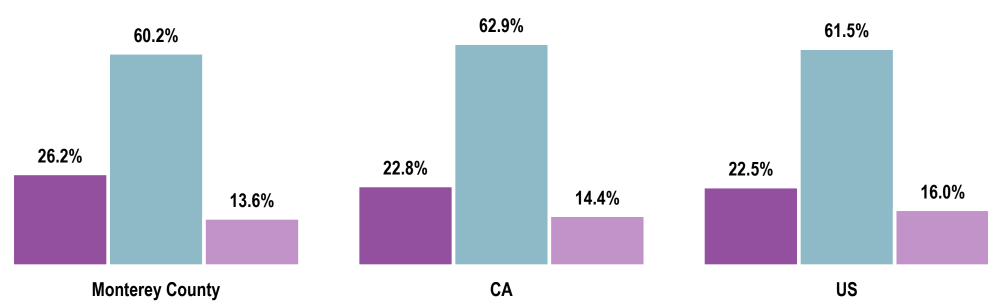
Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved June 2022 via SparkMap (sparkmap.org).

Age

It is important to understand the age distribution of the population, as different age groups have unique health needs that should be considered separately from others along the age spectrum. [COUNTY-LEVEL DATA]

Total Population by Age Groups
(2016-2020)

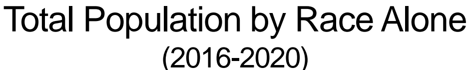
Age 0-17 | Age 18-64 | Age 65+

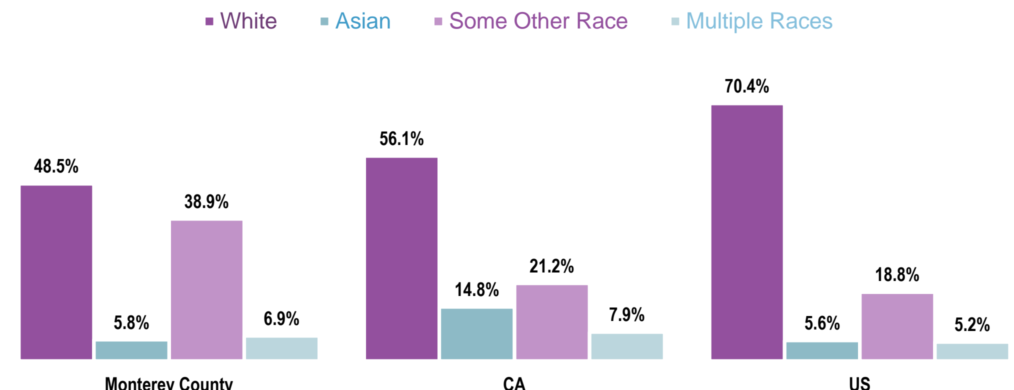


Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved June 2022 via SparkMap (sparkmap.org).

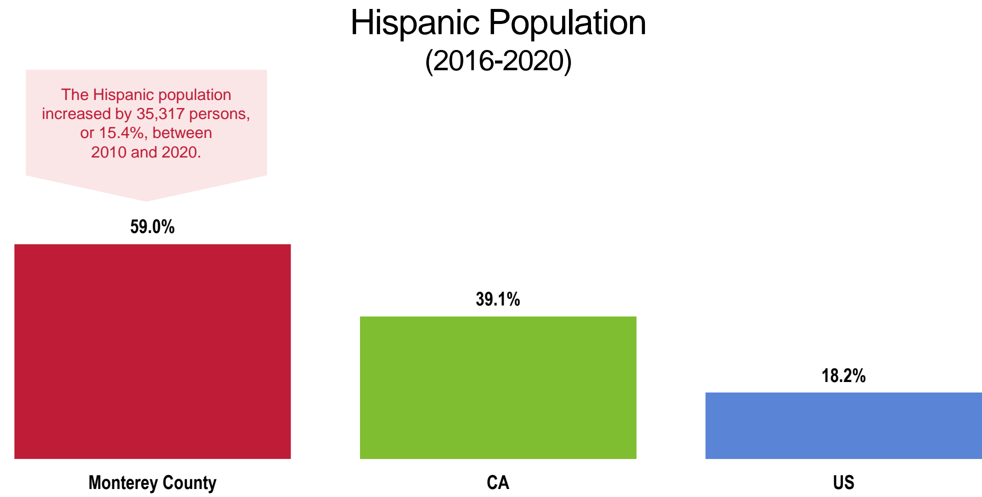
Race & Ethnicity

The following charts illustrate the racial and ethnic makeup of our community. Note that ethnicity (Hispanic or Latino) can be of any race. [COUNTY-LEVEL DATA]





Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved June 2022 via SparkMap (sparkmap.org).



Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved June 2022 via SparkMap (sparkmap.org).

Notes:
- Origin can be viewed as the heritage, nationality group, lineage, or country of birth of the person or the person's parents or ancestors before their arrival in the United States. People who identify their origin as Hispanic, Latino, or Spanish may be of any race.

Social Determinants of Health

ABOUT SOCIAL DETERMINANTS OF HEALTH

Social determinants of health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

Social determinants of health (SDOH) have a major impact on people's health, well-being, and quality of life. Examples of SDOH include:

– Safe housing, transportation, and neighborhoods
– Racism, discrimination, and violence
– Education, job opportunities, and income
– Access to nutritious foods and physical activity opportunities
– Polluted air and water
– Language and literacy skills

SDOH also contribute to wide health disparities and inequities. For example, people who don't have access to grocery stores with healthy foods are less likely to have good nutrition. That raises their risk of health conditions like heart disease, diabetes, and obesity — and even lowers life expectancy relative to people who do have access to healthy foods.

Just promoting healthy choices won't eliminate these and other health disparities. Instead, public health organizations and their partners in sectors like education, transportation, and housing need to take action to improve the conditions in people's environments.

– Healthy People 2030 (https://health.gov/healthypeople)

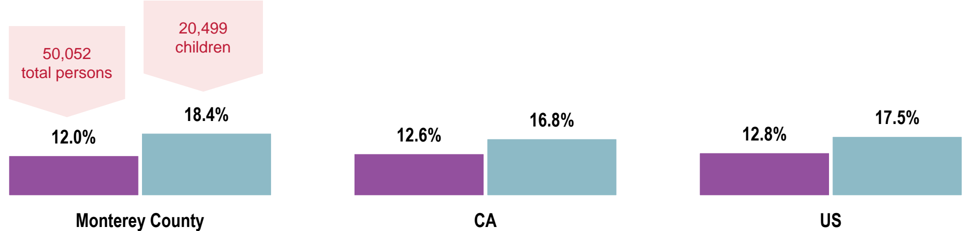
Income & Poverty

Poverty

The following chart outlines the proportion of our county population below the federal poverty threshold in comparison to state and national proportions. [COUNTY-LEVEL DATA]

Population in Poverty
(Populations Living Below the Poverty Level; 2016-2020)
Healthy People 2030 = 8.0% or Lower

▪ Total Population ▪ Children

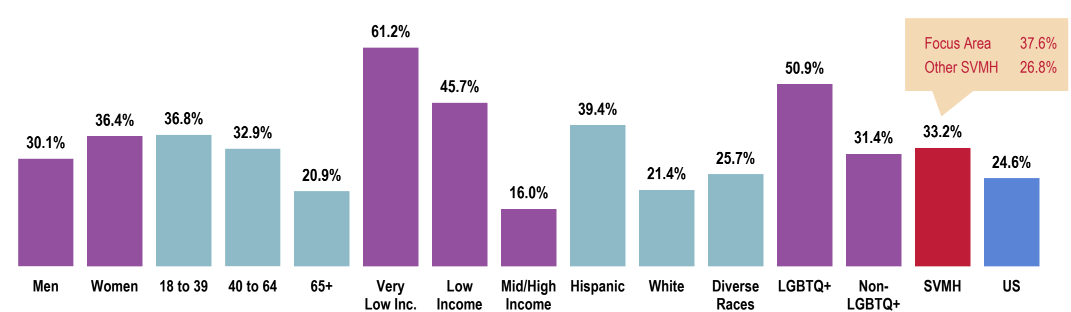


Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved June 2022 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Poverty is considered a key driver of health status. This indicator is relevant because poverty creates barriers to access including health services, healthy food, and other necessities that contribute to poor health status.

Financial Resilience

"Suppose that you have an emergency expense that costs $400. Based on your current financial situation, would you be able to pay for this expense either with cash, by taking money from your checking or savings account, or by putting it on a credit card that you could pay in full at the next statement?"

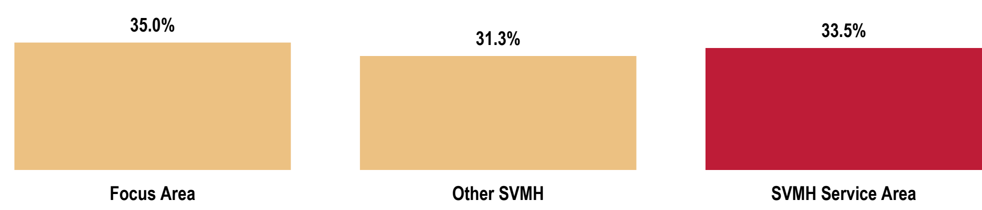


Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 63]
• 2020 PRC National Health Survey, PRC, Inc.

Notes: • Asked of all respondents.
• Includes respondents who say they would not be able to pay for a $400 emergency expense either with cash, by taking money from their checking or savings account, or by putting it on a credit card that they could pay in full at the next statement.

Pandemic Repercussions

"Has the coronavirus pandemic caused you or any other adults in your household to lose a job, work fewer hours than you wanted or needed, or led to a loss of health insurance coverage?"



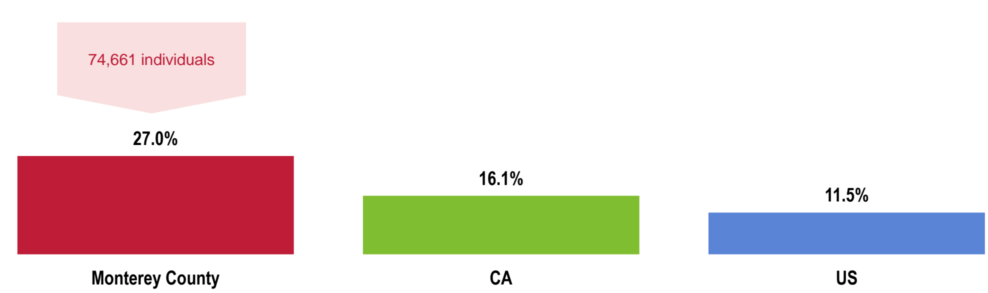
Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 318]

Notes: • Asked of all respondents.

Education

Education levels are reflected in the proportion of our county population without a high school diploma. [COUNTY-LEVEL DATA]

Population With No High School Diploma
(Population Age 25+ Without a High School Diploma or Equivalent, 2016-2020)



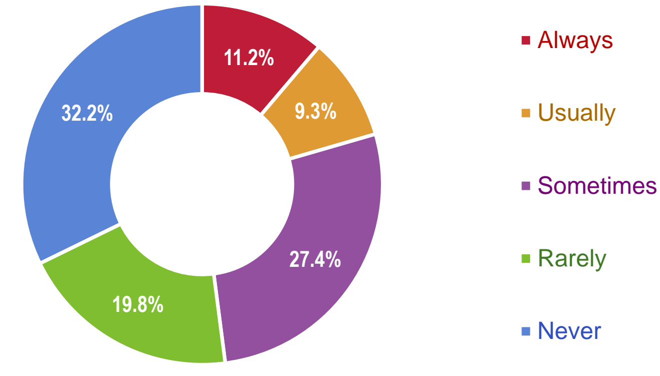
Sources: • US Census Bureau American Community Survey 5-year estimates.
• Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved June 2022 via SparkMap (sparkmap.org).
Notes: • This indicator is relevant because educational attainment is linked to positive health outcomes.

Housing

Housing Insecurity

"In the past 12 months, how often were you worried or stressed about having enough money to pay your rent or mortgage? Would you say you were worried or stressed: always, usually, sometimes, rarely, or never?"

Frequency of Worry or Stress
About Paying Rent or Mortgage in the Past Year
(SVMH Service Area, 2022)

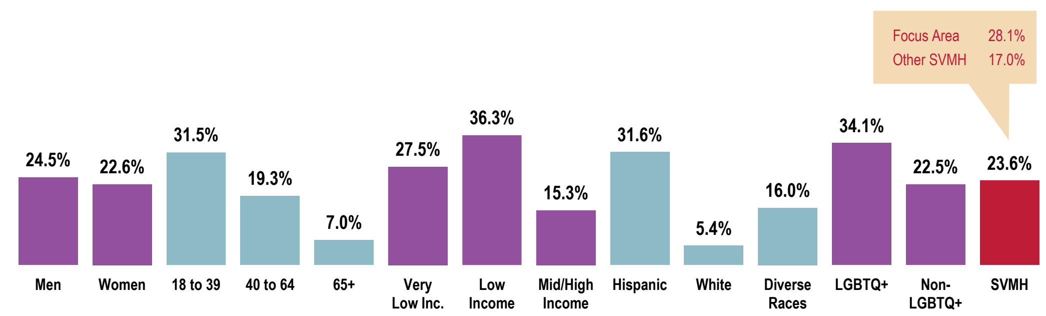


Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 66]
Notes: • Asked of all respondents.

Multigenerational Living

"Many families live in multigenerational households, which are defined as spanning three or more generations. This may include children, parents and grandparents living together, or it might include extended family or unrelated older adults living with younger adults and their children. Does your household included three or more generations of people living together?"

Household Includes Three or More Generations Living Together
(SVMH Service Area, 2022)

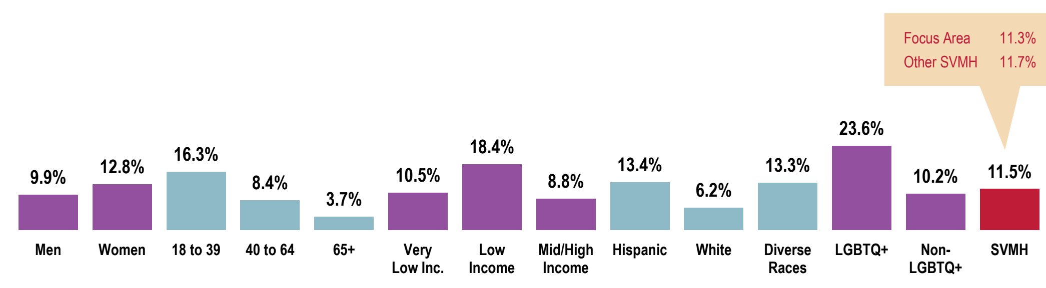


Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 311]
Notes: • Asked of all respondents.

Shared Housing

"To share housing expenses, do you live with anyone outside your immediate family, such as a roommate or boarder?"

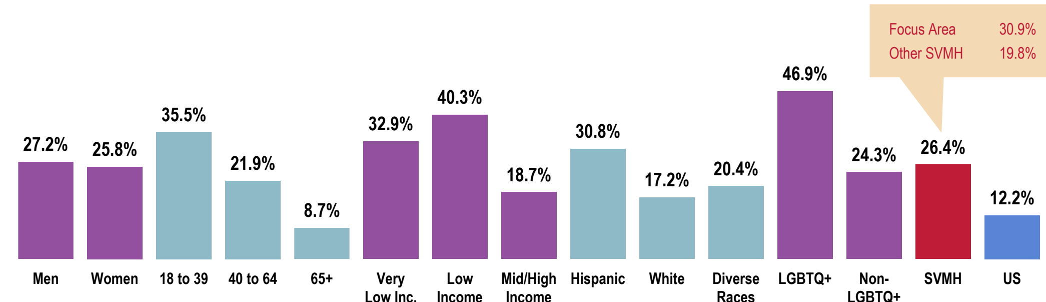
Share Housing Expenses with a Non-Family Member
(SVMH Service Area, 2022)



Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 312]
Notes: • Asked of all respondents.

Unhealthy or Unsafe Housing

"Thinking about your current home, over the past 12 months have you experienced ongoing problems with water leaks, rodents, insects, mold, or other housing conditions that might make living there unhealthy or unsafe?"



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 65]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes respondents who say they experienced ongoing problems in their current home with water leaks, rodents, insects, mold, or other housing conditions that might make living there unhealthy or unsafe.

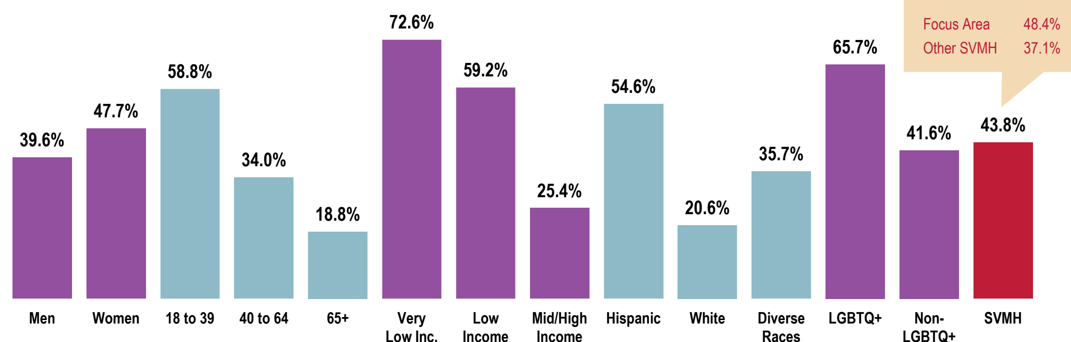
Food Insecurity

"Now I am going to read two statements that people have made about their food situation. Please tell me whether each statement was 'often true,' 'sometimes true,' or 'never true' for you in the past 12 months.

- The first statement is: 'I worried about whether our food would run out before we got money to buy more.'
- The next statement is: 'The food that we bought just did not last, and we did not have money to get more.'"

Agreement with either or both of these statements ("often true" or "sometimes true") defines food insecurity for respondents.

Food Insecurity
(SVMH Service Area, 2022)



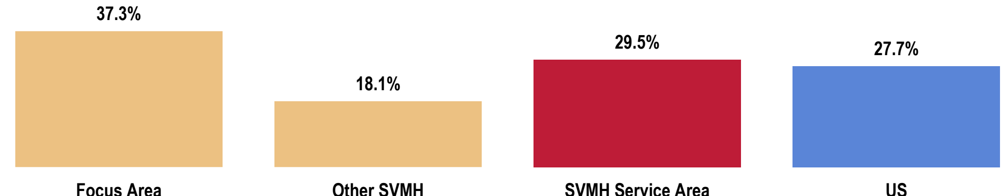
Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 112]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes adults who A) ran out of food at least once in the past year and/or B) worried about running out of food in the past year.

Health Literacy

Low health literacy is defined as those respondents who “seldom/never” find written or spoken health information easy to understand, and/or who “always/nearly always” need help reading health information, and/or who are “not at all confident” in filling out health forms.

Low Health Literacy



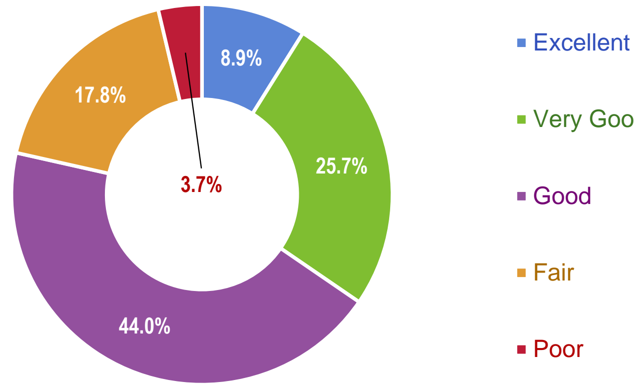
Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 324]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Respondents with low health literacy are those who “seldom/never” find written or spoken health information easy to understand, and/or who “always/nearly always” need help reading health information, and/or who are “not at all confident” in filling out health forms.

HEALTH STATUS

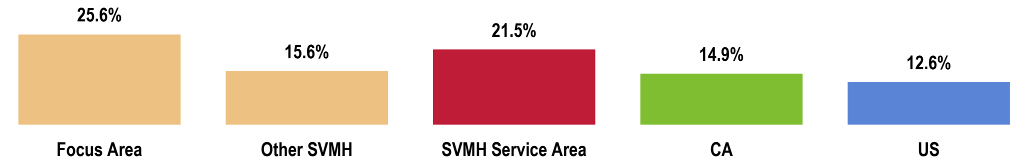
Overall Health

“Would you say that in general your health is: excellent, very good, good, fair, or poor?”



Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 5]
Notes: • Asked of all respondents.

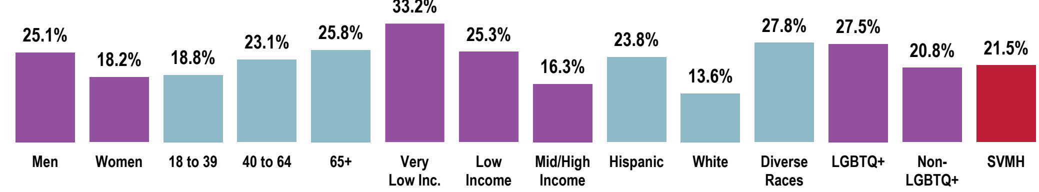
Experience "Fair" or "Poor" Overall Health



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 5]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2021 California data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Experience "Fair" or "Poor" Overall Health
(SVMH Service Area, 2022)



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 5]

Notes:
- Asked of all respondents.

Mental Health

ABOUT MENTAL HEALTH & MENTAL DISORDERS

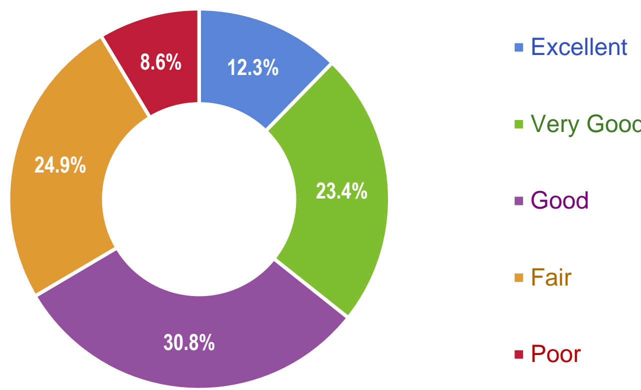
About half of all people in the United States will be diagnosed with a mental disorder at some point in their lifetime. …Mental disorders affect people of all age and racial/ethnic groups, but some populations are disproportionately affected. And estimates suggest that only half of all people with mental disorders get the treatment they need.

In addition, mental health and physical health are closely connected. Mental disorders like depression and anxiety can affect people's ability to take part in healthy behaviors. Similarly, physical health problems can make it harder for people to get treatment for mental disorders. Increasing screening for mental disorders can help people get the treatment they need.

– Healthy People 2030 (https://health.gov/healthypeople)

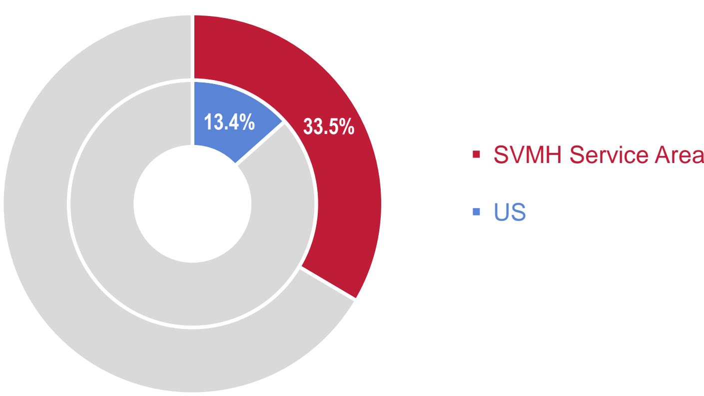
Mental Health Status

"Now thinking about your mental health, which includes stress, depression and problems with emotions, would you say that, in general, your mental health is: excellent, very good, good, fair, or poor?"



Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 90]
Notes: • Asked of all respondents.

Experience "Fair" or "Poor" Mental Health



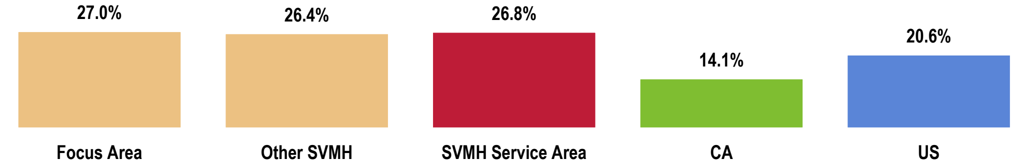
Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 90]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Depression

DIAGNOSED DEPRESSION ▶ **"Has a doctor or other healthcare provider ever told you that you have a depressive disorder, including depression, major depression, dysthymia, or minor depression?"**

Have Been Diagnosed With a Depressive Disorder

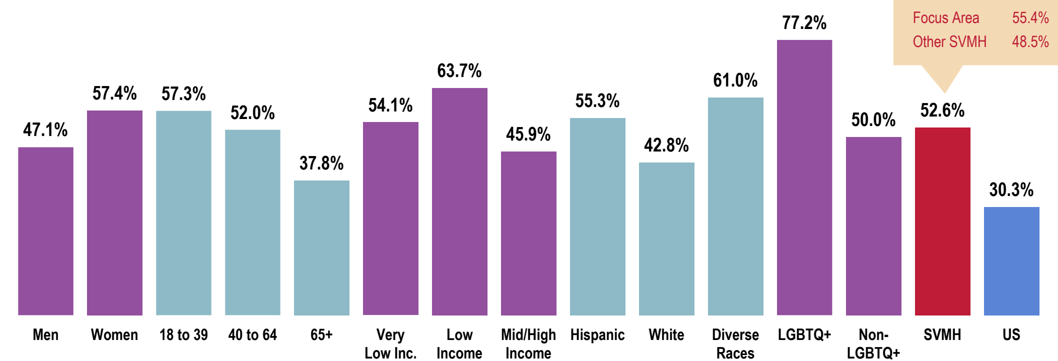


Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 93]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2021 California data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Depressive disorders include depression, major depression, dysthymia, or minor depression.

SYMPTOMS OF CHRONIC DEPRESSION ▶ "Have you had two years or more in your life when you felt depressed or sad most days, even if you felt okay sometimes?"

Have Experienced Symptoms of Chronic Depression
(SVMH Service Area, 2022)



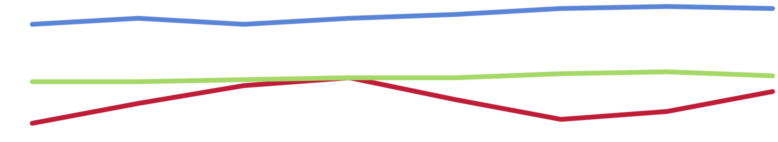
Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 91]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Chronic depression includes periods of two or more years during which the respondent felt depressed or sad on most days, even if (s)he felt okay sometimes.

Suicide

The following chart outlines the most current age-adjusted mortality rates attributed to suicide in Monterey County (refer to "Leading Causes of Death" for an explanation of the use of age-adjusting for these rates). [COUNTY-LEVEL DATA]

Suicide: Age-Adjusted Mortality Trends
(Annual Average Deaths per 100,000 Population)
Healthy People 2030 = 12.8 or Lower



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Monterey County	8.1	9.1	10.0	10.4	9.3	8.3	8.7	9.7
CA	10.2	10.2	10.3	10.4	10.4	10.6	10.7	10.5
US	13.1	13.4	13.1	13.4	13.6	13.9	14.0	13.9

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2022.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

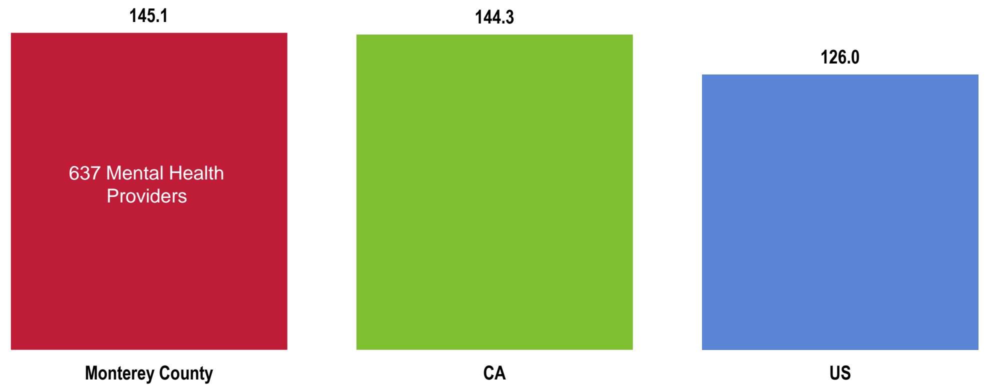
Here, "mental health providers" includes psychiatrists, psychologists, clinical social workers, and counsellors who specialize in mental health care. Note that this indicator only reflects providers practicing in Monterey County and residents in Monterey County; it does not account for the potential demand for services from outside the area, nor the potential availability of providers in surrounding areas.

Mental Health Treatment

The following chart outlines access to mental health providers, expressed as the number of providers (psychiatrists, psychologists, clinical social workers, and counsellors who specialize in mental health care) per 100,000 residents. [COUNTY-LEVEL DATA]

Access to Mental Health Providers

(Number of Mental Health Providers per 100,000 Population, 2021)



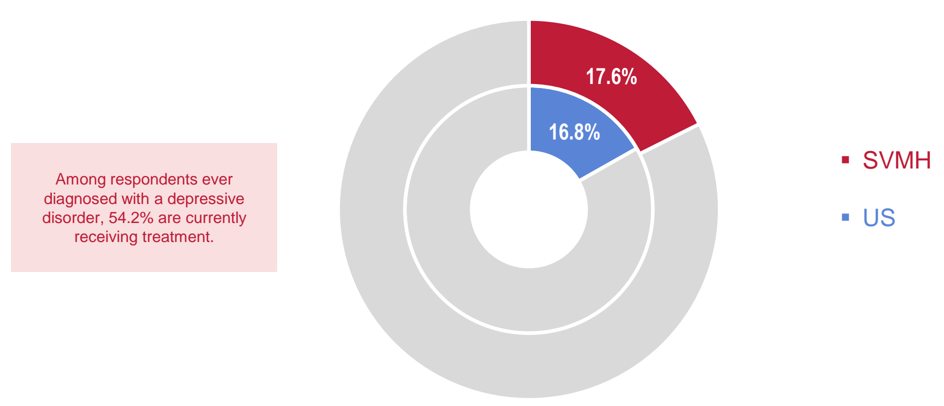
Sources: • University of Wisconsin Population Health Institute, County Health Rankings.
• Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved June 2022 via SparkMap (sparkmap.org).

Notes: • This indicator reports the rate of the county population to the number of mental health providers including psychiatrists, psychologists, clinical social workers, and counsellors that specialize in mental health care.

"Are you now taking medication or receiving treatment from a doctor or other health professional for any type of mental health condition or emotional problem?"

Currently Receiving Mental Health Treatment

Among respondents ever diagnosed with a depressive disorder, 54.2% are currently receiving treatment.

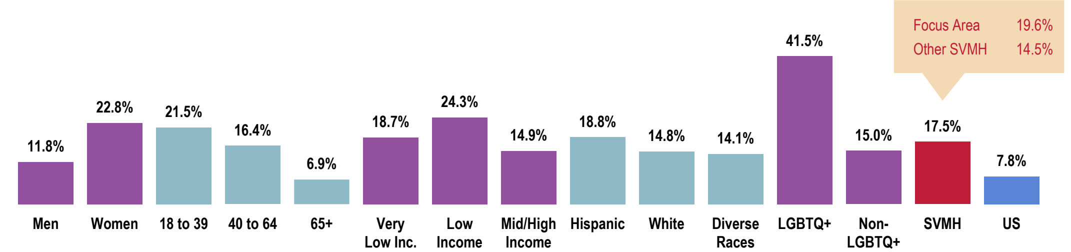


Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Items 93-94]
• 2020 PRC National Health Survey, PRC, Inc.

Notes: • Asked of all respondents.
• "Treatment" can include taking medications for mental health.

“Was there a time in the past 12 months when you needed mental health services but were not able to get them?”

Unable to Get Mental Health Services
When Needed in the Past Year
(SVMH Service Area, 2022)

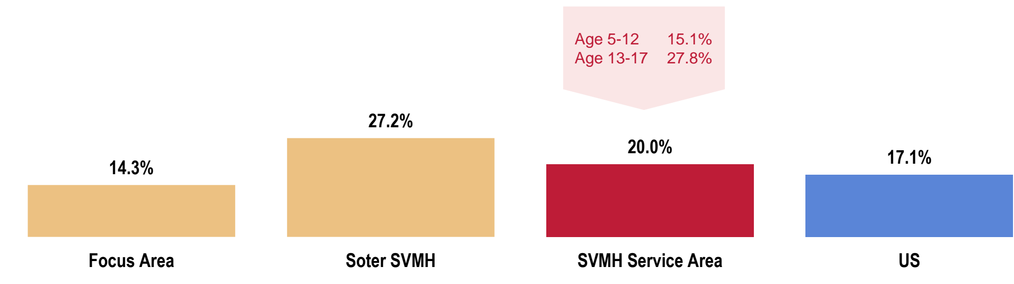


Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 95]
• 2020 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.

Children’s Mental Health

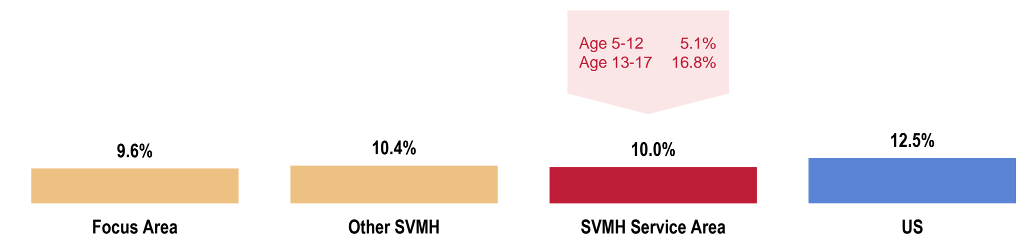
[Age 5-17] “Has this child needed mental health services in the past year?”

Child Has Needed Mental Health Services in the Past Year
(Parents of Children Age 5-17, 2022)



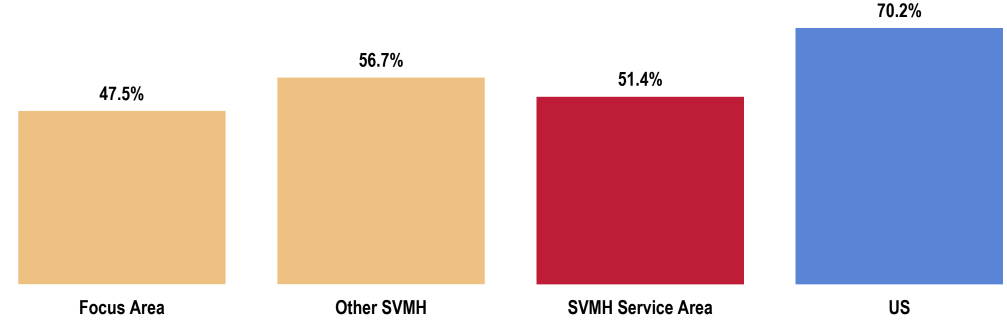
Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 321]
• 2020 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents with children age 5 through 17.

[Age 5-17] "Has this child ever taken prescribed medications to treat his or her mental health?"



Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 322]
• 2020 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents with children age 5 through 17.

[Age 5-17] "Are you aware of the resources in the community for mental health of children?"



Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 323]
• 2020 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents with children age 5 through 17.

Key Informant Input: Mental Health

The following chart outlines key informants' perceptions of the severity of *Mental Health* as a problem in the community:

Perceptions of Mental Health
as a Problem in the Community
(Key Informants, 2022)

Moderate Problem   Minor Problem   No Problem At All

Sources: • PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Access to Care/Services

> Few sites for inpatient treatment or intensive outpatient treatment. – Community Leader
>
> Access for children mental health services, adult mental health. No collaboration with doctors and mental health. I feel that I'm stumbling in the dark in providing psychological care, I have no one to assist me. – Physician
>
> There is no access. – Physician
>
> No services. – Community Leader
>
> Access to treatment. – Social Services Provider
>
> Lack of access to services and cognitive ability to seek them out. – Social Services Provider
>
> Accessing mental health services has continued to be a big challenge in our area given the rise of mental health related needs and lack of providers. – Community Leader
>
> The past two years have unmasked mental health problems for which individuals were barely compensating. We do not have sufficient resources that are accessible and affordable. – Physician
>
> The lack of services available to teens in South Monterey County. – Community Leader
>
> Access to care. – Physician
>
> The biggest challenge is finding a safe place to rest, sleep, or stay that includes access to services for their mental health needs. For those with a mental health diagnosis, there is no one place where they can go to get all of their basic needs met. They need to engage with several different service providers to fully take care of themselves which is a major barrier to getting well and self-sufficiency. – Social Services Provider
>
> Navigating the mental health system when a family member(s) has mental health issues and needs and accessing services. – Public Health Representative
>
> There are no programs and/or facilities in town to help with mental health issues. – Community Leader
>
> Access to services, lack of providers. – Social Services Provider
>
> Accessing care. Currently if you have insurance, the only care provided is at CHOMP. So, if you don't like the doctors, nowhere else to go. If you have Medi-Cal, you are stuck with the county system that seems to think that tele-psych is the answer to everything and not providing in person provider care. Allowing the patient to establish that trust with the provider. Not enough acute inpatient care beds, no adolescent or children's inpatient acute beds. – Other Health Provider
>
> There is just simply not enough mental health care available in a timely fashion for all Monterey County residents. – Physician
>
> Lack of resources in the community. – Other Health Provider
>
> Lack of access to resources due to limited resources. – Social Services Provider
>
> Our mental health services are terrible. Who decided that we should sideline mobile crisis services during COVID? How is that not an essential service? Do we really think that COVID is a bigger risk for a 20 year old with paranoid schizophrenia that is homeless and abusing meth? The lack of leadership and direction is horrific. We need comprehensive reform and people need to be held accountable for providing care to our acutely ill mental health patients. – Social Services Provider
>
> Access to services. Lack of residential treatment facilities. Families who can't care for people who are seriously ill and/or in crisis. – Community Leader

Access to accurate diagnosis and effective, evidence-based treatment. Coordination of care across providers, with PCP's and communication and education of family members. For the chronically mentally ill, there is very poor access to rehabilitation, occupational and housing support services. – Physician

Finding access to mental health care providers, especially in person, is nearly impossible. Most places have long wait lists. It is especially challenging if the mental illness is not extreme. – Social Services Provider

Access and the cost of care. – Community Leader

No mental health providers in our community. Insufficient mental health resources available, even on the peninsula. Mental health services largely unaffordable. – Other Health Provider Lack of adequate numbers of psychiatrists. Lack of a well-organized/publicized mental health care system of providers. Lack of insurance coverage for some of these services. – Physician

Lack of commitment to enhance inpatient services by MCBHD. Limited access for non-Medi-Cal patients. – Public Health Representative

Lack of access to therapists and psychiatrists who will accept Medi-Cal, Medicare, or any commercial insurance. – Social Services Provider

Lack of access to care, expensive care, lack of access for youth inpatient care, stigma. – Public Health Representative

Access to services for both adults and youth. Stigma. – Physician

Minimal to no access to therapeutic or equivalent services. No health insurance or ability to pay for services. Not enough providers for demand of people seeking services. – Community Leader

Not enough access to psychiatrists for low-income individuals, forces long waiting time for diagnosis and treatment. Psychiatric disorders of mild to moderate vs moderate to severe are increasing, especially among alcohol and drug abusers. Access to bridge medication while waiting for an appointment with county for an assessment is not available. Students with anxiety cannot or will not access services in school. This is based on a few reasons including students not wanting to use limited resources set aside for students with severe needs, not enough resources in school or time to access them, stigma, lack of access for students and parents. Parents need someone to talk to, as well. Have same issues of time and access and stigma. With everything going on in our world - politics, environment, cost of living, war, pandemic, there is just not enough fun! Fun is an important component of good mental health – Other Health Provider

Medical treatment, housing, and resources. – Social Services Provider

Lack of behavioral/mental health providers, particularly those who can prescribe. Local psychiatrists have very limited practices and shun patients on the lower end of the socio-economic ladder - homeless probably have the greatest need, but psychiatrists don't see them. Stigma associated with seeking mental health services. Lack of awareness that most governmental and commercial insurances cover BH/MH services. Many healthcare providers are ill-equipped to deal with mental health problems - a very large percentage of patients who unnecessarily access the ER for routine medical care have mental health and/or substance abuse problems. – Community Leader

Lack of coordination of services as well as lack of trained professionals. – Physician

We lack resources in the community to help those with this health concern. The concern is greatest in the uninsured population who lack resources to obtain healthcare services. There is also a language and health literacy barrier that impacts the outcome of this population as well as the community as a whole. – Other Health Provider

Lack of bilingual bicultural therapists. Stigma around accessing mental health services. Cost or perceived cost. – Social Services Provider

Healthcare coverage for therapists. Available MF therapists. Stigma of therapy. – Community Leader

Where to go to get assessed, how to access a provider, how to pay for a provider. I hear there are just not enough providers. Stresses of the pandemic are seen at all ages and will be felt long term. Anxiety, depression, isolation continue to be challenges. – Social Services Provider

Extremely limited providers, long wait times, lack of in-person visits due to COVID restrictions, and a high rate of medication-based assistance vs. counseling services. – Other Health Provider

Access to care. Minimal options: Montage, Monterey County. Lack of private psychiatrists to balance out institutional based practices, patients in crisis need to wait 6-8 weeks for appointments with the larger institutions. Despite huge financial gift, Ohana still not meeting needs. Poor follow through and coordination of care. – Community Leader

Unable to get access to care. – Physician

Due to COVID-19

Mental health was an issue before the pandemic but got worse now and there is not enough access for people in need of services. – Public Health Representative

There aren't enough providers to meet the need that existed prior to COVID and COVID has contributed to pre-existing and new anxiety, depression and isolation. This applies to children, youth and adults. – Social Services Provider

Mental health issues among older adults have exacerbated during the pandemic. Already at risk for depression and anxiety as a result of the losses of aging, these seniors faced a new level of isolation imposed by the pandemic which made them feel even more lonely, fearful and anxious. It limited their independence and their ability to meet their own basic needs and participate in activities outside of their home. They knew their time on this earth was limited and the quality of life they experienced during the pandemic was not what they hoped for. Many lost friends and family members from COVID and are dealing with the grief of that. The challenge ahead is to encourage and support them to reengage with their community and resume their pre-pandemic existence as much as possible. – Social Services Provider

The pandemic has caused people of all ages to struggle with mental health issues. Our senior community are often left alone in housing homes due to COVID-19 restrictions. – Social Services Provider

COVID-19 has exacerbated the mental health issues for many residents. Mental health also plays a part in drug/alcohol addiction issues and homelessness. – Social Services Provider

COVID-19 contributed to mild to moderate mental illness issues due to the ongoing stress of and isolation due to the pandemic. Prior to this, there were already access issues for those needing services. – Social Services Provider

Prevalence/Incidence

Anxiety, depression, bipolar, suicidal ideation and suicide. – Community Leader

Number of patients presenting as 5150 has increased due to the lack of access prior to requiring hospital care. – Other Health Provider

Everyone, and I mean everyone, is struggling with varying mental health issues, notably anxiety. – Community Leader

This is our most significant health issue - loneliness, depression, mental illness, etc. Some are bio-chemically caused - others' mental health issues are caused by lifestyle and situations (that can change our biochemistry). Drug and alcohol abuse also belong here. Mental Health issues are still stigmatized. I was talking with a woman in her 20's whose father wouldn't let her see a therapist when she was in her teens. There are a lot of environmental factors in the world causing depression and other mental health issues, including climate change, war, and COVID. We culturally may not value connectedness and downtime in the US as much as in different cultures. Also, in the US - we don't have a healthy attitude towards alcohol use as some of our European friends - where drinking wine with meals is normal- yet, there is little alcoholism. Locally the lack of high-paying jobs and costly housing forces extreme stress and mental health issues in individuals and families. – Community Leader

Mental health continues to be a huge challenge in CA both with children and adults. Our areas rely primarily on Monterey County Behavioral Health who can't see someone regularly. – Community Leader

Both youth and adults are reporting increased levels of mental illness and distress. – Community Leader

Homeless Populations

Widespread effects, especially with homeless. Lack of resources. – Community Leader

Many mental health patients are homeless and do not seem to be receiving any care. – Other Health Provider

Many homeless are affected by mental health disease and substance use in our community, hence the increase of homeless. – Other Health Provider

There are more homeless folks in our community these days. While I know lack of housing is a contributing factor, I don't know if there are the resources for places and services for people to get help with dealing with mental health issues. – Community Leader

Awareness/Education

Undiagnosed. – Social Services Provider

Currently anxiety and depression and many don't know how to identify it. – Social Services Provider

Where to get treatment. Many are lost and homeless. – Community Leader

Lack of Providers

There is a big shortage of behavioral health providers. There are long wait times and inadequate resources for clinics. There is a lack of behavioral health providers with appropriate language skills and cultural competencies. – Physician

Mental health is a serious issue. There are limited providers in the area with availability to serve the community. There is a need for more diverse providers to serve minority groups. – Public Health Representative

There aren't enough providers. – Community Leader

Denial/Stigma

It is culturally not accepted to say you have a mental health issue. – Social Services Provider

Stigma and access to services. – Community Leader

Lack of Culturally Appropriate Care/Services

> Lack of Spanish speaking MH providers accepting new patients. – Public Health Representative
>
> Access to culturally and language appropriate behavioral health services. – Physician

Stress

> Stressful lives, low income, multiple/stressful jobs, unaffordable housing. Poor access to healthcare services. – Public Health Representative
>
> Stress and anxiety especially related to poverty and economics, racism, isolation, immigration laws, unsupportive workplaces, etc. – Social Services Provider

Impact on Quality of Life

> Mental health issues exacerbate all medical and social issues. – Physician
>
> Inability to work or take care of themselves. Homelessness. Need programs that are available and need to find ways to get that information out to those who need it. – Social Services Provider

Trauma

> Primarily social psychological/community stress/trauma. Trump/political polarization, COVID/family that has died, racial inequality, climate change, Ukraine. – Public Health Representative

Cultural/Personal Beliefs

> Latin-X culture and understanding of mental health needs improvement. Many are unfamiliar with treatment options and while this is a generalization, it still holds true from my perspective. – Social Services Provider

Disease Management

> The ability to provide necessary treatment/therapies to individuals, who are refusing the help. By not allowing health care professionals to treat them, they continue to endanger themselves and others while living in an unhoused situation. Public perception is that the behavior of mentally ill unhoused folks is 'lawless' and demand law enforcement intervention. I think it is not fair to the mentally ill to not find ways for treatment and support. Our County/State is missing out on tapping into their potential and creativity. – Community Leader

Cannot Meet Basic Needs

> Inability to meet basic needs, housing, jobs, education, food, preventative care. Stigma associated with mental health. Lack of access to preventative care. Higher rates of SUD amongst residents. – Public Health Representative

Isolation

> Isolation, structural racism, economic pressures, housing pressures are huge and there is a lack of appropriate resources for our populations to support them in addressing their own regulation so that they can also support their family's regulation. – Community Leader

Family Challenges

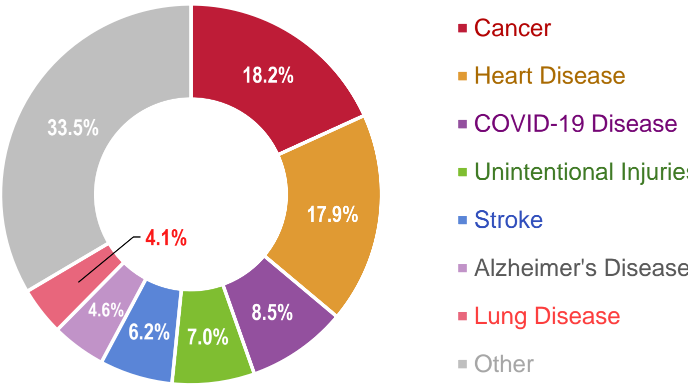
> The mental health challenges are the working parents are not paying attention to their kids and they are not noticing when things are happening to their child's mental health. – Community Leader

DEATH, DISEASE & CHRONIC CONDITIONS

Leading Causes of Death

Distribution of Deaths by Cause

Cancers and heart disease are leading causes of death in Monterey County. [COUNTY-LEVEL DATA]



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2022.

Notes: • Lung disease is CLRD, or chronic lower respiratory disease.

Age-Adjusted Death Rates for Selected Causes

AGE-ADJUSTED DEATH RATES

In order to compare mortality in the region with other localities (in this case, California and the United States), it is necessary to look at rates of death — these are figures which represent the number of deaths in relation to the population size (such as deaths per 100,000 population, as is used here).

Furthermore, in order to compare localities without undue bias toward younger or older populations, the common convention is to adjust the data to some common baseline age distribution. Use of these "age-adjusted" rates provides the most valuable means of gauging mortality against benchmark data, as well as Healthy People 2030 objectives.

The following chart outlines annual average age-adjusted death rates per 100,000 population for selected causes of death in Monterey County. [COUNTY-LEVEL DATA]

For infant mortality data, see *Birth Outcomes & Risks* in the **Births** section of this report.

Age-Adjusted Death Rates for Selected Causes
(2018-2020 Deaths per 100,000 Population)

	Monterey County	California	US	HP2030
Malignant Neoplasms (Cancers)	116.7	132.3	146.5	122.7
Diseases of the Heart	109.3	140.2	164.4	127.4*
COVID-19 (2020 Data)	53.8	68.7	85.0	—
Unintentional Injuries	41.6	37.9	51.6	43.2
Falls [Age 65+]	40.0	41.4	67.1	63.4
Cerebrovascular Disease (Stroke)	34.5	37.8	37.6	33.4
Alzheimer's Disease	25.1	38.2	30.9	—
Chronic Lower Respiratory Disease (CLRD)	24.1	29.3	38.1	—
Diabetes	17.1	22.9	22.6	—
Unintentional Drug-Related Deaths	15.2	15.2	21.0	—
Cirrhosis/Liver Disease	12.4	12.8	11.9	10.9
Pneumonia/Influenza	10.6	13.8	13.4	—
Motor Vehicle Deaths	10.5	9.9	11.4	10.1
Intentional Self-Harm (Suicide)	9.7	10.5	13.9	12.8
Kidney Disease	9.5	9.1	12.8	—
Firearm-Related	7.7	7.7	12.5	10.7
Homicide/Legal Intervention	5.0	5.1	6.1	5.5
HIV/AIDS	1.1	1.7	1.8	—

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2022.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov.

Note:
- *The Healthy People 2030 Heart Disease target is adjusted to account for all diseases of the heart.

Cardiovascular Disease

ABOUT HEART DISEASE & STROKE

Heart disease is the leading cause of death in the United States, and stroke is the fifth leading cause. …Heart disease and stroke can result in poor quality of life, disability, and death. Though both diseases are common, they can often be prevented by controlling risk factors like high blood pressure and high cholesterol through treatment.

In addition, making sure people who experience a cardiovascular emergency — like stroke, heart attack, or cardiac arrest — get timely recommended treatment can reduce their risk for long-term disability and death. Teaching people to recognize symptoms is key to helping more people get the treatment they need.

– Healthy People 2030 (https://health.gov/healthypeople)

Age-Adjusted Heart Disease & Stroke Deaths

The greatest share of cardiovascular deaths is attributed to heart disease. The following charts outline age-adjusted mortality rates for heart disease and for stroke in Monterey County. [COUNTY-LEVEL DATA]

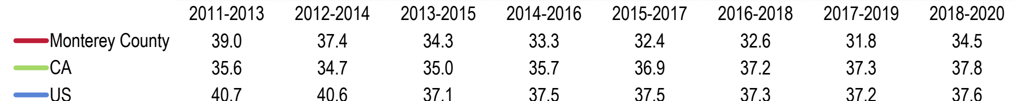
Heart Disease: Age-Adjusted Mortality Trends
(Annual Average Deaths per 100,000 Population)
Healthy People 2030 = 127.4 or Lower (Adjusted)

	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Monterey County	125.2	119.3	116.3	109.7	109.5	107.5	109.2	109.3
CA	154.7	149.1	146.5	143.6	143.9	141.9	139.8	140.2
US	190.6	188.9	168.9	167.5	166.3	164.7	163.4	164.4

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2022.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

Notes:
- The Healthy People 2030 Heart Disease target is adjusted to account for all diseases of the heart.

Stroke: Age-Adjusted Mortality Trends
(Annual Average Deaths per 100,000 Population)
Healthy People 2030 = 33.4 or Lower



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Monterey County	39.0	37.4	34.3	33.3	32.4	32.6	31.8	34.5
CA	35.6	34.7	35.0	35.7	36.9	37.2	37.3	37.8
US	40.7	40.6	37.1	37.5	37.5	37.3	37.2	37.6

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2022.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

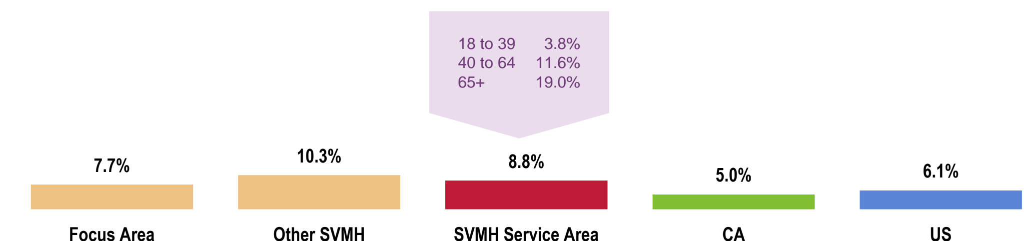
Prevalence of Heart Disease & Stroke

"Has a doctor, nurse, or other health professional ever told you that you had:

- A heart attack, also called a myocardial infarction?
- Angina or coronary heart disease?"

Heart disease prevalence here is a calculated prevalence that includes those responding affirmatively to either.

Prevalence of Heart Disease

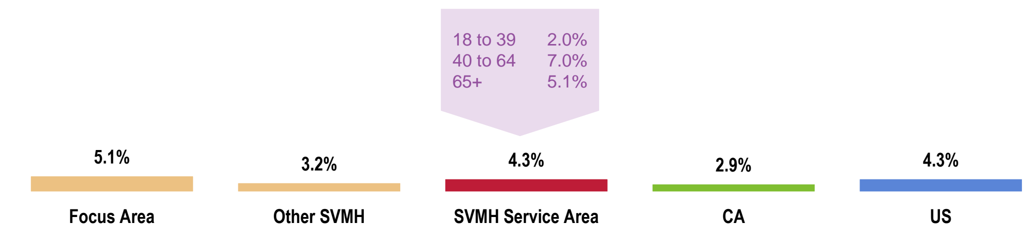


Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 114]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2021 California data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes diagnoses of heart attack, angina, or coronary heart disease.

“Has a doctor, nurse, or other health professional ever told you that you had a stroke?”

Prevalence of Stroke



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 29]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2021 California data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Cardiovascular Risk Factors

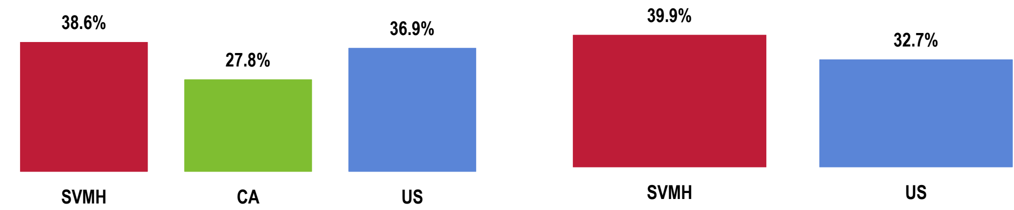
Blood Pressure & Cholesterol

“Have you ever been told by a doctor, nurse, or other health care professional that you had high blood pressure?”

“Blood cholesterol is a fatty substance found in the blood. Have you ever been told by a doctor, nurse, or other health care professional that your blood cholesterol is high?”

Prevalence of High Blood Pressure
Healthy People 2030 = 27.7% or Lower

Prevalence of High Blood Cholesterol



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Items 35-36]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2021 California data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

Notes:
- Asked of all respondents.

Total Cardiovascular Risk

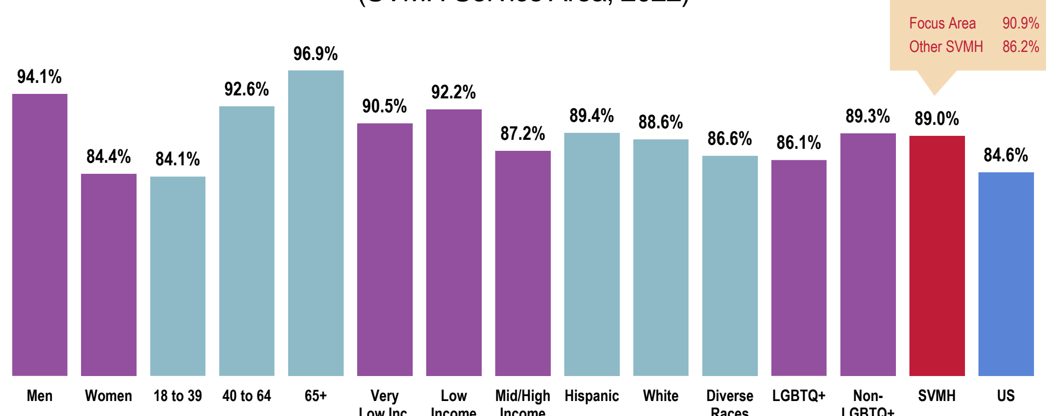
RELATED ISSUE
See also *Nutrition, Physical Activity & Weight* and *Tobacco Use* in the **Modifiable Health Risks** section of this report.

Total cardiovascular risk reflects the individual-level risk factors which put a person at increased risk for cardiovascular disease, including:

- High Blood Pressure
- High Blood Cholesterol
- Cigarette Smoking
- Physical Inactivity
- Overweight/Obesity

Modifying these behaviors and adhering to treatment for high blood pressure and cholesterol are critical both for preventing and for controlling cardiovascular disease.

The following chart reflects the percentage of adults in the SVMH Service Area who report one or more of the following: being overweight; smoking cigarettes; being physically inactive; or having high blood pressure or cholesterol.

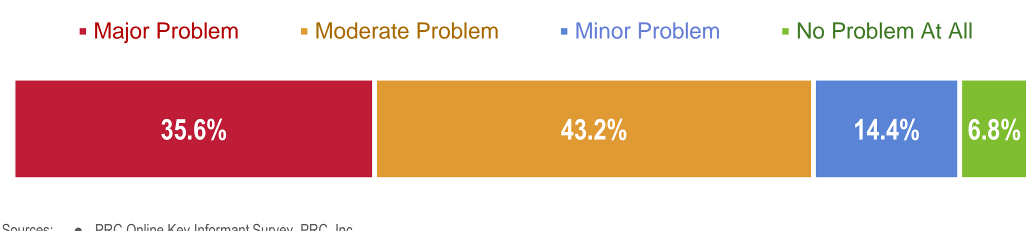


Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 115]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Reflects all respondents.
- Cardiovascular risk is defined as exhibiting one or more of the following: 1) no leisure-time physical activity; 2) regular/occasional cigarette smoking; 3) high blood pressure; 4) high blood cholesterol; and/or 5) being overweight/obese.

Key Informant Input: Heart Disease & Stroke

The following chart outlines key informants' perceptions of the severity of *Heart Disease & Stroke* as a problem in the community:



Sources: • PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Prevalence/Incidence

> Heart disease and stroke are leading causes of premature death. – Public Health Representative
>
> Nationally one of the leading causes of death. – Social Services Provider
>
> Heart disease remains a leading cause of death and disability in our community. The risk is exacerbated by poor primary care access and lack of effective prevention programs. – Public Health Representative
>
> Heart disease is the leading cause of death for men and women. – Public Health Representative
>
> Younger people in our community are having strokes. Some of this is their general health and some of this is from addiction. Heart disease is a major complaint, HBP, and heart attacks seem to happen to lots of the community members. – Community Leader
>
> Data suggests that heart disease and stroke continue to be major contributors to premature mortality. – Social Services Provider
>
> There is an aging population on the peninsula and these conditions represent a large portion of the morbidity and mortality in that population. And in other parts of the county, we see a heavy burden of heart disease, even in a younger population, due to obesity and diabetes co-morbidities. – Physician
>
> I don't have the specific data of incidences, but heart disease and strokes. Cardiovascular diseases cause one in three deaths in the US. So, I would assume that we have a similar prevalence. – Community Leader

Co-Occurrences

> Related to high rate of diabetes mellitus. – Social Services Provider
>
> Heart disease continues to live hand in hand with diabetes. Diets that lack the proper nutrition and lack of physical activity. – Social Services Provider
>
> We see a lot of diabetics who also have heart disease. Many end up without necessary surgery because they cannot be cleared medically for anesthesia because of heart disease. – Other Health Provider
>
> Obesity, diabetes, and hypertension have a high prevalence in our community. – Physician
>
> Diabetes and hypertension go hand in hand with heart disease. Since the numbers are so high in Monterey County, untreated and uncontrolled DM and HBP eventually cause heart disease. – Public Health Representative

Awareness/Education

> Lack of access to preventative care programs and education. Most of our outreach and messaging is not culturally appropriate and mainly in English. – Social Services Provider
>
> Awareness of how to prevent/address heart disease and stroke, lack of safe spaces to exercise, access to healthy and affordable food. – Social Services Provider
>
> Education and consistency with the importance of lipid and blood pressure control. – Physician
>
> Misinformation and misunderstanding about the need for prevention, therefore people are uninformed about the need to get exercise and take their medications regularly. – Physician

Diet

> People are getting their heart arteries clogged from all the bad eating choices they are making. Stress is another issue that people go through, and it ends up causing them a stroke. – Community Leader
>
> Poor diet, obesity, sedentary lifestyles and aging all contribute to this. – Community Leader
>
> Diet and education. – Community Leader

Aging Population

> Major causes of morbidity and mortality in our aging communities. – Physician
>
> They are among the leading causes of death in older adults which is the population we serve in our organization. Many of them are receiving ongoing treatment and medications for their condition. Others have had medical interventions that keep them independent enough to maintain some quality of life and emotionally well enough to socially engage with their families and community. The more resourced and educated seniors recognize the importance of a healthy lifestyle on their condition and are pro-active in learning about and accessing resources. Those less resourced and educated do not fare as well with these conditions. – Social Services Provider

Stress

> Stress and the social determinants of health are major contributing factors. More must be done to improve the quality of life for folks at all income levels, particularly BIPoC (farmworkers and migrants). – Public Health Representative
>
> Stress. – Social Services Provider

Weight Status

> Higher rates of overweight/obesity lead to higher rates of heart disease and strokes. People don't have access to healthy foods and safe places to recreate. Delayed access to preventative care. – Public Health Representative
>
> The community is overweight, and diets are poor. – Other Health Provider

Access to Care for Persons Who Are Uninsured/Underinsured

> We lack resources in the community to help those with this health concern. The concern is greatest in the uninsured population who lack resources to obtain healthcare services. We need more preventative and education services to live healthier lives especially those that lack resources to eat healthy and live healthy lives. – Other Health Provider

Persons at Increased Risk for Adverse Health Outcomes

> Because alcoholics and addicts who are not accessing health care services are susceptible. – Social Services Provider

Lifestyle

> We are a community of Latino background who does not eat or exercise. – Community Leader

High Blood Pressure

> High blood pressure. The majority of our guests eat unhealthy diets, which contributes to high blood pressure. – Social Services Provider

Cancer

ABOUT CANCER

Cancer is the second leading cause of death in the United States. …The cancer death rate has declined in recent decades, but over 600,000 people still die from cancer each year in the United States. Death rates are higher for some cancers and in some racial/ethnic minority groups. These disparities are often linked to social determinants of health, including education, economic status, and access to health care.

Interventions to promote evidence-based cancer screenings — such as screenings for lung, breast, cervical, and colorectal cancer — can help reduce cancer deaths. Other effective prevention strategies include programs that increase HPV vaccine use, prevent tobacco use and promote quitting, and promote healthy eating and physical activity. In addition, effective targeted therapies and personalized treatment are key to helping people with cancer live longer.

– Healthy People 2030 (https://health.gov/healthypeople)

Age-Adjusted Cancer Deaths

The following chart illustrates age-adjusted cancer mortality (all types) in Monterey County. [COUNTY-LEVEL DATA]

Cancer: Age-Adjusted Mortality Trends
(Annual Average Deaths per 100,000 Population)
Healthy People 2030 = 122.7 or Lower

	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Monterey County	140.0	136.0	130.6	129.4	127.9	125.4	121.6	116.7
CA	149.9	147.3	144.6	142.2	139.7	137.1	134.4	132.3
US	171.5	168.0	160.1	157.6	155.6	152.5	149.3	146.5

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2022.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

Lung cancer is by far the leading cause of cancer deaths in Monterey County. [COUNTY-LEVEL DATA]

Age-Adjusted Cancer Death Rates by Site
(2018-2020 Annual Average Deaths per 100,000 Population)

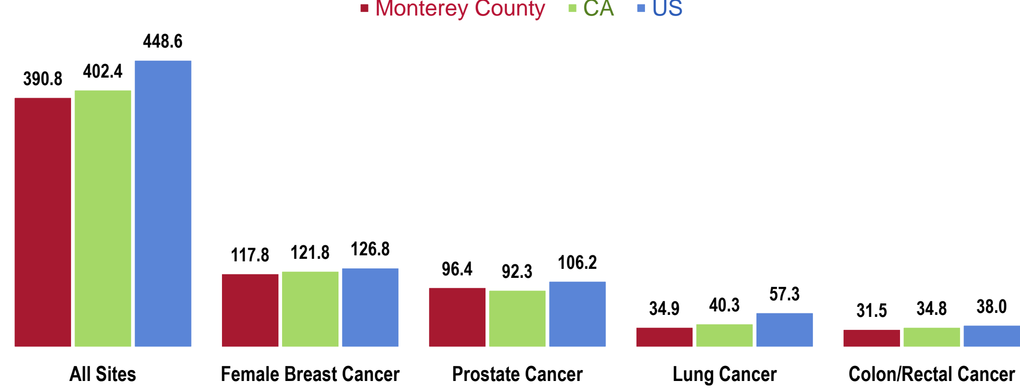
	Monterey County	California	US	HP2030
ALL CANCERS	116.7	132.3	146.5	122.7
Lung Cancer	20.1	23.7	33.4	25.1
Prostate Cancer	15.9	19.6	18.5	16.9
Female Breast Cancer	13.9	18.7	19.4	15.3
Colorectal Cancer	10.2	12.2	13.1	8.9

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2022.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Cancer Incidence

"Incidence rate" or "case rate" is the number of newly diagnosed cases in a given population in a given year, regardless of outcome. These rates are also age-adjusted. It is usually expressed as cases per 100,000 population per year. [COUNTY-LEVEL DATA]

Cancer Incidence Rates by Site
(Annual Average Age-Adjusted Incidence per 100,000 Population, 2014-2018)



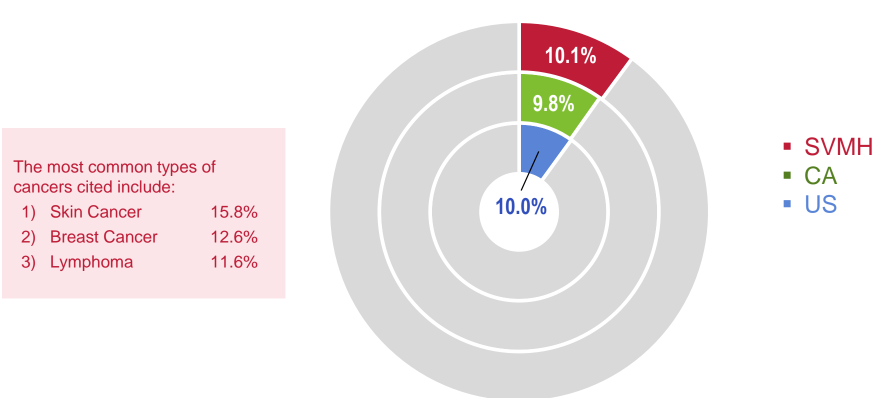
Sources:
- State Cancer Profiles.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved June 2022 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the age adjusted incidence rate (cases per 100,000 population per year) of cancers, adjusted to 2000 US standard population age groups (under age 1, 1-4, 5-9, ..., 80-84, 85 and older). This indicator is relevant because cancer is a leading cause of death and it is important to identify cancers separately to better target interventions.

Prevalence of Cancer

"Have you ever suffered from or been diagnosed with cancer?"

"Which type of cancer were you diagnosed with? (If more than one past diagnosis, respondent was asked about the most recent.)



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Items 25-26]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2021 California data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Reflects all respondents.

RELATED ISSUE
See also *Nutrition, Physical Activity & Weight* and *Tobacco Use* in the **Modifiable Health Risks** section of this report.

ABOUT CANCER RISK

Reducing the nation's cancer burden requires reducing the prevalence of behavioral and environmental factors that increase cancer risk.

- All cancers caused by cigarette smoking could be prevented. At least one-third of cancer deaths that occur in the United States are due to cigarette smoking.
- According to the American Cancer Society, about one-third of cancer deaths that occur in the United States each year are due to nutrition and physical activity factors, including obesity.

– National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention

Cancer Screenings

The American Cancer Society recommends that both men and women get a cancer-related checkup during a regular doctor's checkup. It should include examination for cancers of the thyroid, testicles, ovaries, lymph nodes, oral cavity, and skin, as well as health counseling about tobacco, sun exposure, diet and nutrition, risk factors, sexual practices, and environmental and occupational exposures.

FEMALE BREAST CANCER

The US Preventive Services Task Force (USPSTF) recommends biennial screening mammography for women aged 50 to 74 years.

CERVICAL CANCER

The US Preventive Services Task Force (USPSTF) recommends screening for cervical cancer every 3 years with cervical cytology alone in women aged 21 to 29 years. For women aged 30 to 65 years, the USPSTF recommends screening every 3 years with cervical cytology alone, every 5 years with high-risk human papillomavirus (hrHPV) testing alone, or every 5 years with hrHPV testing in combination with cytology (cotesting). The USPSTF recommends against screening for cervical cancer in women who have had a hysterectomy with removal of the cervix and do not have a history of a high-grade precancerous lesion (i.e., cervical intraepithelial neoplasia [CIN] grade 2 or 3) or cervical cancer.

COLORECTAL CANCER

The US Preventive Services Task Force (USPSTF) recommends screening for colorectal cancer starting at age 50 years and continuing until age 75 years.

– US Preventive Services Task Force, Agency for Healthcare Research and Quality, US Department of Health & Human Services

Note that other organizations (e.g., American Cancer Society, American Academy of Family Physicians, American College of Physicians, National Cancer Institute) may have slightly different screening guidelines.

Screening levels in the community were measured in the PRC Community Health Survey relative to three cancer sites: female breast cancer (mammography); cervical cancer (Pap smear testing); and colorectal cancer (sigmoidoscopy and fecal occult blood testing).

BREAST CANCER SCREENING ▶ "A mammogram is an x-ray of each breast to look for cancer. How long has it been since you had your last mammogram?"

Breast cancer screening is calculated here among women age 50 to 74 who indicate mammography within the past 2 years.

CERVICAL CANCER SCREENING ▶ "A Pap test is a test for cancer of the cervix. How long has it been since you had your last Pap test?"

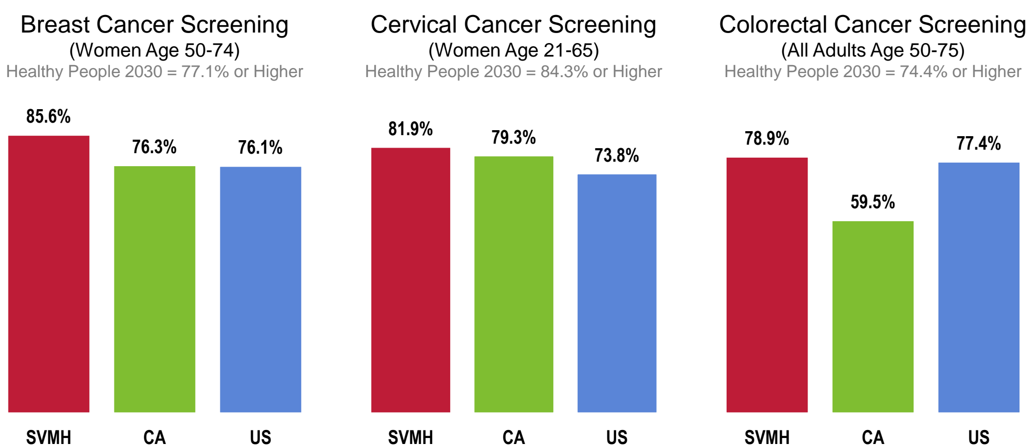
[If Pap test in the past five years] "HPV, or the human papillomavirus, is a common infection that can cause several types of cancer. When you received your last Pap test, were you screened for HPV?"

"Appropriate cervical cancer screening" includes Pap smear testing (cervical cytology) every three years in women age 21 to 29 and Pap smear testing and/or HPV testing every 5 years in women age 30 to 65.

COLORECTAL CANCER SCREENING ▶ "Sigmoidoscopy and colonoscopy are exams in which a tube is inserted in the rectum to view the colon for signs of cancer or other health problems. How long has it been since your last sigmoidoscopy or colonoscopy?"

“A blood stool test is a test that may use a special kit at home to determine whether the stool contains blood. How long has it been since you had your last blood stool test?”

“Appropriate colorectal cancer screening” is calculated here among men and women age 50 to 75 years who have had a fecal occult blood test within the past year and/or a lower endoscopy (sigmoidoscopy or colonoscopy) within the past 10 years.

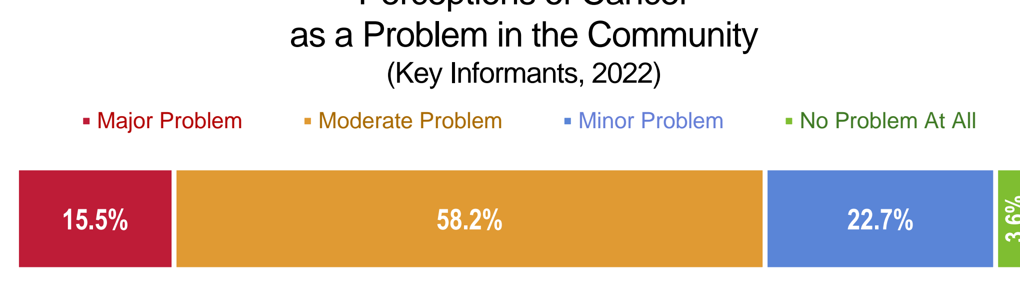


Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Items 116-118]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2021 California data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

Notes:
- Each indicator is shown among the gender and/or age group specified.

Key Informant Input: Cancer

The following chart outlines key informants’ perceptions of the severity of *Cancer* as a problem in the community:



Sources:
- PRC Online Key Informant Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Among those rating this issue as a “major problem,” reasons related to the following:

Prevalence/Incidence

> It seems to me that we have a large amount of people that end up with some sort of cancer issue. – Community Leader
>
> Too many suffer and die from it in our community. – Community Leader

> There are still too many people dying from cancers that could be detected and treated early. Although access to screening has improved, the ability of the average person to access and pay for treatment is limited due to the high cost. In terms of prevention, Monterey County has many sources of known cancer-causing chemicals, again there have been improvements in some things such as pesticide use, there is still work to be done. In terms of equity, the burden of disease and death falls on those who have the least access to resources. – Public Health Representative
>
> I used to hear a lot about breast cancer and now I'm hearing quite a few men talk about having prostate cancer. It could be that they are discussing more, but I also would guess that there is an increase in prevalence. – Community Leader
>
> It's one of the major causes of death in Monterey County. – Public Health Representative
>
> Last I knew it was on the list of causes of premature death in the county. – Community Leader
>
> High frequency of new cases. – Physician

Access to Care/Services

> There are no services currently available locally and folks need to go north for consultations and treatment. Would be good to be able to have some treatments administered locally. – Community Leader
>
> There are suboptimal resources for patients with cancer. – Physician
>
> I believe we do not have any facility that I know of in Monterey County that specifically deals with cancer patients and helping their families deal with it. – Other Health Provider

Persons at Increased Risk for Adverse Health Outcomes

> The population of Monterey County is nearly 60% Latino. Cancer is the #1 cause of death for Latinos. Although there are two community cancer centers (CHOMP and SVMH) the county hospital Natividad Medical Center, admirable is so many respects, does not offer medical treatment for cancer. This has grave implications and fragmented or no treatment or cancer care for low-income Latinos - and generally for farm workers, immigrants and other traditionally underserved populations. – Community Leader
>
> We continue to see high incidences of cancer among our low-income residents. This can be attributed to income disparity among our Latino communities who must choose between paying the rent, feeding their families, or childcare. Taking care of their health and getting preventative care takes a back seat as opposed to taking care of the family. – Social Services Provider

Access to Care for Persons Who Are Uninsured/Underinsured

> I believe it goes undetected because patients are not doing their routine checkup because they don't have insurance, maybe due to loss of job or unable to afford to pay for co-pays and out of pocket costs. – Social Services Provider

Affordable Care/Services

> While we may or may not have similar rates of cancer in the community, we have a problem (along with every other community) with the extremely high cost of chemotherapy. Most importantly, though, we engage in significant over-treatment from not acknowledging when treatment is futile soon enough - and transitioning to hospice or comfort care. – Physician

Prevention/Screenings

> Many people hold off on health screenings that can help detect cancer at an early stage. – Social Services Provider

Prevention/Screening

> Many people are not aware of the signs of cancer and the local hospitals do not want to spend the time testing people until it is too late. – Community Leader

Access to Affordable Healthy Food

> Former Fort Ord Military Base. Limited access to healthy food. – Social Services Provider

Environmental Contributors

> Agricultural pesticides. – Community Leader

Respiratory Disease

ABOUT RESPIRATORY DISEASE

Respiratory diseases affect millions of people in the United States. …More than 25 million people in the United States have asthma. Strategies to reduce environmental triggers and make sure people get the right medications can help prevent hospital visits for asthma. In addition, more than 16 million people in the United States have COPD (chronic obstructive pulmonary disease), which is a major cause of death. Strategies to prevent the disease — like reducing air pollution and helping people quit smoking — are key to reducing deaths from COPD.

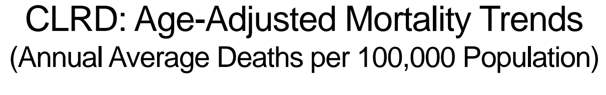
Interventions tailored to at-risk groups can also help prevent and treat other respiratory diseases — for example, pneumonia in older adults and pneumoconiosis in coal miners. And increasing lung cancer screening rates can help reduce deaths from lung cancer through early detection and treatment.

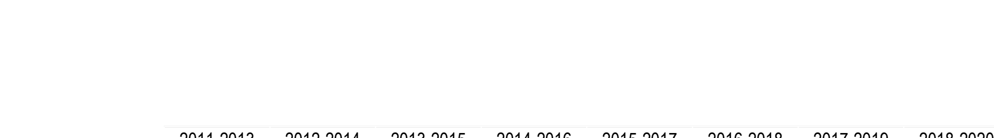
– Healthy People 2030 (https://health.gov/healthypeople)

Age-Adjusted Respiratory Disease Deaths

Chronic lower respiratory diseases (CLRD) are diseases affecting the lungs; the most deadly of these is chronic obstructive pulmonary disease (COPD), which includes emphysema and chronic bronchitis. Mortality for CLRD in Monterey County is illustrated in the charts that follow.

Pneumonia and influenza mortality is also illustrated. [COUNTY-LEVEL DATA]



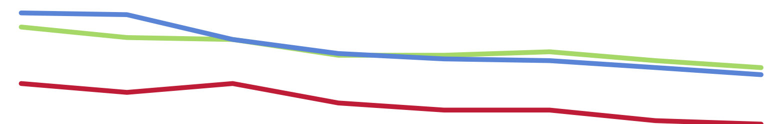


	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Monterey County	27.8	27.7	26.4	27.3	27.7	25.8	24.5	24.1
CA	35.5	33.9	33.5	32.6	32.6	31.9	30.7	29.3
US	46.5	46.2	41.8	41.3	41.0	40.4	39.6	38.1

Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2022.

Notes: • CLRD is chronic lower respiratory disease.

Pneumonia/Influenza: Age-Adjusted Mortality Trends
(Annual Average Deaths per 100,000 Population)



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Monterey County	12.9	12.4	12.9	11.8	11.4	11.4	10.8	10.6
CA	16.1	15.5	15.4	14.5	14.5	14.7	14.2	13.8
US	16.9	16.8	15.4	14.6	14.3	14.2	13.8	13.4

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2022.

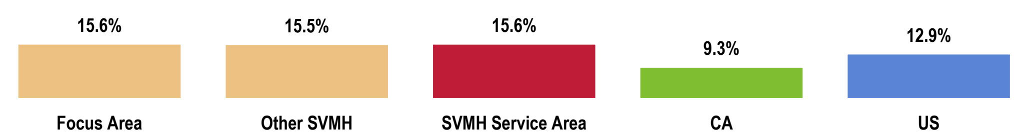
Prevalence of Respiratory Disease

Asthma

ADULTS ▶ "Have you ever been told by a doctor, nurse, or other health professional that you had asthma?" and "Do you still have asthma?" (Calculated here as a prevalence of all adults who have ever been diagnosed with asthma and who still have asthma.)

CHILDREN ▶ "Has a doctor or other health professional ever told you that this child had asthma?" and "Does this child still have asthma?" (Calculated here as a prevalence of all children who have ever been diagnosed with asthma and who still have asthma.)

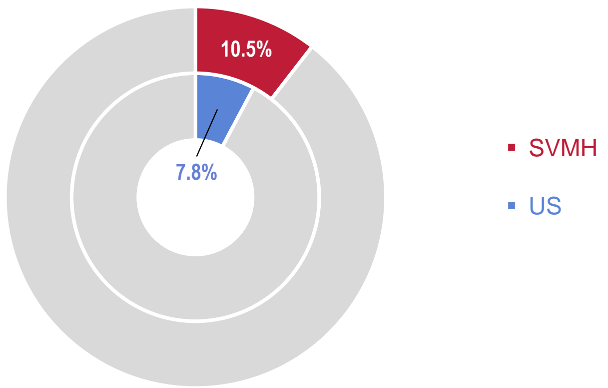
Prevalence of Asthma



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 119]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2021 California data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes those who have ever been diagnosed with asthma and report that they still have asthma.

Prevalence of Asthma in Children
(Parents of Children Age 0-17)



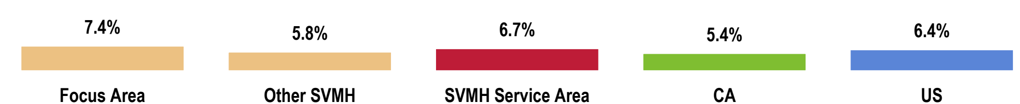
Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 120]
• 2020 PRC National Health Survey, PRC, Inc.

Notes: • Asked of all respondents with children 0 to 17 in the household.
• Includes children who have ever been diagnosed with asthma and are reported to still have asthma.

Chronic Obstructive Pulmonary Disease (COPD)

"Would you please tell me if you have ever suffered from or been diagnosed with COPD or chronic obstructive pulmonary disease, including bronchitis or emphysema?"

Prevalence of Chronic Obstructive Pulmonary Disease (COPD)



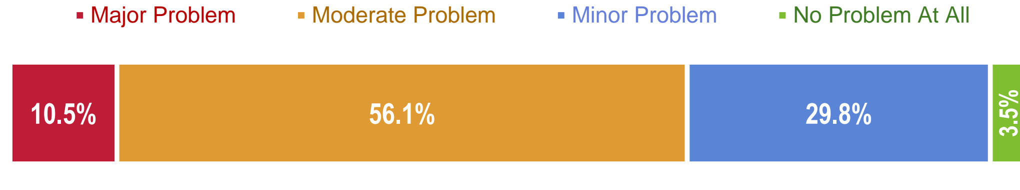
Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 23]
• Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2021 California data.
• 2020 PRC National Health Survey, PRC, Inc.

Notes: • Asked of all respondents.
• Includes those having ever suffered from or been diagnosed with COPD or chronic obstructive pulmonary disease, including bronchitis or emphysema.

Key Informant Input: Respiratory Disease

The following chart outlines key informants' perceptions of the severity of *Respiratory Disease* as a problem in the community:

Perceptions of Respiratory Diseases as a Problem in the Community
(Key Informants, 2022)



Sources: • PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Environmental Contributors

> Pesticides. – Community Leader
>
> Many residents affected by pesticides and other contaminants in the community due to farming and other factories locally. – Other Health Provider
>
> I don't see this as much, but from the Chamacos study, we can attribute some of it to the pesticides used in agriculture. – Social Services Provider
>
> Pesticide exposure. There are lots of pesticides applied in our agricultural fields and communities that live beside the fields, including children in some schools, may have several years to a lifetime of cumulative exposures due to pesticide drift. – Social Services Provider

Prevalence/Incidence

> Higher than statistically expected levels of asthma are prevalent in the community. – Community Leader

Lack of Providers

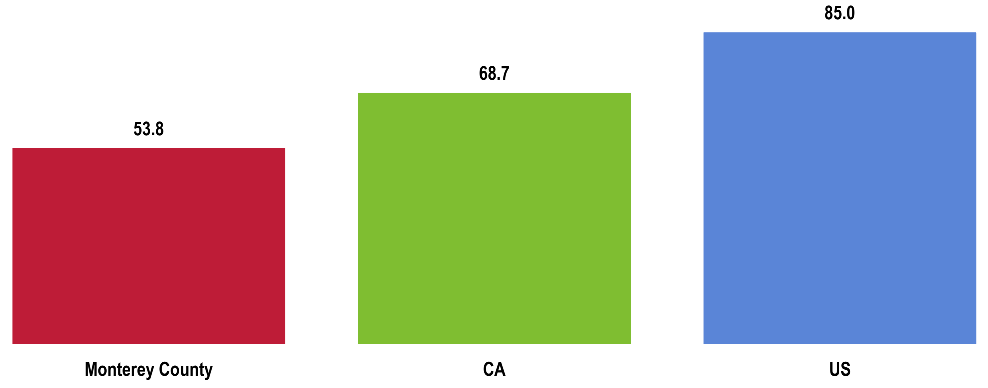
> Lack of access to pulmonary physicians. – Physician

Nutrition

> Food choices. – Social Services Provider

Age-Adjusted COVID-19 Deaths

2020 annual COVID-19 deaths in Monterey County are reported in the following chart. [COUNTY-LEVEL DATA]

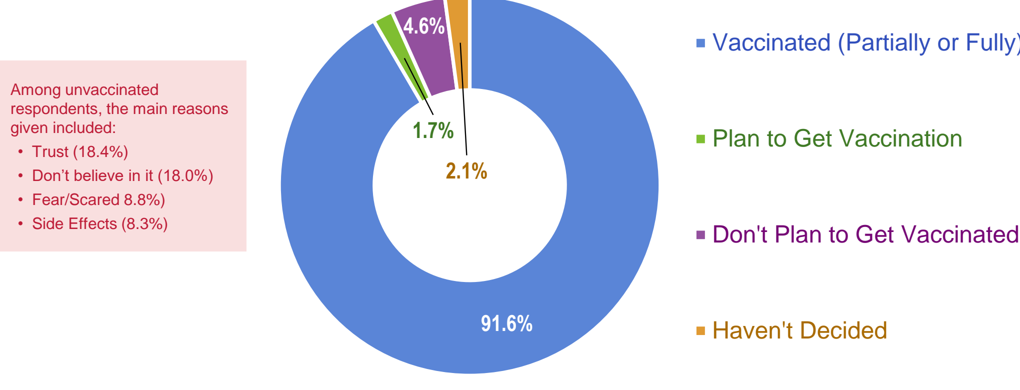


Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2022.

Vaccinations

"Which of the following statements best describes you?

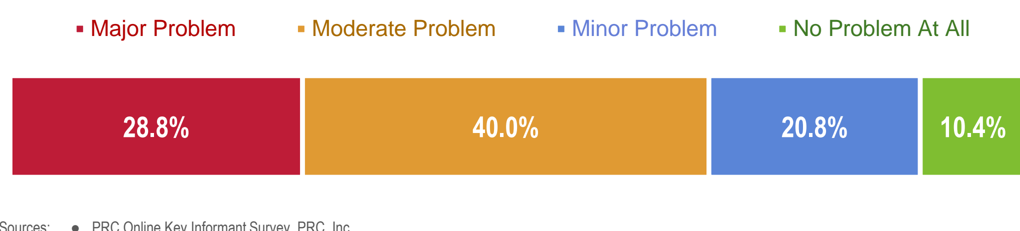
- 'I am vaccinated against COVID-19.'
- 'I plan to receive the vaccine.'
- 'I do not plan to receive the vaccine.'
- 'I haven't decided whether or not to receive the vaccine.'"



Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Items 319-320]
Notes: • Asked of all respondents.

Key Informant Input: Coronavirus Disease/COVID-19

The following chart outlines key informants' perceptions of the severity of *Coronavirus Disease/COVID-19* as a problem in the community:



Sources: • PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Impact on Quality of Life

> This is a major problem for most communities as it relates to not only people getting ill, but also destabilization of livelihood due to income challenges, access to basic needs, displacement from housing. – Community Leader
>
> It has adversely affected physical health, the economy, educational achievement and mental health. It has constricted social interaction. – Community Leader
>
> Impacting every aspect of our lives. – Social Services Provider
>
> The impacts of the COVID-19 pandemic will be felt for years. This includes people who have lost loved ones which affects families emotionally, financially, and physically. The virus is still circulating and mutating, it is unknow what the future will bring. The aftermath of the response which included people being isolated from one another, kids not going to school, loss of jobs/income, and long term COVID effects have shaken the community. There is also an overall "meanness" that has descended on the community, people are acting in their interest alone and not the community's interest. Tempers are shorter. People who have been involved with the response are burned out and exhausted. There are those who worked the front lines who will change careers, which could lead to a bigger worker shortage in some areas. There is also a growing group of people, may be small right now, who do not trust messages from government, could be CDC, FDA or local & state government, & they are vocal. – Public Health Representative
>
> Because the pandemic has polarized the community and led to major behavioral changes in a large segment of the population, including increases in anxiety disorder and increases in substance abuse. The response to the pandemic, now two years later, has resulted in a shift in employment practices and expectations like the great resignation, rebalance of work/personal time, demand to work from home and a schism between jobs like those in healthcare that require in person contact for success, vs jobs that are well served remotely. The school response has led to an increased need for childcare and the expectations of what childcare includes (homework support). Some students taking classes remotely are abusing alcohol and drugs, more depressed and anxious. We have seen an uptick in fentanyl overdoses, Logistically, we have a huge space deficit as we continue to social distance. Masking and other protocols have reduced other respiratory ailments. – Other Health Provider
>
> Pandemic has cause tremendous economic loss, delayed educational opportunities for children, and pushed families already struggling before COVID-19 into more stressful and unhealth situations. Furthermore, the underlying causes of many of the health disparities seen during the pandemic have not been addressed, such as lack of affordable housing and paid sick leave, or improved in the last 2 years leaving communities in a worse place than pre-pandemic. – Public Health Representative

Vaccination Rates

> We still have folks that are vaccine hesitant and until our 0- to 5-year-olds are able to be vaccinated, there is a risk to them and our general community at large. The numbers are also starting to pick up again. – Community Leader
>
> There continues to be a shortfall in the number/percentage of our county who have been vaccinated and boosted. There continues to be misinformation fueling vaccine hesitancy. – Physician
>
> We still have lots of people who are not vaccinated. – Physician

While vaccination rates are higher than other CA counties and other states, we also deal with vaccination hesitancy, varying/limited access to vaccinations and testing and resources for residents testing positive or dealing with hospitalizations/death of family members. Also, there is ongoing uncertainty regarding the future (more variants, etc.) – Social Services Provider

Low percentage of vaccinated residents. – Social Services Provider

While vaccination rates are higher than other CA counties and other states, we also deal with vaccination hesitancy, varying/limited access to vaccinations and testing and resources for residents testing positive or dealing with hospitalizations/death of family members. Also, there is ongoing uncertainty regarding the future (more variants, etc.) – Social Services Provider

Our community was one of the highest rated locations for coronavirus infections. Per county zip code COVID-19 vaccine data, 61% of our community has received the first dose compared to the county of 77% for first dose and 69% fully vaccinated. – Social Services Provider

Hesitancy from some people to get vaccinated. – Public Health Representative

Prevalence/Incidence

High transmission rate, communal housing amplifies spread, lack of education about vaccine. – Social Services Provider

COVID has been a major problem in every community, and I think ours has done a great job at getting those with less access to healthcare vaccines. – Community Leader

Ongoing infections. – Physician

COVID-19 variants are changing on a daily basis. Virus spikes are often happening after holiday seasons. Low vaccination rates amongst children between ages 5-11 years old. COVID-19 has affected our senior community, a very vulnerable population. – Social Services Provider

Infectious disease, including TB, valley fever and syphilis, not to mention COVID, have been steadily increasing. Prevention services, education and programs to build natural immunity are limited. – Community Leader

Seasonal surges put a huge strain on our hospitals, with Emergency Rooms and inpatient wards at near max capacity. Quarantine and isolation are also huge challenges for working adults, particularly those with school age children. – Physician

Persons at Increased Risk for Adverse Health Outcomes

Long term disinvestment in communities of color have led to inequities related to social determinants of health. COVID-19 surges result in significant differences in impact with higher rates in communities of color due to these differences in SDoH, such as overcrowded housing due to high cost of living and low wages for essential workers. – Social Services Provider

Lack of accommodations for immunocompromised people. This became evident with the COVID pandemic and society's desire to return to "normalcy". This has left immunocompromised and other at-risk people to navigate the world without any supports and constant questions and insults from people when attempting to mask and/or social distance. The consistent answer that deprives people from social and civic engagement and contributes to mental health problems is "just stay home." – Social Services Provider

The infection and death rate has hit the Latino farmworker community disproportionately hard. Overcrowded housing conditions, lack of medical services and insurance coverage, the need to work during the pandemic as essential workers, the lack of sick leave and some benefits, forced workers to work despite feeling ill. – Community Leader

Awareness/Education

Confusing messaging seems to create a fear of accessing both immediate and preventive medical and dental care. – Other Health Provider

Consistent education and communication is key for locals and visitors alike. – Physician

Under reporting. Mixed messages. – Other Health Provider

Access to Care/Services

Many of our students have lost loved ones, many were essential workers that couldn't miss work and continued despite being sick and didn't access health care. – Social Services Provider

Access to services and resources are not equitable in the community. The lowest income people living in rural areas are affected more than others. COVID-19 has impacted the health care system and preventive health care services are affected. – Other Health Provider

There are not hospitals or medical care in town or programs to help with any COVID-19 related issue. – Community Leader

Housing

> Some high-density neighborhoods. Multiple families sharing single households. Hospitality and agriculture work environments make it difficult for some to work safely. – Social Services Provider
>
> The housing, including overcrowding, and language challenges many of our neighbors face. – Physician

Disease Management

> People do not follow protocol. – Social Services Provider

Funding

> In my opinion, some of the money can be spent better or programs such as VIDA could hire more qualified people. There is a void of true assistance for community members that become infected. – Social Services Provider

Injury & Violence

ABOUT INJURY & VIOLENCE

INJURY ► In the United States, unintentional injuries are the leading cause of death in children, adolescents, and adults younger than 45 years. …Many unintentional injuries are caused by motor vehicle crashes and falls, and many intentional injuries involve gun violence and physical assaults. Interventions to prevent different types of injuries are key to keeping people safe in their homes, workplaces, and communities.

Drug overdoses are now the leading cause of injury deaths in the United States, and most overdoses involve opioids. Interventions to change health care providers' prescribing behaviors, distribute naloxone to reverse overdoses, and provide medications for addiction treatment for people with opioid use disorder can help reduce overdose deaths involving opioids.

VIOLENCE ► Almost 20,000 people die from homicide every year in the United States, and many more people are injured by violence. …Many people in the United States experience physical assaults, sexual violence, and gun-related injuries. Adolescents are especially at risk for experiencing violence. Interventions to reduce violence are needed to keep people safe in their homes, schools, workplaces, and communities.

Children who experience violence are at risk for long-term physical, behavioral, and mental health problems. Strategies to protect children from violence can help improve their health and well-being later in life.

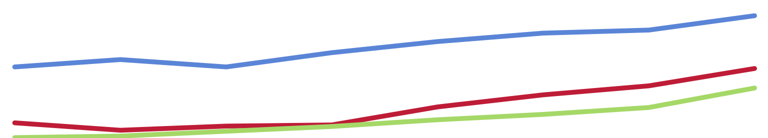
– Healthy People 2030 (https://health.gov/healthypeople)

Unintentional Injury

Age-Adjusted Unintentional Injury Deaths

The following chart outlines age-adjusted mortality rates for unintentional injury in Monterey County. [COUNTY-LEVEL DATA]

Unintentional Injuries: Age-Adjusted Mortality Trends
(Annual Average Deaths per 100,000 Population)
Healthy People 2030 = 43.2 or Lower



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Monterey County	31.3	29.9	30.7	30.9	34.3	36.6	38.3	41.6
CA	28.5	28.8	29.7	30.6	31.9	32.9	34.2	37.9
US	41.9	43.3	41.9	44.6	46.7	48.3	48.9	51.6

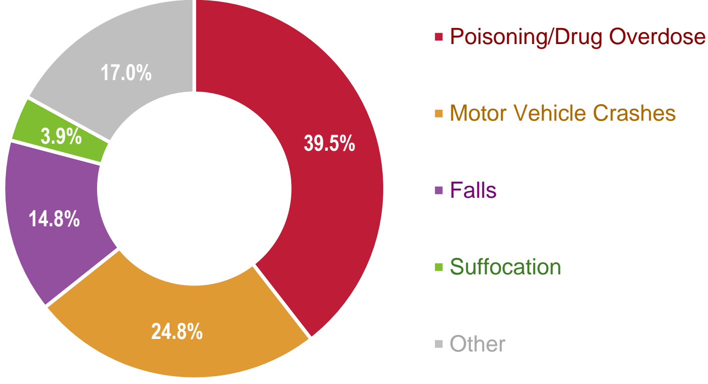
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2022.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

Leading Causes of Unintentional Injury Deaths

Leading causes of accidental death in Monterey County include the following: [COUNTY-LEVEL DATA]

RELATED ISSUE
For more information about unintentional drug-related deaths, see also *Substance Use* in the **Modifiable Health Risks** section of this report.

Leading Causes of Unintentional Injury Deaths
(Monterey County, 2018-2020)



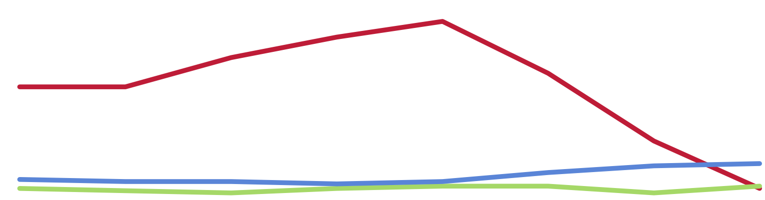
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2022.

Intentional Injury (Violence)

Age-Adjusted Homicide Deaths

Age-adjusted mortality attributed to homicide is shown in the following chart. [COUNTY-LEVEL DATA]

Homicide: Age-Adjusted Mortality Trends
(Annual Average Deaths per 100,000 Population)
Healthy People 2030 = 5.5 or Lower



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Monterey County	9.5	9.5	10.8	11.7	12.4	10.1	7.1	5.0
CA	5.0	4.9	4.8	5.0	5.1	5.1	4.8	5.1
US	5.4	5.3	5.3	5.2	5.3	5.7	6.0	6.1

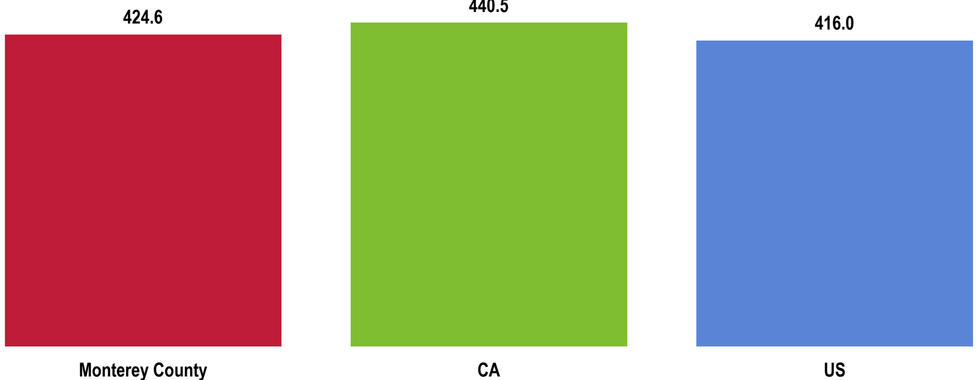
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2022.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

Violent Crime

Violent crime is composed of four offenses (FBI Index offenses): murder and non-negligent manslaughter; forcible rape; robbery; and aggravated assault.

Note that the quality of crime data can vary widely from location to location, depending on the consistency and completeness of reporting among various jurisdictions. [COUNTY-LEVEL DATA]

Violent Crime
(Rate per 100,000 Population, 2014-2016)

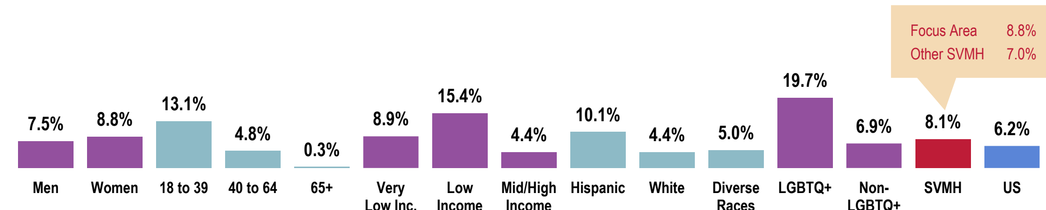


Sources:
- Federal Bureau of Investigation, FBI Uniform Crime Reports.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved June 2022 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the rate of violent crime offenses reported by the sheriff's office or county police department per 100,000 residents. Violent crime includes homicide, rape, robbery, and aggravated assault. This indicator is relevant because it assesses community safety.
- Participation by law enforcement agencies in the UCR program is voluntary. Sub-state data do not necessarily represent an exhaustive list of crimes due to gaps in reporting. Also, some institutions of higher education have their own police departments, which handle offenses occurring within campus grounds; these offenses are not included in the violent crime statistics but can be obtained from the Uniform Crime Reports Universities and Colleges data tables.

VIOLENT CRIME EXPERIENCE ▶ "Have you been the victim of a violent crime in your area in the past 5 years?"

Victim of a Violent Crime in the Past Five Years
(SVMH Service Area, 2022)

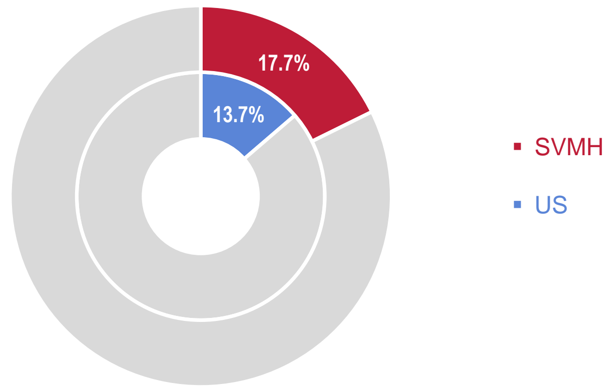


Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 38]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

INTIMATE PARTNER VIOLENCE ▶ "The next questions are about different types of violence in relationships with an intimate partner. By an intimate partner, I mean any current or former spouse, boyfriend, or girlfriend. Someone you were dating, or romantically or sexually intimate with, would also be considered an intimate partner. Has an intimate partner ever hit, slapped, pushed, kicked, or hurt you in any way?"

Have Ever Been Hit, Slapped, Pushed, Kicked, or Hurt in Any Way by an Intimate Partner



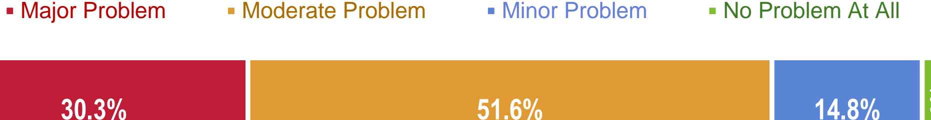
Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 39]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Key Informant Input: Injury & Violence

The following chart outlines key informants' perceptions of the severity of *Injury & Violence* as a problem in the community:

Perceptions of Injury and Violence as a Problem in the Community
(Key Informants, 2022)



Sources: • PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Gang Violence

We have a large amount of violent injuries that present to the hospital due to gang violence etc. – Other Health Provider

Gang violence. – Social Services Provider

We have gang shootings very frequently in our county. – Community Leader

Obvious, gang violence. Also, the background incidence of domestic violence. – Physician

Gang wars and drugs. – Physician

Violence rates are increasing in Salinas. It's mostly gang-related - and we have been here before, but it's been a few years. I'm not sure if Fentanyl is included here - but along with the rest of the country - more and more drugs sold on the street are laced with Fentanyl and sadly - people are dying from this. – Community Leader

We live in gang infested areas and violent crime is rampant. Every day you see the police catch some youngster with ghost guns, there at shootings, carjacking, thefts, etc. – Community Leader

Gang violence and gang affiliation in the Salinas and South Monterey County regions continues to be a problem as resources for youth to choose alternatives to violence is limited. – Community Leader

Prevalence/Incidence

We have a huge increase of patients coming in with self-harm, stabbing themselves, shooting themselves, hangings, along with an increase of shootings in the community. There seems to be a big shift in the police department- not sure if less officers and more officers retiring due to the pandemic and the defund the police atmosphere. – Other Health Provider

The disproportionate rate of violence relative to our community's size. – Public Health Representative

Natividad has a Trauma Center that exists to meet a demonstrated gap in services for treating traumatic and violent injuries. Violence is increasing again in Monterey County. – Social Services Provider

I work in a school and my students daily inform me about acts of violence they have heard about or witnessed involving people they know. – Community Leader

Every day on the local news there is a story about violence and injury in the county. Shootings, stabbings, car crashes, the list goes on. – Public Health Representative

Rates of injury and violence are high in many Monterey County communities. – Public Health Representative

Violence has been increasing in all areas of Monterey County, even on the peninsula. The violence almost always results in injuries. – Social Services Provider

Domestic/Family Violence

Domestic violence, drunk driving, easy access to guns and gun violence all contribute to make this a major problem. – Physician

Our clients are victims of domestic violence and/or human trafficking. Through their experiences we are aware of greater community need. – Social Services Provider

Domestic Violence is seeing a high and beds/rooms/shelters are not readily available. People who are fleeing unsafe situations should be immediately cared for. If our shelters are full, have an overflow available Our first responders are sometimes too busy to help with restraining orders, or those that break restraining orders are "talked to" but not punished for breaking orders. – Social Services Provider

Access to Care/Services

> Lack of quality mental health services and very limited resources and support for local police agencies. – Other Health Provider
>
> There are no services that address abuse, drug/alcohol abuse treatment, and gangs. – Physician

Alcohol/Drug Use

> There are many issues with drug and alcohol abuse as well as gang issues. – Other Health Provider
>
> Alcohol/substance abuse in our community is increasing, resulting in injury and violence. Violence also increasing due to untreated mental illness and substance abuse. Families are overwhelmed and often times these situations have violent outcomes. – Social Services Provider

Due to COVID-19

> Many people, especially our youth are experiencing trauma symptoms from living through the challenges of a pandemic, feeling isolated, disconnected, and fearful of others. Due to these factors, people have become less patient with each other. The media in recent history has seem to highlight and even glorify violence sending the message that it's okay to engage in such behaviors. It is also important to note that self-harm and suicide are forms of injury and violence. – Community Leader
>
> Pandemic has increased mental health needs. Folks isolated with family members who may engage in domestic violence. Women who experience DV are often financially dependent on the perpetrators of DV. – Social Services Provider

Teen/Young Adult Usage

> Violence is growing among teens, causing them to get into fights and some occasions causing harm with dangerous weapons. – Community Leader
>
> The youthful nature of Salinas' population combined with the teen violence varying statistics. – Physician

Motor Vehicle Accidents

> Motor vehicle accidents and gunshot wounds contribute to this. – Community Leader

Gun Violence

> Too many gun violence incidents. – Community Leader

Impact on Quality of Life

> In addition to the physical damage, the psychological damage, including long lasting PTSD can be devastating. Additionally, violence tends to affect younger people who have more years of productive life that may be lost or affected. – Physician

Diabetes

ABOUT DIABETES

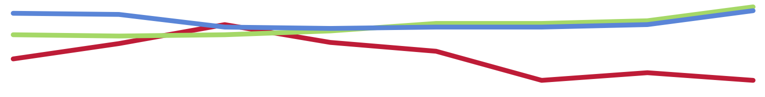
More than 30 million people in the United States have diabetes, and it's the seventh leading cause of death. …Some racial/ethnic minorities are more likely to have diabetes. And many people with diabetes don't know they have it.

Poorly controlled or untreated diabetes can lead to leg or foot amputations, vision loss, and kidney damage. But interventions to help people manage diabetes can help reduce the risk of complications. In addition, strategies to help people who don't have diabetes eat healthier, get physical activity, and lose weight can help prevent new cases.

– Healthy People 2030 (https://health.gov/healthypeople)

Age-Adjusted Diabetes Deaths

Age-adjusted diabetes mortality for Monterey County is shown in the following chart. [COUNTY-LEVEL DATA]



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Monterey County	18.8	20.0	21.5	20.1	19.4	17.1	17.7	17.1
CA	20.7	20.6	20.7	21.0	21.6	21.6	21.8	22.9
US	22.4	22.3	21.3	21.2	21.3	21.3	21.5	22.6

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2022.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

Prevalence of Diabetes

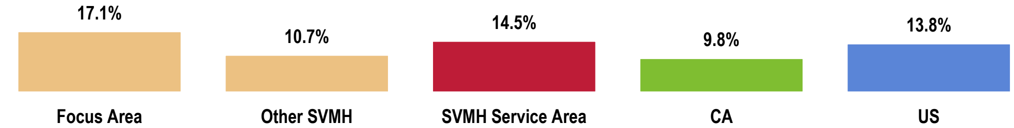
"Have you ever been told by a doctor, nurse, or other health professional that you have diabetes? (If female, add: not counting diabetes only occurring during pregnancy?)"

"Have you ever been told by a doctor, nurse, or other health professional that you have pre-diabetes or borderline diabetes? (If female, add: other than during pregnancy?)"

[Adults who do not have diabetes] "Have you had a test for high blood sugar or diabetes within the past three years?"

Prevalence of Diabetes

Another 20.2% of adults have been diagnosed with "pre-diabetes" or "borderline" diabetes.

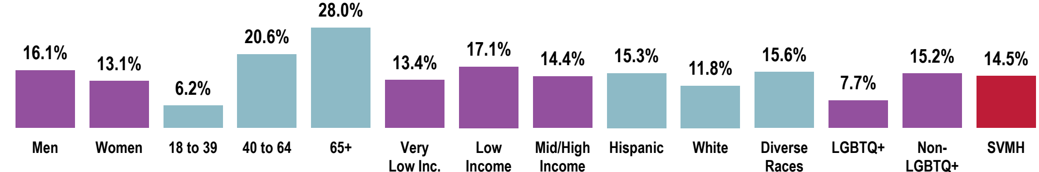


Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 121]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2021 California data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Prevalence of Diabetes
(SVMH Service Area, 2022)

Note that among adults who have not been diagnosed with diabetes, 62.4% report having had their blood sugar level tested within the past three years.



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Items 33, 121]

Notes:
- Asked of all respondents.
- Excludes gestational diabetes (occurring only during pregnancy).

Key Informant Input: Diabetes

The following chart outlines key informants' perceptions of the severity of *Diabetes* as a problem in the community:

Perceptions of Diabetes as a Problem in the Community
(Key Informants, 2022)

Sources: • PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Awareness/Education

> Education and support. Support groups (like AA, perhaps) could be helpful. Those groups likely exist already. – Social Services Provider
>
> Getting access to education and nutrition education. Consistent coverage for needed medication and testing supplies. Consistent axillary services, i.e., eye care, foot care, and disease management. – Physician
>
> Education on healthy lifestyles is needed for working families. – Community Leader
>
> Understanding how diet plays a role in their long-term health. Limited access to resources. People do not have time in the day to cook healthy meals, so they often turn to fast foods or unhealthy snacks in place of a home cooked meal. Stressful and sedentary lifestyles. – Other Health Provider
>
> Education, access to healthy foods, access to health care, ability to afford medications. – Social Services Provider
>
> Education and awareness about the impact their diet has on their health. Cultural issues regarding food preferences. – Social Services Provider
>
> Education that can address cultural traditions regarding nutrition and exercise. Access to quality food that is affordable. Lack of participation by businesses that offer employee lunches to offer healthy food options and encourage healthy eating and activities. – Other Health Provider
>
> There is a large gap in understanding the seriousness of the disease and most importantly how to manage it realistically. Access to early prevention/screening is a concern. The lack of providers (MD's, NP's, PA's) that are bilingual and culturally reflective is a concern. – Other Health Provider
>
> For the people newly diagnosed with this it seems to be access to healthy food, along with knowledge and time to be able to cook healthy meals and change lifestyles. – Physician
>
> Access to culturally appropriate diabetes education, access to diabetes specialty care (or even primary care for that matter), access to healthy food options, cost of medications. – Physician
>
> Monitoring of the disease, intervention, education about diet, and expensive drugs. – Community Leader
>
> Diabetes information and services. – Community Leader
>
> Education about the symptoms and causes of diabetes and the proper management of their diet and exercise. – Social Services Provider
>
> Inability to deliver comprehensive diabetes prevention education to the total at risk population. – Public Health Representative
>
> Knowledge about how to prevent/treat diabetes and access to programs that can help. – Social Services Provider
>
> Education and food/nutrition classes. – Community Leader
>
> Understanding of the long-term effects. – Community Leader
>
> Access to education and healthy options. – Community Leader
>
> Lack of education on prevention and then health implications. – Social Services Provider
>
> Lack of education on nutrition, eating healthy on a budget, foods that are culturally relevant, and exercising as a family. Overall nutrition education is so important, followed with cooking classes as a family. – Social Services Provider

Access to Care/Services

> People of the community are not as resourceful. Natividad, where most underserved clients seek medical care, lacks a robust diabetic center and an endocrinologist to manage their care at an affordable cost to patients with little to no coverage. Most of these patients work, and evening clinic hours are needed. – Other Health Provider
>
> Cost of testing supplies. Access to healthy foods and the time to engage in physical activity. – Social Services Provider
>
> Access to care and education consisting of diabetes management, medication and supplies to check blood sugars. Access to healthy foods at a price our community can afford. – Other Health Provider
>
> Obtaining needed medical care. Many times, individuals do not have health insurance or do not qualify for health insurance. Thus, they do not seek medical care when needed. Educating the community on what diabetes is and how it affects the body. Education on proper diabetic diet. There are many misconceptions about diabetes within the community. – Social Services Provider
>
> Early detection and health education. – Other Health Provider
>
> Delayed access to preventative care. Lack of access to healthy foods and safe places to recreate. Long working hours preventing individuals from obtaining routine healthcare appointments. Lack of funding to purchase medications and strips needed. – Public Health Representative
>
> Lack of access to health care, cost of medications, lack of access to good healthy foods, screening availability, lack of understanding about the disease. – Public Health Representative
>
> It's a combination of lack of providers and knowledge. I'm a health insurance agent and met with a client yesterday who has to drive 50 miles to get to a specialist to help her manage her diabetes. She said there used to be a specialist closer that she used. But that is no longer available. And the other area is knowledge. We need to have more community-led classes for adults, and to somehow get the info to teenagers in a way that sets them up for success in having a healthy lifestyle. – Community Leader
>
> Access to affordable insulin, time, and resources for meal preparation, time and resource for exercise. – Social Services Provider
>
> Lack of access to preventative care programs and education. Lack of food security and access. For the Indigenous speaking residents, the term or concept of diabetes does not even exist. Most of our outreach and messaging is not culturally appropriate and mainly in English. – Social Services Provider
>
> Access to continuity of care, which can build trust and understanding over time. The care that is available is not continuity care in many cases. – Physician
>
> Access to resources. – Physician
>
> Lack of access to culturally, linguistic, and literacy-level appropriate prevention and management programs. – Social Services Provider
>
> Not enough local services and access to top level care. – Community Leader

Access to Affordable Healthy Food

> Access to healthy foods and proper eating habits are a big challenge. Lack of access to open space in cities of Salinas and Pajaro Valley. When people are detected with diabetes, they often lack the health insurance to buy strips and other equipment. Additionally, people don't have the economic resources to buy organic fruits and vegetables to keep a healthy diet. – Social Services Provider
>
> Access to affordable healthy foods. – Public Health Representative
>
> Healthful food is expensive. Our financially most vulnerable are left eating foods that place them at the highest risk for diabetes, processed foods and fast food. – Physician
>
> Healthier food, lack of exercise. – Physician
>
> Having readily available healthy foods which are affordable and time and resources for exercise/physical activity. – Physician
>
> Access to healthy food and lifestyle based on income. When a great portion of our community is living in poverty, they may not see a way to have a healthy lifestyle. – Community Leader
>
> Access to healthy food options. – Physician
>
> High relative cost of nutritious foods. Lack of easy access to qualified dieticians. – Public Health Representative
>
> Access to healthy food. – Social Services Provider

Obesity

> Obesity. Prevalence of cheap "fast food." Socio-economic factors that mean families with two working parents have less time to prepare healthy meals for themselves and family members. Sedentary lifestyles. – Community Leader
>
> Being overweight due to their inability to control their diet and lack of exercise. – Community Leader
>
> High frequency of obesity. – Physician

> Continued problem (perhaps worsening) with childhood obesity, creating new type 2 diabetics every day. – Physician
>
> Obesity due to poor nutrition and sedentary behavior is a major cause of high levels of obesity in our community. – Community Leader

Affordable Medications/Supplies

> Lack of access to affordable preventative services. Cost of insulin and other diabetes medicine for the un- and under-insured. – Public Health Representative
>
> Expensive medication for people that are not part of a program. – Public Health Representative
>
> Cost of medication and nutrition counseling. – Other Health Provider
>
> Cost of insulin, change of lifestyle. – Social Services Provider
>
> Affordable meds. – Physician

Nutrition

> Nutrition, exercise, prevention, understanding, insulin, implementing new diet (culturally different, cost, time, knowledge, etc.). – Public Health Representative
>
> Poor eating habits are causing young children to end up getting diabetes. – Community Leader
>
> Poor eating habits. Obesity. – Community Leader
>
> Cultures of overeating and focusing on foods that aren't nutrient-dense. I don't know about access to health care with diabetes specifically. I do think health care and insurance expenses could easily be barriers. – Community Leader
>
> Poor diet habits. – Social Services Provider

Persons at Increased Risk for Adverse Health Outcomes

> Monterey County Latino residents have a high percentage of type 2 diabetes. The biggest challenges are education across the board (from physical activity to what we eat), access to medication, and the latest treatments. South and North County residents need to be able to access this type of information. – Social Services Provider
>
> Although we live in the salad bowl of the country, there is limited access to fresh fruits and vegetables in the communities of color, Latino/Black. Preventive health education services should be available to all communities. – Other Health Provider

Follow-Up/Support

> Support services for learning a new diet and lifestyle. – Social Services Provider
>
> Patients getting lost to follow up. As more patients enter the insurance market, previous neglect and denial have resulted in out-of-control diabetics with many complications. – Other Health Provider

Prevalence/Incidence

> A large percentage of our population is diabetic or pre-diabetic. – Community Leader
>
> Forty five percent of MoCo residents have diabetes or pre-diabetes. Most lack primary care. Incidence of complications from DM (e.g. limb amputation) correlates with lower socioeconomic zones and more at-risk SDOH. – Physician

Lifestyle

> Incorporating lifestyle/nutrition choices to address diabetes that are affordable and accessible. Type 2 diabetes among youth, diagnosis of diabetes earlier, support systems for living with diabetes. – Community Leader
>
> Lifestyle changes are difficult to do due to costs, time, and behavior change requirements, cultural differences and appropriateness of lifestyle change programs. – Social Services Provider

Disease Management

> Self-management. – Social Services Provider

Access for Medicare/Medi-Cal Patients

> Lack of providers accepting new patients and patients with Medi-Cal. – Physician

Health Equity

> Historical, persistent trauma, and structural racism! Unless we eliminate the causes, the symptoms will continue to be there. – Community Leader
>
> Health equity. – Physician

Kidney Disease

ABOUT KIDNEY DISEASE

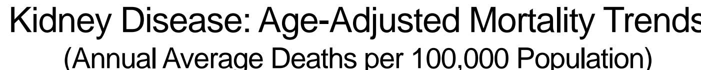
More than 1 in 7 adults in the United States may have chronic kidney disease (CKD), with higher rates in low-income and racial/ethnic minority groups. And most people with CKD don't know they have it. …People with CKD are more likely to have heart disease and stroke — and to die early. Managing risk factors like diabetes and high blood pressure can help prevent or delay CKD. Strategies to make sure more people with CKD are diagnosed early can help people get the treatment they need.

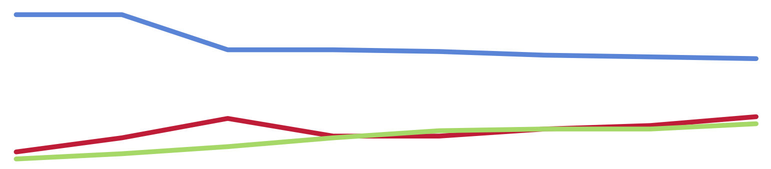
Recommended tests can help identify people with CKD to make sure they get treatments and education that may help prevent or delay kidney failure and end-stage kidney disease (ESKD). In addition, strategies to make sure more people with ESKD get kidney transplants can increase survival rates and improve quality of life.

– Healthy People 2030 (https://health.gov/healthypeople)

Age-Adjusted Kidney Disease Deaths

Age-adjusted kidney disease mortality is described in the following chart. [COUNTY-LEVEL DATA]





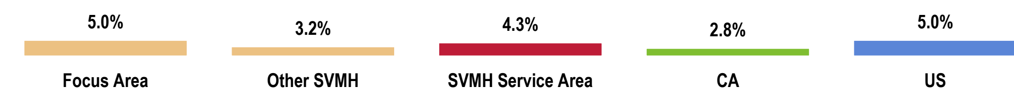
	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Monterey County	7.5	8.3	9.4	8.4	8.4	8.8	9.0	9.5
CA	7.1	7.4	7.8	8.3	8.7	8.8	8.8	9.1
US	15.3	15.3	13.3	13.3	13.2	13.0	12.9	12.8

Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2022.

Prevalence of Kidney Disease

"Would you please tell me if you have ever suffered from or been diagnosed with kidney disease?"

Prevalence of Kidney Disease



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 24]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2021 California data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Key Informant Input: Kidney Disease

The following chart outlines key informants' perceptions of the severity of *Kidney Disease* as a problem in the community:

Perceptions of Kidney Disease as a Problem in the Community (Key Informants, 2022)

Sources:
- PRC Online Key Informant Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Co-Occurrences

> The serious consequences of high incidence of type 2 diabetes. – Physician
>
> HTN and DM not well managed. – Physician
>
> Uncontrolled diabetes leads to kidney disease. A lot of our patients do not have access to diabetes care training or education, which leads to uncontrolled damage to the kidneys. – Other Health Provider

Access to Care/Services

> Huge resources needed to manage. – Physician

Prevalence/Incidence

> The amount of dialysis centers in Monterey County is 13. Kidney disease is attributed to diabetes; until we get a handle on diabetes, this number will continue to increase. – Social Services Provider

Diet

> Diet and lifestyle have affected this community. – Other Health Provider

Potentially Disabling Conditions

Multiple Chronic Conditions

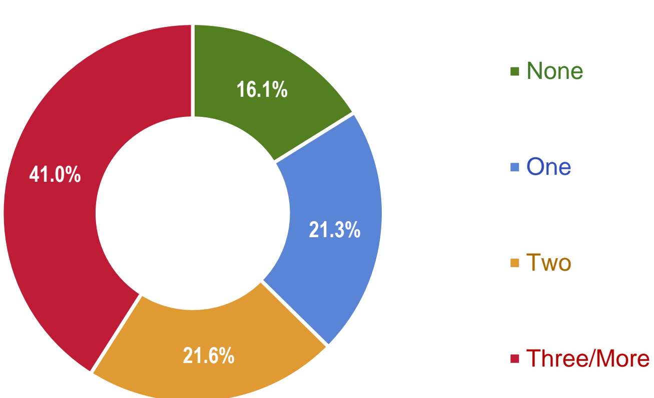
The following charts outline the prevalence of multiple chronic conditions among surveyed adults, taking into account all of the various conditions measured in the survey.

For the purposes of this assessment, chronic conditions include:

- Asthma
- Cancer
- Chronic pain
- Diabetes
- Diagnosed depression
- Heart attack/angina
- High blood cholesterol
- High blood pressure
- Kidney disease
- Lung disease
- Obesity
- Stroke

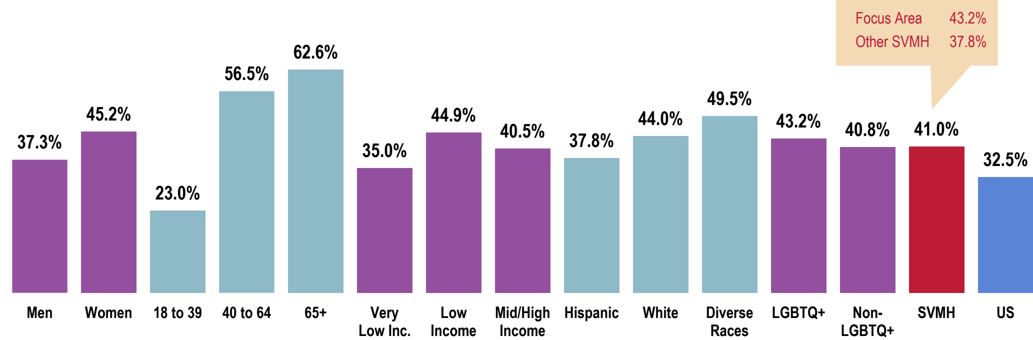
Multiple chronic conditions are concurrent conditions.

Number of Current Chronic Conditions
(SVMH Service Area, 2022)



Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 123]
Notes: ● Asked of all respondents.
● In this case, chronic conditions include lung disease, arthritis, sciatica, cancer, osteoporosis, kidney disease, heart attack/angina, stroke, asthma, high blood pressure, high blood cholesterol, diabetes, high-impact chronic pain, obesity, and/or diagnosed depression.

Currently Have Three or More Chronic Conditions
(SVMH Service Area, 2022)



Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 123]
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.
● In this case, chronic conditions include lung disease, cancer, kidney disease, heart attack/angina, stroke, asthma, high blood pressure, high blood cholesterol, diabetes, obesity, chronic pain, and/or diagnosed depression.

Activity Limitations

ABOUT DISABILITY & HEALTH

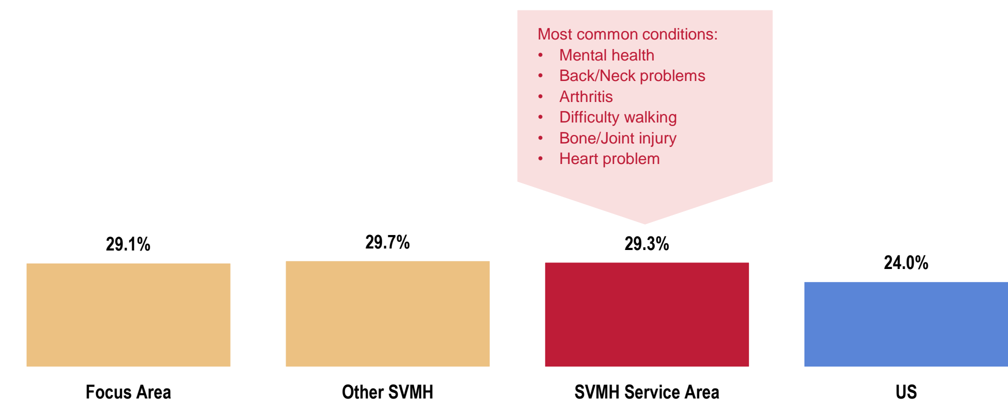
Studies have found that people with disabilities are less likely to get preventive health care services they need to stay healthy. Strategies to make health care more affordable for people with disabilities are key to improving their health.

In addition, people with disabilities may have trouble finding a job, going to school, or getting around outside their homes. And they may experience daily stress related to these challenges. Efforts to make homes, schools, workplaces, and public places easier to access can help improve quality of life and overall well-being for people with disabilities.

– Healthy People 2030 (https://health.gov/healthypeople)

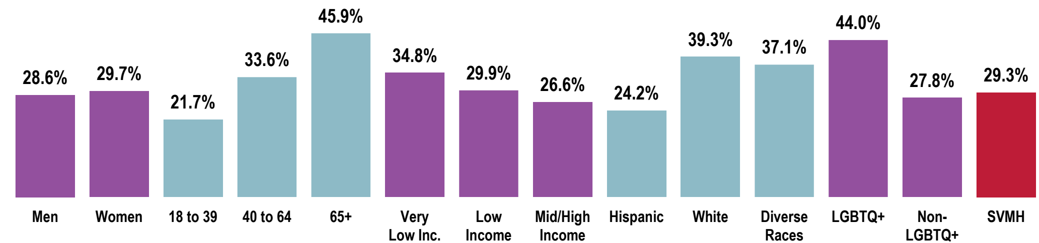
"Are you limited in any way in any activities because of physical, mental, or emotional problems?"

[Adults with activity limitations] "What is the major impairment or health problem that limits you?"



Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Items 96-97]
• 2020 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.

Limited in Activities in Some Way
Due to a Physical, Mental or Emotional Problem
(SVMH Service Area, 2022)

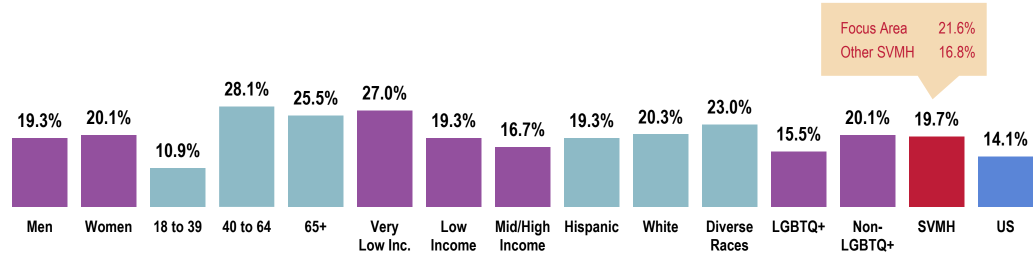


Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 96]
Notes: • Asked of all respondents.

High-Impact Chronic Pain

"Over the past six months, how often did physical pain limit your life or work activities? Would you say: never, some days, most days, or every day?" (Reported here among those responding "most days" or "every day.")

Experience High-Impact Chronic Pain
(SVMH Service Area, 2022)
Healthy People 2030 = 7.0% or Lower



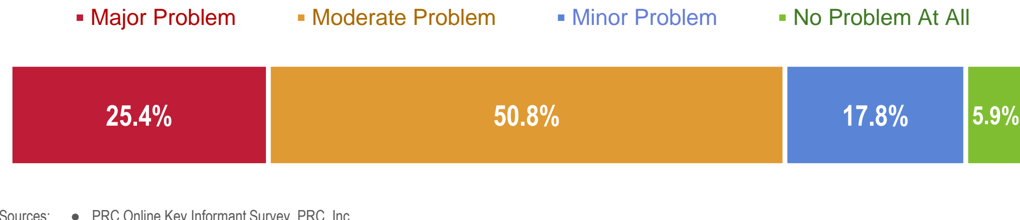
Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 37]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2021 California data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov [Objective MICH-8.1]

Notes:
- Asked of all respondents.
- High-impact chronic pain includes physical pain that limits life or work activities on "most days" or "every day" of the past six months.

Key Informant Input: Disability & Chronic Pain

The following chart outlines key informants' perceptions of the severity of *Disability & Chronic Pain* as a problem in the community:

Perceptions of Disability & Chronic Pain as a Problem in the Community
(Key Informants, 2022)



Sources: • PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Access to Care/Services

> There are inadequate resources for pain management and behavior support. – Physician
>
> Lack of medical resources. – Social Services Provider
>
> Again, sporadic, uncoordinated care. We are a manual labor heavy economy here. – Physician
>
> Not enough services to assist people with disabilities and many areas are not particularly ADA friendly. – Community Leader
>
> We lack resources in the community to help those with this health concern. The concern is greatest in the uninsured population who lack resources to obtain healthcare services. Language and health literacy is a barrier. – Other Health Provider
>
> It is an act of God to get a doctor to prescribe pain medication because they are all afraid of losing their license here in California. I feel people are sourcing out illegal substance to care for their pain as there seems to be an increase of use of illegal narcotics and OD. I don't think enough outreach is done to refer or publicize chronic pain clinics. I work in health care, and I wouldn't know where to send someone. – Other Health Provider
>
> Access to care and wellness options for disabled individuals and persons living with chronic pain. – Physician
>
> Lack of proper specialist local care. – Community Leader

Prevalence/Incidence

> According to the CDC, chronic pain is one of the top reasons people seek medical care. It's a national issue that also impacts the residents of Monterey County. – Community Leader
>
> Many community members are using pain medications and accessing the Emergency Room to address pain. – Other Health Provider
>
> Almost all of the guests we serve have some form of disability. Many of them suffer from chronic pain, which is made worse by sleeping on the ground or in cars. – Social Services Provider

Follow-Up/Support

> The community are not getting the medical support they need, so they end up buying drugs that help and it ends up causing them to die. – Community Leader
>
> Mobility and social framework for those disabled are lacking. – Physician
>
> Disability: more supportive services for those with disabilities including advocates to assist with social security benefits and scheduling with doctors specialized in the "disability" Chronic pain: I believe many people suffering with chronic pain do not have places to turn and is little understood – Social Services Provider

Aging Population

> As the population ages, vision and hearing can fail, and arthritis and degenerative disc and other conditions increase. Also, mental distress is often pressed with physical pain symptoms. – Community Leader
>
> Seaside has a large older adult population where many are challenged with managing disabilities and/or chronic pain due to deteriorated functionality. – Community Leader

Impact on Quality of Life

> Both conditions can create physical/mobility challenges particularly as people age and they can exacerbate the aging progress. These conditions can be barriers to accessing resources and in engaging in healthy physical and social activities. Chronic pain often has a negative impact on the overall mental health of an individual and can contribute to substance abuse and other negative social behaviors. – Social Services Provider

Lack of Providers

> Treatment of chronic pain done appropriately can decrease the reliance on opioid pain medications, but we do not have enough properly trained and credentialed pain management specialists in our county. Primary care providers are often not skilled or don't have time or otherwise are unable to manage chronic pain patients. The lack of appropriate pain management in our county contributes to over-dependence on opioid pain medications and utilization of Emergency Departments. – Physician

Persons at Increased Risk for Adverse Health Outcomes

> Farmworkers with lack of access to care. – Public Health Representative

Obesity

> Due to the high prevalence of obesity, low fitness, related comorbidities such as diabetes and substance use disorders, and workplace or non-workplace injuries. – Public Health Representative

Substance Use

> Substance abuse. Providers not prescribing responsibly. – Other Health Provider

Work Related

> Ag work leave people with many disabilities and chronic pain, and not everyone can address issues until it's severe because of the lack of access to affordable primary care. – Public Health Representative

Due to COVID-19

> During the pandemic, many people put off regular health care, this has led to chronic issues including pain. A lack of access to regular care in general also exacerbates the issues. These are also issues that have ripple effects throughout the community. Caregivers need help and respite. Disabled individuals and those in chronic pain cannot be at their best to participate in the community. – Public Health Representative

Alzheimer's Disease

ABOUT DEMENTIA

Alzheimer's disease is the most common cause of dementia and the sixth leading cause of death in U.S. adults.1 Nearly 6 million people in the United States have Alzheimer's, and that number will increase as the population ages.

Dementia refers to a group of symptoms that cause problems with memory, thinking, and behavior. People with dementia are more likely to be hospitalized, and dementia is linked to high health care costs.

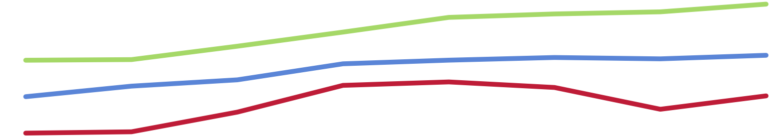
While there's no cure for Alzheimer's disease, early diagnosis and supportive care can improve quality of life. And efforts to make sure adults with symptoms of cognitive decline — including memory loss — are diagnosed early can help improve health outcomes in people with dementia. Interventions to address caregiving needs can also help improve health and well-being in people with dementia.

– Healthy People 2030 (https://health.gov/healthypeople)

Age-Adjusted Alzheimer's Disease Deaths

Age-adjusted Alzheimer's disease mortality is outlined in the following chart. [COUNTY-LEVEL DATA]

Alzheimer's Disease: Age-Adjusted Mortality Trends
(Annual Average Deaths per 100,000 Population)

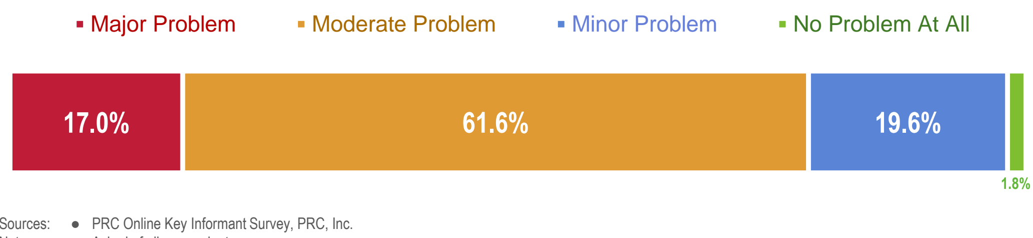


	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Monterey County	19.8	20.0	22.8	26.6	27.1	26.3	23.2	25.1
CA	30.2	30.3	32.2	34.2	36.3	36.8	37.1	38.2
US	25.0	26.5	27.4	29.7	30.2	30.6	30.4	30.9

Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2022.

Key Informant Input: Dementia/Alzheimer's Disease

The following chart outlines key informants' perceptions of the severity of *Dementia, Including Alzheimer's Disease* as a problem in the community:



Sources: • PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Access to Care/Services

> No treatment. – Physician
>
> I have met well over 20 aging adults who are suffering from Alzheimer's and Dementia and none of them receive quality care, companion services, specialized services, or in home/recreation services! My own mother had dementia and received very little services. – Community Leader
>
> We have a lot of patients who are suffering from this disease and not a lot of resources to assist them. – Other Health Provider
>
> Limited specialty services dedicated to this growing group. Limited to nonexistent geriatric psych resources. – Public Health Representative

Aging Population

> Older demographic in county. – Social Services Provider
>
> Age of community, high number of patients. – Physician
>
> We have an aging population, as the population ages there will be a larger demand for services related to this population. – Public Health Representative

Follow-Up/Support

> There are limited services to families for support. There are no long-term facilities to help care for patients with limited financial means when these patients need more help than the family can provide. A private setting is about $5 to 10,000 a month. Often these patients are dumped in the hospital, and we are unable to discharge them home and no skilled nursing wants to take them out of fear of wandering. Not enough locked settings. – Other Health Provider
>
> We do not have adequate caregiver support or caregiving options for patients with dementia, leaving families struggling to deal with disruptive, aggressive, or vulnerable family members. While we do have some local senior communities with memory units, these are expensive and not all families can afford them. – Physician
>
> Social framework to support elderly lacking. – Physician

Affordable Care/Services

> I've reviewed the local data and there is a tremendous need for support for people with limited financial means. – Public Health Representative
>
> Because I am hearing about more cases among client family members and not enough resources for low-income families to afford support, like in house supports, respite or good nursing facilities. Also, I am worried that we have diverted attention form seniors over the past several years. – Other Health Provider

Incidence/Prevalence

> I work for a nonprofit that services seniors. There is a prevalence of the types of dementia and assisted living is cost prohibitive, even for people who are not low income. Memory Care is even worse. My nonprofit offers low-income housing for seniors and there is literally nowhere for our residents to find a higher level of care. Dementia does not qualify for skilled nursing, and even then, there is a very limited number of Medi-Cal beds available, even if the person qualifies for Medi-Cal. I make a decent living myself and even I can't afford memory care. – Social Services Provider
>
> A significant portion of our community is elderly, and the incidence of these diseases is relatively high. These diseases lead to a devastating impact on patients' lives and require extensive intervention and care (medical, psychological, social). Our medical system is not ideally oriented to providing this care. – Physician

Impact on Caregivers/Families

> Tremendous caregiver strain and poor management of medical issues. – Physician

Impact on Quality of Life

> As an agency that serves older adults that are dealing with dementia and Alzheimer's disease, we see the impact on their lives and their families. They often need long-term care placement and advocacy and reach out to our Ombudsman program for help and guidance. Their spouses or family members often need other kinds of support that is provided through our counseling program, Medicare assistance, benefits checkup, transportation and even tax program. These services provide emotional support and financial relief for them during this very stressful journey. – Social Services Provider

Language Barrier

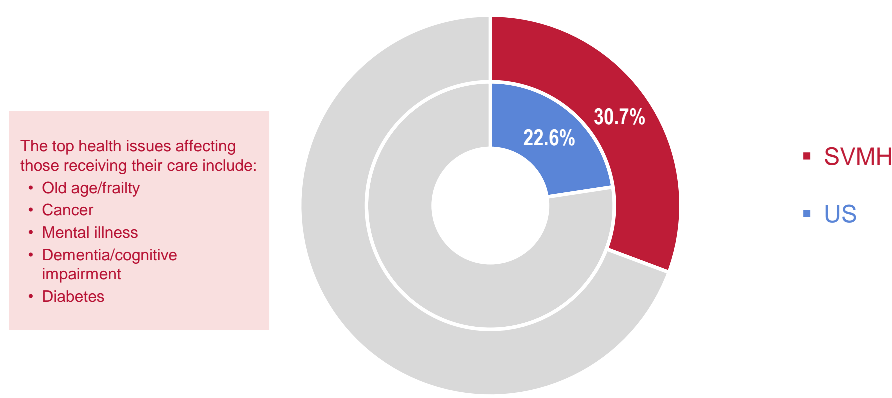
> Access to services for Spanish-speaking individuals with family members with dementia/Alzheimer's is a problem in our community. Many do not know what services are out there for their family or caregivers. – Public Health Representative

Caregiving

"People may provide regular care or assistance to a friend or family member who has a health problem, long-term illness, or disability. During the past 30 days, did you provide any such care or assistance to a friend or family member?"

[Among those providing care] "What is the main health problem, long-term illness, or disability that the person you care for has?"

Act as Caregiver to a Friend or Relative with a Health Problem, Long-Term Illness, or Disability



Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Items 98]
• 2020 PRC National Health Survey, PRC, Inc.

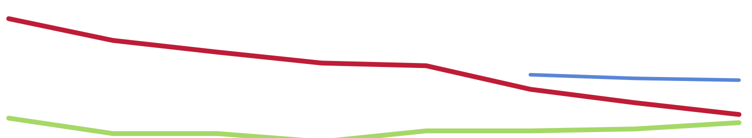
Notes: • Asked of all respondents.

BIRTHS

Prenatal Care

Early and continuous prenatal care is the best assurance of infant health. Lack of timely prenatal care (care initiated during the first trimester of pregnancy) is outlined in the following chart. [COUNTY-LEVEL DATA]

Lack of Prenatal Care in the First Trimester
(Percentage of Live Births)



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Monterey County	29.1%	26.7%	25.4%	24.2%	23.9%	21.3%	19.8%	18.5%
CA	18.1%	16.4%	16.4%	15.5%	16.7%	16.7%	16.9%	17.6%
US						22.9%	22.5%	22.3%

Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics. Data extracted June 2022.

Note: • This indicator reports the percentage of women who do not obtain prenatal care during their first trimester of pregnancy. This indicator is relevant because engaging in prenatal care decreases the likelihood of maternal and infant health risks. This indicator can also highlight a lack of access to preventive care, a lack of health, knowledge insufficient provider outreach, and/or social barriers preventing utilization of services.

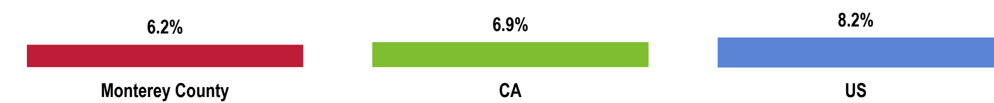
Birth Outcomes & Risks

Low-Weight Births

Low birthweight babies, those who weigh less than 2,500 grams (5 pounds, 8 ounces) at birth, are much more prone to illness and neonatal death than are babies of normal birthweight.

Largely a result of receiving poor or inadequate prenatal care, many low-weight births and the consequent health problems are preventable. [COUNTY-LEVEL DATA]

Low-Weight Births
(Percent of Live Births, 2013-2019)

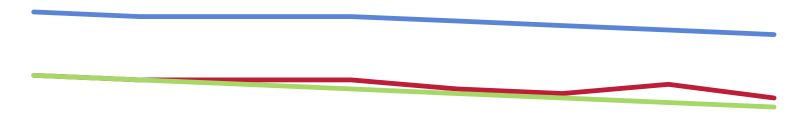


Sources: • Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved June 2022 via SparkMap (sparkmap.org).
Note: • This indicator reports the percentage of total births that are low birth weight (Under 2500g). This indicator is relevant because low birth weight infants are at high risk for health problems. This indicator can also highlight the existence of health disparities.

Infant Mortality

Infant mortality rates reflect deaths of children less than one year old per 1,000 live births. These rates are outlined in the following chart. [COUNTY-LEVEL DATA]

Infant Mortality Trends
(Annual Average Infant Deaths per 1,000 Live Births)
Healthy People 2030 = 5.0 or Lower



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Monterey County	4.6	4.5	4.5	4.5	4.3	4.2	4.4	4.1
CA	4.6	4.5	4.4	4.3	4.2	4.1	4.0	3.9
US	6.0	5.9	5.9	5.9	5.8	5.7	5.6	5.5

Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics. Data extracted June 2022.
• Centers for Disease Control and Prevention, National Center for Health Statistics.
• US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov
Notes: • Rates are three-year averages of deaths of children under 1 year old per 1,000 live births.

Family Planning

ABOUT FAMILY PLANNING

Nearly half of pregnancies in the United States are unintended, and unintended pregnancy is linked to many negative outcomes for both women and infants. …Unintended pregnancy is linked to outcomes like preterm birth and postpartum depression. Interventions to increase use of birth control are critical for preventing unintended pregnancies. Birth control and family planning services can also help increase the length of time between pregnancies, which can improve health for women and their infants.

Adolescents are at especially high risk for unintended pregnancy. Although teen pregnancy and birth rates have gone down in recent years, close to 200,000 babies are born to teen mothers every year in the United States. Linking adolescents to youth-friendly health care services can help prevent pregnancy and sexually transmitted infections in this age group.

– Healthy People 2030 (https://health.gov/healthypeople)

Births to Adolescent Mothers

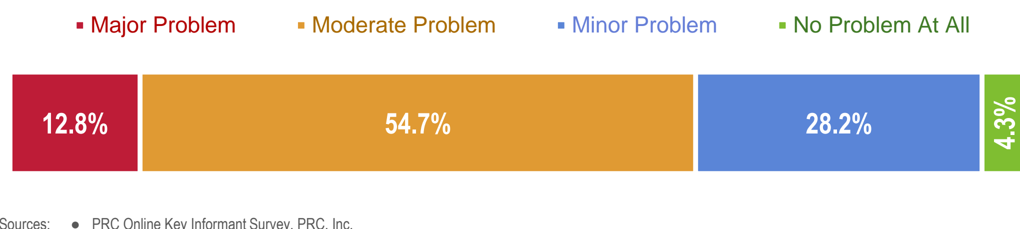
The following chart describes births to adolescent mothers under the age of 20 years. [COUNTY-LEVEL DATA]

Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved June 2022 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the rate of total births to women under the age of 15–19 per 1,000 female population age 15–19. This indicator is relevant because in many cases, teen parents have unique social, economic, and health support services. Additionally, high rates of teen pregnancy may indicate the prevalence of unsafe sex practices.

Key Informant Input: Infant Health & Family Planning

The following chart outlines key informants' perceptions of the severity of *Infant Health and Family Planning* as a problem in the community:



Sources: ● PRC Online Key Informant Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Awareness/Education

> Lack of easily accessible information. – Community Leader
>
> We still have new parents putting their infants in bed with them and then accidentally rolling over on the infant and killing them. We have had a few of these cases in our county. New parents need to be better aware of the dangers of co-sleeping. – Community Leader

Lack of Culturally Appropriate Care/Services

> Most of our outreach and messaging is not culturally appropriate and mainly in English. – Social Services Provider
>
> Access to culturally and linguistically appropriate maternal child services. – Physician

Teen Pregnancy

> Socio-economic issues and high birth rates amongst teen moms. – Social Services Provider
>
> Too many young teens are having sex and getting pregnant at a young age. – Community Leader

Due to COVID-19

> Infant health -- as due to the pandemic families have not had the same access to resources/supports as they did previously. – Community Leader

MODIFIABLE HEALTH RISKS

Nutrition

ABOUT NUTRITION & HEALTHY EATING

Many people in the United States don't eat a healthy diet. …People who eat too many unhealthy foods — like foods high in saturated fat and added sugars — are at increased risk for obesity, heart disease, type 2 diabetes, and other health problems. Strategies and interventions to help people choose healthy foods can help reduce their risk of chronic diseases and improve their overall health.

Some people don't have the information they need to choose healthy foods. Other people don't have access to healthy foods or can't afford to buy enough food. Public health interventions that focus on helping everyone get healthy foods are key to reducing food insecurity and hunger and improving health.

– Healthy People 2030 (https://health.gov/healthypeople)

Daily Recommendation of Fruits/Vegetables

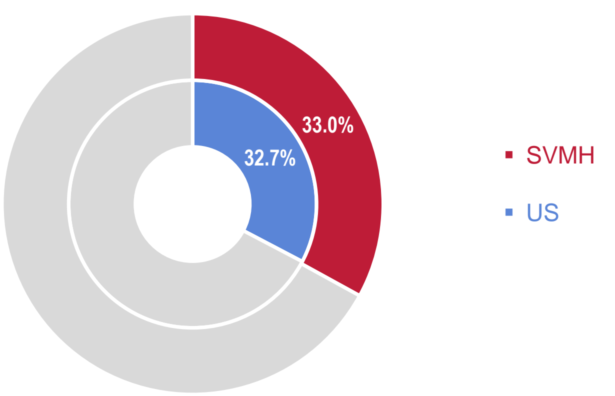
To measure fruit and vegetable consumption, survey respondents were asked multiple questions, specifically about the foods and drinks they consumed on the day prior to the interview.

"Now I would like you to think about the foods you ate or drank yesterday. Include all the foods you ate, both at home and away from home. How many servings of fruit or fruit juices did you have yesterday?"

"How many servings of vegetables did you have yesterday?"

The questions above are used to calculate daily fruit/vegetable consumption for respondents. The proportion reporting having 5 or more servings per day is shown here.

Consume Five or More Servings of Fruits/Vegetables Per Day

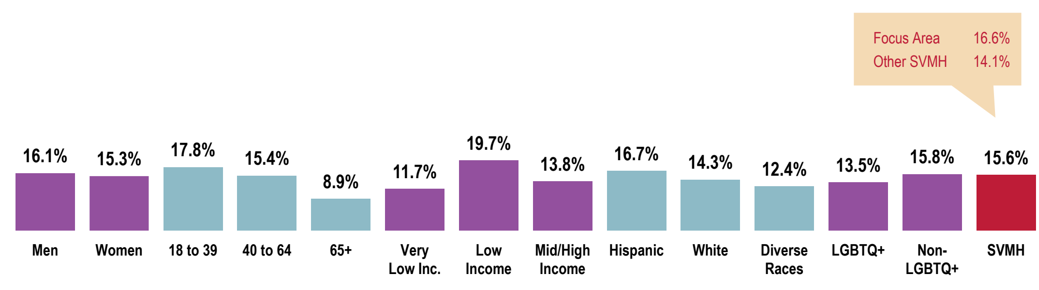


Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 125]
• 2020 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.
• For this issue, respondents were asked to recall their food

Sugar-Sweetened Beverages

"During the past seven days, how many servings of sugar-sweetened beverages did you have? Please include beverages such as soda, Kool-Aid, sweetened fruit juice, sports drinks, energy drinks, or sweet tea. Do not include 'diet' drinks."

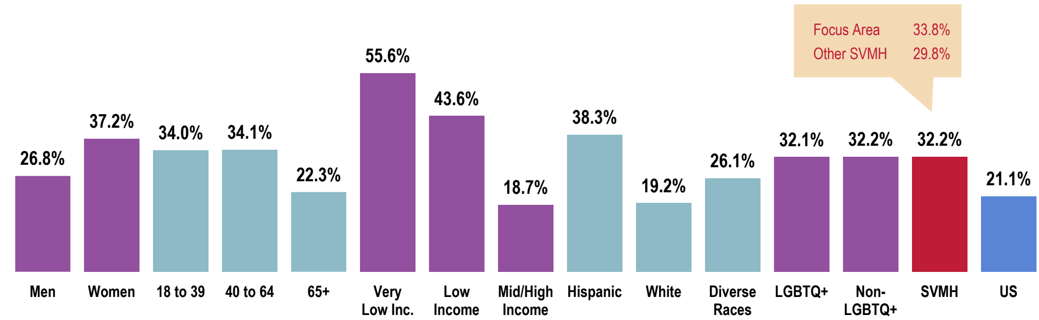
Had Seven or More Sugar-Sweetened Beverages in the Past Week
(SVMH Service Area, 2022)



Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 325]
Notes: • Asked of all respondents.

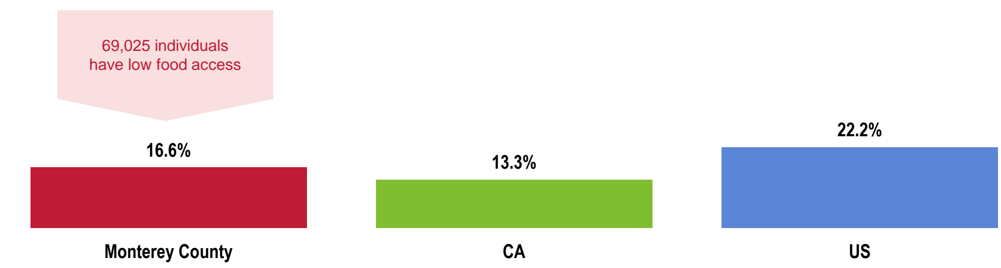
Access to Fresh Produce

"How difficult is it for you to buy fresh produce like fruits and vegetables at a price you can afford — would you say: very difficult, somewhat difficult, not too difficult, or not at all difficult?"



Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 79]
• 2020 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.

Low food access is defined as living more than ½ mile from the nearest supermarket, supercenter, or large grocery store. This related chart is based on US Department of Agriculture data. [COUNTY-LEVEL DATA]



Sources: • US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas (FARA).
• Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved June 2022 via SparkMap (sparkmap.org).
Notes: • This indicator reports the percentage of the population with low food access. Low food access is defined as living more than ½ mile from the nearest supermarket, supercenter, or large grocery store. This indicator is relevant because it highlights populations and geographies facing food insecurity.

Physical Activity

ABOUT PHYSICAL ACTIVITY

Physical activity can help prevent disease, disability, injury, and premature death. The Physical Activity Guidelines for Americans lays out how much physical activity children, adolescents, and adults need to get health benefits. Although most people don't get the recommended amount of physical activity, it can be especially hard for older adults and people with chronic diseases or disabilities.

Strategies that make it safer and easier to get active — like providing access to community facilities and programs — can help people get more physical activity. Strategies to promote physical activity at home, at school, and at childcare centers can also increase activity in children and adolescents.

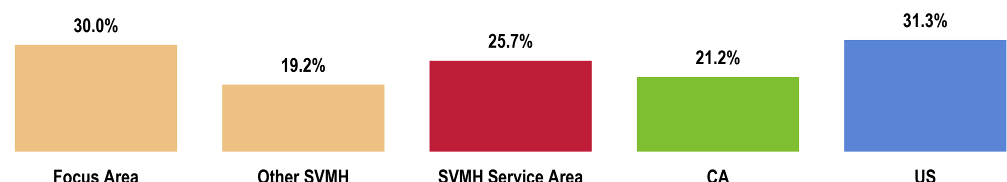
– Healthy People 2030 (https://health.gov/healthypeople)

Leisure-Time Physical Activity

"During the past month, other than your regular job, did you participate in any physical activities or exercises, such as running, calisthenics, golf, gardening, or walking for exercise?"

No Leisure-Time Physical Activity in the Past Month

Healthy People 2030 = 21.2% or Lower



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 82]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2021 California data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

Notes:
- Asked of all respondents.

Meeting Physical Activity Recommendations

ADULTS: RECOMMENDED LEVELS OF PHYSICAL ACTIVITY

Adults should do 2 hours and 30 minutes a week of moderate-intensity (such as walking), or 1 hour and 15 minutes (75 minutes) a week of vigorous-intensity **aerobic** physical activity (such as jogging), or an equivalent combination of moderate- and vigorous-intensity aerobic physical activity. The guidelines also recommend that adults do **muscle-strengthening** activities, such as push-ups, sit-ups, or activities using resistance bands or weights. These activities should involve all major muscle groups and be done on two or more days per week.

The report finds that nationwide nearly 50 percent of adults are getting the recommended amounts of aerobic activity and about 30 percent are engaging in the recommended muscle-strengthening activity.

– 2013 Physical Activity Guidelines for Americans, US Department of Health and Human Services. www.cdc.gov/physicalactivity

To measure physical activity frequency, duration and intensity, respondents were asked:

"During the past month, what type of physical activity or exercise did you spend the most time doing?"

"And during the past month, how many times per week or per month did you take part in this activity?"

"And when you took part in this activity, for how many minutes or hours did you usually keep at it?"

Respondents could answer the above series for up to two types of physical activity. The specific activities identified (e.g., jogging, basketball, treadmill, etc.) determined the intensity values assigned to that respondent when calculating total aerobic physical activity hours/minutes.

Respondents were also asked about strengthening exercises:

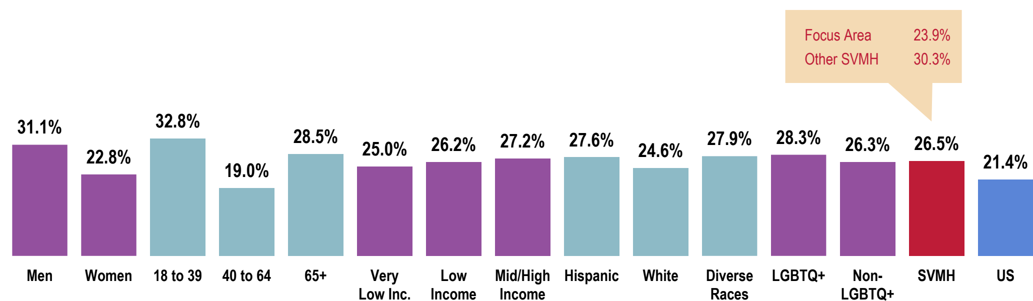
"During the past month, how many times per week or per month did you do physical activities or exercises to strengthen your muscles? Do not count aerobic activities like walking, running, or bicycling. Please include activities using your own body weight, such as yoga, sit-ups, or push-ups, and those using weight machines, free weights, or elastic bands."

"Meeting physical activity recommendations" includes adequate levels of both aerobic and strengthening activity:

- Aerobic activity is at least 150 minutes per week of light to moderate activity, 75 minutes per week of vigorous physical activity, or an equivalent combination of both;
- Strengthening activity is at least 2 sessions per week of exercise designed to strengthen muscles.

Meets Physical Activity Recommendations
(SVMH Service Area, 2022)

Healthy People 2030 = 28.4% or Higher



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 126]
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

Notes:
- Asked of all respondents.
- Meeting both guidelines is defined as the number of persons age 18+ who report light or moderate aerobic activity for at least 150 minutes per week or who report vigorous physical activity 75 minutes per week or an equivalent combination of moderate and vigorous-intensity activity *and* report doing physical activities specifically designed to strengthen muscles at least twice per week.

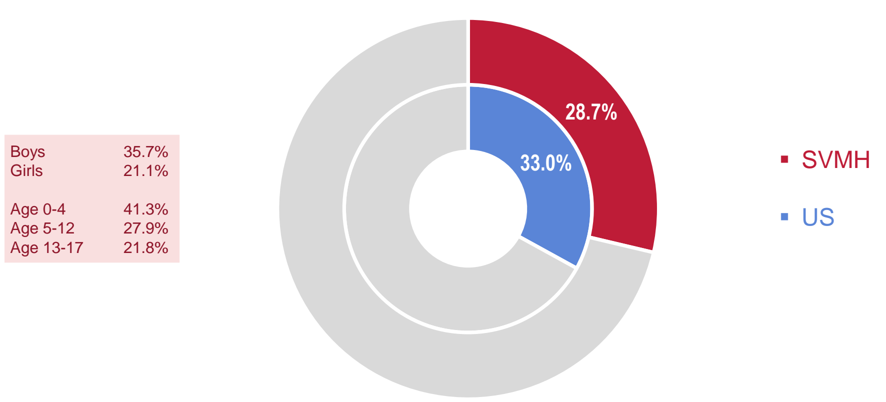
Children's Physical Activity

CHILDREN: RECOMMENDED LEVELS OF PHYSICAL ACTIVITY

Children and adolescents should do 60 minutes (1 hour) or more of physical activity each day.

– 2013 Physical Activity Guidelines for Americans, US Department of Health and Human Services. www.cdc.gov/physicalactivity

"During the past 7 days, on how many days was this child physically active for a total of at least 60 minutes per day?"



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 109]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents with children age 2-17 at home.
- Includes children reported to have one or more hours of physical activity on

Weight Status

ABOUT OVERWEIGHT & OBESITY

Obesity is linked to many serious health problems, including type 2 diabetes, heart disease, stroke, and some types of cancer. Some racial/ethnic groups are more likely to have obesity, which increases their risk of chronic diseases.

Culturally appropriate programs and policies that help people eat nutritious foods within their calorie needs can reduce overweight and obesity. Public health interventions that make it easier for people to be more physically active can also help them maintain a healthy weight.

– Healthy People 2030 (https://health.gov/healthypeople)

Body Mass Index (BMI), which describes relative weight for height, is significantly correlated with total body fat content. The BMI should be used to assess overweight and obesity and to monitor changes in body weight. In addition, measurements of body weight alone can be used to determine efficacy of weight loss therapy. BMI is calculated as weight (kg)/height squared (m^2). To estimate BMI using pounds and inches, use: [weight (pounds)/height squared ($inches^2$)] x 703.

In this report, overweight is defined as a BMI of 25.0 to 29.9 kg/m^2 and obesity as a BMI ≥30 kg/m^2. The rationale behind these definitions is based on epidemiological data that show increases in mortality with BMIs above 25 kg/m^2. The increase in mortality, however, tends to be modest until a BMI of 30 kg/m^2 is reached. For persons with a BMI ≥30 kg/m^2, mortality rates from all causes, and especially from cardiovascular disease, are generally increased by 50 to 100 percent above that of persons with BMIs in the range of 20 to 25 kg/m^2.

– Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. National Institutes of Health. National Heart, Lung, and Blood Institute in Cooperation With The National Institute of Diabetes and Digestive and Kidney Diseases. September 1998.

Adult Weight Status

CLASSIFICATION OF OVERWEIGHT AND OBESITY BY BMI	BMI (kg/m^2)
Underweight	<18.5
Normal	18.5 – 24.9
Overweight	25.0 – 29.9
Obese	≥30.0

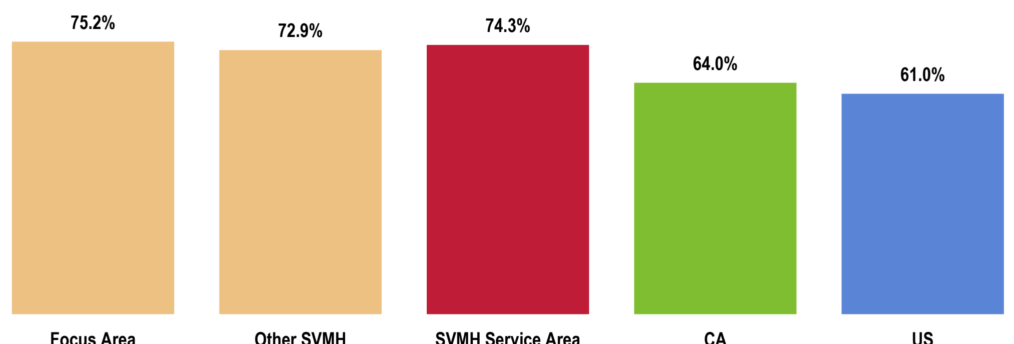
Source: Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. National Institutes of Health. National Heart, Lung, and Blood Institute in Cooperation With The National Institute of Diabetes and Digestive and Kidney Diseases. September 1998.

"About how much do you weigh without shoes?"

"About how tall are you without shoes?"

Reported height and weight were used to calculate a Body Mass Index or BMI value (described above) for each respondent. This calculation allows us to examine the proportion of the population who is at a healthy weight, or who is overweight or obese (see table above).

Prevalence of Total Overweight (Overweight and Obese)

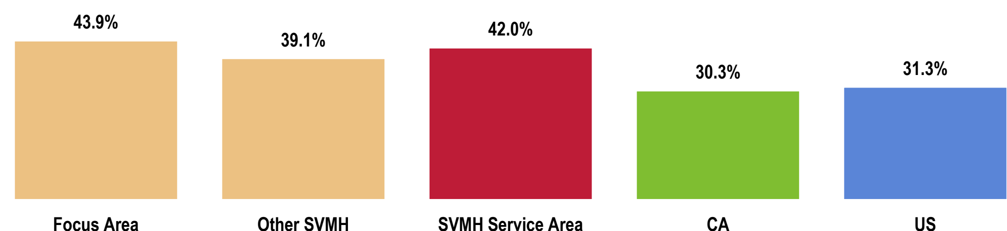


Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Items 128]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2021 California data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Based on reported heights and weights, asked of all respondents.
- The definition of overweight is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 25.0, regardless of gender. The definition for obesity is a BMI greater than or equal to 30.0.

Prevalence of Obesity

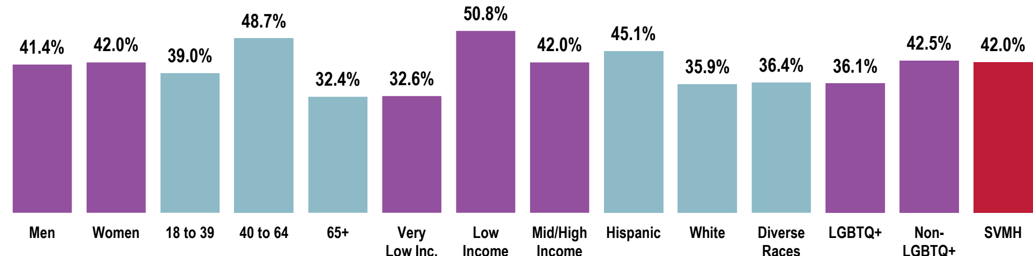
Healthy People 2030 = 36.0% or Lower



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 128]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2021 California data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

Notes:
- Based on reported heights and weights, asked of all respondents.
- The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0, regardless of gender.

Prevalence of Obesity
(SVMH Service Area, 2022)
Healthy People 2030 = 36.0% or Lower



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 128]
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

Notes:
- Based on reported heights and weights, asked of all respondents.
- The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0, regardless of gender.

Children's Weight Status

ABOUT WEIGHT STATUS IN CHILDREN & TEENS

In children and teens, body mass index (BMI) is used to assess weight status – underweight, healthy weight, overweight, or obese. After BMI is calculated for children and teens, the BMI number is plotted on the CDC BMI-for-age growth charts (for either girls or boys) to obtain a percentile ranking. Percentiles are the most commonly used indicator to assess the size and growth patterns of individual children in the United States. The percentile indicates the relative position of the child's BMI number among children of the same sex and age.

BMI-for-age weight status categories and the corresponding percentiles are shown below:

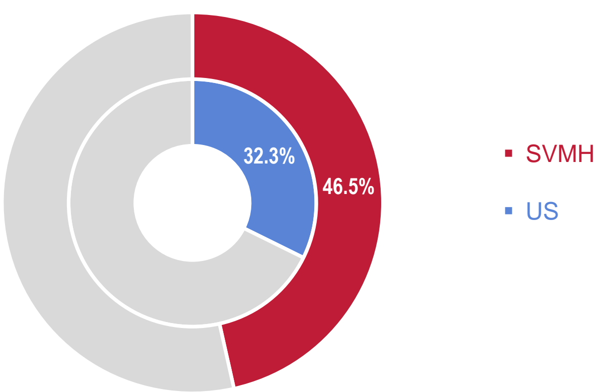
- Underweight — <5th percentile
- Healthy Weight — ≥5th and <85th percentile
- Overweight — ≥85th and <95th percentile
- Obese — ≥95th percentile

– Centers for Disease Control and Prevention

The following questions were used to calculate a BMI value (and weight classification as noted above) for each child represented in the survey:

"How much does this child weigh without shoes?"

"About how tall is this child?"

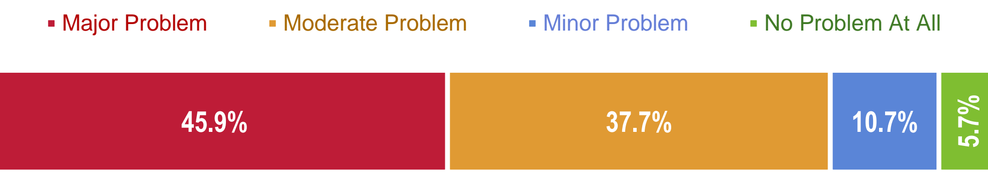


Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 131]
• 2020 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents with children age 5-17 at home.
• Overweight among children is determined by children's Body Mass

Key Informant Input: Nutrition, Physical Activity & Weight

The following chart outlines key informants' perceptions of the severity of *Nutrition, Physical Activity & Weight* as a problem in the community:

Perceptions of Nutrition, Physical Activity, and Weight as a Problem in the Community
(Key Informants, 2022)



Sources: • PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Access to Affordable Food

Limited access to nutritional foods. Food is expensive. Lack of organized activities to support and promote healthy living. – Community Leader

Access to healthy food at an affordable price. Due to the pandemic parks and other public places have been closed for families to go to. Nutrition education is essential for our community to be educated on the effects long term of chronic illnesses and diseases. – Other Health Provider

Lack of access to good food, way too much access to fast, processed foods, cost of fresh food, lack of walkable streets, stress. – Public Health Representative

Lack of equitable access to nutritious foods and safe spaces to recreate. Immediate access to low cost, high fat, and high calorie foods (fast foods, convenient snacks, etc.). Lack of access to preventative care. Lacking infrastructure that promotes walkability/bikeability. – Public Health Representative

Access to healthy food and safe open space used for physical activity. – Social Services Provider

Lack of access to affordable nutritious foods, feelings of not being safe when exercising outside, lack of access to culturally, linguistically, and literacy-level appropriate educational programs. – Social Services Provider

Low income, higher relative cost of relative foods. Stressful jobs and home life due to income disparities, unaffordable housing. – Public Health Representative

It's expensive to eat healthy, people are working long hours and don't exercise enough, or their neighborhoods make it difficult to exercise safely. – Social Services Provider

Affordable healthy food options, affordable exercise spaces that are safe. – Physician

Financial access to healthy options, education about healthy options and how they impact prevention of chronic disease. – Social Services Provider

Nutrition

Too many fast foods. – Community Leader

Easy access to junk food. – Community Leader

I see so many kids that choose to eat chips, candy, and soda after school without regard for the long term mental and physical consequences of eating such foods. – Community Leader

Too easy availability of unhealthy foods, lack of education and support. Complexity of individual medical/genetic factors which contribute to obesity. Complexity of lifestyles which are not supportive of making time for physical activity. – Physician

Fast food, food insecurity, sedentary lifestyles all contribute. People have lost the ability to cook from scratch, so eat high salt, high fat, prepackaged meals. – Community Leader

Children are growing up without proper nutrition (fast food) because it is easier and less expensive than some foods. Many of our youth are overweight especially as we come out of the pandemic. We are trying to help our community by partnering with ALL IN Monterey and Food Bank by providing fresh vegetables, but it is only once a week in a limited way. We are encouraging lots of active activities and new opportunities for our youth and families. – Social Services Provider

Food choices. – Social Services Provider

Obesity

Obesity is all around the county. Sadly, the younger generation seems to not really care. The teenagers are busy eating Red Hot Corn Chips and Red Bull. It seems only those involved in sports have any idea how to eat and exercise. The older groups also are mostly overweight and show little care about their diets and general health, until something tragic happens to them or a family member. Diabetes is mostly a plague in Mo Co. – Community Leader

Massive problems with obesity, starting with toddlers. Lack of emphasis on regular physical activity in families and schools. – Physician

Although there is a younger population in the Salinas Valley there is a disproportionate amount of early chronic conditions related to obesity and metabolic syndrome. There are areas where fresh produce and healthy food choices are not available or not affordable. There are areas that do not have adequate or safe outdoor spaces for exercise. – Physician

Obesity, sedentary lifestyles, pandemic stress, lack of time to cook healthy meals. – Other Health Provider

Obesity is at epidemic levels, which means that diabetes is also rampant. – Physician

Many of our diabetic patients are obese with poor eating habits. – Other Health Provider

Awareness/Education

The community needs more preventative programs to improve nutrition, physical activity, and overall community health. There also needs to be an effort to have safer communities, walking/running paths, parks free of violence and drugs. – Other Health Provider

Lack of access to nutritional education and programs. Food insecurities for immigrant communities and residents in a lower social-economic status. – Social Services Provider

There is no consistent program that coordinates education with physical activity. We need a weight loss program the patients can access on a regular basis. – Physician

Education and facilities. – Community Leader

Once again, it is the lack of education and outreach to the community. – Social Services Provider

Education and stress. – Community Leader

Access to Care/Services

No city, county or state provided facilities or programs to assist these individuals. We assist individuals with drug and alcohol abuse, why are there no city, county or state funded facilities or programs to do the same for people with weight or diabetic issues? – Community Leader

> Again, it's an access issue. People living in Monterey/Pacific Grove have different access to healthy foods, safe places to exercise, etc. than those living in King City or Salinas. We should be focusing on equity in the county and putting more resources towards the communities that are struggling to make ends meet. – Social Services Provider

Persons at Increased Risk for Adverse Health Outcomes

> There are very little to no public resources located in South Monterey County that teach our unique demographic how to eat healthier nutritionally and how to keep yourself healthier. Most of our migrant and generational migrant residents do not participate in any exercise regimen nor purchase high quality nutritionally rich foods. This is a significant area of need. – Community Leader
>
> Poor nutrition in the highest risk communities. Latino and people of color. Low access to healthy foods. – Other Health Provider

Built Environment

> Lack of outdoor recreation time/space. Portion size. Inactivity. – Social Services Provider
>
> Lack of access to safe parks and routes. – Public Health Representative
>
> The Salinas Valley was not really planned as a walking community. Many unincorporated areas do not have sidewalks and the streets are in disrepair which makes it hard to walk and exercise outdoors. Many people do not have funds/transportation to access nutritional food. – Social Services Provider

Lack of Time

> Recreation time. – Social Services Provider
>
> Working families have difficulty finding time to eat healthy and to exercise. Fast food is inexpensive and easily available. – Community Leader

Due to COVID-19

> The pandemic has challenged people working from home to eat healthy and exercise. Gyms were closed, not everyone can afford or have space to purchase equipment for home use. Healthy food is TOO EXPENSIVE for people with low incomes. It is a struggle to teach people with families to eat healthy when it is cheaper and faster to eat poorly. Our fast-food stores should increase their healthy options. Increases in anxiety and depression lead to weight gain. – Other Health Provider
>
> COVID-19 has added to the challenges of weight gain and nutrition. There has been a lot of coverage that many people "overate" and stopped exercising over the past two years. – Social Services Provider

Lifestyle

> Too many of our working families do not have time to exercise, eat right with smaller portion size, and don't know enough about nutrition to eat healthy foods. Families that do not have financial resources tend to purchase food that is low cost and low-cost foods can be the less nutritious foods. – Community Leader
>
> For most people it's not access - it's the will or the time to prepare nutritional meals or exercise. I don't want to minimize the expense of food now - and that it may be less expensive to go to McDonald's than to feed your family nutritional foods. There are also some families that don't have adequate housing and can't prepare healthy meals. But for the majority of residents - it's will and desire. – Community Leader

Safety

> Public safety and fear of crime makes it hard for children and adults to incorporate outdoor activities into their daily lives. – Other Health Provider

Childhood Obesity

> Childhood obesity. – Other Health Provider

Substance Use

ABOUT DRUG & ALCOHOL USE

More than 20 million adults and adolescents in the United States have had a substance use disorder in the past year. …Substance use disorders can involve illicit drugs, prescription drugs, or alcohol. Opioid use disorders have become especially problematic in recent years. Substance use disorders are linked to many health problems, and overdoses can lead to emergency department visits and deaths.

Effective treatments for substance use disorders are available, but very few people get the treatment they need. Strategies to prevent substance use — especially in adolescents — and help people get treatment can reduce drug and alcohol misuse, related health problems, and deaths.

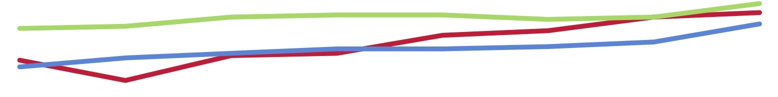
– Healthy People 2030 (https://health.gov/healthypeople)

Alcohol

Age-Adjusted Cirrhosis/Liver Disease Deaths

Heavy alcohol use contributes to a significant share of liver disease, including cirrhosis. The following chart outlines age-adjusted mortality for cirrhosis/liver disease in Monterey County. [COUNTY-LEVEL DATA]

Cirrhosis/Liver Disease: Age-Adjusted Mortality Trends
(Annual Average Deaths per 100,000 Population)
Healthy People 2030 = 10.9 or Lower



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Monterey County	10.3	9.4	10.5	10.6	11.4	11.6	12.2	12.4
CA	11.7	11.8	12.2	12.3	12.3	12.1	12.2	12.8
US	10.0	10.4	10.6	10.8	10.8	10.9	11.1	11.9

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2022.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

Excessive Drinking

Excessive drinking includes heavy and/or binge drinkers:

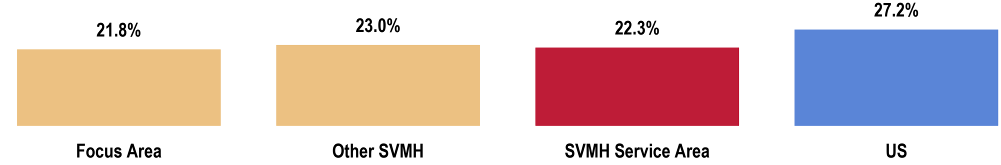
- HEAVY DRINKERS ► men reporting 2+ alcoholic drinks per day or women reporting 1+ alcoholic drink per day in the month preceding the interview.
- BINGE DRINKERS ► men reporting 5+ alcoholic drinks or women reporting 4+ alcoholic drinks on any single occasion during the past month.

"During the past 30 days, on how many days did you have at least one drink of any alcoholic beverage such as beer, wine, a malt beverage, or liquor?"

"On the day(s) when you drank, about how many drinks did you have on the average?"

"Considering all types of alcoholic beverages, how many times during the past 30 days did you have 5 (if male)/4 (if female) or more drinks on an occasion?"

Excessive Drinkers



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 136]
- 2020 PRC National Health Survey, PRC, Inc.

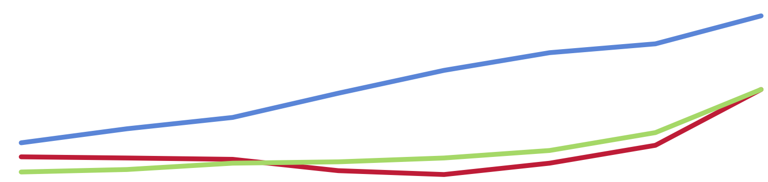
Notes:
- Asked of all respondents.
- Excessive drinking reflects the number of persons aged 18 years and over who drank more than two drinks per day on average (for men) or more than one drink per day on average (for women) OR who drank 5 or more drinks during a single occasion (for men) or 4 or more drinks during a single occasion (for women) during the past 30 days.

Drugs

Age-Adjusted Unintentional Drug-Related Deaths

Unintentional drug-related deaths include all deaths, other than suicide, for which drugs are the underlying cause. A "drug" includes illicit or street drugs (e.g., heroin and cocaine), as well as legal prescription and over-the-counter drugs; alcohol is not included. The following chart outlines countywide age-adjusted mortality for unintentional drug-related deaths. [COUNTY-LEVEL DATA]

Unintentional Drug-Related Deaths: Age-Adjusted Mortality Trends
(Annual Average Deaths per 100,000 Population)



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Monterey County	9.9	9.8	9.7	8.8	8.5	9.4	10.8	15.2
CA	8.7	8.9	9.4	9.5	9.8	10.4	11.8	15.2
US	11.0	12.1	13.0	14.9	16.7	18.1	18.8	21.0

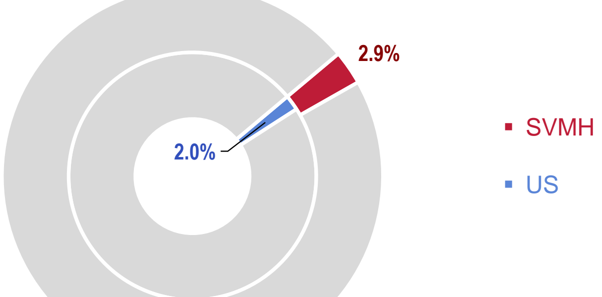
Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2022.

Illicit Drug Use

Note: As a self-reported measure – and because this indicator reflects potentially illegal behavior – it is reasonable to expect that it might be underreported, and that actual illicit drug use in the community is likely higher.

"During the past 30 days, have you used an illegal drug or taken a prescription drug that was not prescribed to you?"

Illicit Drug Use in the Past Month
Healthy People 2030 = 12.0% or Lower



Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 49]
• 2020 PRC National Health Survey, PRC, Inc.
• US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

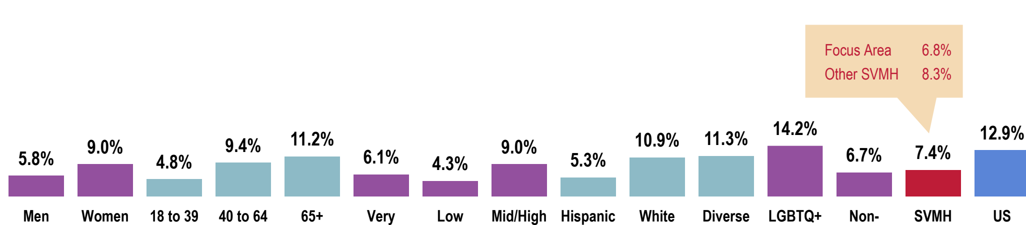
Notes: • Asked of all respondents.

Use of Prescription Opioids

Opioids are a class of drugs used to treat pain. Examples presented to respondents include morphine, codeine, hydrocodone, oxycodone, methadone, and fentanyl. Common brand name opioids include Vicodin, Dilaudid, Percocet, OxyContin, and Demerol.

"Opiates or opioids are drugs that doctors prescribe to treat pain. Examples of prescription opiates include morphine, codeine, hydrocodone, oxycodone, methadone, and fentanyl. In the past year, have you used any of these prescription opiates?"

Used a Prescription Opioid in the Past Year
(SVMH Service Area, 2022)



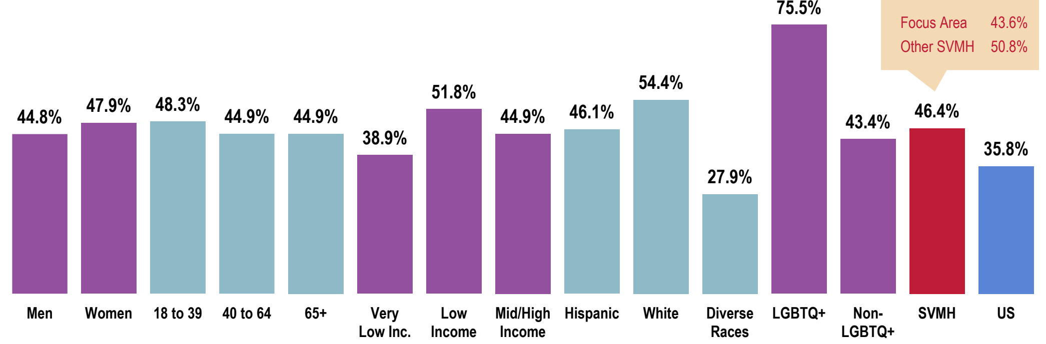
Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 50]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Personal Impact From Substance Use

"To what degree has your life been negatively affected by your own or someone else's substance use issues, including alcohol, prescription, and other drugs? Would you say: a great deal, somewhat, a little, or not at all?"

Life Has Been Negatively Affected by Substance Use (by Self or Someone Else)
(SVMH Service Area, 2022)



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 52]
- 2020 PRC National Health Survey, PRC, Inc.

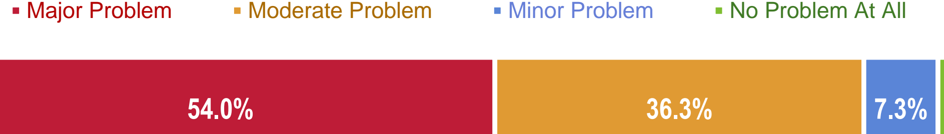
Notes:
- Asked of all respondents.

- Includes response of "a great deal," "somewhat," and "a little."

Key Informant Input: Substance Use

The following chart outlines key informants' perceptions of the severity of *Substance Use* as a problem in the community:

Perceptions of Substance Use
as a Problem in the Community
(Key Informants, 2022)



Sources: ● PRC Online Key Informant Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Access to Care/Services

Lack of programming to meet the diverse socio-economic demographics of the community. – Public Health Representative

Similar to mental health, I think local access to available services is an issue. – Community Leader

Lack of long-term rehabilitation centers (residential) and support group dynamics for different abuse issues. CHOMP Crisis Center does a wonderful job, but cost of quality programs is often not affordable for many, if not most. – Other Health Provider

There are no facilities or meetings in our community. There was an AA meeting, not sure if it has restarted. – Physician

The bifurcation between physical health and SUD systems in CA makes services cumbersome and difficult to access. – Community Leader

Access to hygienic needles and safe disposal areas for used syringes. – Social Services Provider

Lack of resources or doctors who are willing to manage these patients. – Other Health Provider

Timely, culturally appropriate care for substance abuse. – Physician

Distance. – Community Leader

Nothing in local community. No education. – Community Leader

The treatment needs to go to where the people are, gently, consistently, to build trust without judgment. – Physician

There are not enough treatment programs available. – Physician

No services in our community. Lack of affordable referral services. – Other Health Provider

Very limited, silo'd programs. Sunstreet Centers, Beacon House, and others provide components of care, but families must bridge across these services with psychiatry services. Most patients need to leave the county or state to access intensive services (day or residential treatment). – Physician

Treatment and prevention are siloed and often not available at the source (i.e. in the schools). – Physician

Huge substance abuse problem here. Not enough treatment beds and of course you need the patient to want treatment to attend. It was better when the court used to force treatment onto individuals to avoid jail time. – Other Health Provider

Lack of access to enough affordable providers for inpatient recovery and lack of initiation of medication assisted treatment in emergency department and hospital settings. – Social Services Provider

Lack of adequate number of substance use treatment providers and centers. Lack of insurance coverage. – Public Health Representative

The biggest barriers are getting a medical evaluation, affordable treatment options, breakthrough treatments, and housing. Substance abusers need to travel outside our area for treatment options. There are only the Sun Street Centers, Dorothy's Kitchen, and a religious group affiliated with Liberty Chapel in our area. – Social Services Provider

Access to services, long wait lists, and high costs for low-income people are a big issue. – Public Health Representative

Lack of drug/alcohol residential treatment facilities and drug/alcohol trained counselors. Difficulty for families with medical or no insurance to access. – Community Leader

Lack of facilities and lack of interest in those addicted to illegal substances. – Community Leader

Lack of availability, cost or perceived costs, culturally appropriate services. – Social Services Provider

Lack of treatment beds. Cost of services, stigma. – Public Health Representative

The lack of adequate treatment facilities, unwillingness of some residents to access treatment. – Social Services Provider

Limited availability. – Social Services Provider

Access to treatment. – Social Services Provider

The greatest barriers are decriminalization of drugs, lack of treatment beds, and a lack of understanding by the community on what it actually takes to get people sober and back on their feet. – Social Services Provider

No residential services for youth. Limited capacity of current Medi-Cal programs for all levels of care. ASAM requirement. Stigma. Pharmacy barriers/reluctance to treating substance use disorders. – Physician

The greatest barrier to accessing substance abuse treatment is not knowing Sun Street Centers are located in South Monterey County, costs associated with treatment, and our gang/drug sales issues in South County. – Community Leader

Low number of certified providers. Lack of funding source for treatment services for youth. Stigma associated with being a substance abuser. – Public Health Representative

Limited financial support for organizations addressing this issue. Limited beds in sober living facilities. Care, when available, is not enforced. – Community Leader

All of our programs have waiting lists. In addition, we lose people all the time that are only willing to commit when they call or walk in the door. Medi-Cal requirements for intake are so time consuming that, by the time we can admit someone into treatment, they cannot be found. Those that are really willing and keep calling are often waiting for a bed because of COVID response, or limited beds for social distancing, or not enough qualified staff because we cannot afford to hold on to staff with Medi-Cal rates, or because the new graduates want to work from home. – Other Health Provider

Stigma/Denial

Desire by the participant. Awareness of programs. Transportation and shelter to participate in the programs. – Social Services Provider

Stigma and lack of resources. – Community Leader

Stigma, lack of resources for people who don't qualify for Medi-Cal. – Social Services Provider

Stigma. Cost/lack of insurance coverage. Lack of available slots in programs designed for minors and pregnant women. – Public Health Representative

Diagnosis/Treatment

Criminalizing substance abuse rather than providing treatment and ongoing services. Substance abuse needs ongoing, proactive treatment. People suffering in this way need to experience support, not shame. – Community Leader

Quality of programs. – Social Services Provider

Co-Occurrences

We see a lot of meth abuse that leads to psychiatric concerns. – Other Health Provider

Untreated depression and mental illness, which often leads to self-medicating. – Community Leader

Government/Politics

I think this relates closely to the previous social psychological mental health challenges. The political polarization includes attacks against science, climate change measures, racial equity, and effective COVID solutions. The unhealthy environment leads to less robust sources of resilience that reduce substance abuse or make attending treatment more likely (e.g. weaker family relationships, fewer friends, decreased participation in social/community activities, less trust/expectation from children in the adults around them, etc.) – Public Health Representative

Awareness/Education

Substance abuse to include alcohol and drugs is a great concern in our communities. There needs to be more community involvement to bring awareness to this public health concern and most importantly the impact on the individual and the community as a whole presently and in the future. There need to be prevention programs for youth and substance abuse programs that are easily accessed for those that suffer from this mental health illness. Providers are needed that specialize in substance abuse such as MD's, NP's and mental health counselors. The programs and services should be available in Spanish and English as well as access to other languages. – Other Health Provider

Early education. – Physician

Multiple Factors

> Lack of focus addressing the root causes. Not enough facilities. Not enough knowledge of the drugs that can stop the reactions to overdoses. – Community Leader

Lack of Providers

> There are not enough treatment providers in our county. – Community Leader

Disease Management

> Contemplation of the individual in engaging services or not. Availability of treatment at appropriate levels of care to not only address substance use challenges, but influences contributing to choose to use such as being homeless, suffering abuse or mistreatment, numbing self to effects of trauma. – Community Leader

Prevalence/Incidence

> I would like to congratulate drugs for winning the war on drugs. We continue to watch people die of overdose despite our best efforts. Whatever we are currently doing is not enough. The deaths of local teenagers from fentanyl is particularly painful for families and the community. Additionally, one only has to drive down highway 1 to see the ravaging effect of methamphetamines on our community - the homeless encampments with people hoarding junk who are using methamphetamine. Ask any local police officer or ER staff member and they see people high on methamphetamine acting aggressively under the influence on a daily basis. – Physician

Persons at Increased Risk for Adverse Health Outcomes

> In our community we have river people who are allowed to live in our river and continue with their addictions. They do not want help but they need it but the laws are such that intervening with their lifestyles is prohibited. In the meantime, they cause fires in the river, use the river as a bathroom and continue their addictions. It is appalling that we have let this happen. Mental health and addictions need to be addressed by the State and County laws and programs. – Community Leader

Youth

> Our youth are being tempted in the world of drugs. Fentanyl, now cocaine and vaping are damaging our youth physically, emotionally, and physiologically. – Social Services Provider

Violence

> Gang violence and mental health issues are the cause of the high substance abuse. – Other Health Provider

Prevention/Screenings

> Preventive programs for teens we need in South County. – Community Leader

Tobacco Use

ABOUT TOBACCO USE

More than 16 million adults in the United States have a disease caused by smoking cigarettes, and smoking-related illnesses lead to half a million deaths each year.

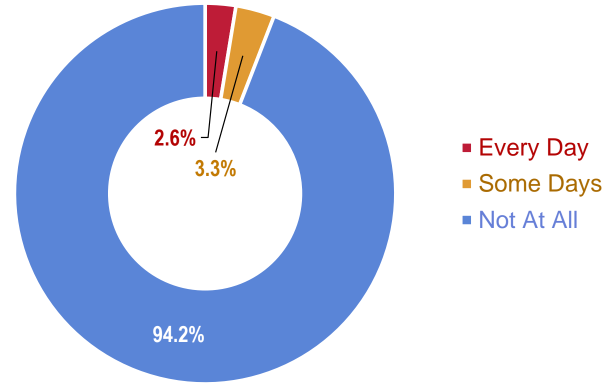
Most deaths and diseases from tobacco use in the United States are caused by cigarettes. Smoking harms nearly every organ in the body and increases the risk of heart disease, stroke, lung diseases, and many types of cancer. Although smoking is widespread, it's more common in certain groups, including men, American Indians/Alaska Natives, people with behavioral health conditions, LGBT people, and people with lower incomes and education levels.

Several evidence-based strategies can help prevent and reduce tobacco use and exposure to secondhand smoke. These include smoke-free policies, price increases, and health education campaigns that target large audiences. Methods like counseling and medication can also help people stop using tobacco.

– Healthy People 2030 (https://health.gov/healthypeople)

Cigarette Smoking

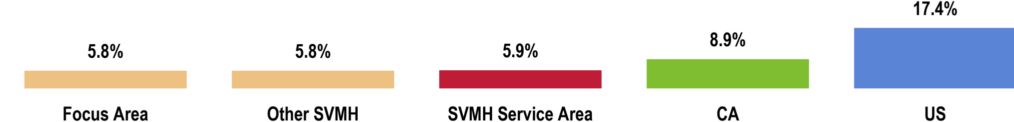
"Do you now smoke cigarettes every day, some days, or not at all?" ("Current smokers" include those smoking "every day" or on "some days.")



Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 40]
Notes: • Asked of all respondents.

Cigarette Smoking Prevalence

Healthy People 2030 = 5.0% or Lower



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 40]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2021 California data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

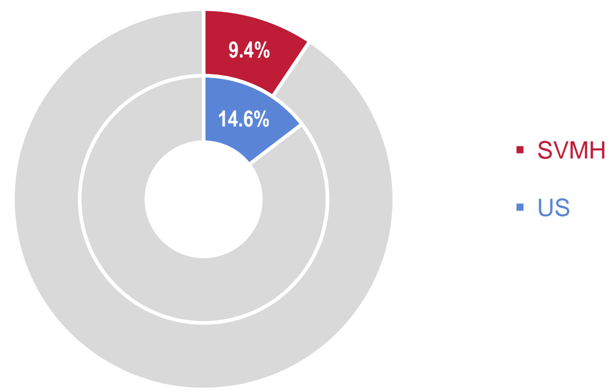
Notes:
- Asked of all respondents.
- Includes those who smoke cigarettes every day or on some days.

Environmental Tobacco Smoke

"In the past 30 days, has anyone, including yourself, smoked cigarettes, cigars or pipes anywhere in your home on an average of four or more days per week?"

The following chart details these responses among the total sample of respondents, as well as among only households with children (age 0-17).

Member of Household Smokes at Home



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Items 43, 134]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- "Smokes at home" refers to someone smoking cigarettes, cigars, or a pipe in the home an average of four or

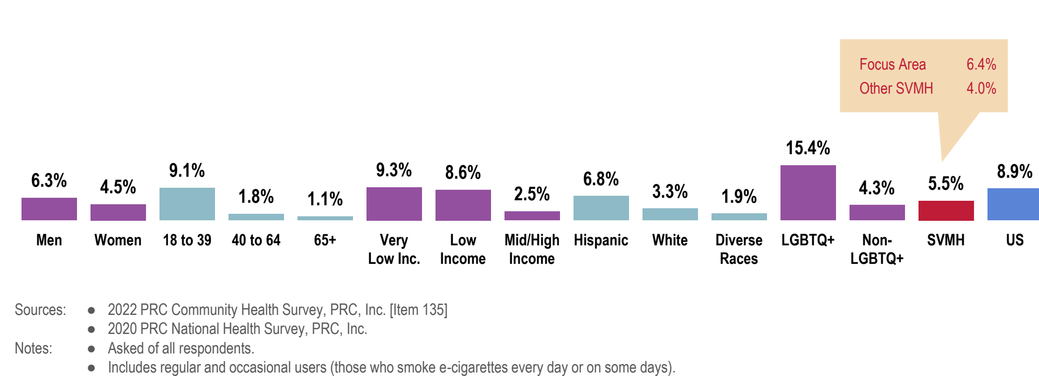
Use of Vaping Products

"The next questions are about electronic vaping products, such as electronic cigarettes, also known as e-cigarettes. These are battery-operated devices that simulate traditional cigarette smoking, but do not involve the burning of tobacco. The cartridge or liquid "e-juice" used in these devices produces vapor and comes in a variety of flavors. Have you ever used an electronic vaping product, such as an e-cigarette, even just one time in your entire life?"

"Do you now use electronic vaping products, such as e-cigarettes, "every day," "some days," or "not at all"?"

"Current use" includes use "every day" or on "some days."

Currently Use Vaping Products
(SVMH Service Area, 2022)

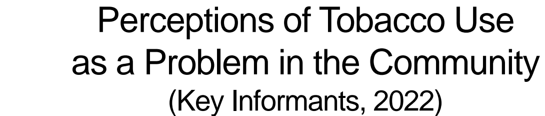


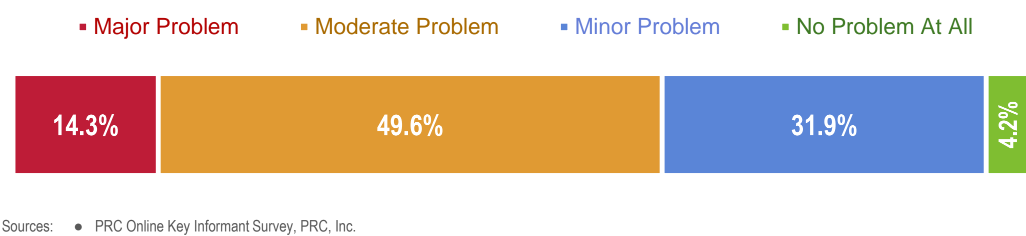
Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 135]
• 2020 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.
• Includes regular and occasional users (those who smoke e-cigarettes every day or on some days).

Key Informant Input: Tobacco Use

The following chart outlines key informants' perceptions of the severity of *Tobacco Use* as a problem in the community:

Perceptions of Tobacco Use as a Problem in the Community
(Key Informants, 2022)





Sources: • PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

E-Cigarettes

> Vaping has completely penetrated the youth market. – Physician
> Youth vaping has increased significantly. – Community Leader

> Think it is more vaping. Vaping does not allow others to know what you are actually vaping, whether it is MJ or nicotine. Thus, people are getting high right in front of you and you don't even realize. See it a lot in driving. – Other Health Provider

Prevalence/Incidence

> There are tons of cigarette butts on the ground throughout the county (some places more than others). With the population we serve, it is very common. – Social Services Provider
>
> Stopping tobacco use is one of the single most important things that can be done to promote health. – Physician
>
> Large amount of members continue to smoke. – Community Leader

Impact on Quality of Life

> Lung cancer, COPD. – Community Leader
>
> Because tobacco is addictive and can destroy your lungs, teeth, throat, etc. Tobacco is now consumed in vaping paraphernalia, which allow for a mix with other substances like cannabis, fentanyl, and hallucinogens. – Other Health Provider

Co-Occurrences

> Persons with mental illness and substance use smoke at a rate about 5 times the general population. Our efforts at smoking cessation have not been successful. About 50% of adults with mental illness smoke and about 80% of people with both substance use disorders and mental illness smoke. – Social Services Provider

Easy Access

> Access. – Social Services Provider

Persons at Increased Risk for Adverse Health Outcomes

> Communities continue to use tobacco regularly, especially with the people of color. – Other Health Provider

Sexual Health

ABOUT HIV & SEXUALLY TRANSMITTED INFECTIONS

Although many sexually transmitted infections (STIs) are preventable, there are more than 20 million estimated new cases in the United States each year — and rates are increasing. In addition, more than 1.2 million people in the United States are living with HIV (human immunodeficiency virus).

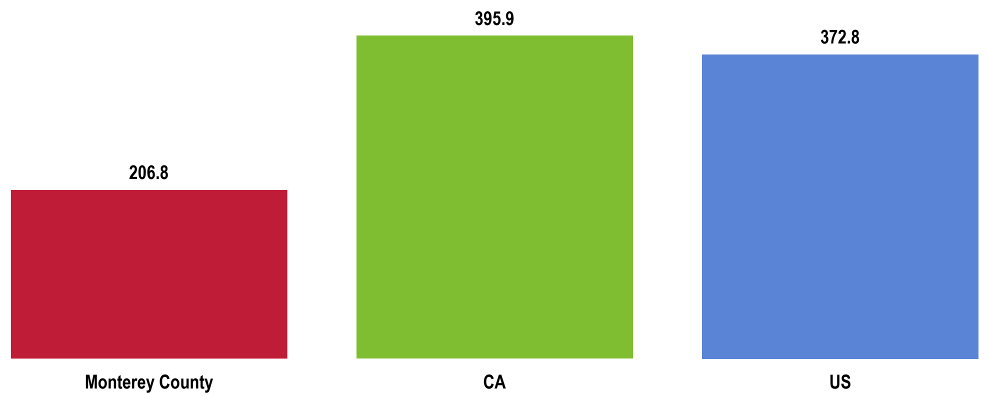
Adolescents, young adults, and men who have sex with men are at higher risk of getting STIs. And people who have an STI may be at higher risk of getting HIV. Promoting behaviors like condom use can help prevent STIs.

Strategies to increase screening and testing for STIs can assess people's risk of getting an STI and help people with STIs get treatment, improving their health and making it less likely that STIs will spread to others. Getting treated for an STI other than HIV can help prevent complications from the STI but doesn't prevent HIV from spreading.

– Healthy People 2030 (https://health.gov/healthypeople)

HIV

The following chart outlines prevalence (current cases, regardless of when they were diagnosed) of HIV per 100,000 population in Monterey County. [COUNTY-LEVEL DATA]



Sources:
- Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved June 2022 via SparkMap (sparkmap.org).

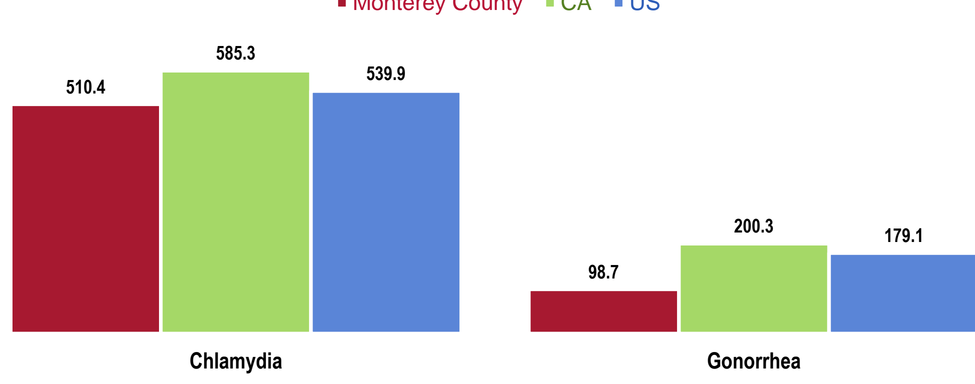
Notes:
- This indicator is relevant because HIV is a life-threatening communicable disease that disproportionately affects minority populations and may also indicate the prevalence of unsafe sex practices.

Sexually Transmitted Infections (STIs)

CHLAMYDIA ▶ Chlamydia is the most commonly reported STI in the United States; most people who have chlamydia are unaware, since the disease often has no symptoms.

GONORRHEA ▶ Anyone who is sexually active can get gonorrhea. Gonorrhea can be cured with the right medication; left untreated, however, gonorrhea can cause serious health problems in both women and men.

The following chart outlines countywide incidence for these STIs. [COUNTY-LEVEL DATA]

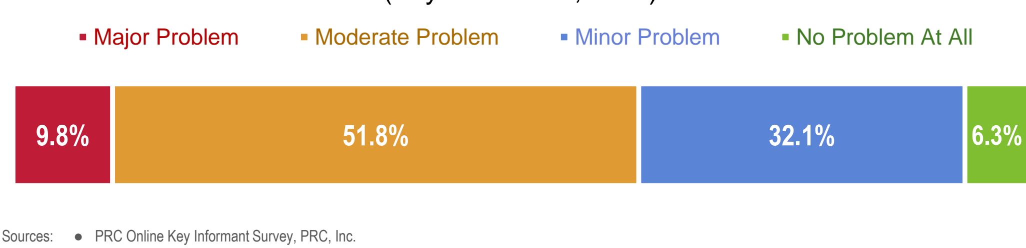


Sources:
- Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved June 2022 via SparkMap (sparkmap.org).

Notes:
- This indicator is relevant because it is a measure of poor health status and indicates the prevalence of unsafe sex practices.

Key Informant Input: Sexual Health

The following chart outlines key informants' perceptions of the severity of *Sexual Health* as a problem in the community:



Sources: • PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Prevalence/Incidence

> The number of STIs in Monterey County was going up before the pandemic and it continues to rise. Lack of services and access to care. – Public Health Representative
>
> Levels of syphilis and other STIs are increasing. – Community Leader

Sexual Violence

> Sexual assault, teenage and unintended pregnancies, and sexually transmitted infections are still very commonplace in the community. There is a lack of school-based health services and in general, inadequate access to healthcare services. – Public Health Representative

Teen/Young Adult Usage

> The youthful Salinas population and the county STI data. – Physician

ACCESS TO HEALTH CARE

Lack of Health Insurance Coverage

Survey respondents were asked a series of questions to determine their healthcare insurance coverage, if any, from either private or government-sponsored sources.

“Do you have any government-assisted healthcare coverage, such as Medicare, Medi-Cal (or another state-sponsored program), or VA/military benefits?”

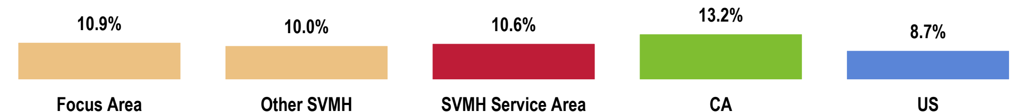
“Do you currently have: health insurance you get through your own or someone else’s employer or union; health insurance you purchase yourself; or, you do not have health insurance and pay for health care entirely on your own?”

Here, lack of health insurance coverage reflects respondents age 18 to 64 (thus excluding the Medicare population), who have no type of insurance coverage for healthcare services – neither private insurance nor government-sponsored plans (e.g., Medi-Cal).

Lack of Health Care Insurance Coverage

(Adults Age 18-64)

Healthy People 2030 = 7.9% or Lower



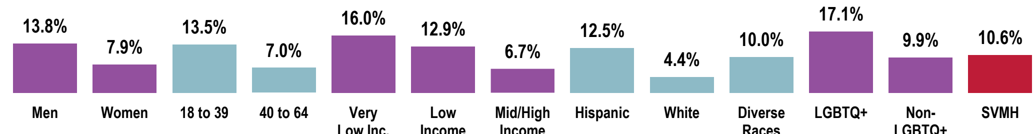
Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 137]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2021 California data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

Notes:
- Asked of all respondents under the age of 65.

Lack of Health Care Insurance Coverage

(Adults Age 18-64; SVMH Service Area, 2022)

Healthy People 2030 = 7.9% or Lower



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 137]
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov [Objective AHS-1]

Notes:
- Asked of all respondents under the age of 65.

Difficulties Accessing Health Care

Barriers to Health Care Access

To better understand healthcare access barriers, survey participants were asked whether any of the following barriers to access prevented them from seeing a physician or obtaining a needed prescription in the past year.

"Was there a time in the past 12 months when you needed medical care, but had difficulty finding a doctor?"

"Was there a time in the past 12 months when you had difficulty getting an appointment to see a doctor?"

"Was there a time in the past 12 months when you needed to see a doctor, but could not because of the cost?"

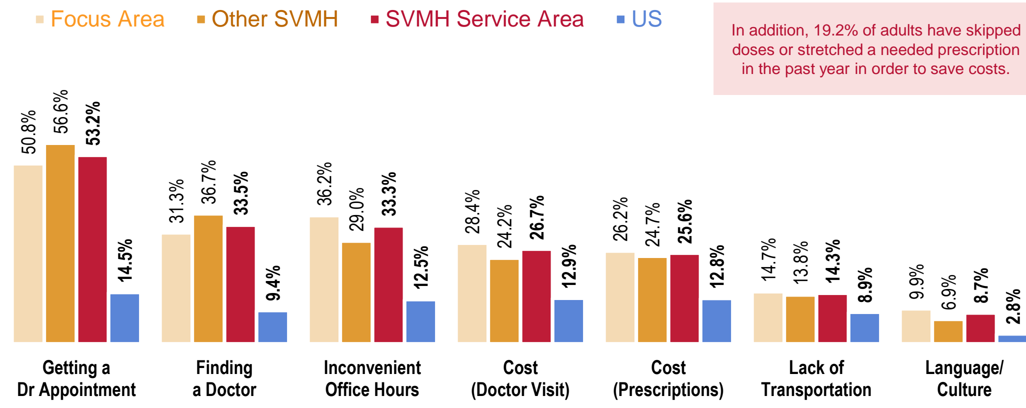
"Was there a time in the past 12 months when a lack of transportation made it difficult or prevented you from seeing a doctor or making a medical appointment?"

"Was there a time in the past 12 months when you were not able to see a doctor because the office hours were not convenient?"

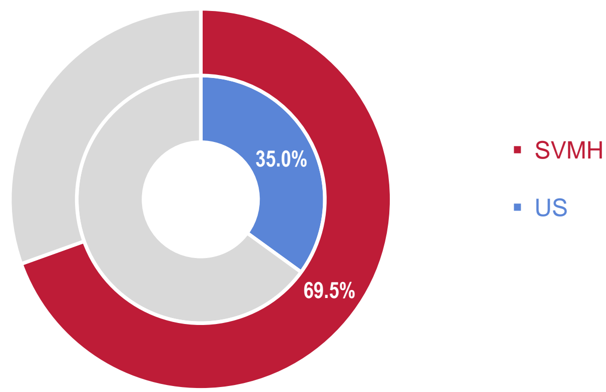
"Was there a time in the past 12 months when you needed a prescription medicine, but did not get it because you could not afford it?"

"Was there a time in the past 12 months when you were not able to see a doctor due to language or cultural differences?"

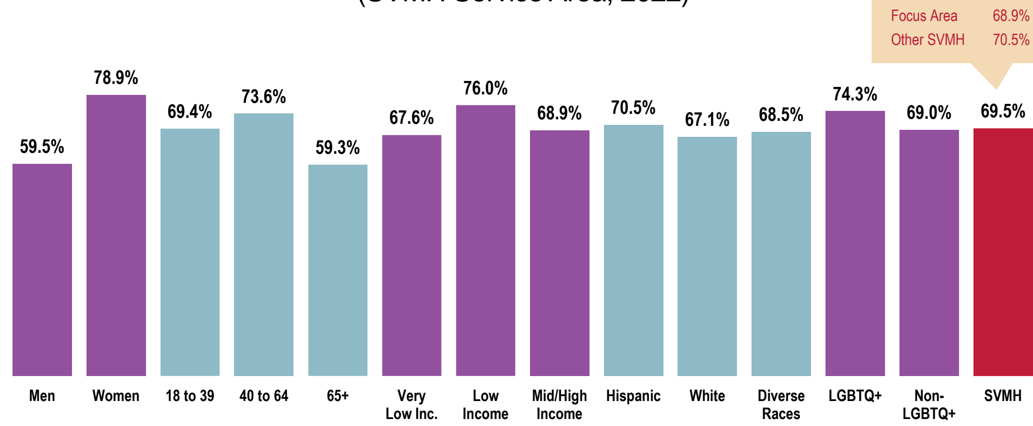
The percentages shown in the following chart reflect the total population, regardless of whether medical care was needed or sought.



The following charts reflect the composite percentage of the total population experiencing problems accessing healthcare in the past year (indicating one or more of the aforementioned barriers or any other problem not specifically asked), again regardless of whether they needed or sought care.



Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 140]
• 2020 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.
• Percentage represents the proportion of respondents experiencing one or more barriers to accessing health care in the past 12 months.

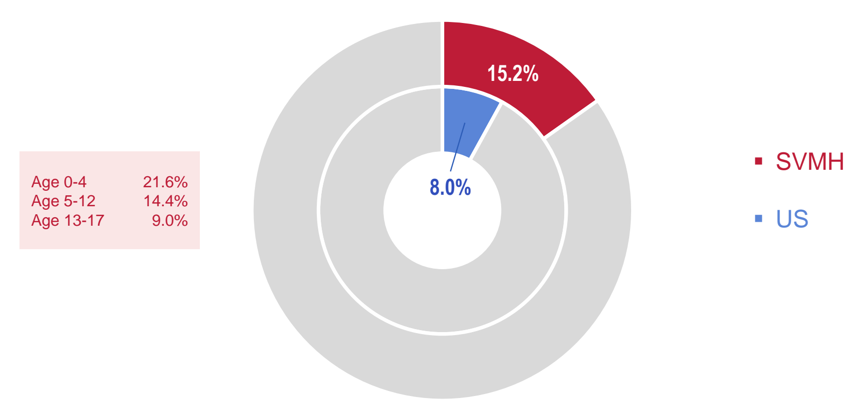


Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 140]
Notes: • Asked of all respondents.
• Percentage represents the proportion of respondents experiencing one or more barriers to accessing health care in the past 12 months.

Accessing Health Care for Children

Surveyed parents were also asked if, within the past year, they experienced any trouble receiving medical care for a randomly selected child in their household.

"Was there a time in the past 12 months when you needed medical care for this child, but could not get it?"

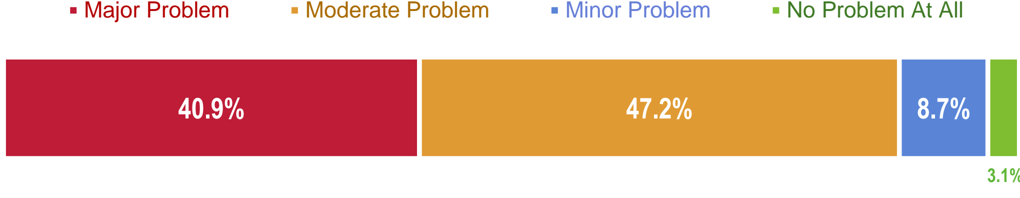


Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Items 104]
• 2020 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents with children 0 to 17 in the household.

Key Informant Input: Access to Health Care Services

The following chart outlines key informants' perceptions of the severity of *Access to Health Care Services* as a problem in the community:

Perceptions of Access to Healthcare Services as a Problem in the Community
(Key Informants, 2022)



Sources: • PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Access to Care/Services

> Access points are not where people can get to them. Hours and days are inconvenient. There are not enough services. – Social Services Provider
>
> Inequities in access plays a major role in this challenge. These inequities include location of services, transportation challenges, availability of services (open hours for facilities may not align with residents' availability). – Social Services Provider

A proportion of county residents do not have health insurance and find it difficult to afford services. Others move on and off Medi-Cal due to their income level and/or work situation, which creates uncertainty for them for ongoing primary care services. And there are growing issues with enough providers in the county due to retirements and the high cost of living discouraging new providers. Lastly, there are challenges with distance to services for those in south county, especially for specialty services. – Social Services Provider

Lacking health insurance. No primary care physician or facility identified. Inequities to Access Healthcare Services for homeless, low-income, culturally and socially disenfranchised populations. Healthcare services too expensive. – Community Leader

Lack of health insurance, money, and language. – Social Services Provider

Transportation, translation/interpretation, feeling comfortable/feeling like will understand what to do, understanding information/diagnoses, documentation status, cost, fear/lack of understanding about costs, lack of insurance, ability to take time off of work without fear of reprisal/losing job, unable to afford any time off (sacrifice food/rent for family in order to go to doctor/hospital). – Public Health Representative

Many who have no health insurance and a large population that may be worried about their safety (possible deportation) if they try to access healthcare. – Community Leader

Many of the families in our county do not have health insurance and those that do, do not have great insurance, so they still have to pay so much from their own pocket. There are also challenges with transportation to health facilities. – Community Leader

Cost of healthcare, lack of insurance, lack of adequate primary care providers, behavioral medicine, and mental health professionals, social workers, and case managers. – Public Health Representative

Cost and transportation. – Social Services Provider

Cost of care and medications, locations of clinics, appointment availability (having to wait a long time to get in), not knowing where to go other than the Emergency Room, especially in the more rural areas, lack of access to a medical home. – Public Health Representative

Transportation, noninsured, access to good health care in the community where they live. Continued expansion of housing but health care growing at a slower pace. Funding to upgrade, capital improvements, to expand. – Social Services Provider

Fear of statutory service providers, language, transport, misinformation, perceived financial cost, childcare/loss of earnings. – Social Services Provider

Access challenges related to options awareness, affordability, hours, and travel. Having more outreach services spearheaded by community health workers would help. – Physician

Cost, transportation. – Social Services Provider

Lack of primary care access. Severe lack of behavioral health resources, particularly providers who can prescribe psych meds. Difficulty getting patient referrals to underserved specialties (e.g., psych, cancer care, chronic pain, substance abuse, neurologists, urologists, etc.). Patients unnecessarily accessing expensive healthcare services; for example, patient with URI seeks care in the ED because she can't get an appointment with her PCP for two weeks. Shortage of critical, non-licensed healthcare workers, like medical assistants and Community Health Advocates. – Community Leader

Access to care, especially primary care, is a challenge that runs across all socioeconomic groups. – Public Health Representative

Access to preventive medicine and primary care services outside of "normal" business hours. Limited number of pediatricians and obstetricians serving North and South County areas. – Public Health Representative

Limited locations of public health clinics, although Clinica de Salud, Soledad Health Center, and other community-based clinics help fill some of the voids. We also have a lack of primary care physicians in the County. It's very difficult to gain access into a practice. Many are completely full. – Community Leader

Mismatch of where primary care is accessible and where those in greatest need of primary care live. – Physician

We are a rural community far from most services. – Community Leader

We do not have adequate SUD and mental health services in our county. – Physician

Navigating the multiple systems. Wait time for MCBH is unacceptable, our students have been on wait lists for four plus months. Access in indigenous languages. – Community Leader

Lack of Providers

Lack of primary care doctors and the cost of accessing high quality primary care. As a consequence, people that have an injury or do not feel well cannot find care. – Community Leader

There are not enough primary care providers in the county. Wait times for specialists are very long as well. It is difficult to attract new providers to the county due to cost of living. There are many residents in our county that are reluctant to seek medical care due to immigration status or fear of cost associated with care. We do not have enough medical providers/practices with the necessary cultural competencies to care for our special populations. – Physician

Lack of providers, MDs especially. – Physician

There are not enough PCPs in our community. Many retirements have left patients without primary care and no one seems to be taking new patients, especially on the Monterey Peninsula. – Other Health Provider

There is a limited number of providers (MDs, NPs, PAs) to include those that are bilingual, culturally reflective of community. COVID only further aggravated situation. Language, technological, and transportation barriers are an issue. – Other Health Provider

Not enough medical providers in our area. The ones we have are oversubscribed and appointments are hard to get. My gynecologist is in Sac for instance. No one seemed to care about my medical history in this area. – Community Leader

Limited providers that provide affordable healthcare access. – Other Health Provider

Not enough healthcare professionals available to provide services to the community. This includes MDs, mid-levels, nurses, MA's. The health care system is very impacted and health providers are overworked. there are also not enough culturally in tuned providers with the needs of the highest risk communities. – Other Health Provider

Insurance Issues

Lack of affordable insurance. Covered California is not affordable for many. Insufficient number of offices willing to accept Medicare and Medi-Cal. Insufficient primary care offices. Long waits to obtain specialty care. – Other Health Provider

Lack of health insurance and coverage for people with insurance. Dental and vision only available for a few lucky ones. – Public Health Representative

The unusually high cost of health care in our hospitals results in higher insurance premiums and limited choices, as some insurance companies choose to avoid Monterey County. – Physician

It's part of a much larger issue; for some reason carriers such as Blue Shield charge higher premiums in Monterey County than they do for neighboring counties. As a result, many people go without health insurance because they fall in the middle (can't qualify for Medi-Cal and can't afford a Covered California subsidized plan). – Community Leader

Lower income people have a harder time finding adequate care due to limited number of providers that accept Medi-Cal. – Social Services Provider

Insufficient providers who accept Medi-Cal. Lack of mental health providers who accept commercial insurance for mental health treatment. Lack of psychiatrists in area. – Social Services Provider

Insurance status and people who are "uninsurable" but are valuable contributors to Monterey County. – Social Services Provider

Doctors/hospital systems not accepting insurances. Doctors that don't stick around. – Social Services Provider

Persons at Increased Risk for Adverse Health Outcomes

High undocumented immigrant population. – Public Health Representative

Indigenous communities face cultural and linguistic challenges when accessing health care services. Also, many of them don't know the services available to them. – Community Leader

The community that I serve is homeless. Mental illness and addiction are major problems. The best way to access services seems to be through the jail system. Folks often have to access services through the Emergency Room. This is costly and wasteful. – Social Services Provider

With a high population of migrant farmworkers in Monterey County, access to health care services has been a challenge because of people’s immigration status. People on occasions are afraid to access services because of the fear that health care services can be considered public charge (grounds of inadmissibility are reasons that a person could be denied a green card, visa, or admission into the United States). The indigenous community across Monterey County hesitates to access health services because of language barriers. Transportation is a challenge for people in rural areas and seniors who struggle with transportation. – Social Services Provider

Working parents have long hours, often six days per week, and are challenged to schedule health care visits for wellness or illness for themselves and for their children. – Community Leader

The biggest challenge with the patient population we serve is majority are undocumented and are not eligible for full scope Medi-Cal and Covered California. We also serve patients that are not eligible for sponsored care through their employer. Recently referrals from ER have been due to patients losing health coverage due to cost and have to decide whether they pay for health coverage or paying their rent, food and bills for their families. – Other Health Provider

Due to COVID-19

The impact of COVID-19 had a significant impact on accessing health care services anywhere from hospitals to individual physicians and needed procedures were delayed. – Social Services Provider

At this time, due to COVID appointments are anywhere from four to eight weeks out for preventative care. In addition, health care is expensive, and costs associated with health care continue to rise. – Social Services Provider

Income/Poverty

> Lower social-economic residents, in particular field workers, do not have health insurance and access to appropriate healthcare services. Many are unaware of County programs available to them. Due to language barriers many find it difficult to navigate healthcare system. Finally, because of little to no health outreach many residents done regularly seek preventative care. – Social Services Provider
>
> Distribution of access, equity in access. Those with challenged resources or circumstances suffer the greatest. A divide enlarges given current delivery care methods/operations. – Physician

Systemic Racism

> Systemic racism is the root cause. Visible causes are lack of access to culturally appropriate options for families in accessible locations. Lack of welcome environments including the offering of culturally healing practices; multilingual supports. There should be more training in Facilitating Attuned Interactions (FAN) so that providers really listen to and be with patients. – Community Leader
>
> The racist design to systems that prevent overall access to all residents in MoCo. – Community Leader

Limited Medical Specialists

> Availability of some medical specialists, e.g. nephrology, urology, pulmonology. – Physician
>
> Hand specialists. – Other Health Provider

Affordable Care/Services

> There are not enough affordable options for families or individuals that require ongoing medical care and support in their homes which would enable them to age in place. They end up in the emergency rooms and hospitals more often as a result of this lack of support. There are inadequate affordable facilities for these individuals to be placed at the next level of care which is assisted living/residential care. Many older adults are placed at the next highest level which is skilled nursing because there is some short-term Medicare coverage and long-term Medi-Cal coverage for that level if they qualify. Many of these residents' needs could be met at the residential care level if that were a more affordable option. There is currently no reimbursement system in place to cover residential care. Locally the range of cost is $3,500/per month to $10,000 plus. – Social Services Provider

Mental Healthcare

> In southern Monterey County there is a lack of access to specialists and mental health providers. Both are major issues, but the one that worries me the most is access to mental health providers. That issue has been there for a while, and became even more critical during COVID. – Community Leader

Preventative Care

> Offering preventive, free care clinics to help identify treatable conditions early. – Community Leader

Transportation

> Most of the guests (clients) we serve either walk or take public transportation, so it is not always easy to access the facilities. Additionally, they don't always have the funds available. – Social Services Provider

Coordination of Care

> Communications among health organizations is very often insufficient. I have doctors in Salinas who do not get information (MRI, x-rays, etc.) in a timely fashion from Mee Memorial Health System. – Community Leader

Health Equity

> Health equity as a broader conversation and topic. We should address this sooner. – Physician

Caregiver Stress

> Home care or high-quality facility-based care for terminally ill patients (less than a year to live) w/o substantial financial resources. Relative caregivers experience enormous stress, risk of health issues, and serious financial burden including having to leave jobs to care for a dying relative. – Community Leader

Racial Disparity

> Racial disparity. Racism. It impacts the health of all impacted, the poor, racial/ethnic minorities, women and other groups. – Other Health Provider

Primary Care Services

ABOUT PREVENTIVE CARE

Getting preventive care reduces the risk for diseases, disabilities, and death — yet millions of people in the United States don't get recommended preventive health care services.

Children need regular well-child and dental visits to track their development and find health problems early, when they're usually easier to treat. Services like screenings, dental check-ups, and vaccinations are key to keeping people of all ages healthy. But for a variety of reasons, many people don't get the preventive care they need. Barriers include cost, not having a primary care provider, living too far from providers, and lack of awareness about recommended preventive services.

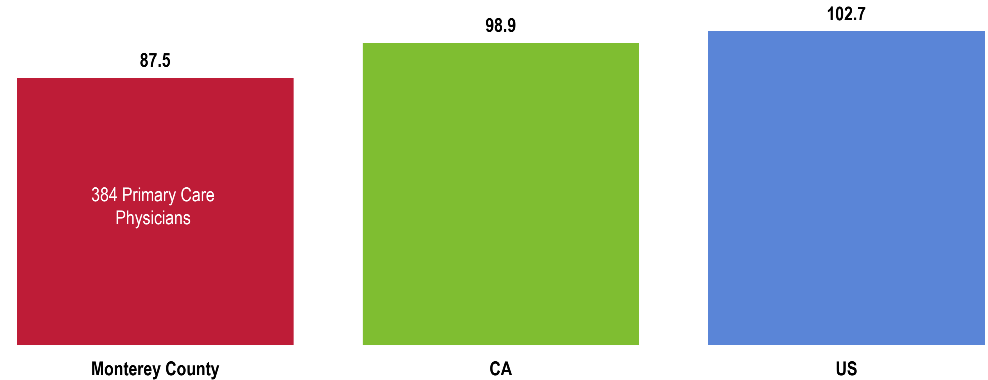
Teaching people about the importance of preventive care is key to making sure more people get recommended services. Law and policy changes can also help more people access these critical services.

– Healthy People 2030 (https://health.gov/healthypeople)

Access to Primary Care

This indicator is relevant because a shortage of health professionals contributes to access and health status issues.

Access to Primary Care
(Number of Primary Care Physicians per 100,000 Population, 2021)



Sources:
- US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved June 2022 via SparkMap (sparkmap.org).

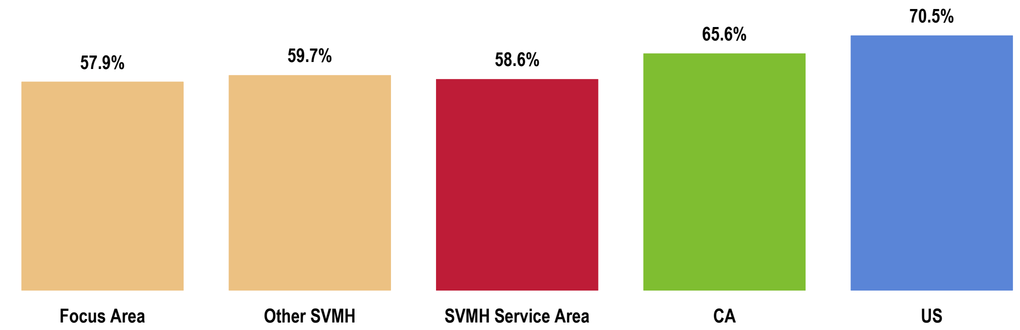
Notes:
- Doctors classified as "primary care physicians" by the AMA include: General Family Medicine MDs and DOs, General Practice MDs and DOs, General Internal Medicine MDs, and General Pediatrics MDs. Physicians age 75 and over and physicians practicing sub-specialties within the listed specialties are excluded. This indicator is relevant because a shortage of health professionals contributes to access and health status issues.

Utilization of Primary Care Services

ADULTS ▶ "A routine checkup is a general physical exam, not an exam for a specific injury, illness or condition. About how long has it been since you last visited a doctor for a routine checkup?"

CHILDREN ▶ "About how long has it been since this child visited a doctor for a routine checkup or general physical exam, not counting visits for a specific injury, illness, or condition?"

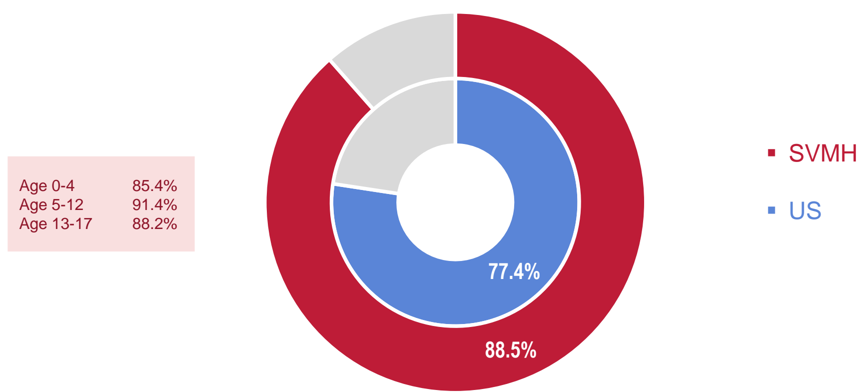
Have Visited a Physician for a Checkup in the Past Year



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 18]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2021 California data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Child Has Visited a Physician for a Routine Checkup in the Past Year (Parents of Children 0-17)



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 105]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents with children 0 to 17 in the household.

Oral Health

ABOUT ORAL HEALTH

Tooth decay is the most common chronic disease in children and adults in the United States. …Regular preventive dental care can catch problems early, when they're usually easier to treat. But many people don't get the care they need, often because they can't afford it. Untreated oral health problems can cause pain and disability and are linked to other diseases.

Strategies to help people access dental services can help prevent problems like tooth decay, gum disease, and tooth loss. Individual-level interventions like topical fluorides and community-level interventions like community water fluoridation can also help improve oral health. In addition, teaching people how to take care of their teeth and gums can help prevent oral health problems.

– Healthy People 2030 (https://health.gov/healthypeople)

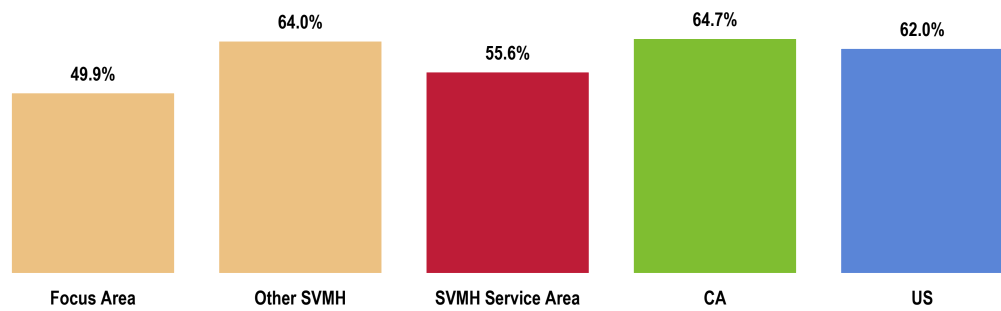
Dental Care

ADULTS ▶ "About how long has it been since you last visited a dentist or a dental clinic for any reason?"

CHILDREN AGE 2-17 ▶ "About how long has it been since this child visited a dentist or dental clinic?"

Have Visited a Dentist or Dental Clinic Within the Past Year

Healthy People 2030 = 45.0% or Higher



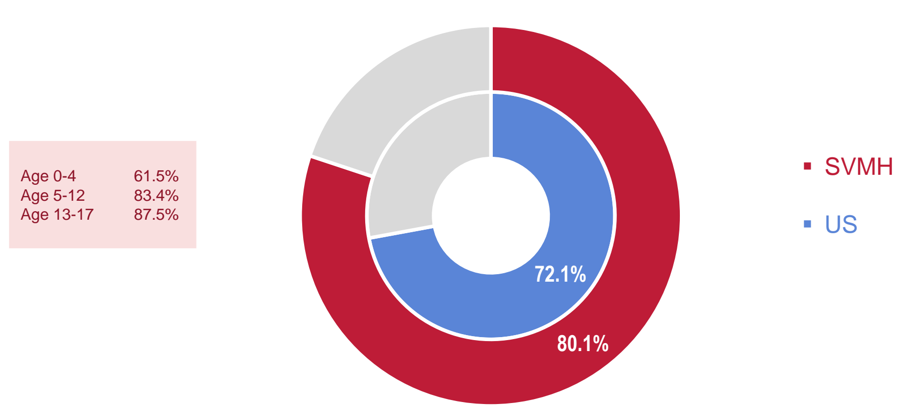
Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 20]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2021 California data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

Notes:
- Asked of all respondents.

Child Has Visited a Dentist or Dental Clinic Within the Past Year

(Parents of Children Age 2-17)

Healthy People 2030 = 45.0% or Higher



Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 108]
• 2020 PRC National Health Survey, PRC, Inc.
• US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

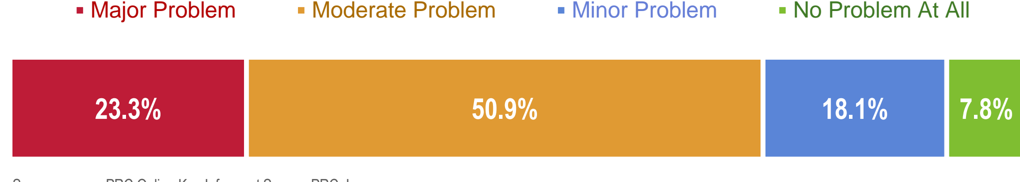
Notes: • Asked of all respondents with children age 2 through 17.

Key Informant Input: Oral Health

The following chart outlines key informants' perceptions of the severity of *Oral Health* as a problem in the community:

Perceptions of Oral Health as a Problem in the Community

(Key Informants, 2022)



Sources: • PRC Online Key Informant Survey, PRC, Inc.

Notes: • Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Affordable Care/Services

> Cost of services and access to providers is limited. – Social Services Provider
>
> Affordable access for vulnerable populations in the county. – Physician
>
> Poor access to dental services, due to cost and lack of adequate dental insurance. – Public Health Representative
>
> I know I carry two dental insurances and that it is often the most expensive health expense I'll have during a year. In general, we don't see the importance of access to oral health as a significant health issue. This is embedded in the current health insurance structure. – Community Leader
>
> Limited access for those without adequate financial resources. – Physician

Access to Care/Services

> Lack of access to dentist at an early age, drinking juices and sodas at a young age, it goes back to early education. – Social Services Provider
>
> Lack of access and insurance. – Social Services Provider

> None of our 400 guests have access to proper dental care. Even some of our staff lack access. – Social Services Provider
>
> Lack of services. – Community Leader

Prevalence/Incidence

> Looking at the teeth of the people I encounter while out and about. Cost of care, lack of access. People with teeth that hurt cannot focus in school or at work. – Public Health Representative
>
> Extensive dental decay in children. – Public Health Representative
>
> increased number of kids and adults with huge amount of work needed. Youth are incarcerated with really bad or poor dental care. Not sure if it is lack of knowledge or just don't care. Would be nice to see the schools referring and checking kids while they are in school. – Other Health Provider
>
> Many children are affected by poor hygiene and outcomes are cavities and gum disease. – Other Health Provider

Access to Care for Persons Who Are Uninsured/Underinsured

> Dental care is extremely expensive. Few dentists accept Medi-Cal dental for adults. The Medi-Cal dental benefit for adults is so poor that teeth are extracted that could be saved if there was sufficient coverage. In addition, the cost of dental restorations including implants, crowns, etc. is so high that most people can't afford this care, even with dental insurance. Dental insurance is not part of Medicare, and most seniors need extensive dental work. – Social Services Provider
>
> Most health insurance doesn't cover dental care and many people, especially youth, have unidentified or treated caries. – Social Services Provider
>
> Limited Emergency, M-Cal doesn't cover dental. – Public Health Representative

Impact on Quality of Life

> Oral health is the gateway to overall health, however it is often overlooked as important to one's health. Limited services and high costs of care for seniors has become an increasing concern. – Other Health Provider
>
> Unaddressed issues. – Social Services Provider
>
> Children without access to dental care cannot concentrate in school. People in long term care cannot eat comfortably without access to dental care. Oral infections are dangerous if untreated. – Community Leader

Persons at Increased Risk for Adverse Health Outcomes

> Oral surgery for the indigent. Many such people need more extensive work for serious reasons (e.g., bone marrow transplant) than are provided for by the existing admirable low-income dental services. – Community Leader

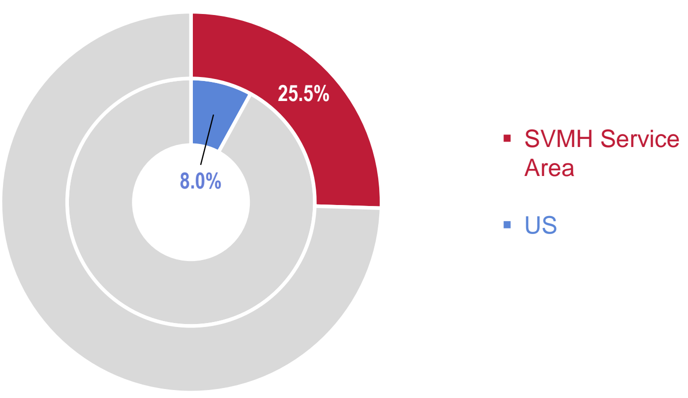
Education/Awareness

> Lack of education on the importance of oral health care for children. Cultural beliefs that fail to recognize the importance of preventive dental care. Lack of dental insurance. Lack of ability to access affordable dental services. – Other Health Provider

LOCAL RESOURCES

Perceptions of Local Health Care Services

"How would you rate the overall health care services available to you? Would you say: excellent, very good, good, fair, or poor?"



Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 6]
• 2020 PRC National Health Survey, PRC, Inc.

Notes: • Asked of all respondents.

Resources Available to Address the Significant Health Needs

The following represent potential measures and resources (such as programs, organizations, and facilities in the community) identified by key informants as available to address the significant health needs identified in this report. This list only reflects input from participants in the Online Key Informant Survey and should not be considered to be exhaustive nor an all-inclusive list of available resources.

Access to Health Care Services

211
ACCESS Services
Alisal Family Resource Centers
Alliance on Aging
BHC
Big Sur Health Center
Blue Zones Project Monterey County
Building Healthy Communities
CCAH
Center for Community Advocacy
Centro Binacional de Pueblo Indigena
Centro Binational para el Desarrollo Indigena Oaxaqueno
Charity Care Programs
Choices Home Healthcare
CHOMP
CHWs
City of Gonzales Community Health Worker Program
City/County Representatives
Clinica de Salud Clinics
Community Health Clinics
Community Health Workers
Community Human Services Corporation
County Behavioral Health
County Free Clinics
County Supervisors
Covered California
CSVS Clinic Network
Doctors on Duty
Eden Valley Care Center
Employers
Esperanza Care
Facilitating Attuned Interactions
Farm Worker Organizations
Federally Qualified Health Centers
First 5
George L. Mee Memorial Hospital
Health Department
Hospitals
Interim, Inc.
Meals on Wheels
Medi-Cal
Mission Medical
Mobile Clinics
MoGo
Montage Health
Montage Medical Group
Montage Van
Monterey County
Monterey County Behavioral Health
Monterey County Clinic Services Bureau
Monterey County Crisis Team
Monterey County Department of Social Services
Monterey County Health Department
Monterey County Hospitals and Clinics
Monterey County Public Health
Natividad
Natividad Hospital
Natividad Medical Center
Ohana Program
Pinnacle Health Care
Planned Parenthood
Primecare
Promotoras
Public Health
Reflective Practice
RotaCare Clinic
Salinas Valley Medical Clinic
Salinas Valley Memorial Healthcare System
Salinas Valley Memorial Hospital
Salud Para la Gente
School System
Seaside Family Health Clinic
Share Center
Sliding Scale Clinics
Social Media
Soledad Community Health Care District
Soledad Medical Center
Soledad Women's Center
Sun Street Centers
SVMHS Mobile Health Clinic
SVMHS Taylor Farms Family Health & Wellness Center
Telehealth

- The Colibri Cohort
- The Navigation Center
- Urgent Care Clinics
- VIDA Program
- VNA
- Wellness Centers
- YMCA/YWCA

Cancer

- Ag Commissioner's Office
- American Cancer Society
- Breast and Cervical Cancer Treatment Program
- Breast Cancer Assist Group of the Monterey Peninsula
- Cancer Alliance
- CHOMP
- CHOMP Cancer Center
- CSVS Clinic Network
- Doctor's Offices
- Every Woman Counts Program
- Health Department
- Hospice Giving Workshops
- Mobile Clinics
- Montage Health
- Nancy Ausonio Mammography Center
- Natividad Hospital
- Natividad Medical Center
- PRUCOL Medi-Cal
- Rotocare Weekly Clinic
- Salinas Valley Memorial Healthcare System
- Salinas Valley Memorial Hospital
- Salinas Valley Memorial Hospital Cancer Resource Center
- Soledad Community Health Care District
- Soledad Medical Center
- Stanford
- SVMC Cancer Care
- Women's Health Center

Coronavirus Disease/COVID-19

- 211
- Alternate Housing for COVID Positive
- Blue Zones Project Monterey County
- Building Healthy Communities
- Center for Community Advocacy
- Centro Binacional de Pueblo Indigena
- CHISPA Inc.
- CHOMP
- City of Seaside Community Development Department
- City of Seaside Family and Community Support Program
- Clinica de Salud Clinics
- Coalition for Homeless Services Providers
- Community Based Organizations
- Community Foundation
- Community Foundation for Monterey County
- Community Resources
- Community Testing Sites
- County Assistance PPE
- COVID-19 Collaborative
- CVS
- Doctor's Offices
- Doctors on Duty
- Free Government Testing and Vaccinations
- George L. Mee Memorial Hospital
- Grower-Shipper Association Foundation
- Health Department
- Homeless Outreach
- Hospitals
- Laurel Family Practice Clinic
- Media
- Medi-Cal
- Mental Health Services
- Montage Health
- Monterey County
- Monterey County Department of Social Services
- Monterey County Health Department
- Monterey County Hospitals and Clinics
- Monterey County Housing and Human Development
- Monterey County Office of Education
- Monterey County Public Health
- Natividad Hospital
- Pacific Cancer Care
- Pharmacies
- Rental and Utility Assistance
- Salinas Valley Memorial Healthcare System
- Salinas Valley Memorial Hospital
- Salvation Army
- San Ardo School
- Soledad Medical Center
- Soledad Wellness Pharmacy
- State of California and Federal Programs
- SVMHS Mobile Health Clinic
- SVMHS Taylor Farms Family Health & Wellness Center
- The Village Project
- Vaccine Clinics
- VIDA Program
- VNA

Dementia/Alzheimer's Disease

- Alliance on Aging
- Alzheimer's Association
- Caregiver Support Groups
- Carmel Foundation
- Central Coast Senior Services
- CHOMP
- Community Based Organizations
- Doctor's Offices
- Hospice Giving Workshops
- Hospitals
- Independent Transportation Network
- Long-Term Care Facilities
- Madonna Care
- Meals on Wheels
- Montage Health
- Montage Medical Group
- Monterey County Area Agency on Aging
- Monterey County Behavioral Health
- Pacific Coast Manor
- Private Caregiving Companies
- Salinas Valley Medical Clinic
- Salinas Valley Memorial Healthcare System
- Sam Trevino - www.hpcn.org
- Senior Living Communities
- Support Groups

Diabetes

- 211
- ADA
- Ag Companies
- American Diabetes Association
- Aspire Health Diabetes Innovation
- Bilingual Accredited Diabetes Education Centers
- Blue Zones Project Monterey County
- Building Healthy Communities
- CalFresh Healthy Living Program
- CHI Programs
- CHOMP
- CHOMP Diabetes Clinic
- Clinica de Salud Clinics
- Community Health Clinics
- Community Health Innovations
- Community Human Services Corporation
- Community Wellness Programs
- CSVS Clinic Network
- Diabetes Care Center
- Diabetes Collaborative
- Diabetes Prevention Program
- Doctor's Offices
- Don't Feed the Beast
- Don't Feed the Diabetes
- Education
- Esperanza Care
- Everyone's Harvest
- Farmers
- Farmer's Markets
- Food Bank
- Food Prescription Programs
- George L. Mee Memorial Hospital
- Harmony at Home
- Health Department
- Hospitals
- Meals on Wheels
- Mobile Clinics
- Montage Health
- Montage Health Diabetes Education
- Montage Medical Group
- Monterey County Behavioral Health
- Monterey County Clinic Services Bureau
- Monterey County Employee Wellness Program
- Monterey County Health Department
- Monterey County Health Services
- Monterey County Hospitals and Clinics
- National Diabetes Prevention Program
- Natividad
- Natividad Diabetes Center
- Natividad Foundation
- Natividad Hospital
- Natividad Medical Center
- Natividad Medical Clinics
- Nonprofits
- Nutrition Services
- Parks and Recreation
- Pharmacies
- Prime Time
- Produce Prescription Program
- Promotoras
- Public Health
- RotaCare Clinic
- Salinas Valley Memorial Healthcare System
- Salinas Valley Memorial Hospital
- School System
- Seaside Family Health Clinic
- SNAP Services
- Soledad Dialysis
- Soledad Medical Center
- St. John's Catholic Church
- SVMC Diabetes & Endocrine Center
- SVMC Pediatric Diabetes Clinic
- SVMHS Mobile Health Clinic
- SVMHS Mobile Health Clinic
- SVMHS Taylor Farms Family Health & Wellness Center

- The Big Share
- VIDA Program
- VNA
- WIC

Disability & Chronic Pain

- 211
- Alliance on Aging
- Alternative Health Services
- Behavioral Health Services
- Blind and Visually Impaired Center
- Central Coast Center for Independent Living
- CHOMP
- City of Seaside Family and Community Support Program
- Community Based Organizations
- Community Human Services Corporation
- Doctor's Offices
- Doctors on Duty
- Employers
- Esperanza Care
- Meals on Wheels
- Mental Health Services
- Montage Health Wellness Centers
- Monterey County Health Department
- Monterey County Start
- Monterey Spine and Joint Pain Management Team
- Parks and Recreation
- Prescribe Safe Monterey County
- Public Health
- Salinas Valley Medical Clinic
- Salinas Valley Memorial Hospital
- Seaside Family Health Clinic

Heart Disease & Stroke

- 211
- American Heart Association
- Bilingual Cardiology Clinics
- Blue Zones Project Monterey County
- CHOMP
- CHOMP Stroke Center
- CSVS Clinic Network
- Culturally Appropriate Prevention/Management Services
- Doctor's Offices
- Farmer's Markets
- George L. Mee Memorial Hospital
- Health Department
- Health Fairs
- Hospitals
- Montage Health Tyler Heart Institute
- Montage Health Wellness Centers
- Montage Medical Group
- Monterey County Health Department
- Natividad ARU
- Natividad Hospital
- Natividad Medical Center
- Nonprofits
- Nutrition Services
- Parks and Recreation
- Physical Therapy Groups
- Public Health
- Salinas Valley Heart Care Program
- Salinas Valley Memorial Hospital
- Salinas Valley Memorial Hospital Stroke Center
- SVMC Central Coast Cardiology
- SVMHS Mended Hearts Program
- SVMHS Taylor Farms Family Health & Wellness Center
- YMCA/YWCA

Infant Health & Family Planning

- CPSP
- First 5
- Harmony at Home
- Hospitals
- Maternal Mental Health Task Force
- Monterey County Behavioral Health
- Monterey County Bright Beginnings/First 5
- Natividad Medical Clinics
- Planned Parenthood
- SNAP Services
- SVMC PrimeCare
- SVMHS Mobile Health Clinic
- SVMHS Taylor Farms Family Health & Wellness Center
- WIC

Injury & Violence

- Behavioral Health Department
- Behavioral Health Services
- Building Healthy Communities
- CASP
- Choice
- CHOMP
- City of Seaside Family and Community Support Program
- Community Action for Safety and Peace
- Community Alliance for Safety and Peace
- Community Based Organizations
- Community Human Services Corporation

- District Attorney's Office
- Doctor's Offices
- Elected Officials
- Gang Task Force
- Harmony at Home
- Health Department
- Hospitals
- Law Enforcement
- MILPA
- Monterey County Behavioral Health
- Monterey County Health Department
- Monterey County Sheriff's Department
- Natividad
- Natividad Foundation
- Natividad Medical Center
- Natividad Trauma Center
- Parks and Recreation
- Partners for Peace
- Police
- Rape Crisis Center
- Safer Streets Program
- Salinas Valley Memorial Healthcare System
- School System
- Shelters
- Silver Star Resources
- Stryve
- Substance Prevention Programs
- Sun Street Centers
- SVMHS Taylor Farms Family Health & Wellness Center
- The Village Project
- Transportation Agency for Monterey County
- Victims Witness
- YMCA/YWCA
- Youth Resource Center
- Youth Violence Prevention Task Force

Kidney Disease

- Aspire Health Diabetes Innovation
- Aspire Pediatric Wellness Program
- DaVita Dialysis Center
- Education
- Nutrition Services

Mental Health

- 211
- Alliance on Aging
- Beacon Health
- Behavioral Health Department
- Behavioral Health Services
- Big Sur Health Center
- Boys and Girls Club
- Breakthrough Behavior Clinic
- Building Healthy Communities
- CALAIM
- Catholic Charities
- CCAH
- CHOMP
- CHOMP Behavioral Health
- CHOMP Crisis Center
- CHOMP Outpatient Mental Health
- City of Seaside Family and Community Support Program
- Clinica de Salud Clinics
- Community Based Organizations
- Community Hospital Mental Health
- Community Human Services Corporation
- Community Partnership for Youth
- County Behavioral Health
- County Mental Health Services
- CSUMB PGCC
- Doctor's Offices
- Doctors on Duty
- Downtown Streets Team
- EAP Programs
- F5MC
- Faith Community
- Federally Qualified Health Centers
- First 5
- Gathering for Women
- Harmony at Home
- Hartnell Behavioral Health Services
- Hartnell College
- Heal Together
- Health Department
- Hospitals
- Insurance Plans
- Interim, Inc.
- Kingship Center
- Law Enforcement
- Mental Health Services
- Montage Health
- Montage Medical Group
- Monterey County Behavioral Health
- Monterey County Crisis Team
- Monterey County Health Department
- Monterey County Outpatient Mental Health Services
- Monterey MDOT/CAT
- Monterey Psychiatric Center
- NAMI
- Natividad
- Natividad Hospital
- Natividad Medical Center

- Ohana Program
- Online Resources
- Public Health
- Rape Crisis Center
- Recovery Center
- Salvation Army
- San Andreas Regional Services
- School System
- Silver Star Resources
- Soledad Medical Center
- Spiritual Healing
- SUHSD Wellness Centers
- Suicide Hotline
- Sun Street Centers
- Sunset Center
- SVMC Behavioral Health
- The County
- The HUB
- The Village Project
- VA Monterey
- VNA
- Wrap Around Services
- YMCA/YWCA

Nutrition, Physical Activity, & Weight

- 211
- ADA
- All In Monterey
- Aspire Health Diabetes Innovation
- Aspire Pediatric Wellness Program
- Big Sur Land Trust
- Blue Zones Project Monterey County
- Building Healthy Communities
- CCAH
- Clinica de Salud Clinics
- Coastal Kids
- Community Church
- Community Partnership for Youth
- Doctor's Offices
- Farmers
- Farmer's Markets
- Fitness Centers/Gyms
- Food Bank
- George L. Mee Memorial Hospital
- Hartnell College
- Healthy Youth Task Force
- Kids Eat Right Program
- MCOE
- Meals on Wheels
- Montage Health
- Montage Health Nutrition
- Montage Health Wellness Centers
- Monterey County
- Monterey County Behavioral Health
- Monterey County Health Department
- Monterey County Office of Education
- Monterey County Public Health
- Natividad Foundation
- Natividad Medical Center
- Nonprofits
- Nutrition/Fitness Collaborative of the Central Coast
- Parks and Recreation
- Policy Makers and Planners
- Prime Care Salinas Valley Medical Clinic
- Produce Prescription Program
- Promotoras
- Public Health
- Salinas Soccer Complex
- Salvation Army
- School System
- Self-Determination
- SNAP Services
- Soledad Community Health Care District
- Soledad Medical Center
- Sports Center
- Support Groups
- SVMC Diabetes & Endocrine Center
- SVMHS Health Promotions
- SVMHS Taylor Farms Family Health & Wellness Center
- Transportation Agency for Monterey County
- Weight Watchers
- WIC
- YMCA/YWCA
- Youth Sports

Oral Health

- 211
- Big Sur Dental
- Clinica de Salud Clinics
- CSVS Clinic Network
- Dental Society
- Dentist's Offices
- Dientes
- Doctor's Offices
- Education
- Insurance Plans
- Medi-Cal/Denti-Cal Providers
- Mission Dental
- Monterey Bay Dental Society Referral Source
- Monterey County Food Bank
- Monterey County Health Department
- Oral Health Van
- School System

- Seaside Family Health Clinic
- Western Dental

Respiratory Disease

- CHOMP
- Doctor's Offices
- Education
- Federally Qualified Health Centers
- Montage Medical Group
- Strict Regulations Around Pesticides in Farming
- SVMHS Mark Velcoff, MD Asthma Camp

Sexual Health

- Clinica de Salud Clinics
- Doctor's Offices
- Doctors on Duty
- Monterey County Health Department
- NIDO Clinic
- Planned Parenthood
- School System
- Seaside Family Health Clinic
- SVMC Health Care for Women

Substance Use

- 211
- AA/NA
- Beacon House
- Bridge Restoration Ministries
- Bright Future Recovery
- Childcare
- CHOMP
- CHOMP Crisis Center
- CHOMP Recovery Center
- CHS
- City of Seaside Family and Community Support Program
- Community Human Services Corporation
- Doctor's Offices
- Door to Hope
- Dorothy's Place
- Genesis House
- Governor
- Hospitals
- Inpatient Clinics for Youth
- Insurance Plans
- Interim, Inc.
- Mental Health Services
- Montage Health
- Monterey County Behavioral Health
- Monterey County Health Department
- Monterey County Office of Education
- Monterey MDOT/CAT
- Natividad Hospital
- Nonprofits
- Prescribe Safe Monterey County
- Public Health
- Reb Close
- Residential Treatment Facilities
- Salinas Valley Memorial Healthcare System
- Salud Para la Gente
- School System
- Silver Star Resources
- Spiritual Healing
- Substance Use Treatment Professionals
- Sun Street Centers
- Sunrise Center
- Support and Resources for Kids and Youth
- Support Groups
- The Bridge Restoration Ministry
- The Village Project
- Valley Health
- VHA
- Victory Outreach

Tobacco Use

- Alternative Products to Reduce Use
- Blue Zones Project Monterey County
- Community Partnership for Youth
- Doctor's Offices
- First 5
- George L. Mee Memorial Hospital
- Hospitals
- Monterey County Public Health
- Sun Street Centers
- The Village Project
- Tobacco Cessation Programs
- Tobacco Free Zones Near Schools
- Youth Resource Center
- Youth Violence Prevention Task Force

APPENDIX

EVALUATION OF PAST ACTIVITIES

In early 2020, Salinas Valley Memorial Healthcare System (SVMHS) conducted a Community Health Needs Assessment (CHNA) from which prioritized health needs were identified and implementation goals and strategies were developed in the following areas:

- Behavioral Health
- Healthcare Access and Delivery (also prioritized in 2017 CHNA)
- Healthy Lifestyles, including:
    - Diabetes and Obesity (also prioritized in 2017 CHNA)
    - Food and Housing Insecurity

There are two important factors to consider in the Evaluation of Past Activities:

1. **The emergence and dominance of COVID-19 on the healthcare landscape:** SVMHS and our partner health systems in Monterey County acted with leadership, strength and collaboration in immediately addressing the global pandemic and health crisis in our community. There was a seismic and necessary shift in priorities during 2020 and 2021 to save lives, reduce hospitalizations and protect hospital staff and the community at large from the coronavirus. Our collective response prioritized COVID-19 education and resources. Once the COVID-19 vaccine received Emergency Use Authorization, SVMHS was aggressive in getting all staff vaccinated and holding and supporting community vaccination clinics. Our COVID-19 response became a top priority and, as such, will be addressed in this evaluation, even though it was not an earlier-identified focus of concern.

   In addition, SVMHS and our partner organizations showed resolve in maintaining an eye on previously identified community health needs. A focus on overall health and wellness is essential to protecting our community from emerging or unexpected health threats such as COVID-19. Despite COVID-19 requiring an abundance of resources and attention, which we are proud to report in this evaluation, we still managed to make progress addressing the key fundamental priorities of expanded Behavioral Health, Healthcare Access and Delivery, and Healthy Lifestyles – all three of which became even more paramount during the COVID-19 threat.

2. **The collaboration and early submission of data:** SVMHS recognized a unique opportunity to embark on yet another, more collaborative CHNA in 2022 and joined Community Hospital of the Monterey Peninsula, Mee Memorial Healthcare System, Natividad, the Monterey County Health Department and United Way Monterey County to launch the Monterey County Health Needs Collaborative (MCHNC). The nature of the Collaborative offers an earlier-than-required Evaluation of Past Activities to be included with the 2022 MCHNC survey report. MCHNC was born, in part, from the success of previously established partnerships with these entities. Together, these partners address strategic approaches to community health as well as expand alliances during the pandemic to quickly identify, prioritize and implement strategies to protect and optimize the health of everyone in our communities, including our own healthcare staff.

Addressing Significant Health Needs

Focusing on the top-identified needs from our CHNA – as well as healthcare system resources and overall alignment with the healthcare system's mission, goals and strategic priorities — SVMHS is proud to have developed, supported or continued to build upon the success of a wide variety of impactful strategies and programs.

PRIORITY AREA: BEHAVIORAL HEALTH IMPACT

Goal #1: Increase the proportion of people with access to coordinated behavioral healthcare services.

Strategy: Increase patient visits to behavioral health specialists at Salinas Valley Medical Clinic Behavioral Health.

- In 2020, 349 new patients were served, and 3,356 individual therapy sessions were provided through Salinas Valley Medical Clinic Behavioral Health, 924 more individual sessions provided as compared to 2019.
- In 2021, 332 new patients were served, and 3,185 individual therapy sessions were provided.

Strategy: Increase opportunity for underserved to receive referrals to behavioral and mental health resources.

- In 2020, SVMHS tripled the size of the existing SVMHS Taylor Farms Family Health & Wellness Center in Gonzales, from 6,400 square feet to 20,000 square feet, to help address disparities in health equity and increase opportunities for behavioral health programs and physician referrals to mental health specialists.

Goal #2: Increase opportunities for community members to achieve better mental health.

Strategy: Introduce mindfulness programming.

- SVMHS created free mindfulness programming for community members throughout Monterey County looking for improvement in their overall health and well-being, stress reduction and improved resiliency.
- Mindfulness Meditation Classes were offered three times per week via Zoom.
- Mindfulness Meditation was utilized by 933 participants in 2020 and 1,117 in 2021.
- Two new classes were launched in 2021: Group Chair Class for Movement & Mediation and Balance, Mobility & Meditation. Both classes were held virtually.
- 246 people participated in the Group Chair Class for Movement & Mediation and 102 people participated in Balance, Mobility & Meditation.

Strategy: Provide support to community based 501C3 organizations administering behavioral health services or improving mental health through education and support.

- In 2020 and 2021, SVMHS directed Community Funding to the Alzheimer's Association in the amount of $5,000 per year to support programs providing Alzheimer's education, care and support.
- In 2020 and 2021, SVMHS directed Community Funding to Sun Street Centers in the amount of $6,000 per year to support programs preventing alcohol and drug addiction by offering education, treatment and recovery services to all, regardless of income.
- SVMHS directed Community Funding to Rancho Cielo in the amount of $25,660 in 2020 and $30,000 in 2021, for programs that build skills and transform lives of at-risk youth.
- In 2021, SVMHS directed $5,000 in Community Funding to Harmony at Home, a nonprofit agency whose mission is to end the cycles of violence and abuse by empowering children and young adults with the knowledge, skills and confidence to lead healthy and productive lives.
- In 2020 and 2021, SVMHS directed Community Funding to First Tee of Monterey County in the amount of $5,000 per year to support programs focused on building inner strength, self-confidence and resilience in youth.

- In 2021, SVMHS directed $15,000 in Community Funding to the American Red Cross for providing mental health support services for people dealing with disasters.
- In 2021, SVMHS directed $5,000 in Community Funding to the Monterey County Rape Crisis Center for providing emotional support services for people suffering from sexual trauma.
- In 2021, SVMHS directed $5,000 in Community Funding to Coastal Kids Home Care, which is dedicated to the physical, mental and emotional health of children.
- In 2021, SVMHS directed $5,000 in Community Funding to the Arts Council for Monterey County, which offers opportunities to heal through art.
- In 2021, SVMHS directed $5,000 in Community Funding to Partners for Peace, which gives parents and children the tools to support healthy relationships.
- In 2021, SVMHS directed $5,000 in Community Funding to Valley Health Associates, which offers intervention, prevention, and treatment services for opioid and alcohol substance abuse.

Strategy: Co-sponsor Blue Zones Project Monterey County initiatives with mental health components.

- In 2020, 20 Blue Zones Purpose Workshops, two-hour events led by certified facilitators that help people find clarity of purpose, were held with 318 participants. In 2021, 428 people attended 27 Purpose Workshops.

Goal #3: In response to the occupational stress of the COVID-19 pandemic, develop additional programs and emotional recovery opportunities for SVMHS staff to support resiliency, healing, and connection.

Strategy: Develop professional retreat opportunities.

- In August 2021, the 1440 Multiversity Foundation and Salinas Valley Memorial Hospital Foundation funded more than 50 SVMHS employees' attendance at a two-day retreat in the Santa Cruz Mountains called "Healing Our Healthcare Heroes." Participants shared their experiences, learned healthy ways to deal with trauma, and are receiving a year of ongoing support resources.

Strategy: Expand 2019 involvement in the BETA HEART® Care for the Caregiver program, which provides resources and guidance to support healthcare workers' physical and emotional well-being.

- In 2020, SVMHS identified a committee to create our own one-on-one support program for employees who experience a traumatic event at work. Code Lavender launched in December 2021 with a rigorous internal awareness campaign.
- 61 peer supporters who work in many different roles throughout the hospital have been trained and certified through a BETA HEART program.
- Code Lavender is activated through a secure texting program, and peer supporters are dispatched to aid colleagues in similar roles who've experienced trauma.
- SVMHS will be launching additional Care for the Caregiver initiatives going forward, such as coordinated education and discussion on sensitive subjects, social worker and leader support, and wellness programs.

Goal #4: Provide greater health equity and cultural sensitivity in community grief support services.

Strategy: Create a monolingual grief support program.

- Thanks to the generosity of the Hospice Giving Foundation and a matching donation from Salinas Valley Memorial Hospital Foundation, a monolingual grief support program was developed and launched for Spanish-speaking families who experienced the loss of a loved one at SVMHS due to COVID-19.
- In 2021, the program supported 91 grieving Spanish-speaking individuals through 145 counseling sessions with licensed social workers. This is one of five exemplars highlighted by the committee granting SVMHS Magnet Recognition for nursing excellence.

Strategy: Create a healing tribute for families and staff to memorialize patients who pass away due to COVID-19.

- Through a nurse lead initiative, SVMHS introduced the Heartbeat in a Bottle Program, which ensures that the last EKG tracings of patients who pass away in the care of Salinas Valley Memorial Hospital are placed in a bottle to be given to grieving families. This is one of five exemplars highlighted by the committee granting SVMHS Magnet Recognition for nursing excellence.

PRIORITY AREA: HEALTHCARE ACCESS & DELIVERY IMPACT

Goal #1: Improve access to affordable, high-quality healthcare for at-risk community members.

Strategy: Launch a Mobile Health Clinic to reach underserved populations where people often have difficulty accessing healthcare because of cost, distance, fear, cultural comfort or problems making appointments.

- In January 2020, the SVMHS Mobile Health Clinic went on the road to bring no-cost services to underserved communities, regardless of immigration status.
- In 2020, the SVMHS Mobile Health Clinic staff conducted 1,373 patient visits in underserved areas. In 2021, with aggressive outreach and education efforts, the total number of visits increased significantly to 3,635.
- In 2021, SVMHS Mobile Health Clinic staff provided 231 students with sports physicals required for athletic participation.
- The Mobile Health Clinic also assesses each patient's social needs to support whole person health and reduce food insecurity, providing more than $10,000 in grocery gift cards and food bags.

Strategy: Create innovative Community Staff Support Project (CSSP) to utilize staff to serve the community and nonprofits with 'volunteer labor', educators and service providers.

- SVMHS created the Community Staff Support Project (CSSP) in 2020. The CSSP redeployed staff to support the community while maintaining salary and benefits for employees. Any employee who saw a reduction in their regularly scheduled work hours due to COVID-19 was eligible to participate. This is one of five exemplars highlighted by the committee granting SVMHS Magnet Recognition for nursing excellence.
- 185 SVMHS employees worked 10,500 volunteer hours during the CSSP project
- Established bilingual COVID-19 hotline for public
- Created drive-up COVID-19 testing centers
- Partnered with Grower-Shipper Association (GSA) to deploy bilingual SVMHS RN's to agricultural fields to provide on-site education

- Between April 2020 and February 2021, GSA secured safe quarantine housing/hotel rooms for 393 COVID-19 positive ag workers and SVMHS bilingual healthcare workers conducted daily resident calls and visits that addressed questions, symptom management and medications, as needed.

Strategy: Increase the number of people with Medicare and Medi-Cal coverage.

- SVMHS invested in Aspire Health Plan with Montage Health to bring affordable health insurance and greater access to care to people in its community. This community-centered, not-for-profit organization has earned a four-star rating from the Centers for Medicare and Medicaid Services (CMS) for its Medicare Advantage plan.

- Aspire enrolled 1,404 new members and ended 2020 with 5,590 Members. In 2021, 906 new members enrolled and the program ended the year with 5,799 members.

- Aspire called to check in on 100% of all Medicare Advantage members during the COVID-19 shelter-in-place. These calls resulted in follow-up calls to coordinate medication, transportation, food and other services for isolated members.

- SVMHS assisted 813 patients in 2020 and 726 patients in 2021 with insurance enrollment via Patient Financial Services Advocates.

- Each year, SVMHS covers the cost of care for those who are uninsured or underinsured. In 2020, that unreimbursed care totaled $165,375,990 and in 2021 the amount totaled $207,286,089.

Strategy: Increase specialty care providers in Gonzales to improve access to quality care for underserved south county area.

- Added gastroenterology and cardiology care to specialty providers at SVMHS Taylor Farms Family Health & Wellness Center which also includes family medicine, prenatal care, behavioral health, diabetes care and education, orthopedic surgery and podiatry.

Strategy: Increase care providers to easily accessed urgent care locations.

- Our nine Doctors on Duty (DOD) urgent care centers recorded a total of 138, 301 patient visits in 2020, which increased to 150,948 in 2021.

- DOD clinical healthcare staff, which includes physicians, nurse practitioners and physician assistants, totaled 83 providers in 2020, an increase of 10 from 2019, and added another seven providers in 2021 to reach 90 total providers.

- In total, between 2020 and 2021, DOD administered 11,858 COVID-19 vaccines, 4,224 flu vaccines and 8,953 other immunizations.

Strategy: Provide COVID-19 testing and vaccination opportunities.

- To date (June 1, 2022), Salinas Valley Medical Clinic has administered 63,774 COVID-19 vaccine doses to the public, the vast majority during mass community-based vaccine clinics.

- To date (June 1, 2022), Salinas Valley Medical Clinic administered 14,876 COVID-19 tests.

- In 2020, Salinas Valley Memorial Hospital administered 25, 193 COVID-19 tests, of which 4,662 were positive, allowing community members to take the appropriate isolation and quarantine action.

- In 2021, Salinas Valley Memorial Hospital administered 28,053 COVID-19 tests, of which 2,133 were positive, allowing community members to take the appropriate isolation and quarantine action.

Strategy: Fight flu and COVID-19 with free community vaccination clinics in partnership with Monterey County Health Department.

- In 2020, SVMHS partnered with the Monterey County Health Department to provide free community clinics to increase access to the flu vaccine. More than 1,000 people were vaccinated

during three free clinics in 2020, helping to reduce the severity of respiratory conditions brought on by the flu.

- In 2021, SVMHS partnered with the Monterey County Health Department to offer five free community clinics to increase access to COVID-19 and flu vaccine, resulting in more than 1200 people receiving the flu vaccine and 100 receiving COVID-19 vaccine.

Strategy: Offer free community Ask the Expert (ATE) education sessions in Spanish and English on topics of significant medical and health and wellness issues.

- In 2020, SVMHS Marketing's Community Engagement and Outreach produced 5 English and 4 Spanish language for a total of 9 virtual ATE sessions covering prioritized topics of COVID-19, CHNA Behavioral Health and CHNA Healthy Lifestyles including: COVID-19 Pandemic Dealing with Stress, Supporting Colleagues; COVID-19 Pandemic, Not Delaying Medical Care & Telehealth; Overcoming Fear of ER During COVID-18 Pandemic; COVID-19, Quarantine, and the Flu; Teen Vaping and Smoking; and Latinos, COVID-19, Flu Season and the Holidays.

- In 2021, SVMHS Marketing's Community Engagement and Outreach produced 13 English and 10 Spanish language for a total of 23 virtual ATE sessions covering prioritized topics of COVID-19, CHNA Behavioral Health and CHNA Healthy Lifestyles including: COVID-19 Vaccines; ATE Heart Month Heart Health, TAVR, Watchman, and Heart Healthy Cooking; Diabetes; Spanish Cooking Demo; Women's Health; Men's Health; Strokes; Obesity; Breast cancer; COVID-19 & Flu Virus; and Healthy Holiday Cooking.

Goal #2 Increase access to social and non-medical services that support health for low-income and vulnerable populations.

Strategy: Provide support to community-based 501C3 organizations offering access to healthcare and specialty programs.

- SVMHS directed Community Funding to the American Cancer Society in the amount of $10,000 in 2020 and $5,000 in 2021 to support access to healthcare and specialty programs.

- In 2020, SVMHS directed Community Funding to the Alliance on Aging in the amount of $7,500 and provided $2,000 in 2021, to support access to healthcare and specialty programs for seniors.

- In 2020 and 2021, SVMHS directed Community Funding to the ALS Association in the amount of $1,000 per year to support access to healthcare and specialty programs.

- In 2020 SVMHS provided $500 in Community Funding to the Breast Cancer Assistance Group of Monterey County, and in 2021 contributed $1,000 to support access to healthcare and specialty programs.

- SVMHS directed $505,000 in Community Funding in 2020, and $510,000 in 2021, to the Hartnell College Foundation to support access to care by increasing opportunities for and supporting the nursing pipeline.

- In 2020 and 2021, SVMHS directed Community Funding to the Leukemia & Lymphoma Society in the amount of $10,000 per year to support access to and delivery of healthcare education, support and research.

- SVMHS directed $68,250 in Community Funding in 2020, and $35,000 in 2021, to the Partnership for Children, which offers access to healthcare and programs supporting families experiencing serious illness.

- SVMHS directed Community Funding to Salinas Veterans Day Parade Inc. in the amount of $1,500 in 2020 and $2,500 in 2021, to support programs that provide access to care, increase opportunities for and support of military veterans.

- In 2020 and 2021, SVMHS directed Community Funding to Central Coast VNA & Hospice in the amount of $10,000 per year to support access to healthcare and specialty programs.

- In 2020, SVMHS directed $10,000 in Community Funding to the Hospice Foundation for the Central Coast, which provides valuable support to people with serious illness.

PRIORITY: HEALTHY LIFESTYLES IMPACT

Goal #1: Increase community members' ability to live healthy lifestyles targeting diabetes and obesity and food and housing insecurity.

Strategy: Create Walk with a Doc program.

- Through a partnership that included SVMHS and SVMC physicians and healthcare providers, BLM Park Rangers for the Fort Ord National Monument Badger Hills Trailhead and Blue Zones Project Monterey County, SVMHS created the Walk with a Doc program, which connects the community to local physicians through monthly walking events with SVMHS & SVMC healthcare providers. The physician or healthcare provider presents on a health topic, followed by a 2-mile walk.
- The program increases physical activity and knowledge of healthcare topics among participants.
- Five walks with a total of 96 participants were held in 2020, walks were suspended in 2021 due to the ongoing pandemic.

Strategy: Introduce the SVMHS Community Farmers' Market & Fresh Produce Prescription Program (FPRx).

- Through a partnership that included the SVMC Diabetes & Endocrine Center, SVMC PrimeCare, SVMHS Cardiac Wellness Center, Aspire Health Pediatric Wellness Program, SVMHS staff and Everyone's Harvest, SVMHS created FPRx, open each Friday from May-November.
- FPRx participants are provided with $25 in market tokens each week for a total of 27 weeks. Market tokens are used to purchase fresh fruits & vegetables. Participants are also provided with health and wellness information and new recipes each week.
- Participants take part in three biometric screenings during the program. These screenings capture their height, weight, waist circumference and Body Mass Index (BMI).
- 68 patients were enrolled in FPRx in 2020 and 93 were enrolled in 2021.
- SVMHS Farmers' Market engagement totaled 5,675 visitors in 2020 and 13,500 in 2021.

Strategy: Expand Blue Zones initiatives promoting healthy lifestyles

- Blue Zones initiatives promote health through elements such as physical activity and stress management, seek to improve people's environment, and discourage junk food consumption and smoking.
- In 2020 in Salinas, 10 new Blue Zones Project approved worksites were added, as well as two schools and four restaurants. There were 5,700 engagements through the project.
- In 2021 in Salinas, 10 new Blue Zones Project approved worksites were, as well as 11 schools, 10 restaurants and two grocery stores, and there were 7,300 engagements.
- Dozens of walking and hiking social groups, known as Moais, were launched to meet regularly at shoreline recreation trails, nature preserves, cityscapes and other landmarks. In 2020, 11 walking Moais were created, and there were 65 participants. In 2021, 11 walking Moais were created, with 138 participants.
- In 2020, volunteers committed 730 hours to Blue Zone Project initiatives and in 2021, the number of volunteer hours skyrocketed to 1,730.
- In 2021, the project's nonsmoking advocacy efforts contributed to the Monterey County Board of Supervisors' update of its no-smoking ordinance to include county parks.
- Blue Zones expanded into South County and the Peninsula Cities region in 2021, and efforts ramped up throughout Monterey County to clean up parks and beaches, partner with grocery stores to highlight healthy foods, create outdoor learning environments at local schools and implement the Diabetes Innovation initiative.

Strategy: Provide support to community-based 501C3 organizations providing healthy living programs and resources.

- In 2020, SVMHS directed Community Funding to the American Heart Association in the amount of $7,500 to support initiatives primarily targeting heart disease, which is often linked to diabetes and obesity.
- In 2020, SVMHS directed $5,000 in Community Funding to the Arthritis Foundation to provide healthy living services for underserved youth.
- SVMHS directed $12,500 in Community Funding in 2020, and $14,500 in 2021, to the Boys & Girls Clubs of Monterey County to provide healthy living services including healthy meals for underserved youth.
- SVMHS directed $2,500 in Community Funding in 2020, and $10,000 in 2021, to the Community Foundation for Monterey County, which is dedicated to healthy, safe and vibrant communities.
- In 2020 and 2021, SVMHS directed Community Funding to Impower Inc. in the amount of $5,000 per year in support of nonprofits focused on health and well-being of the community.
- In 2020 and 2021, SVMHS directed Community Funding to the Juvenile Diabetes Research Foundation in the amount of $10,000 per year to support diabetes education and research for the juvenile population.
- SVMHS directed $13,000 in Community Funding in 2020, and $25,000 in 2021, to United Way of Monterey County for Monterey County, in support of programs focused on healthy lifestyles, economic equality and affordable housing.
- In 2021, SVMHS directed $25,000 in Community Funding to El Sistema USA, which provides providing music education in underserved populations, advancing social equality.
- In 2021, SVMHS directed $10,000 in Community Funding to Central Coast YMCA to support youth development, healthy living and social equity.
- In 2021, SVMHS directed $10,000 in Community Funding to University Corporation, which exists to enhance educational programs for students, faculty and the public.
- In 2021, SVMHS directed $5,000 in Community Funding to Big Sur Land Trust to protect, preserve and encourage outdoor experiences for all.
- In 2021, SVMHS directed $1,500 in Community Funding to Junior Achievement, a program for underserved high school students.
- In 2021, SVMHS directed $12,000 in Community Funding to the Mexican Heritage Group of Salinas, which creates cultural and ethnic awareness in Salinas, supporting diversity and inclusion.
- In 2021, SVMHS directed $5,000 in Community Funding to the Action Council of Monterey County to support programs and services to encourage diversity and inclusion.
- In 2021, SVMHS directed $25,000 in Community Funding to the California International Airshow to support a STEM education tent to expose and engage hundreds of underserved youth from predominately low-income areas of south county.
- In 2021, SVMHS directed $10,000 in Community Funding to Communities for Sustainable Monterey County, which works locally to meet the challenges of declining resources and climate change by helping our communities transition to sustainable practices.
- In 2021, SVMHS directed $1,000 in Community Funding to the League of United Latin American Citizens, which is the largest and oldest Hispanic and Latino civil rights organization in the United States focused on equity and inclusion.

Goal #2: Improve diabetes management and weight control in our community.

Strategy: Offer education, screenings, health coaching and medical guidance for the prevention and management of diabetes.

- The SVMC Diabetes & Endocrine Center in Salinas serves people with Type 1 and Type 2 diabetes and other metabolic and endocrine disorders with care and education.
- In partnership with the University of California San Francisco, the Pediatric Diabetes Clinic (located in the SVMC Diabetes & Endocrine Center) continues to support families who would otherwise have to take time away from work and school to travel to the Bay Area for critical services for children with Type 1 and Type 2 diabetes.
- There were 31,558 visits to the SVMC Diabetes & Endocrine Center between 2020-2021, 548 of which were pediatric visits.
- Since 2015, the Center has offered a Diabetes Education Class series, which has served 2,491 patients. Education classes are offered four days a week at varying times in English and Spanish.
    - In 2020, 27 class series were held for a total of 108 group class sessions. There were 362 participants. The average A1C before receiving education among participants was 9.1%. After the classes, the average A1C decreased to 7.2%.
    - In 2021, 29 class series were held for a total of 116 group class sessions. There were 318 participants. The average A1C before receiving education among participants was 8.5%. After the classes, the average A1C decreased to 7.3%.
- Launched in 2021, Diabetes Innovation is the first disease-specific intervention with Blue Zones Project.
    - At worksites, Diabetes Innovation initiatives include adding glucose screening as a requirement for worksite wellness biometrics, diabetes and diabetes-prevention education as a requirement for the employee education model, and development and distribution of diabetes and diabetes-prevention resources.
    - In schools, integration of the Diabetes Innovation means adding the American Diabetes Association assessment implementation with students and families to increase awareness, diabetes and diabetes-prevention programs as a focus for student/family education and programs, and diabetes and diabetes-prevention resources.
    - The initiative has grown to include more than two dozen workplaces, collectively employing thousands of individuals, and an increasing number of schools, restaurants and grocery stores. All are working toward a common goal of making healthy choices easier and helping people build on simple and sustainable habits to lead a balanced life.

Strategy: Partner with the Aspire Medicare Advantage for the Diabetes Prevention Program (DPP) for adult and pediatric services.

- In 2020, there were 401 approved referrals for patients with prediabetes, 146 DPP enrollments and 333 patients scheduled for health coaching.
- In 2021, there were 664 approved referrals for patients with prediabetes, 126 DPP enrollments and 317 patients scheduled for health coaching. Between 2020 and 2021, 87 enrolled patients lost a combined total of 521 pounds, with an average weight loss of 5.5%. Also, 191 Aspire MA members with prediabetes or enrolled into an Aspire Population Health Service.
- Aspire pivoted all healthy lifestyle coaching services to telephonic or video calls to ensure programming continued during COVID and shelter-in-place orders.
- Since 2019, the Pediatric Wellness Program, operated by Aspire Health in partnership with SVMHS and Montage Health, has reached 2,500+ families, partnering with 20+ referring providers from Monterey, Seaside, Marina, Salinas, Greenfield and Gonzales. The Pediatric Wellness Program provides no-cost group and individual health coaching in both English and Spanish – in-person, virtually or by phone – for a family-based approach to wellness and diabetes prevention.

- In 2020, there were 1,622 referrals to the Pediatric Wellness Program and 1,099 enrollments, and in 2021, there were 1,889 referrals and 1,028 enrollments.

Strategy: Offer the Lifestyle and Metabolic Program (LAMP), which provides long term kind, compassionate and comprehensive treatment for motivated and committed patients living with obesity.

- LAMP is designed for patients with a BMI>30, and it is at least a 6-month program based on individual need.
- The program provides patients with education, medical treatment, psychological treatment, support with lifestyle changes and bariatric surgery, all while empowering patients to manage their own health in a positive way.
- The program served 368 patients in 2020 and 510 patients in 2021.

Goal #3: Combat food and housing insecurity.

Strategy: Screen for community members experiencing food insecurity.

- Through the Blue Zones project, SVMHS is working to aid community members struggling with food insecurity. Following the integration of key questions to screen for patient food insecurity at the Diabetes and Endocrine Center, the healthcare system has also trained healthcare providers and staff on the process and expanded screening throughout SVMC clinics.
- Additionally, as noted earlier, SVMHS Mobile Health Clinic is addressing food insecurity with screening, grocery gift cards and grocery bags.

Strategy: Provide support to community-based 501C3 organizations combatting food insecurity.

- In 2021, SVMHS directed $4,000 in Community Funding to Meals On Wheels of the Monterey Peninsula to provide healthy meals to housebound individuals and elderly without easy access to nutritious food options.

  In 2021, SVMHS directed $5,000 in Community Funding to Brighter Bites, a national nonprofit organization that delivers fresh fruits and vegetables directly into families' hands.

Strategy: Commit funds to community housing.

- In 2020, SVMHS directed $5,000 in Community Funding to the Center for Community Advocacy to improve housing and health conditions for farmworkers and their families.
- In 2020 and 2021, SVMHS directed Community Funding to Community Housing Improvement in the amount of $5,000 per year to support housing programs.
- In 2020 and 2021, SVMHS directed Community Funding to the Kinship Center in the amount of $5,000 per year to support this organization dedicated to finding every foster, abused or unwanted child a loving, permanent home.
- SVMHS directed $5,500 in Community Funding in 2020, and $6,000 in 2021, to the Monterey Bay Economic Partnership to support housing and economic equality.
- In 2020, SVMHS directed $5,000 in Community Funding to the Salvation Army to support housing and economic equality.

Summary Evaluation Assessment

During 2020 and 2021, Salinas Valley Memorial Hospital cared for 1,759 patients with COVID-19. Sadly, 221 of those patients succumbed to their illness. Staff throughout our Healthcare System faced unprecedented challenges, and yet rose to meet the demands and embraced opportunities to improve the health and well-being of our patients, community and each other.

Our staff prioritized COVID-19 testing, care and vaccination distribution, while continuing to meet the community's ongoing healthcare and wellness needs, supporting innovative initiatives with a redeployed workforce, more access points for medical care, connections to social and behavioral support, and programs that promote healthy living and disease prevention. In 2020, SVMHS provided a total of $806,850 in Community Funding, and in 2021 provided $959,500, to support nonprofit organizations focused on improving the health of their communities. Additionally, in the midst of these busy and challenging times, in

2021, SVMHS also achieved the gold standard for nursing practice – American Nurses Credentialing Center (ANCC) Magnet Recognition®, the highest and most prestigious distinction any healthcare organization can achieve for nursing excellence.

We look forward to additional and enhanced collaboration with our healthcare partners to improve the health and well-being of the community with the evaluation of an updated assessment through the Monterey County Health Needs Collaborative and the implementation of strategic policies and programs to address those identified needs.

Salinas Valley Health Medical Center Fiscal Years 2023–2025 Implementation Strategy

General Information

Contact Person:	Adrienne Laurent
Years the Plan Refers to:	Fiscal Years 2023–2025
Date Written Plan Was Adopted by Authorized Governing Body:	February 23, 2023
Authorized Governing Body that Adopted the Written Plan:	Salinas Valley Health Board of Directors
Name and EIN of Hospital Organization Operating Hospital Facility:	Salinas Valley Health Medical Center EIN 94-6004020
Address of Hospital Organization:	450 East Romie Lane Salinas, CA 93901

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I. About Salinas Valley Health

Salinas Valley Health, a public healthcare district, is an integrated network of healthcare programs, services, and facilities that serve thousands of people each year throughout Monterey County and beyond. Opened in 1953, Salinas Valley Health Medical Center anchors Salinas Valley Health. Licensed for 263 beds, this acute-care medical center features several specializations that enable people to get the advanced care they need without having to travel out of the area. The medical center employs approximately 2,000 people and has a medical staff of 300 board-certified physicians across a range of specialties.

Mission: To provide quality healthcare to our patients and to improve the health and wellbeing of our community.

Vision: A community where good health grows through every action, in every place, for every person.

COMMUNITY HEALTH INITIATIVES

Blue Zones Project Monterey County

Blue Zones Project Monterey County, which our healthcare system brought to this area and sponsors, builds changes in our community that make the healthy choice easy. The transformative health initiative involves everyone – worksites, schools, faith-based organizations, restaurants, and grocery stores – and takes a systemic approach to improved well-being through policy, design and collaboration. Monterey County is one of more than 70 Blue Zones Communities across North America, impacting more than four million people in total. Its work has produced double-digit drops in obesity, smoking, and body mass index, among other health and well-being improvements. Salinas Valley Health Collaborates with Montage Health and Taylor Farms in sponsoring the Blue Zones Project, which has a staff of 18 people and serves all of Monterey County.

Mobile Health Clinic

Delivering free medical care directly where it is needed most, the Mobile Health Clinic has improved access to quality medical services in Monterey County. In addition to primary and preventive care, community health advocates support the health and social needs of patients, helping them navigate services and providing supplies for those in financial need: blood pressure and glucose test kits; grocery and gas cards; stuffed animals and pajamas for children. Having recently served its 10,000th patient, the Mobile Clinic breaks through common barriers to healthcare, such as expense, travel and fear. Its use of diverse resources is helping improve care-coordination, well-being and health outcomes for some of our most vulnerable populations. Salinas Valley Health collaborates with two Family Resource Centers, two local high schools and other entities in low income areas.

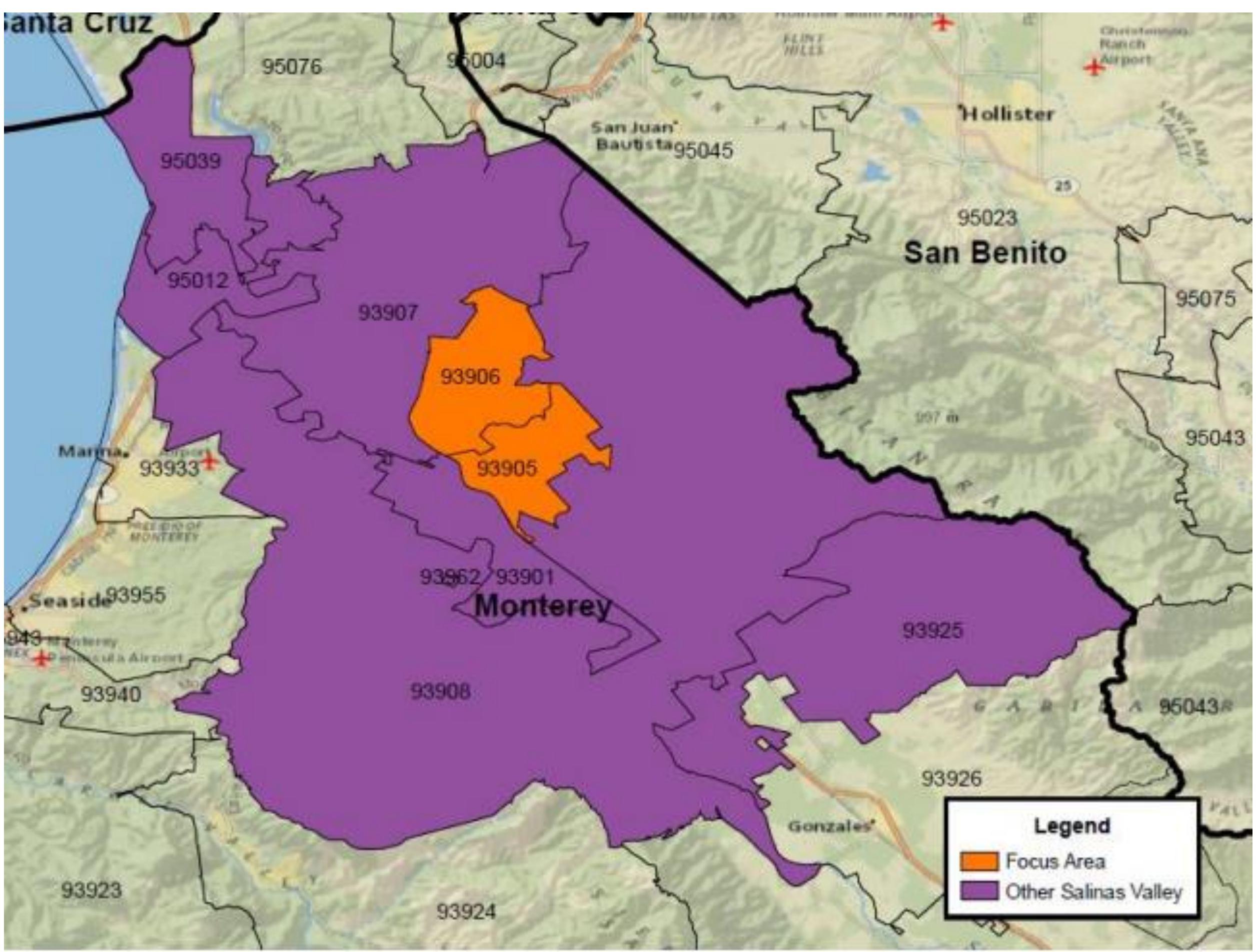
Health Education and Awareness Classes

Improving access to services and providing powerful opportunities for connection and support, our health education and awareness classes help our community rise in good health and well-being. In-person and virtual classes offer a wealth of resources – from getting ready for a new baby to diabetes foot care, nutrition services for cancer survivors, support groups for cardiac patients, seminars on legal issues for life planning, meditation classes and more. Our medical providers have frank conversations during *Walk*

With a Doc events. *Ask the Experts* presentations share in-depth information on medical advances and common health concerns. Student programs ranging from fourth grade to post-secondary inspire our future healthcare professionals. Outreach beyond the walls of our campus is fundamental in everything we do to support our community.

II. Salinas Valley Health's Service Area

The Internal Revenue Service defines the "community served" as individuals who live within the medical center's service area. This includes all residents in a defined geographic area and does not exclude low-income or underserved populations. According to its 2022 CHNA report, Salinas Valley Health's community is its service area, composed of ZIP Codes 93901, 93905, 93906, 93907, 93908, 93925, 93962, 95012, and 95039. The map below shows the service area in purple, as well as a more central "focus area" in orange, representing geographies of particular concern to Salinas Valley Health.



However, SMVHS recognizes the need to work collaboratively with its community partners in Monterey County, and therefore, for purposes of its community benefit program, Salinas Valley Health identifies

Monterey County as its target community. The following statistics are for Monterey County as a whole, except where specifically noted.

Monterey County comprises 12 cities, eight census-designated places, and large areas of unincorporated rural land. In 2020, nearly 433,000 people lived there. The ethnic makeup of the county is highly diverse: More than half (59 percent) of the population is of Latinx ethnicity and nearly two in five (39 percent) are of "some other race."[1]

Income, as a key social determinant, has a significant impact on health outcomes. Twelve percent of the county's population is living below the federal poverty threshold, a lower proportion than the state or nation. However, over 18% of the county's children live in poverty, which is a higher proportion than California or the U.S. overall.[2] One-third (33%) of survey respondents in Salinas Valley Health's service area reported they do not have cash on hand to cover a $400 emergency expense, a greater percentage than U.S. respondents (25%).[3]

Among county adults age 25 and older, over one-quarter (27%) do not have a high-school diploma (or equivalent). This proportion is substantially worse than either California (16%) or the U.S. overall (12%).[1]

III. Purpose of Implementation Strategy

This Implementation Strategy (IS) Report describes Salinas Valley Health's planned response to the needs identified through the 2022 Community Health Needs Assessment (CHNA) process. It fulfills Section 1.501(r)-3 of the IRS regulations governing nonprofit hospitals. Subsection (c) pertains to implementation strategy specifically, and its requirements include a description of the health needs that the hospital will and will not address. Per these requirements, the following descriptions of the actions (strategies) to take include the anticipated impact of the strategies, the resources Salinas Valley Health plans to commit to address the health needs, and any planned collaboration between the medical center and other facilities or organizations in addressing the health needs.

For information about Salinas Valley Health's 2022 CHNA process and for a copy of the 2022 CHNA report, please visit svmh.com/chna.

[1] U.S. Census Bureau, American Community Survey, 5-year estimates, 2016–2020; Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension.

[2] U.S. Census Bureau, American Community Survey, 5-year estimates, 2016–2020; Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension; U.S. Department of Health and Human Services, Healthy People 2030.

[3] 2022 PRC Community Health Survey, PRC, Inc. and 2020 PRC National Health Survey, PRC, Inc.

IV. List of Community Health Needs Identified in the 2022 CHNA

The 2022 CHNA assessed community health needs by gathering input through online surveys from persons representing the broad interests of the community, including ratings of the degree to which various health issues were a problem in the community. In addition, quantitative (statistical) data were analyzed to identify poor health outcomes and health trends. The CHNA study team[4] compiled statistical data and provided comparisons against statewide averages and rates.

Significant health needs, for the purposes of the 2022 CHNA, were determined after consideration of various criteria, including: standing in comparison with benchmark data (particularly national data); identified trends; the preponderance of significant findings within topic areas; the magnitude of the issue in terms of the number of persons affected; and the potential health impact of a given issue. The list of needs also takes into account those issues of greatest concern to the community leaders (key informants) giving input to the CHNA process.[5]

The 2022 CHNA identified a total of 12 health needs. A variety of community leaders evaluated, discussed, and prioritized these 12 health issues in September 2022, which are listed below in community prioritization order. The health need prioritization process is described in more detail in Salinas Valley Health's CHNA report. Salinas Valley Health's executive team then selected the health needs that Salinas Valley Health will address during FY2023–2025. The health need selection process is described in Section VI of this report.

2022 COMMUNITY HEALTH NEEDS LIST

1. **Diabetes**
2. **Mental Health**
3. **Access to Healthcare Services**
4. **Nutrition, Physical Activity, & Weight**
5. **Heart Disease & Stroke**
6. **Substance Use**
7. **Housing**
8. **Infant Health & Family Planning**
9. **Injury & Violence**
10. **Cancer**

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[4] The study team was composed of Salinas Valley Health, Community Hospital of the Monterey Peninsula, Mee Memorial Healthcare System, Monterey County Health Department, Natividad, and United Way Monterey County. For more details, see Salinas Valley Health's 2022 CHNA report.

[5] Salinas Valley Health 2022 CHNA Report, page 12.

11. **Oral Health**
12. **Potentially Disabling Conditions**

V. Those Involved in the Implementation Strategy (IS) Development

Salinas Valley Health selected the health needs to address. Actionable Insights, LLC, provided guidance and expertise for this process and conducted research on evidence-based and promising practices for each selected health strategy. Actionable Insights is a consulting firm whose principals have experience conducting CHNAs and providing expertise on implementation strategy development and IRS reporting for hospitals.

VI. Health Needs that Salinas Valley Health Plans to Address

A. PROCESS AND CRITERIA USED TO SELECT HEALTH NEEDS

Salinas Valley Health met with Actionable Insights on October 11, 2022, to discuss the health needs identified through the community assessment and to select needs from the list. After reviewing the data and the community's prioritization of the 12 health needs documented in the 2022 CHNA, Salinas Valley Health, by consensus, selected three of the health needs that had been identified. The selected needs are listed below in alphabetical order.

1. **Behavioral Health**
2. **Healthcare Access and Delivery**
3. **Healthy Lifestyles**

For the purposes of this IS, Salinas Valley Health merged Mental Health and Substance Use into the single need "Behavioral Health," renamed Access to Health Care "Healthcare Access and Delivery," and merged Diabetes, Heart Disease & Stroke, and Nutrition, Physical Activity, & Weight into one need named "Healthy Lifestyles" in order to better express the topics on which it will focus in addressing the needs.

B. DESCRIPTION OF HEALTH NEEDS THAT SALINAS VALLEY MEMORIAL HEALTHCARE SYSTEM PLANS TO ADDRESS

BEHAVIORAL HEALTH

Key Informants ranked both mental health and substance use as top concerns. The major topics of their feedback on these needs included:

- Few providers/facilities: Lack of access to care/treatment (esp. in-patient), recovery services, especially for those who cannot afford out-of-pocket payments
- Impact of COVID: Increased population with poor mental health (stress, anxiety, depression, isolation)
- Lack of behavioral health resources for individuals experiencing homelessness
- Lack of awareness/education about mental health/substance use, including in other languages (e.g., Spanish)
- Prevalence of tobacco use
- Increase in youth vaping
- Impact of tobacco use/vaping on quality of life
- Co-occurrence of poor mental health and substance use
- Experience of stigma or denial, criminalizing substance use
- Lack of culturally appropriate care
- Stress (separate from COVID)
- Negative impact of mental health issues on quality of life

The following statistical data did not meet benchmarks or had a worsening trend:

- "Fair/Poor" Mental Health
- Diagnosed Depression
- Symptoms of Chronic Depression
- Stress
- Suicide Mortality
- Difficulty Obtaining Mental Health Services
- [Parents] Awareness of Children's Mental Health Services
- [Parents] Child Has Needed Mental Health Services [Other SVMH Area]
- Cirrhosis Disease Deaths
- Unintentional Drug-Related Deaths
- Personally Impacted by Substance Use (Self or Other's)

HEALTHCARE ACCESS AND DELIVERY

While Key Informants did not rank healthcare access and delivery as a top concern, they provided substantial feedback about the need. The major topics of this feedback included:

- Lack of providers (incl. mental healthcare, preventive care, dentists), limited open hours
- Lack of insurance, cost of coverage
- Inequities that lead to increased risk of adverse health outcomes:
    - Language barriers (especially indigenous languages)
    - Cultural barriers, fear (among undocumented especially)

    - Immigration status
    - Homelessness
    - Mental illness
- Systemic racism
- Delay in care due to COVID
- Income/poverty, cost/affordability of care
- Geographic distance, transportation

The following statistical data did not meet benchmarks or had a worsening trend:

- Barriers to Access:
    - Inconvenient Office Hours
    - Cost of Prescriptions
    - Cost of Physician Visits
    - Appointment Availability
    - Finding a Physician
    - Lack of Transportation
    - Language/Culture
- Skipping/Stretching Prescriptions
- Difficulty Accessing Children's Health Care
- Primary Care Physician Ratio
- Routine Medical Care (Adults)
- Low Health Literacy [Focus Area ZIP Codes]

HEALTHY LIFESTYLES

Key Informants ranked diabetes as well as nutrition, physical activity, and weight as top concerns. The major topics of their feedback on these needs included:

- Lack of awareness, lack of culturally/linguistically appropriate education about when and how/where to seek (early) care for chronic diseases such as heart disease, stroke, diabetes, and drivers such as nutrition/diet, and exercise
- Lack of access to care for diabetes; lack of providers in some cases, cost/affordability in others; lack of follow-up/support
- Cost of medications/supplies for diabetes
- Prevalence of heart disease and stroke as leading causes of premature death; prevalence of diabetes in the county
- Co-occurrence of heart disease or hypertension with diabetes and/or obesity
- Affordable, healthy food access; easy access to fast food/junk food; poor diet as a contributing factor to heart disease and stroke; food insecurity

- Built environment: Lack of access to safe places to recreate as a driver for lack of exercise, diabetes
- Aging population
- Issues of health equity: BIPOC (Black, Indigenous People of Color) and south county residents identified as at increased risk for adverse health outcomes
- Stress, lack of time as a contributing factor to heart disease and stroke, diabetes
- Concern about lifestyle choices
- Obesity, especially among young people, as a contributing factor to heart disease, stroke, and diabetes
- Negative effect of the pandemic on diet, nutrition, and exercise

The following statistical data did not meet benchmarks or had a worsening trend:

- Prevalence of Diabetes [Focus Area ZIP Codes]
- Prevalence of Borderline/Pre-Diabetes
- Kidney Disease Deaths
- Heart Disease as a Leading Cause of Death
- Heart Disease Prevalence
- High Blood Cholesterol Prevalence
- Overall Cardiovascular Risk
- Food Insecurity
- Difficulty Accessing Fresh Produce
- Access to Recreation/Fitness Facilities
- Overweight & Obesity [Adults & Children]

VII. Salinas Valley Health's Implementation Strategy

The federal government requires nonprofit hospitals to complete an Implementation Strategy Report, or ISR. The ISR is a companion to the CHNA, in that it describes how hospitals will use community benefit and other resources to address priority health needs in their service areas. This ISR fulfills federal requirements. Specifically, the ISR must detail:

- Which of the priority health needs will be directly addressed by the hospital as part of its implementation strategy, and which top health needs will not be addressed (and justification)
- The actions, programs, and resources the hospital intends to commit to address the selected health needs
- The anticipated impact of these actions
- Any planned collaboration between the hospital and other hospitals or organizations

The goals and strategies proposed to address the chosen needs are described in the section below. Salinas Valley Health will implement these strategies through a combination of grants, sponsorships, and in-kind support to community-based organizations, community health centers, or clinics. Associated indicators of anticipated impact are listed for each goal.

Salinas Valley Health's definition of "community health" includes not only the physical health of both counties' residents, but also broader social and environmental determinants of health (such as access to and delivery of health care, affordable housing, child care, education, and employment). This more inclusive definition reflects the understanding that myriad factors impact community health. Salinas Valley Health is committed to supporting community health improvement through strategies that address both upstream (social determinants of health) and downstream (health condition) interventions.

HEALTH NEED 1: BEHAVIORAL HEALTH

Long-Term Goal: Increase the ability of community members to have good mental/behavioral health.

Goal	Strategies	Anticipated Impact
1.A Continue/expand access to programs and services that prevent poor mental/behavioral health.	i. Expand access to programs and services that prevent poor mental health (e.g., mindfulness-based stress reduction, bullying prevention, small-group community connections/activities) ii. Expand access to programs and services that address stress, depression, and suicidal ideation (e.g., counseling/therapy, including virtual and in-person) iii. Expand access to programs and services (including prevention education, intervention, and treatment) that address substance use iv. Support programs and policies that prevent or reduce domestic violence and other trauma, and increase healthy coping skills, resilience, and healthy relationships for youth and adults v. Support screening/evaluations and referrals for mental/behavioral health vi. Participate in Medi-Cal Managed Care vii. Provide Charitable Health Coverage	a. Improved access to mental/behavioral health programs and services b. Increased proportion of people served with effective mental/ behavioral health services Among community members served: c. Increased knowledge about methods of coping with stress and depression d. Improved coping skills e. Healthier relationships f. Improved mental/behavioral health

HEALTH NEED 2: HEALTHCARE ACCESS AND DELIVERY

Long-Term Goal: Improve access to affordable, high quality healthcare services for low-income and otherwise vulnerable community members.

Goal	Strategies	Anticipated Impact
2.A Decrease transportation barriers to accessing healthcare	i. Support health care clinics and related programs in close geographic proximity to populations of low socioeconomic status ii. Support Salinas Valley Health physicians serving in community clinics iii. Support mobile health clinic program iv. Support community health fairs, virtual health education sessions, and vaccination clinics	a. Increased number of community members served b. Increased access to preventative care c. Reduced unnecessary ED visits/hospitalizations d. Increased vaccination rates e. Decreased outbreaks of vaccine-preventable diseases
2.B Ensure future supply of health care providers	i. Provide training to health care professionals (e.g., Hartnell College nursing program, CSU-MB PA program) ii. Support pipeline programs for healthcare careers iii. Support the recruitment of healthcare providers to the area	a. Increased number of qualified providers in the community focused on community-based practices b. Standard of care raised
2.C Address other barriers to access	i. Continue to provide uncompensated Medi-Cal care to Medi-Cal patients ii. Provide financial assistance to reduce health care cost barriers to care for low-income individuals iii. Support organizations or programs assisting with insurance enrollment, including community outreach about insurance	a. Reduced health care cost barriers for vulnerable populations b. Improved health insurance rates (% of people with health insurance)

HEALTH NEED 3: HEALTHY LIFESTYLES

Long-Term Goal: Increase ability of community members to live healthy lifestyles.

Goal	Strategies	Anticipated Impact
3.A Increase access to high-quality, affordable, healthy foods for vulnerable populations	i. Expand capacity of existing food access programs, including those specifically addressing health care-related food access (e.g., FPRx) ii. Support additional, culturally relevant food access programs iii. Support implementation of healthy food policies in schools and the county at large	a. Improved access to high-quality, affordable, healthy foods b. Reduced proportion of individuals who are food insecure c. Improved associated health outcomes
3.B Increase access to affordable exercise areas and options	i. Support/expand interventions and practices aimed at reducing recreational, sedentary screen time among community members (e.g., expand access to free/low-cost community exercise classes) ii. Advocate for the development and maintenance of trails, parks, bike paths, etc. especially in low-income/ rural communities	a. Improved access to exercise for low-income individuals b. Increased proportion of individuals who are physically fit c. Improved associated health outcomes
3.C Increase education and initiatives related to healthy lifestyles	i. Participate in health fairs and other opportunities for health screening and education (which include followup) ii. Support community health workers (CHAs) in health education, and as outreach, enrollment, and information agents to increase healthy behaviors iii. Support/expand Blue Zones initiatives promoting healthy lifestyles	a. Increased knowledge about healthy behaviors b. Improved health outcomes, particularly related to health disparities
3.D Reduce uncontrolled chronic diseases such as diabetes and hypertension	i. Support/expand initiatives and programs for diabetes and obesity prevention and intervention (e.g., screenings, diabetes and diabetes-prevention education, treatment)	a. Increased knowledge about healthy behaviors b. Improved health outcomes, particularly related to health disparities

Goal	Strategies	Anticipated Impact
	ii. Support/expand initiatives and programs for heart disease and stroke prevention and intervention (e.g., screenings, education, treatment)	

VIII. Evaluation Plans

Salinas Valley Health will monitor and evaluate the strategies described above for the purpose of tracking the implementation of those strategies as well as to document the anticipated impact. Plans to monitor activities will be tailored to each strategy and will include the collection and documentation of tracking measures, such as the number of grants made, number of dollars spent, and number of people reached/served. In addition, Salinas Valley Health will require grantees to track and report outcomes/impact, including behavioral and physical health outcomes as appropriate.

IX. Health Needs that Salinas Valley Health Does Not Plan to Address

As described in Section VI(A) of this report, Salinas Valley Health will address the three health needs that met all of the selection criteria. Salinas Valley Health will not address the following identified health needs:

Cancer: Salinas Valley Health is better positioned to address drivers of this need via strategies related to healthy lifestyles, and education about this need via healthcare access and delivery strategies. Additionally, cancer was of lower priority to the community than the needs selected to be addressed by Salinas Valley Health.

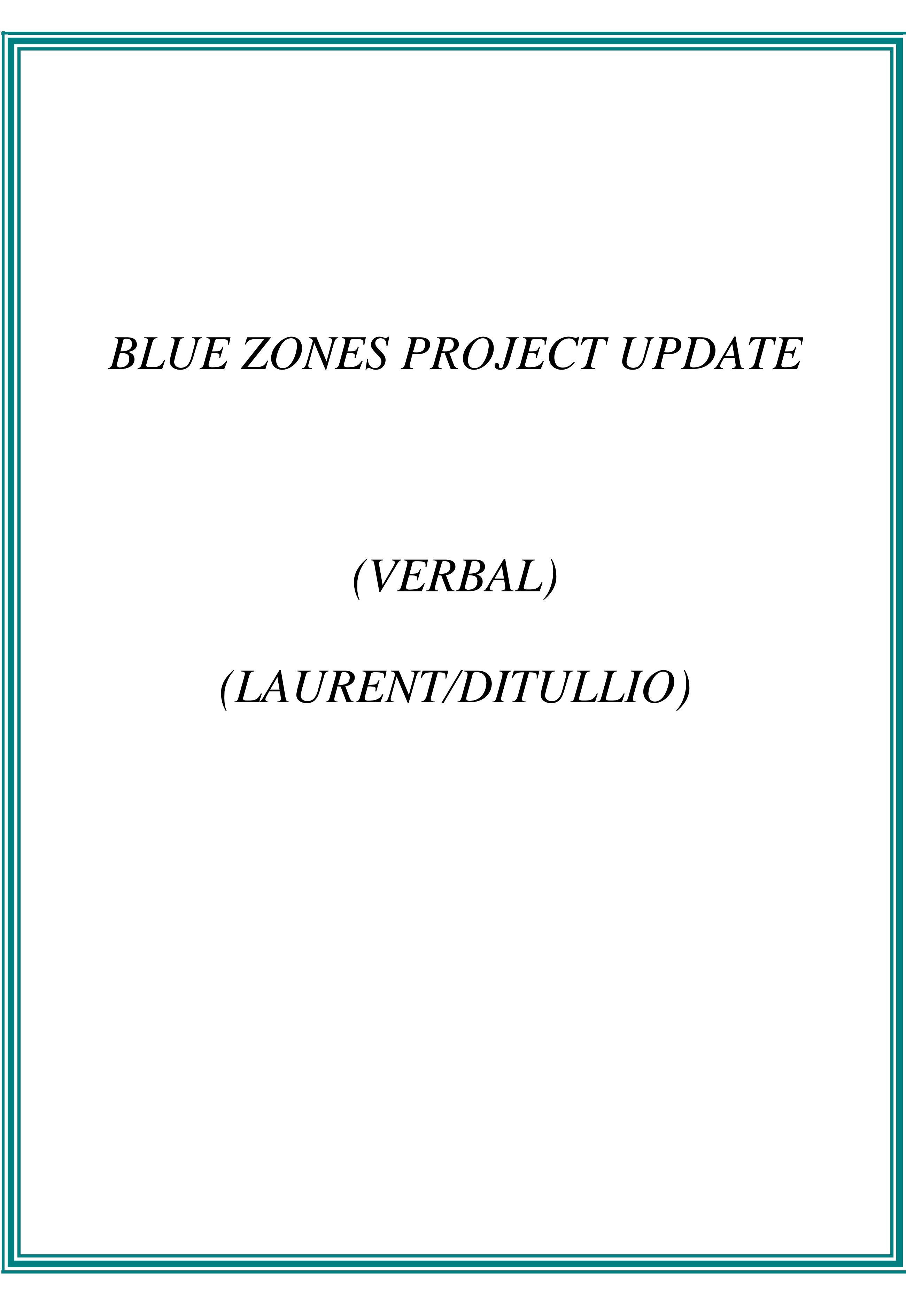
Housing: This topic is outside of Salinas Valley Health's core competencies (i.e., Salinas Valley Health has little expertise in this area) and the medical center feels it cannot make a significant impact on this need through community benefit investment. Also, housing was of lower priority to the community than the needs that Salinas Valley Health selected.

Infant Health & Family Planning: Salinas Valley Health is better positioned to address drivers of this need via healthcare access and delivery strategies. Additionally, this need was of lower priority to the community than the needs selected to be addressed by Salinas Valley Health.

Injury & Violence: This need was of lower priority to the community than the needs selected to be addressed by Salinas Valley Health. Behavioral health issues such as substance use, stress, and anxiety have been shown to be drivers of injury and violence. Thus, Salinas Valley Health believes that strategies intended to address the community's behavioral health need have the potential to address injury and violence as well.

Oral Health: Salinas Valley Health is better positioned to address drivers of this need via strategies related to healthcare access and delivery. Also, oral health was of lower priority to the community than the needs selected to be addressed by Salinas Valley Health.

Potentially Disabling Conditions: This need was of lower priority to the community than the needs selected to be addressed by Salinas Valley Health. In addition, potentially disabling conditions may serve as barriers to healthcare access and delivery. Salinas Valley Health believes that strategies intended to address the community's healthcare access and delivery need can also address barriers posed by potentially disabling conditions.



BLUE ZONES PROJECT UPDATE

(VERBAL)

(LAURENT/DITULLIO)

REPORT FROM THE SALINAS VALLEY MEMORIAL HOSPITAL SERVICE LEAGUE

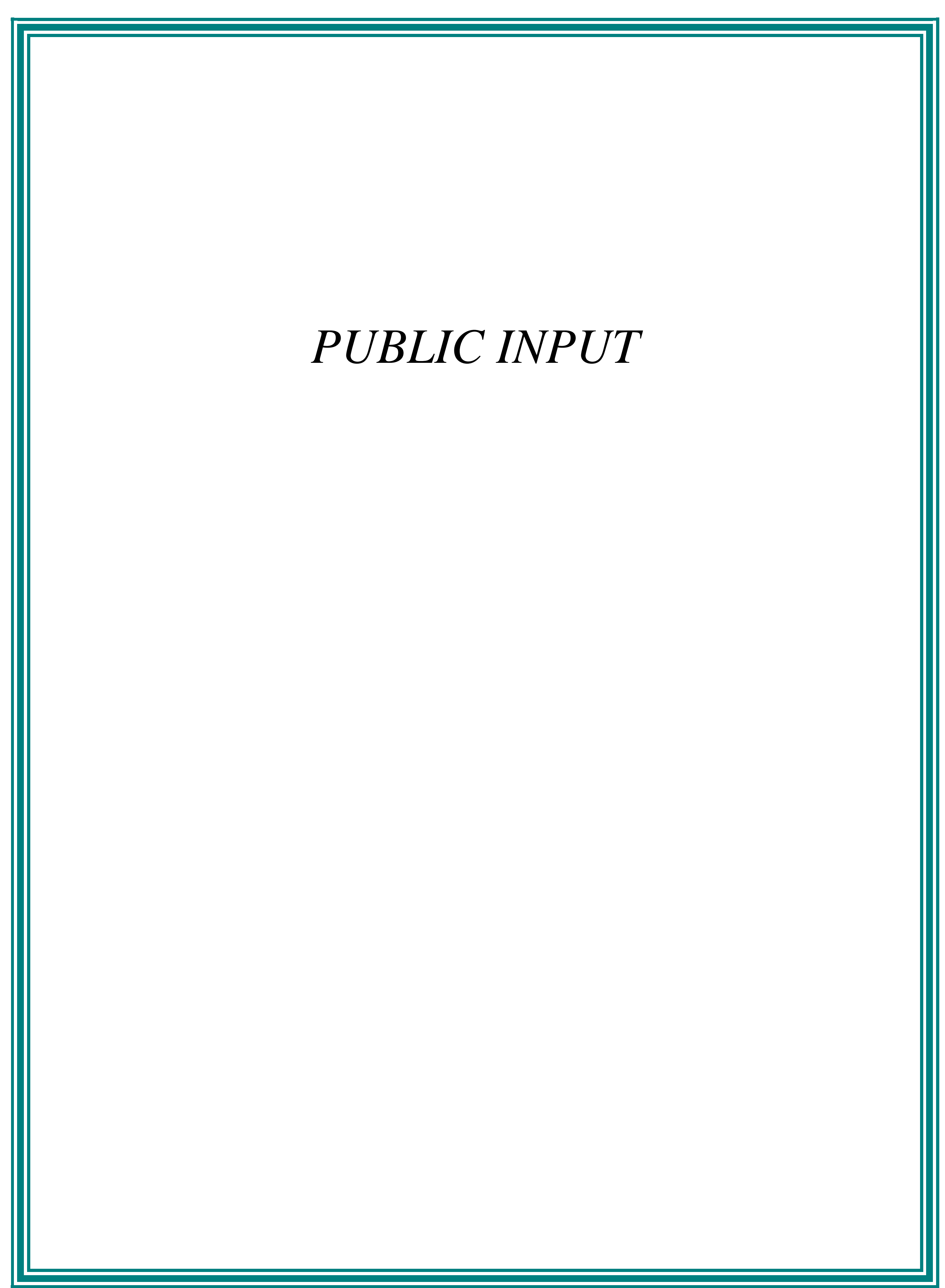
(VERBAL)

(LAURENT/GRAHAM)

REPORT FROM THE SALINAS VALLEY MEMORIAL HOSPITAL FOUNDATION

(VERBAL)

(DELGADO/WARDWELL)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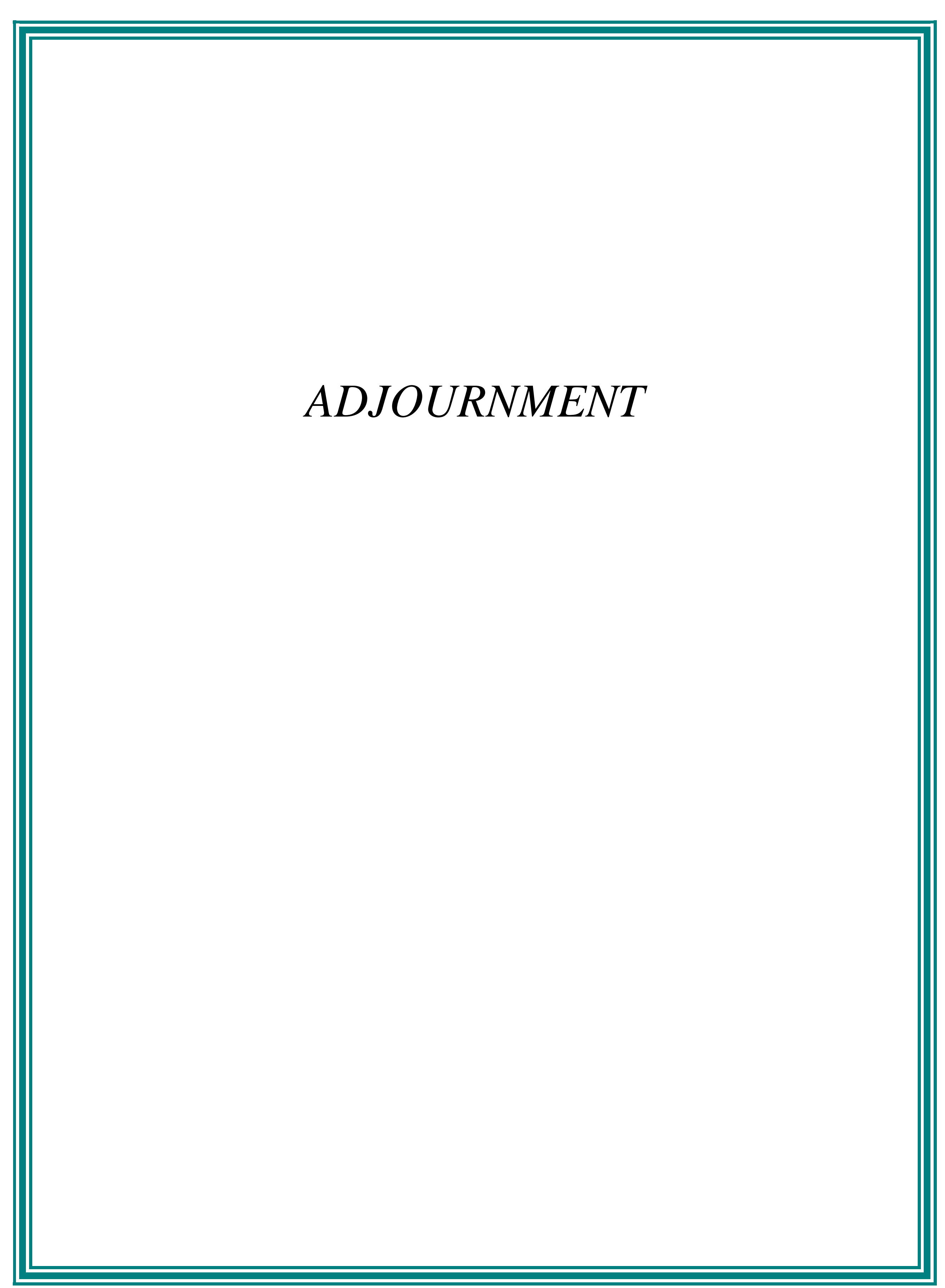
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