2017 Community Health Needs Assessment

Salinas Valley Memorial Healthcare System

Authors & Acknowledgments

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Actionable Insights, LLC, helps organizations discover and act on data-driven insights to achieve better outcomes.

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I. Executive Summary

Community Health Needs Assessment (CHNA) Background

In early 2017, Salinas Valley Memorial Healthcare System (SVMHS) conducted an extensive community health needs assessment (CHNA) to identify critical health needs of the community.

SVMHS's FY2016-17 CHNA meets the IRS CHNA requirements pursuant to the Patient Protection and Affordable Care Act of 2010 (ACA) (see IRS Checklist in Attachment 1). This CHNA report was adopted by SVMHS's Board on June 15, 2017. The CHNA process completed in 2017 and described in this report was conducted in compliance with current federal requirements. This assessment includes input from the community and experts in public health, clinical care, and others. This CHNA will also serve as the basis for implementation strategies that are required to be filed with the IRS as part of the hospital organization's Form 990, Schedule H.[1]

Summary of Prioritized Community Health Needs

SVMHS obtained community input during January and February 2017 via key informant interviews with local health experts and community leaders/ representatives, and through the review of an extensive 2015 survey of community residents. SVMHS obtained secondary data from a variety of sources; see Attachment 3 for a complete list.

Based on the community input and secondary data, SVMHS identified the following community health needs. These needs were prioritized by key informants and community survey respondents, and hospital representatives ranked each need further via a multiple-criteria system. The needs are listed below in priority order, from greatest to least.

- Diabetes & Obesity
- Access to & Delivery of Care
- Behavioral Health
- Violence & Preventable Injury
- Economic Security
- Cardiovascular Disease/Stroke

[1] For other abbreviations, see Glossary, Attachment 2.

- Cancers
- Maternal/Infant Health
- Oral Health
- Infectious Diseases

Summary of Needs Assessment Process & Methods

In February 2017, SVMHS identified community health needs by synthesizing community input and statistical data, and then filtering those needs against a set of criteria. Needs were then prioritized by key informants and via the results of a countywide community survey, and then ranked further by a group of hospital representatives using additional criteria. The results of the prioritization are included in the section of this report titled, "Identification & Prioritization of Community Health Needs."

Next Steps

After making this FY2016-17 CHNA report publicly available in 2017, our hospital will develop implementation plans based on this assessment.

II. Introduction/Background

About Our Hospital

Salinas Valley Memorial Healthcare System (SVMHS) is an integrated network of healthcare programs, services, and facilities that serve thousands of people throughout Monterey County each year. Opened in 1953, Salinas Valley Memorial Hospital, a public district hospital, is the cornerstone of SVMHS. Licensed for 263 beds, this acute care hospital features several specializations that enable people to get the advanced care they need without having to travel out of the area. The hospital employs more than 1,600 people and has a medical staff of 300 board-certified physicians across a range of specialties.

SVMHS also meets community healthcare needs in the following ways:

- Urgent care clinics: SVMHS serves as the 85% majority owner of 10 urgent care centers in Monterey and Santa Cruz counties, including Doctors on Duty, Salinas Urgent Care, Harden Urgent Care, and the student health center at California State University, Monterey Bay. SVMHS also has 20% ownership in three Pinnacle Urgent Care centers.
- Salinas Valley Medical Clinic (SVMC), a multi-specialty medical clinic staffed by physicians board-certified in cardiology, oncology, women's health, pulmonology, infectious disease, critical care, neurology, endocrinology, vascular, thoracic, orthopedic and general surgery. The SVMC model is dedicated to building a strong partnership with referring physicians and providing the highest quality of care to patients.
- Taylor Farms Family Health & Wellness Center in Gonzales, a primary care clinic that provides preventive care, wellness initiatives, and disease management programs.
- Outpatient care and diagnostic centers:
    - The Ryan Ranch Center for Advanced Diagnostic Imaging, which gives patients access to cardiology experts and top technologies for comprehensive cardiovascular diagnosis.
    - The Cardiovascular Diagnostic Outpatient Clinic in Salinas, which provides cardiac and vascular imaging and cardiac stress tests for patients with coronary artery disease, peripheral vascular disease, neurovascular disease, cardiomyopathy, congestive heart failure, and vascular disease, as well as those needing cardiovascular risk assessments and help with cardiovascular disease prevention.

- The Cardiac Wellness Center, which provides comprehensive cardiac care and wellness services for patients who have undergone a heart procedure. One of only 37 such programs in California certified by the American Association of Cardiovascular and Pulmonary Rehabilitation, this program includes medically supervised exercise, education, support, and encouragement in a safe, monitored setting.
- The Wound Healing Center, a physician-led, technologically advanced, outpatient center designed specifically for patients with chronic, non-healing wounds.
- The Cancer Resource Center, a program that provides patients, family members, and the public with information and resources related to cancer diagnosis, treatment, risk reduction, and emotional support. This program is available free of charge to the entire community and is not restricted to patients of SVMHS.
- The Nancy Ausonio Mammography Center, which provides breast cancer diagnostic and screening procedures.
- The Sleep Medicine Center, which provides diagnoses and therapies for people with sleep disorders such as insomnia, narcolepsy, sleep apnea, snoring, and restless leg syndrome.

- Partnerships and joint ventures:
  - Joint ownership of three entities designed to improve community health: Aspire Health Plan, Community Health Innovations (CHI), and Coastal Management Services. Aspire Health Plan offers a Medicare Advantage plan, which allows for top-rated hospital care, doctors, and drug benefits within a single plan. CHI supports the shifting focus of healthcare from treating the sick to keeping people healthy. Coastal Management Services provides administrative services, including claims processing. The partnership with Montage Health gives SVMHS a 49% stake in the three companies.
  - Central Coast Health Connect: A health information exchange in Monterey County offered in partnership with Community Hospital of the Monterey Peninsula and Natividad Medical Center; SVMHS has 50% ownership and governance.
  - Central Coast Visiting Nurse Association (VNA) & Hospice: SVMHS is a governing member of the VNA. This program provides home healthcare services and hospice for people living throughout Monterey and San

Benito counties as well as the southern portions of both Santa Cruz and Santa Clara counties.

- Joint venture with Stanford Children's Health in a Level III neonatal intensive care unit (NICU) and Perinatal Diagnostic Center. The NICU partnership allows SVMHS to care for critically ill babies onsite at Salinas Valley Memorial Hospital. Additionally, Salinas Valley Memorial's Perinatal Diagnostic Center, a partnership with Stanford Children's Health Lucile Packard Children's Hospital, is the first and only center in Monterey County specializing in high-risk pregnancies.
- Monterey Peninsula Surgery Centers (five locations): SVMHS is a 12% owner of these outpatient surgical centers, which partner with 200 top area surgeons to offer a wide variety of surgeries.
- Vantage Eye Surgery Center: SVMHS is a 20% owner of this Medicare-approved outpatient facility offering a wide range of services, including surgical procedures for the care of all ocular conditions.
- Salinas Valley Imaging: SVMHS is a 50% owner in magnetic resonance imaging (MRI) services.
- Brookdale at Harden Ranch: SVMHS owns 100% of the building and land at this assisted living residence, which serves memory care residents (those with Alzheimer's and dementia) as well as assisted living residents.

Community Health Needs Assessment (CHNA) Background/Purpose

In early 2017, SVMHS conducted an extensive community health needs assessment (CHNA) for the purpose of identifying critical health needs of the community. This FY2016-17 CHNA report was adopted by SVMHS's Board on June 15, 2017.

The FY2016-17 CHNA will also serve to assist SVMHS in meeting IRS CHNA requirements pursuant to the Patient Protection and Affordable Care Act of 2010 (ACA). The ACA, which was enacted on March 23, 2010, includes requirements for nonprofit hospitals that wish to maintain their tax-exempt status. Regulations finalized December 31, 2014, also provided guidance related to section 501(r) of the Internal Revenue Code. These regulations include a mandate for all nonprofit hospitals to conduct a CHNA and develop and adopt an implementation strategy (IS) every three years.[2] The CHNA must be conducted by the last day of a hospital's taxable year (which is June 30, 2017, for SVMHS).

[2] www.gpo.gov/fdsys/pkg/FR-2014-12-31/pdf/2014-30525.pdf.

The CHNA process completed in 2017 and described in this report was conducted in compliance with current federal requirements. The CHNA report must document how the assessment was done, including the community served, who was involved in the assessment, the process and methods used, and the significant community's health needs that were identified and prioritized as a result of the assessment. This assessment includes input from the community and experts in public health, clinical care, and others. This CHNA will serve as the basis for implementation strategies that are required to be filed with the IRS as part of the hospital organization's 2017 Form 990, Schedule H, four and a half months into the next taxable year (by November 15, 2017, for SVMHS).

The IRS definition of community health needs includes social determinants of health in addition to morbidity (quality of life) and mortality. This expansive definition of health needs reveals the broader lens being brought to bear on both upstream and downstream factors that contribute to health. Such an expanded view presents opportunities for healthcare organizations to look beyond the immediate issues to identify and take action on a larger set of influences on health, including social determinants of health.

III. Community Served

Definition of Community Served

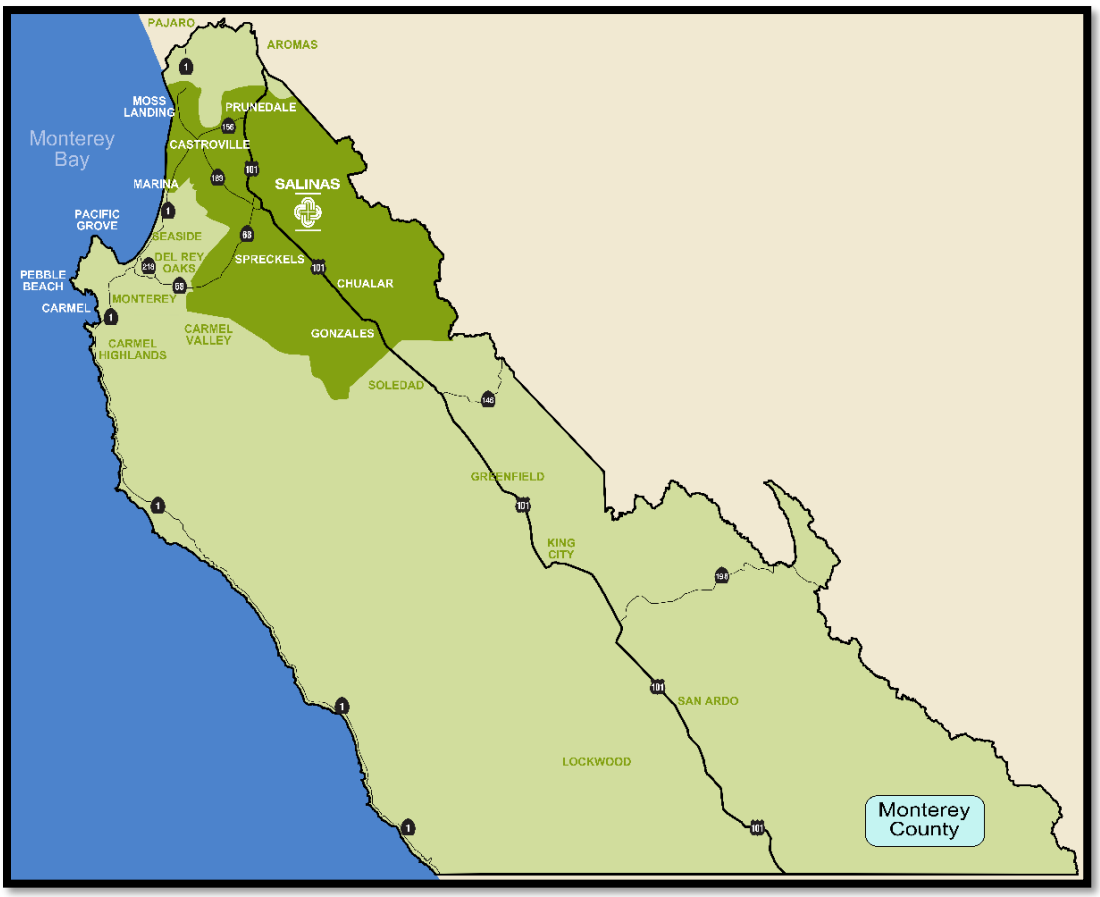
The vast majority (98%) of SVMHS hospital patients come from Monterey County. Thus, for purposes of its community benefit program, SVMHS identifies Monterey County as its target community.

Map & Description of Community Served

Monterey County, the community which SVMHS serves, includes (in order of population from greatest to least) the cities of Salinas, Seaside, Monterey, Soledad, Marina, Greenfield, Pacific Grove, King City, Gonzales, Carmel-by-the-Sea, Del Rey Oaks, Lockwood, and Sand City, as well as unincorporated areas and other census-designated places shown on the map on the next page.

Between 2000 and 2010, the population of Monterey County increased by 3.3%. The population of the county is 424,927. Adults aged 25-64 make up 51% of the population, and one in 10 residents (11%) are adults aged 65 and over. Children under 18 make up more than a quarter (27%) of the population, and youth 18-24 comprise 11%. The median age is 33.3 years.

Figure 1, Map of Community Served (Monterey County, California)



Source: Salinas Valley Memorial Healthcare System. Additional graphic design by Actionable Insights, LLC.

Table 1, Demographic Data

	Monterey County	California
Total Population	424,927	38,066,920
White	75.3%	62.1%
Asian	6.2%	13.5%
Black/African American	2.8%	5.9%
Native American/Alaskan Native	1.0%	0.8%
Pacific Islander/Native Hawaiian	0.5%	0.4%
Some Other Race	10.6%	12.9%
Multiple Races	3.7%	4.5%
Hispanic/Latino of Any Race	56.5%	38.2%

Source: U.S. Census Bureau, American Community Survey, 2010-2014.
Note: Percentages do not add up to 100% because, by U.S. Census Bureau definition, Hispanic/Latino is an ethnicity and not a race. Hispanic/Latino individuals may be of any race.

Regarding race/ethnicity, three quarters (75%) of the population in Monterey County are White, and more than half (56%) are of Hispanic/Latino ethnicity (see note beneath Table 1 regarding ethnicity and race). Black individuals make up less than 3% of the population, and about 6% of residents are Asian. Nearly 11% are of "some other race."

More than one in four residents (26%) has limited English proficiency,[3] and 15% live in linguistically isolated households.[4] All socioeconomic indicators are worse in Monterey County than in the state overall.

Table 2, Socioeconomic Data

	Monterey County	California
Medi-Cal Eligible Population (All)	40.1%	33.4%
No High School Diploma	28.8%	18.5%
Children in Poverty (<100% FPL)	25.6%	22.7%
Uninsured	20.9%	16.7%
Adults in Poverty (<100% FPL)	17.2%	16.4%
Unemployed	5.5%	5.3%

Sources: *Medi-Cal* statistics from California Department of Health Care Services (2016), September 2015 data. *Unemployment rate* from U.S. Department of Labor, Bureau of Labor Statistics, for October 2016. *Other statistics* from U.S. Census Bureau, American Community Survey, 2010-2014. Note: FPL = Federal Poverty Level.

IV. 2013 CHA Results & Impact

In 2013-14, SVMHS was involved in a community health assessment (CHA) performed by the Monterey County Health Department and the related Monterey County Community Health Improvement Plan (CHIP). Both the CHA[5] and the CHIP[6] were posted on the Monterey County Health Department's public website. As of the time of this 2017 CHNA report, no written comments had been received about the 2013 CHA (Zerounian, personal communication, June 1, 2017).

In 2013, SVMHS identified the health needs found in the list below.

[3] Speaks a language other than English at home and speaks English less than "very well."

[4] Households where no person 14 years old and over speaks only English, or in which no person 14 years old and over speaks a non-English language and speaks English "very well."

[5] http://www.co.monterey.ca.us/government/departments-a-h/health/general/accreditation/2013-monterey-county-community-health-assessment-cha

[6] http://www.co.monterey.ca.us/government/departments-a-h/health/general/accreditation/2014-2018-community-health-improvement-plan-for-monterey-county

Table 3, Monterey County 2013 Health Needs

Identified Health Need	Health Need Chosen by SVMHS
General health status:	
Heart disease (incl. mortality)	Yes
Cancer (incl. mortality)	Indirectly
Unintentional injuries/mortality	No
Communicable diseases	Indirectly
Health-related quality of life:	
Equitable access to health care	Yes
Determinants of health:	
Education	No
Poverty	Indirectly
Health disparities:	
Birth outcomes	Indirectly
Diabetes (incl. mortality)	Yes
Cancer screenings	Indirectly
Homicides	No

The three chosen needs plus Asthma reflect certain objectives identified for Monterey County in its 2014-2018 Community Health Improvement Plan (CHIP)[6] and also relate to the four broad areas or categories of need identified in Monterey County, namely, general health status, health-related quality of life and well-being, determinants of health, and disparities. The needs that were chosen "indirectly" are those that SVMHS has addressed through its access efforts. Asthma was chosen despite not being called out strongly in the 2013 CHA due to the focus on it in the 2014-18 CHIP.

For the 2017 CHNA, SVMHS built upon the 2013 CHA by delving more deeply into questions of healthcare access, delivery, barriers to care, and solutions. SVMHS also specifically strove to understand the impact of the full implementation of the Affordable Care Act on county residents' access to healthcare, including healthcare affordability.

FY2014-2016 Implemented Strategies

The 2013 CHA and the needs identified in it formed the foundation of SVMHS's implementation strategies for FY2014-16 (July 1, 2014 to June 30, 2017), which were initiated beginning in SVMHS's fiscal year 2014 (July 1, 2014 to June 30, 2015).

The IRS published its final regulations in December 2014. These regulations include a requirement that hospitals report on the impact of their implementation strategies. The

following section describes the evaluation of community benefit programs identified in SVMHS's implementation strategies. The information below represents the most currently available July 1, 2014 to May 31, 2017. Due to the requirement that this report be adopted and publicly posted by the end of the fiscal year, the FY 2017 data are necessarily incomplete.

FY14-16 Community Benefit Investments

In FY14-16, SVMHS invested its community benefit efforts in programs that benefit the large community, including health research, health education and training, serving vulnerable populations, charity care, and unreimbursed Medi-Cal and Medicare. These are essential services for those individuals in our communities who are in need. As part of SVMHS's support for its community partners and other community-based organizations, SVMHS also conducted a variety of activities for community members in FY14-16, which ranged from health insurance enrollment to fitness classes, health education/screenings, and student clinical rotations. The section below describes the extent of SVMHS's community benefit investments based on its FY14-16 implementation strategies and the results of those investments.

FY14-16 Evaluation Findings

A. Diabetes & Obesity.
Objective: Decrease obesity and diabetes.

Direct funding to community programs:

- Provided funding in 2014-15 to support programs at the Central Coast YMCA (physical activity), Victory Mission Inc. (nutritious food at homeless shelter), and the Food Bank of Monterey County (nutritious food).

In-kind donations:

- Food Addicts Anonymous – in-kind space donation
- Food Addicts in Recovery – Provide in-kind reservations, marketing, and space
- Monterey Bay Type 1 Diabetes Support Group – Provide in-kind reservations, marketing, and space

Collaboration:

- Collaborated with Community Hospital of the Monterey Peninsula (CHOMP) & Monterey County Health Department – Countywide diabetes prevention program
- Participated in Impact Monterey County Collaborative

- Participated in Community Health Fairs hosted by other groups – SVMHS provides staffing and educational materials with diabetes signs/symptoms, nutrition information, simple screenings (15-30 annually); 20,443visitors to booths over the past 3 years.
- Held Farmers' Market at SVMH – Open to the public, Service lines and education available, health recipes (seasonally, May-October); 18,188 visitors over the past 3 years.

SVMHS programs:

- Ask the Experts, includes diabetes screening and prevention materials (4x annually); 1,574 attendees over the past 3 years.
- Breast Feeding Made Easy (monthly); 279 attendees over the past 3 years.
- Breast Feeding Support Group (weekly); 283 attendees over the past 3 years.
- Exercise Challenge – 10-week program designed to encourage people to get regular aerobic exercise, open to all organizations in Monterey County (annually); 8,693 attendees over the past 3 years.
- Fresh Produce Rx – Provides Rx for fresh produce in collaboration with cardiac care, diabetes, and pre-diabetes; 2,304 participants over the past 3 years.
- From Eyes to Exercise and Food to Foot Care – Comprehensive diabetes series held in English and Spanish (monthly); 2,799 attendees over the past 3 years.
- Healthy Living: Mindful Eating (2x monthly); 88 participants over the past 3 years.
- Lactation Services (ongoing); 45 participants over the past 3 years.
- Maintain Don't Gain – 8-week program with a focus on cardiovascular exercise and healthy eating during the holidays (seasonally, Nov-Dec); 1,008 participants over the past 3 years.
- Mindful Meditation Stress Reduction (weekly); 522 participants over the past 3 years.
- Nutrition Classes – Varied topics, including Weigh Less, Portion Distortion, Controlling Cholesterol, All About Salt and Sodium (monthly); 169 attendees over the past 3 years.
- Nutrition Service for Cardiac Patients – DASH diet, label reading, weight management, etc.
- PiYo classes, blend of Pilates and yoga, 6 session series, ongoing; 655 participants over the past 3 years.
- Post-exercise education sessions at Cardiac Rehab.
- Qi-Gong: Gentle Movement for Wellness, weekly; 1,405 participants over the past 3 years.

- Step into Health – Focus on achieving a healthy lifestyle in 10,000 steps per day (seasonally, Sept-Oct); 97 participants over the past 3 years.
- Tai Chi Chin – 6 session series (ongoing); 447 participants over the past 3 years.
- Yoga Flow – 6 series sessions (ongoing); 2738 participants over the past 3 years.
- Screening Young People for Type 2 Diabetes – Screening in the community and providing appropriate treatment, either to prevent it when people are at pre-diabetes stage, or ensuring they have access to proper medication.

Sponsorships:

- Provided sponsorships in 2014-15 to Salinas Rotary "Pigs, Pinot & More" event (proceeds to the Salinas Police Athletic League and YMCA for youth fitness programming) and Gonzales Youth Softball (youth fitness programming).
- Provided sponsorships in 2014-15 and 2015-16 to the All-Star Soccer Classic (supporting fitness activities), Meals on Wheels of the Monterey Peninsula "Culinary Classique d'Elegance" event (proceeds to organization supporting nutritious food for home-bound low-income community members), Mission Park Jog-a-thon (community fitness opportunity), and Rancho Cielo Family Fun Day (fitness opportunity for families of justice-involved youth).
- Provided sponsorships in 2014-15, 2015-16, and 2016-17 to the United Way Monterey County (connecting community members with food assistance), Ciclovia Salinas (community bicycle race -- fitness opportunity), Boys & Girls Clubs of Monterey County events (offering fitness opportunities for youth & families), Salinas Valley Half Marathon (community marathon -- fitness opportunity), Monterey County Rape Crisis "Together with Love" Run/Walk (community fitness opportunity), CHISPA's Annual Celebration (organization provides fitness activities and health education to community members), and American Cancer Society, Inc. - Relay for Life of Salinas (community race – fitness opportunity).
- Provided sponsorships in 2014-15 and 2016-17 to JDRF One Walk (community fitness opportunity, supports diabetes research).
- Provided sponsorships in 2015-16 for The First Tee Monterey County, Boots, BBQ, Bottles & Band event (organization supports youth fitness programming) and Hartnell College "SIMA Club" 5k Walk/Run & Family Day (community fitness opportunity, supports club which provides assistance and networking opportunities for community college students interested in medicine and other related careers).
- Provided sponsorships in 2015-16 and 2016-17 to the YMCA (youth fitness programming).
- Provided sponsorships in 2016-17 to the Future Citizens Foundation Boots, Bottles & BBQ event (organization supports youth fitness programming), Salinas

Rotary "Pigs, Pinot & More" event (proceeds to Dorothy's Place for nutritious meals for the homeless), Tatum's Garden Foundation (provided accessible playground for disabled children to be active), Santa Lucia Rotary Foundation event (proceeds to Parks Foundation to support recreational resources, programs and facilities available to the community through the Monterey County Parks system), and The Carmel Foundation Annual Gala event (proceeds to offset expense of nutritious meals for community seniors).

Overall outcomes (see Attachment 7 for data):

According to the most recent CDC data (2013), 37.7% of Monterey County adults are overweight, compared to 35.8% of adults in the state overall. The CDC data also shows that 22.1% of Monterey County adults are obese, virtually the same proportion as the state (22.4%).

According to the most recent CDC data (2013), adult diabetes prevalence in the county was 7.5%, which is lower than the state measure (8.3%).

Recent CA DOE data (2013-14) put Monterey County youth obesity at 24.5% (compared to 19% for the state) and youth overweight at 22.4% (compared to 19.3% for the state).

B. Heart Disease.
Objective: Decrease heart disease.

In addition to all the items supporting Obesity, above:

In-kind donations:

- American Heart Association Heartsaver CPR and AED courses – provide in-kind reservations, marketing and space to AHA

Collaboration:

- Participate in Community Health Fairs hosted by other groups – SVMHS provides staffing and educational materials with CVD and stroke, simple screenings (15-30 annually); 20,443 visitors to booth over the past 3 years.
- Participated in Impact Monterey County Collaborative

SVMHS programs:

- Ask the Experts, includes heart health screening and heart disease prevention materials (1x annually); 451 attendees over the past 3 years.

- CPR Awareness – free public program (annually); 60 attendees over the past 3 years.
- Heart Series – Acute MI/Heart and Stroke Risk Factors education program.
- Mended Hearts – Heart patient visitor program.
- Mended Hearts – Meeting series on heart related topics and peer support (monthly); 850 participants over the past 3 years.
- Nutrition Service for Cardiac Patients – DASH diet, label reading, weight management, etc.
- Post-exercise education sessions at Cardiac Rehab.

Sponsorships:

- Provided sponsorships in 2014-15, 2015-16, and 2016-17 to the American Heart Association and American Stroke Association (supporting research to address factors leading to heart disease and stroke).
- Provided sponsorship in 2015-16 to Cholesterol, Genetics & Heart Disease Institute's Firefighter Heart Disease Prevention event.

Overall outcomes (see Attachment 7 for data):

The heart disease mortality rate, based on the latest CA DPH data (2010-12), is 129.4 for Monterey County. This is better than the state rate (163.2) but worse than the Healthy People 2020 target of 100.8.

C. Asthma.
Objective: Decrease asthma.

Collaboration:

- Participate in Community Health Fairs hosted by other groups – SVMHS provides staffing and educational materials with simple screenings (15-30 annually); 20,443 visitors to booth over the past 3 years.
- Participated in Impact Monterey County Collaborative

SVMHS program:

- Asthma Camp; 96 attendees over the past 3 years.

Overall outcomes (see Attachment 7 for data):

The percentage of adults with asthma, based on the latest BRFSS data (2011-12), is 13.7% for Monterey County. This is better than the state percentage (14.2%).

The asthma hospitalization rate is 7.1 in Monterey County, lower than the state rate of 8.9 (OSHPD 2011).

The air quality in Monterey County is better than the state overall, with the percentage of days with particulate matter over 2.5 at 0% in the county compared to 0.5% in the state (CDC 2012).

D. Healthcare Access & Delivery.
1. Objective: Increase affordable health screening.

In-kind donations:

- Provided in-kind services in 2014-15 to Sun Street Centers (TB screenings to residents of community drug and alcohol recovery centers).

Collaboration:

- Participate in Community Health Fairs hosted by other groups – SVMHS provides staffing and educational materials with simple screenings (15-30 annually); 20,443 visitors to booth over the past 3 years.

SVMHS programs:

- Ask the Experts Programming – free, community wide programming with access to physicians, simple screenings, health service lines and support services (4 times per year, one Bilingual, translation services available at all); 1145 attendees over the past 3 years.
- Sleep Center – sleep screening program.

Sponsorships:

- Provided sponsorships in 2014-15 for the Visiting Nurse Association events (organization provides screenings, immunizations, and other health services to community members) and Monterey County Stand Down (health screenings and enrollment in services for homeless veterans).
- Provided sponsorships in 2015-16 to Salinas Rotary events (proceeds to the Chinatown Health Services Center for community health services access).
- Provided sponsorships in 2016-17 to ACTION Council for Monterey County's Labor of Love Pregnancy Health Fair (health screenings for pregnant community members) and Salinas Rotary "Pigs, Pinot & More" event (proceeds to Dorothy's Place for homeless health center).

2. Objective: Increase access to health care.

In-kind donations:

- American Heart Association First Aid class – provide reservation, marketing and space
- Multiple Sclerosis Support group – provide reservations, marketing and space
- Loss and Grief Support group - – provide reservations, marketing and space

Collaboration:

- Participate in Community Health Fairs hosted by other groups – SVMHS provides staffing and educational materials with MedAssist information (15-30 annually); 2,418 individuals enrolled over the past 3 years.

SVMHS programs:

- Flu Clinics – free, County wide flu clinics, 3 times annually, in Salinas and Gonzales clinic; 2,063 flu shots provided over the past 3 years.
- Philips Lifeline program – A patient support program that allows people to live independently longer (falls prevention and medication allocation are additional options).
- SVMHS App – medication tracking, physician information, management of symptoms, goals.
- Taxi Voucher program.
- Tele-care – a welfare check services provided to those who subscribe (consists of daily calls as requested).
- Wellness at Work– worksite wellness programming for SVMHS and community at large, ongoing; 8,646 community worksites participating over the past 3 years.

Sponsorships:

- Provided sponsorship in 2014-15 for Monterey County Stand Down (health screenings and enrollment in services for homeless veterans).
- Provided sponsorships in 2014-15 and 2015-16 for Aspirenet Cherish Receiving Center event (organization assists in ACA enrollment).

3. Objective: Increase access to culturally appropriate health education and care.

Direct funding to community programs:

- Provided substantial funding to support the Hartnell College Nursing Program.

In-kind donations:

- Alzheimer's Association – various topics monthly. We provide registration, marketing and space.

Collaboration:

- Collaboration with Community Colleges for clinical rotations, internships and externships.
- Collaboration with CSUMB, Service Learning Program.

SVMHS programs:

- Internships available – Phlebotomy, Sterile Surgical Processing, Nursing, Physical/Occupational Therapy, Radiology Tech, Clinical Lab Scientist.
- Scholarships to students seeking clinical roles or allied health roles, $40,000 annually.
- Speakers Forum – variety of speaker topics available to the community via education platform.

Sponsorships:

- Provided sponsorships in 2014-15, 2015-16, and 2016-17 to North Salinas High School's Chapter of Health Occupation Students of America (HOSA) (organization provides opportunities for knowledge, skill and leadership development of health science education students) and CHISPA's Annual Celebration (organization provides fitness activities and health education to community members, including culturally/linguistically competent health education).
- Provided sponsorship in 2014-15 for Center for Community Advocacy events (organization supports low-income neighborhoods in improving health conditions, including culturally appropriate peer health education).
- Provided sponsorships in 2015-16 to Hartnell College "SIMA Club" 5k Walk/Run & Family Day (supports club which provides assistance and networking opportunities for community college students interested in medicine and other related careers), CSUMB - National Minority Health Month Celebration event (offering speaker series about health equity), and Adelante Con Orgullo Mujer Inmigrante event (women's health conference for Spanish-speaking immigrant farmworker and service industry individuals).
- Provided sponsorship in 2016-17 to LULAC - Salinas Council event (promotes health for Latino community members).

Overall Outcomes (see Attachment 7 for data):

Monterey County's statistics on access are generally worse than the state:

There are only 61.8 physicians per 100,000 residents in the county compared to 75.8 per 100,000 in the state (US DHHS 2013). Over half (53.4%) of county residents live in a Primary Care Health Professional Shortage Area compared to state residents (33.1%) (US DHHS 2016).

Over 22% of county residents lack a consistent source of primary care compared to 14.3% in the state (CHIS 2011-12).

A greater percentage of county residents are uninsured (20.9%) compared to state residents (14.2%) (US Census ACS 2010-14).

V. Who Was Involved in the 2017 Assessment

Assessment Team

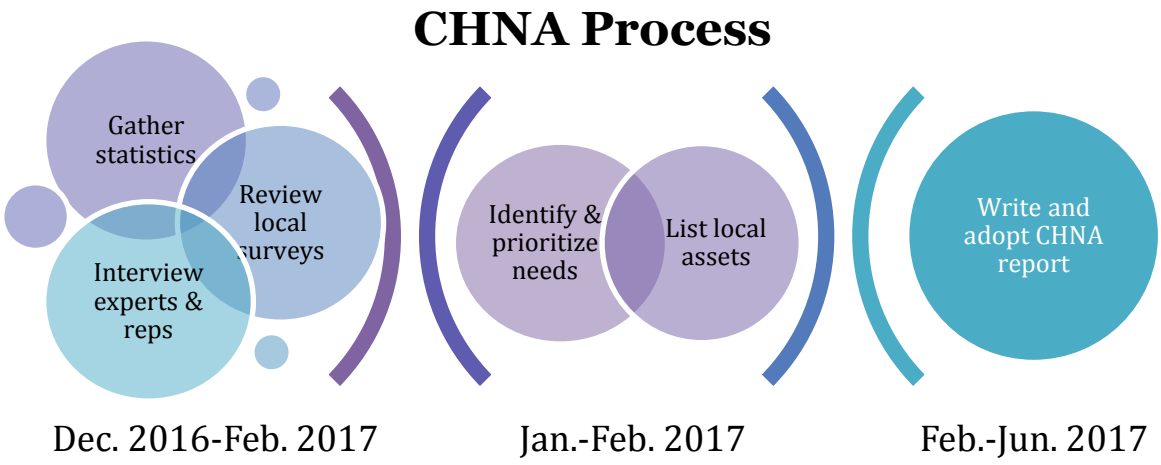
SVMHS worked on its own to conduct the CHNA, with the assistance of its consultants.

Identity & Qualifications of Consultants

SVMHS commissioned Actionable Insights, LLC, to assist with the assessment. The Actionable Insights team collected secondary data, conducted primary research, synthesized primary and secondary data to generate a final community health needs list, assisted with the hospital's prioritization of the community health needs, and documented the process and findings in this report.

Actionable Insights is a consulting firm that helps organizations discover and act on data-driven insights to achieve better outcomes. Melanie Espino and Jennifer van Stelle, Ph.D., the co-founders and principals of Actionable Insights, have extensive experience

Figure 2, Community Health Needs Assessment Process



Source: Actionable Insights, LLC.

conducting CHNAs for many organizations in the greater San Francisco Bay Area and providing expertise on implementation strategy development and IRS reporting for nonprofit and locally-governed hospitals. Their work assists organizations in understanding how social and economic issues in a community are intertwined with community health needs. Actionable Insights also helps healthcare organizations meet IRS mandates, identify evidence-based and promising approaches to addressing community health needs, and prepare for monitoring and evaluation activities.

VI. Process & Methods Used to Conduct the 2017 CHNA

In fiscal year 2017, SVMHS identified community health needs in a process that met the IRS requirements of the CHNA, by identifying health conditions, and secondarily the drivers of those conditions (including healthcare access), via both statistical data and community input. With regard to the latter, SVMHS asked experts and community representatives about the community needs they thought were most important and pressing in the community, asked about drivers of and barriers to the health needs that these experts and representatives had named as a priority, and asked for their solutions to these important, prioritized health needs. SVMHS also specifically attempted to understand how the implementation of the ACA impacted community members' access to healthcare. Finally, SVMHS reviewed the results of a county-wide survey to understand the community's health concerns and priorities.

The CHNA data collection process took place over three months and culminated in a written CHNA report in June of 2017.

Secondary Statistical Data Collection

Sources of Secondary Statistical Data Used in the Assessment

Actionable Insights collected secondary statistical data on Monterey County from the Community Commons data platform, a publicly available source that includes a compilation of over 150 health need indicators.[7] The Community Commons data served as the foundation for SVMHS's statistical data gathering on community health.

In addition, Actionable Insights collected secondary statistical data from the Monterey County Health Department. Data from the California Department of Public Health (epiCenter) and other online sources were also collected. Details about specific sources and dates of the data used may be found in Attachment 3.

Methodology for Collection, Interpretation, & Analysis of Secondary Data

Actionable Insights used a Microsoft Excel spreadsheet to list indicator data. As described, data were collected primarily through the Community Commons data platform and other statistical sources. (See Attachment 4 for a list of indicators on which data were gathered.) Actionable Insights generally retained the health need categories used in the Community Commons data platform spreadsheet (rubric) and integrated data indicators from other sources into the spreadsheet/rubric.

Specifically related to secondary statistical data, SVMHS requested that Actionable Insights examine the following:

- How do the data perform compared to Healthy People 2020 (HP 2020) aspirational goals[8] or against California state rates or percentages?
- Are there disparities in outcomes and/or conditions for people in the Monterey County community?

[7] www.communitycommons.org/groups/community-health-needs-assessment-chna.

[8] Healthy People is an initiative of the U.S. Department of Health and Human Services. For nearly 40 years, it has proffered 10-year national aspirational goals for improving the health of Americans based on existing scientific data. These goals are for the improvement of national health. The most recent set of objectives, for the year 2020 (HP 2020), were updated in December 2014 to reflect the most accurate population data available (www.healthypeople.gov).

Actionable Insights compiled all the Monterey County data indicators and compared them with existing benchmarks (either HP 2020 aspirational goals or statewide averages, whichever was more stringent) in order to evaluate how the indicators performed against these benchmarks. Indicator data were reviewed by gender, age groups, race/ethnicity, and/or geographies when available in order to discover any disparities in outcomes and conditions for people in the community.

Actionable Insights presented these data and its analysis of which indicators failed the benchmarks to SVMHS. SVMHS decided to retain on the list of significant health needs those needs for which at least one "core" data indicator performed poorly against a benchmark, and/or those that half or more of the key informants identified as a health need, and/or those that more than 20% of the adults or youth community members surveyed identified as being of priority to them.[9] More specifically, the core indicator must have been more than 5% (not five percentage points, but 5%) worse than its comparable benchmark. As per Community Commons (2017), "Core indicators are indicators that directly relate to a health outcome of the potential health need. Related indicators [i.e., not 'core'] are indicators that are upstream 'drivers' to the potential health need."

Community Input (Primary & Secondary)

Description of Community Input Process

SVMHS contracted with Actionable Insights to conduct primary research. The Actionable Insights team collected community input via key informant interviews with health experts and other community representatives. In addition, Actionable Insights also reviewed the findings of the 2015 community surveys gathered and shared by the United Way of Monterey County[10] (Impact Monterey County Community Assessment 2015).

Community Input Gathered via Key Informant Interviews

Actionable Insights consulted with six individuals who had the broad knowledge, information, and expertise considered most pertinent to the health needs of the

[9] Note that despite this rubric, there was in fact no case in which a health need identified by half or more of the key informants and/or more than 20% of surveyed community members that did not also have at least one core indicator that performed poorly against a benchmark. The response of "chronic disease" was classified for the purposes of the CHNA as obesity & diabetes and cardiovascular disease/stroke, rather than separated out as its own health need.

[10] http://www.unitedwaymcca.org/yourvoicecounts.

community. These representatives are experts in the health field (i.e., the representative of the county's public health agency) as well as community leaders, representatives, and/or members of medically underserved, low-income, and minority populations. See the list on the next page, including titles and expertise as well as the date each was interviewed. Also, see Attachment 5 for the interview protocol used with the key informants.

Table 3, Details of Key Informant Interviews

Agency	Title	Expertise	Population Representation	Date
County of Monterey Health Department	Director of Health	Public health	1, 2, 3	1/30/2017
Monterey County Office of Education	Assistant Superintendent	K-12 education	1, 2, 3	2/24/2017
Central Coast YMCA	President and CEO	Healthy living	2, 3	1/19/2017
Community Housing Improvement Systems and Planning Association, Inc. (CHISPA)	President and CEO	Affordable homes and healthy neighborhoods	1, 2, 3	1/12/2017
Community Human Services	Senior Program Manager	Behavioral health	1	1/19/2017
United Way of Monterey County	President and CEO	Family financial stability for low-income population	1, 2, 3	1/13/2017

Source: Actionable Insights, LLC.
Note: Population representation is 1 = medically underserved, 2 = low-income, 3 = minority.

Actionable Insights interviewed these experts and community leaders/ representatives by telephone for approximately one hour each during January and February 2017. Key informants were asked to identify the most urgent needs of those they serve, including specific groups or geographies that may have greater or special needs; how healthcare access has changed in the past 10 years; other barriers or drivers to health in their community; and their suggestions to address the health needs they identified, including the use of existing resources.

Community Input Gathered via Impact Monterey County (IMC) Survey Reports

Impact Monterey County (IMC) is a collaborative consisting of local nonprofits, public agencies, businesses, and community members that work together "to identify the most

effective ways to improve life" in Monterey County.[11] IMC and local researchers at California State University Monterey Bay's (CSUMB) Institute for Community Collaborative Studies worked together to develop and implement countywide surveys of residents in support of IMC's Monterey County Community Assessment. The surveys covered residents' concerns and aspirations about education, economic self-sufficiency, and health.

Both adults and youth were surveyed. The adult surveys, in English and Spanish, were gathered between July and October 2014 using both online and paper administration. Over 4,200 adult surveys were collected, although only about 7% were from Spanish-speakers. A total of over 2,900 youth surveys (all in English) were gathered from 11th graders between January and March 2015 via paper administration, with the assistance of the Monterey County Office of Education and the superintendents of the local school districts. Further information on the surveys, CSUMB's methods, the community samples, and the findings may be found at the Impact Monterey County website.[11]

Actionable Insights reviewed the findings of the 2015 IMC surveys in both the adult and the youth reports[10] to better access community insight into health needs and to better understand community concerns.

In all, Actionable Insights consulted with six key informants via individual interviews and included in its data synthesis input gathered from over 7,000 Monterey County community members via the 2015 IMC surveys.

Methodology for Collection & Interpretation of Community Input

With regard to the key informant interviews, each was recorded for internal use only with permission from the interviewees and summarized as a stand-alone data source. When all interviews had been conducted, Actionable Insights used qualitative research software tools[12] to analyze the information and tabulate all of the health needs that were identified by the key informants as important and pressing to the community. The key informant interview findings were combined with the input gathered through the IMC survey reports to determine the community's health needs. This combined articulation was used in part to assess community health priorities.

[11] www.impactmontereycounty.org.

[12] Dedoose Version 7.0.23, web application for managing, analyzing, and presenting qualitative and mixed method research data (2016). Los Angeles, CA: SocioCultural Research Consultants, LLC (www.dedoose.com).

Data Limitations & Information Gaps

Despite the substantial amount of secondary statistical and survey data considered, SVMHS was still limited in its ability to assess some of the identified community health needs due to a lack of data. There were also constraints on how SVMHS was able to understand the needs of special populations, including the undocumented, the LGBTQ population, and monolingual speakers of indigenous languages. Due to the small numbers of these community members, many data are statistically unstable and do not lend themselves to predictability.

Quantitative data about the community were particularly scarce for the following issues:

- Bullying
- Dental health (particularly dental caries)
- Expenditures on alcohol, tobacco, fruits/vegetables, and sugar-sweetened drinks
- Elder health
- Human trafficking
- School breakfast programs
- Sexual behaviors
- Substance use (particularly, the use of illegal drugs and the misuse of opioids and other prescription medication)
- Those classified (or classifying themselves) as "Some Other Race"
- Use of e-cigarettes and related behaviors such as vaping

VII. Identification & Prioritization of Community Health Needs

Criteria & Methods Used to Identify Community Health Needs

To develop the list of community health needs, Actionable Insights synthesized the statistical secondary data with the community input from the key informants and the findings of 2015 IMC community surveys. To be identified as a significant community health need, all three of the following criteria needed to be met:

1. The definition of a "health need" must apply: The issue must be a poor health outcome and its associated health driver, or must be a health driver associated

with a poor health outcome where the outcome itself has not yet arisen as a need.

2. At least one core indicator (see prior definition) performs poorly against the state average or the HP 2020 aspirational goal (if available), whichever is more stringent. Note that the local value must be more than 5% worse than the benchmark – not five percentage points, but 5% – in order to be consider to have performed poorly against the benchmark.
3. The need must be identified as most important or pressing to the community by 50% or more of the key informants, or as a significant community health problem by more than 20% of the adults or youth community members surveyed by IMC.

A total of 10 health needs (some are health conditions, and others are social determinants of health) fit all three criteria and were thus identified as community health needs. The list of needs, in priority order, is found on the next page.

Process & Criteria Used for Prioritization of Health Needs

SVMHS met to discuss the health needs and their impact on the community. Before beginning the prioritization process, SVMHS chose a set of criteria to use in prioritizing the list of health needs. The criteria were:

- **Magnitude/scale of the problem:** Rated based on the extent to which the health need affects a large number of people within the community.
- **Severity of the problem:** Rated based on how severe the need is (such as its potential to cause death or disability) and its degree of poor performance against the relevant benchmark(s).
- **Clear disparities or inequities exist:** Rated based on whether the health need disproportionately impacts the health status of one or more vulnerable population groups. Subgroups may be based on geography, languages, ethnicity, culture, citizenship status, economic status, sexual orientation, age, gender, or others.
- **Community priority:** The community prioritizes the health need over other health needs. Actionable Insights rated this criterion based on the frequency with which the key informants expressed strong concern about each health outcome during CHNA primary data collection, and the level of concern indicated by respondents to the IMC surveys.

Scoring Criteria 1-3: The score levels for the prioritization criteria were:

3: Criterion fits well and indicates an important problem.
2: Criterion applies but the issue is less of a problem than that rated "3."
1: The criterion does not apply and/or the problem is not important.

Actionable Insights created a worksheet listing each of the health needs in alphabetical order and offering the three prioritization criteria for rating. SVMHS representatives rated each of the health needs on each of the three prioritization criteria during an in-person meeting in February 2017. Actionable Insights assigned ratings to the fourth criterion based on the percentage of key informants and IMC survey respondents who prioritized the health need.

Combining the Scores: For each of the first three criteria, group members' ratings were combined and averaged to obtain a combined score. Then, the mean was calculated based on the four criteria scores for an overall prioritization score for each health need.

List of Prioritized Needs: The prioritization scores for each health need ranged between 1.00 and 3.00 on a scale of 1-3, with 1 being the lowest priority possible and 3 being the highest priority possible. The health needs are rank-ordered by prioritization score in the table below. The specific scores for each of the four criteria used to generate the overall community health needs prioritization scores may be found in Attachment 6.

Table 4, Ranked List of Prioritized Community Health Needs

Rank	Health Need	Overall Average Priority Score
1	Diabetes & Obesity	2.94
2	Access & Delivery	2.88
3	Behavioral Health	2.84
4	Violence & Preventable Injury	2.78
5	Economic Security	2.69
6	Cardiovascular Disease/Stroke	2.50
7	Cancers	2.00
8	Maternal/Infant Health	1.97
9	Oral Health	1.78
10	Infectious Diseases	1.41

Source: Actionable Insights, LLC.

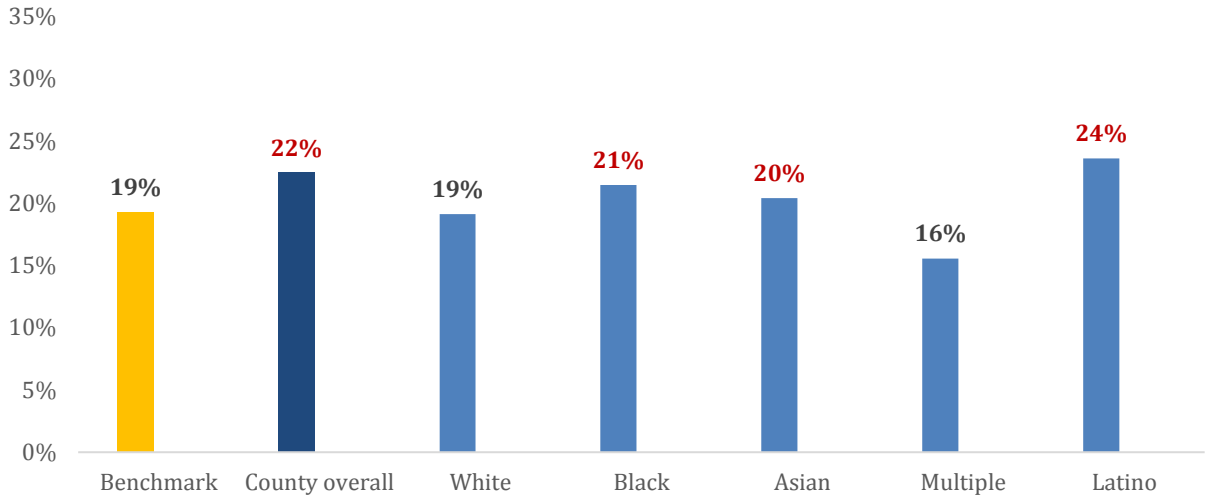
Prioritized Descriptions of All Community Health Needs Identified Through the CHNA

Each identified community health need is summarized below, in community priority order. Specific quantitative data for each of these health needs may be found in Attachment 7.

Diabetes & Obesity

Diabetes and obesity are a combined health need in the community. The core indicators of adult overweight, youth overweight, and youth obesity are all worse than their comparable state benchmarks, while diabetes prevalence is at the same level in the county as in the state. The overweight statistic is worst for Latino youth in the county. A related indicator, youth physical inactivity, is at the same level in the county as in the state, but is much worse for Latino and Black county youth.

Figure 3, Youth Overweight, by Ethnicity



Source: California Department of Education, FITNESSGRAM® Physical Fitness Testing. 2013-14.

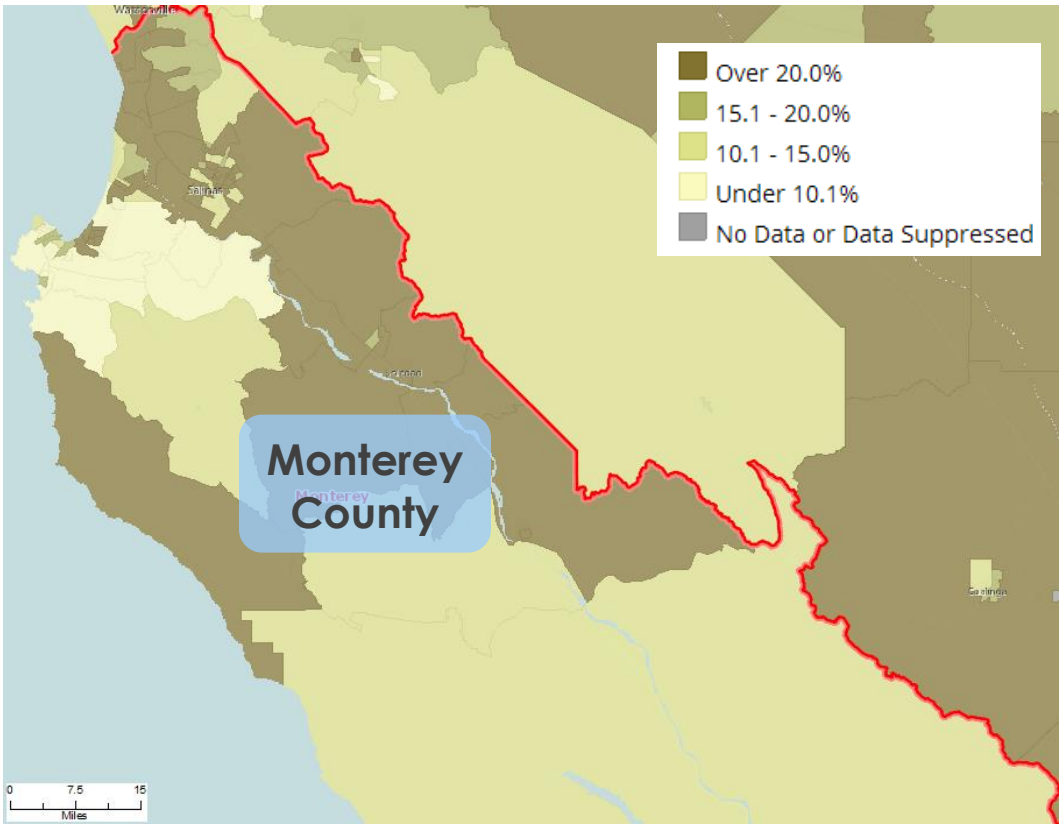
Both key informants and surveyed county residents expressed extreme concern about the levels of diabetes and obesity in the county. Key informants noted that the trends are particularly high among youth, and in fact nearly one in four community youth surveyed cited obesity/overweight as a serious health concern facing their generation. Several key informants were concerned that the food served in schools is not particularly healthy. Over half of adult community residents surveyed said that obesity, overweight, and lack of exercise are significant health problems facing their community, while another third expressed concern over diabetes and lack of nutritious food. Key informants suggested nutrition/exercise education, but some stated that language and cultural competence could be hampering efforts at educating the community about healthy lifestyles.

Additionally, key informants expressed specific concerns about the lack of safe neighborhoods in which to walk/exercise and the lack of fresh produce and nutritious food in certain areas of the county. One mentioned a "reliance on fast food as a dietary staple." Others noted how cheap less-healthy food is in comparison to healthier food, with one saying, "Meat is more affordable than a bag of lettuce."

Access to & Delivery of Care

Access to and delivery of healthcare is a need in the county due to poor rates of general health and lower access to primary care physicians compared to California overall. Related access and delivery indicators that suggest this as a significant health need include the proportion of the uninsured population and the proportion of the population in Health Professional Shortage Areas for primary care (particularly in the east-central part of the county), both of which fail against statewide benchmarks. The Latino population has the highest uninsured rates, while the Black population has the highest disability rates, both suggesting greater access issues than in the county population overall.

Figure 4, Uninsured Population, Percent by Census Tract



Source: Map, Community Commons 2017; data, U.S. Census Bureau, American Community Survey, 2010-14.

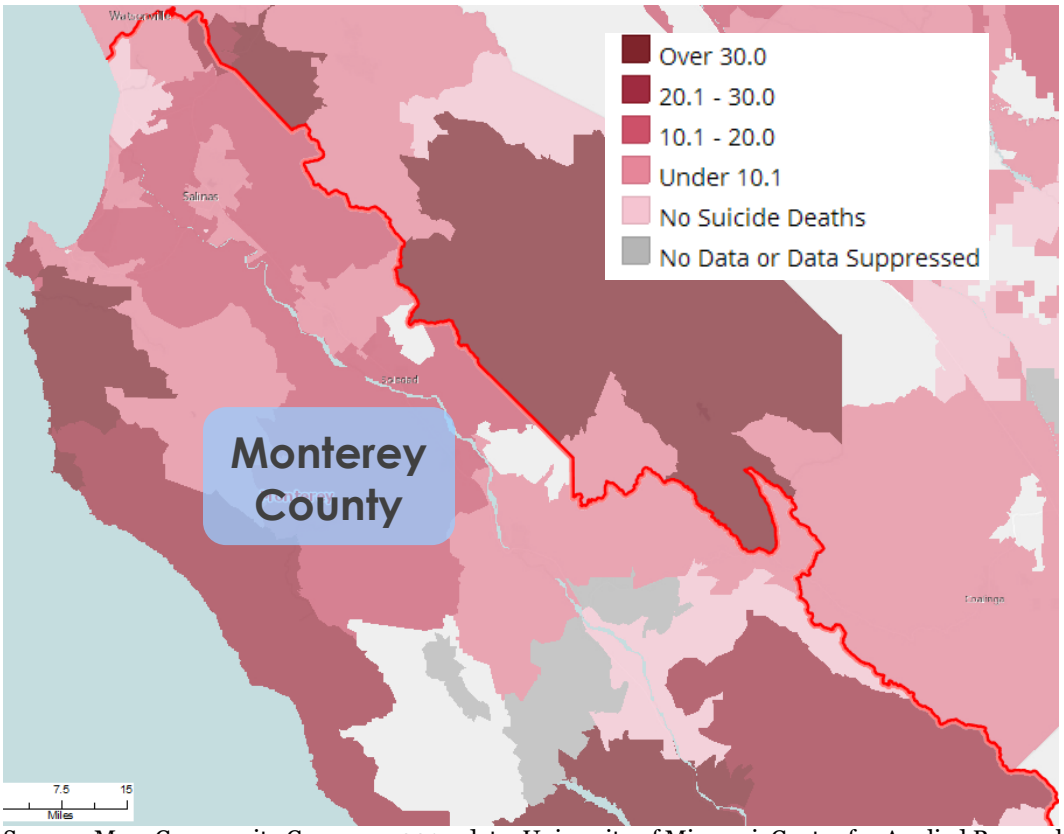
Key informants and surveyed county residents expressed concerns over the affordability of healthcare and health insurance, including the cost of prescription medications and the lack of access to insurance among the undocumented. Both groups identified issues around the inadequate supply of providers countywide (general practitioners and/or specialty practitioners), particularly those who accept Covered California and other "lower-tier" insurances. One key informant also suggested the issue of wait times and hours of availability, noting that expansion of standard clinic hours would help many families who cannot attend an appointment during existing clinic hours. Key informants mentioned issues of transportation from rural areas to the nearest clinics, especially for low-income families, and suggested mobile clinics. Respondents expressed concerns about the lack of medical screenings, particularly for youth. Key informants seemed especially concerned about the experiences of undocumented residents that make them most vulnerable to delivery and access issues, including lack of insurance, not speaking one of the common languages in the area, and having trust issues in coming to a healthcare facility due to fears about deportation. Cultural competence arose as an issue from key informants. Both groups expressed concern about inadequate health/ prevention educational offerings and how few offerings of adequate models of such education are available in the area. These offerings would include education about basic health services (medical, dental, vision, behavioral), sex education, nutrition education, and overall health literacy (including a basic understanding of the health system itself).

Behavioral Health

Behavioral health (both substance use and mental health, including mild to moderate mental health issues) is a need in the county as reflected by a variety of core indicators that fail against benchmarks. These include a higher average number of poor mental health days per month and lower access to mental healthcare providers compared to California overall. Other core indicators include the higher rate of non-fatal emergency department visits for substance abuse compared to California overall, and the higher rate of drug-induced mortality compared to the HP 2020 aspirational goal. While the suicide mortality rate is not worse in the county than the state, there are clearly geographic disparities – including the south and central coast portions of the county – that bear further investigation. Similarly, while the related indicator of the proportion of county residents who report needing mental healthcare is lower than the proportion of state residents, it is vastly higher for the small Black population in the county.

Key informants and surveyed county residents alike expressed concern about substance use in the county. Key informants mentioned Salinas as a hub for drug distribution and gang connections with related cartels. Surveyed county residents focused on youth smoking and alcohol abuse, as well as the abuse of legal and illegal

Figure 5, Age-Adjusted Suicide Mortality Rate, by Zip Code



Source: Map, Community Commons 2017; data, University of Missouri, Center for Applied Research and Environmental Systems and California Department of Public Health (CDPH) - Death Public Use Data. 2010-12. Rate per 100,000 population.

drugs generally. Key informants mentioned these (alcohol and over the counter drug abuse) as well as specifically identifying addiction to opioids, heroin, and methamphetamine as of major concern in the community. Key informants expressed that addiction issues cross class/income boundaries and are a community-wide problem. Surveyed county residents and key informants alike reported concern about the limited availability of substance disorder services. One key informant in particular noted the stigma associated by the community with harm-reduction efforts such as needle exchange programs (NEPs), which have been proven effective elsewhere.[13] Key informants made the connection between drug and alcohol use and self-medication as a coping strategy for other issues.

[13] See, for example, Hurley et al.'s 1997 meta-analysis of NEPs in 81 U.S. cities in *The Lancet* at http://www.druglibrary.org/schaffer/misc/effectiveness_of_neps_for_preven.htm. Note also Vlahov et al. (2001) in the *American Journal of Epidemiology*: "…the Secretary of the US Department of Health and Human Services did report in 1998 that the scientific evidence showed that needle exchange programs reduced HIV incidence and did not increase drug abuse. The Surgeon General reiterated this finding in 2000." http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.462.9129&rep=rep1&type=pdf.

Both key informants and surveyed county residents expressed concern about stress, anxiety, and depression. Both groups acknowledged that these can be driven by – among other things – the experience of unsafe neighborhoods, chronic conditions, homelessness, and lack of money for basic needs. Key informants in particular focused on the lack of providers ("impacted services") for mental health and crisis counseling, as well as specifically for mild and moderate issues. One key informant specifically identified the continued increase in health insurance premiums and the continued decrease in what that insurance covers, especially with respect to behavioral health. ER use anecdotally appears to be rising in response to these provider supply and demand issues. Key informants also brought to attention the connection between mental health, addiction, and physical health issues. Finally, key informants identified issues of trauma that affect youth and the lack of "timely access to therapeutic services for both individual and family care," as well as the "lack of in-depth, consistent service over long periods of time."

Violence & Preventable Injury

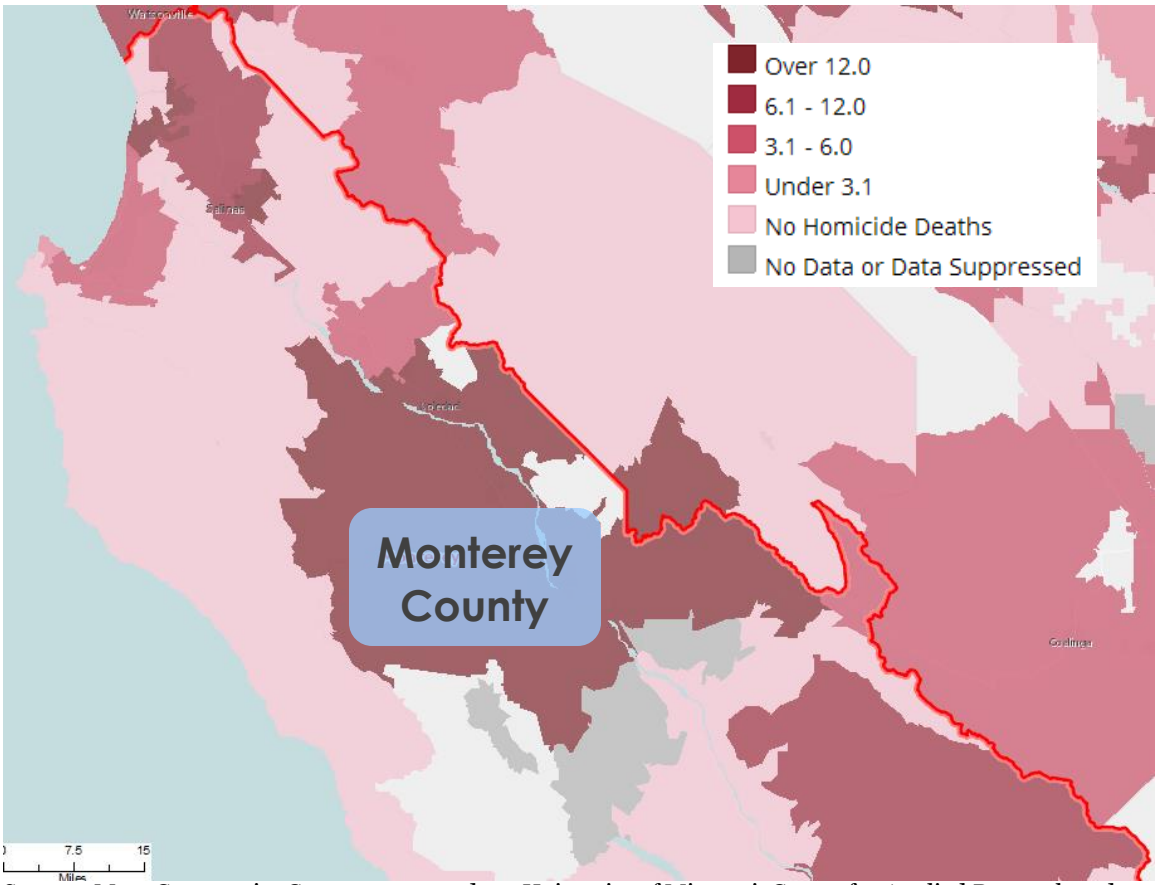
Violence and preventable injury is a health need in the county as shown by the variety of core indicators that miss their benchmarks. These include homicide mortality and pedestrian accident mortality rates, both of which are higher than their comparable HP 2020 aspirational goals. Additionally, the assault rate and the rate of deaths from unintentional poisonings are higher in the county than in the state. Finally, the county rate of non-fatal emergency department visits due to domestic violence against females aged 10 and older is higher than the state rate.

Both key informants and surveyed county residents expressed extreme concerned about violence in the county. About 60% of both adults and youth surveyed reported that the main problem facing their community is gang violence. Key informants focused on both gang violence and gun violence. The majority of surveyed youth also named shootings and homicides, while only about one third of surveyed adults mentioned homicides. One key informant expressed serious concern about the "severe states of secondary trauma and post trauma due to the violence in our community" and went on to say that "persistent violence is a major barrier to the health of our youth."

Overall, two in five adults surveyed expressed concern about bullying, while only about one in four youth did so. Key informants did not discuss bullying per se, but did express concern about domestic violence and human trafficking, the latter both sex-related and forced labor. Unsafe neighborhoods were an issue; while key informants and those surveyed mostly focused on violence in neighborhoods, some noted concerns about car

accidents. Some made the connection between unsafe neighborhoods and less physical activity, greater stress, and lack of well-being.

Figure 6, Age-Adjusted Homicide Mortality Rate, by Zip Code



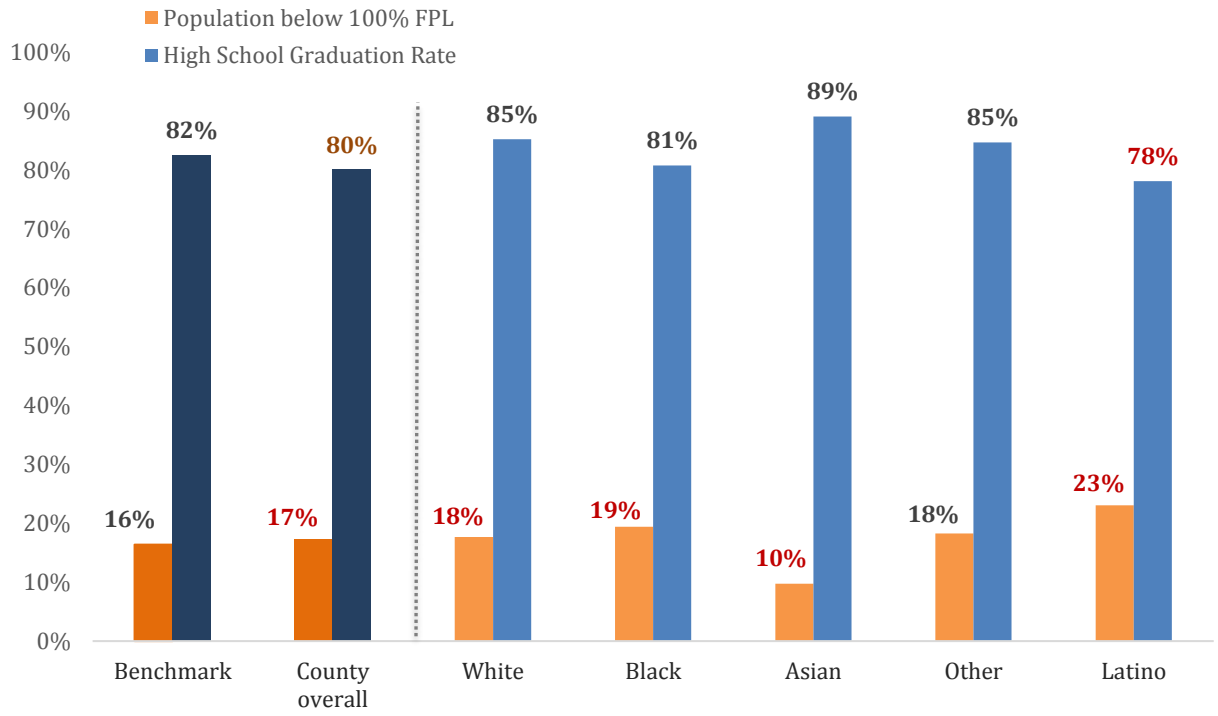
Source: Map, Community Commons 2017; data, University of Missouri, Center for Applied Research and Environmental Systems and California Department of Public Health (CDPH) - Death Public Use Data. 2010-12. Rate per 100,000 population.

Economic Security

Jobs, income, education, and housing are all considered factors in the community health need of economic security. The percentage of county residents with incomes below the federal poverty level, a core indicator of economic security, is higher (worse) than the state, with extreme disparities for Latino and Native populations. Education-related indicators, such as the percentage of adults over the age of 25 without a high school diploma, the percentage of preschool-age children enrolled in preschool, and the percentage of fourth-grade students reading below proficiency, are all worse in the county compared to state benchmarks or HP 2020 aspirational goals. Where these statistics are available by ethnicity, they show particular disparities for the county's Latino population. Also, Monterey County has more than double the proportion of

homeless individuals compared to the state overall. Finally, the indicator of the proportion of substandard housing is higher (worse) in the county than in the state.

Figure 7, Income and Education Indicators, by Ethnicity



Source: *Percent below Federal Poverty Level*, US Census Bureau, American Community Survey, 2010-14; *High School Graduation Percentage*, California Department of Education, 2013.

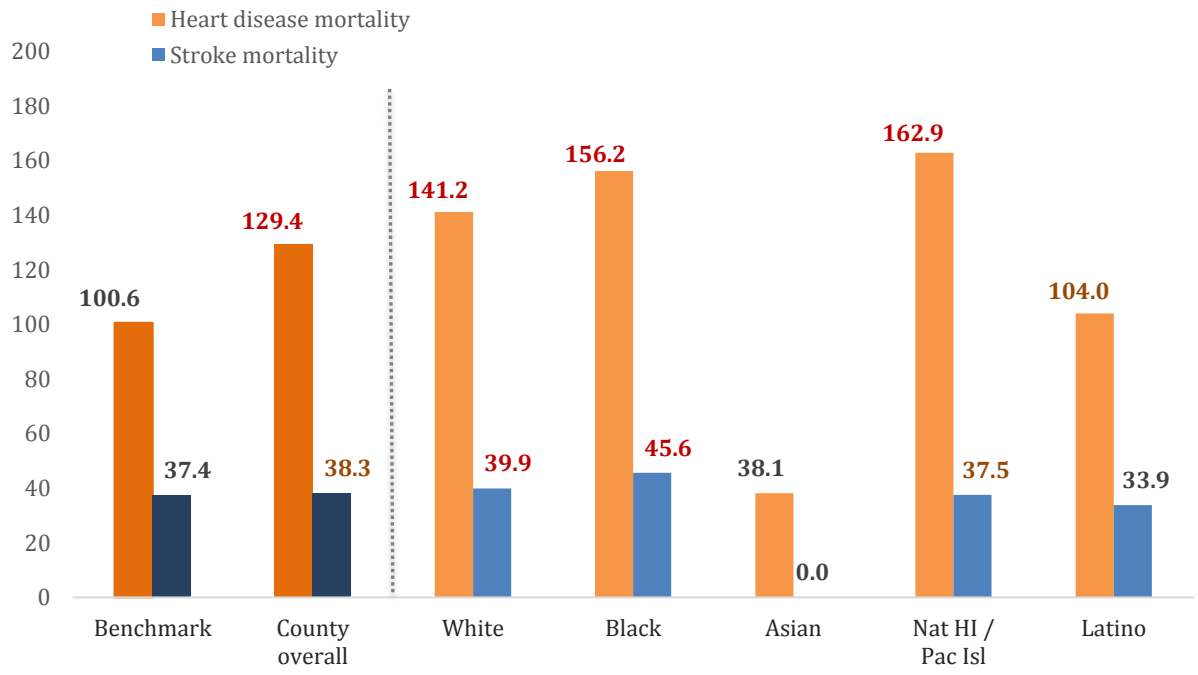
Key informants brought up all four aspects of economic security. Affordability of basic needs (including issues of hunger), child care, healthcare, and housing were all mentioned. Most spoke about the high cost of housing, which places county residents in danger of homelessness or of being inadequately housed. The lack of affordable housing was reflected in surveyed English-speaking adult community members. Spanish-speaking adult community members who were surveyed focused more on the lack of higher-paying jobs and on the lack of job opportunities for youth, which youth who were surveyed also mentioned. Key informants echoed these job concerns, noting that most jobs in the largest area industries (agriculture and hospitality) do not pay a living wage. Key informants mentioned that many adults work multiple jobs, and one key informant relayed that certain jobs offer no sick leave. Multiple and/or seasonable jobs can "result in parents being relatively absent and/or unable to supervise and/or adequately provide for children," stated one key informant. These existing jobs can be dangerous (e.g., chemical exposure) and, key informants noted, employ a mostly illiterate, uneducated, or "unskilled" workforce, which increases community impoverishment. Surveyed adult

English-speaking community members and youth both also focused on these inter-twined issues, expressing frustration at poor education and at the high cost of living.

Cardiovascular Disease/Stroke

Cardiovascular disease/stroke is a health need in the county. The level of heart disease prevalence, one of the core indicators of this health need, is higher in the county than in the state. Also, the rate of mortality from ischemic heart disease, another core indicator, is worse among county residents than the HP 2020 aspirational goal. With regard to heart disease mortality, county Pacific Islander and Black populations are particularly at risk. A greater proportion of county residents than state residents have unmanaged high blood pressure, a related indicator. Finally, while the rate of stroke mortality, a core indicator, is not worse overall in the county than in the state, it is worse for the Black population of the county and worse for residents on the county's central coast and southern areas.

Figure 8, Age-Adjusted Mortality Rates for Stroke and Ischemic Heart Disease, by Ethnicity



Source: University of Missouri, Center for Applied Research and Environmental Systems, California Department of Public Health (CDPH) - Death Public Use Data, 2010-12.

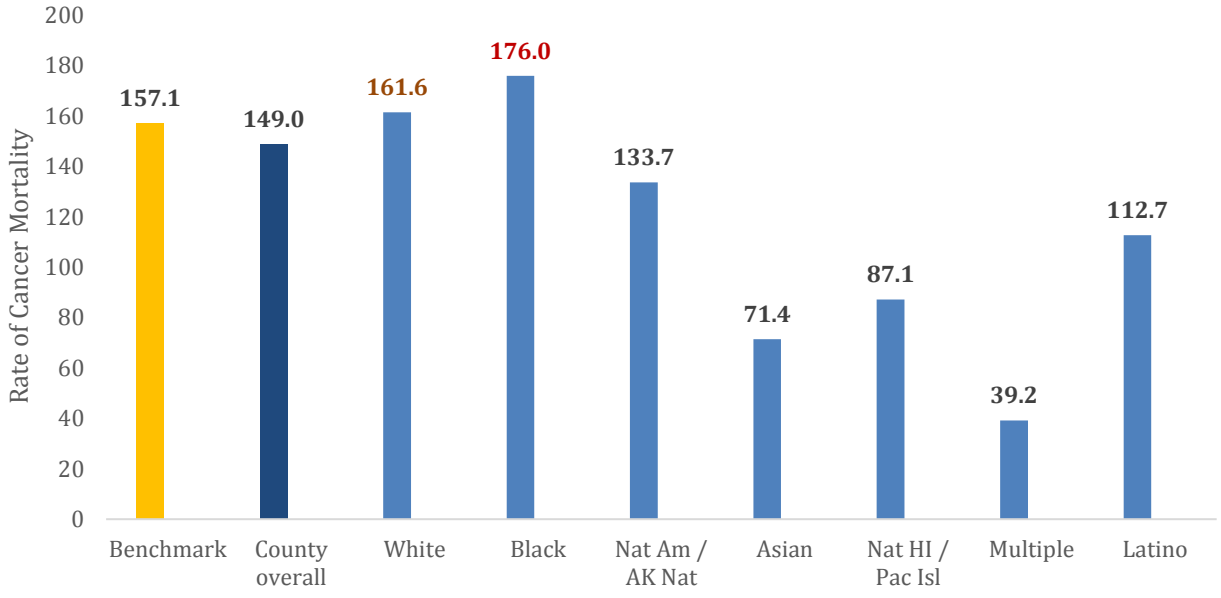
Key informants and surveyed community members were much more focused on obesity and healthy lifestyle (nutrition and physical activity) concerns, the drivers of this health need, than on cardiovascular disease and stroke outcomes specifically. We describe

these further in the Diabetes & Obesity health need section. However, we note that one in five county adults surveyed indicated that heart disease is a significant health problem facing their community, as did a small percentage (<2%) of youth, who also named stroke and high blood pressure.

Cancers

Cancers are a health need in the county specifically with respect to disparities among certain groups. For example, the rate of overall cancer mortality, a core indicator, is not worse in the county than the HP 2020 aspirational goal. However, the county's Black population and the population in the southern part of the county both experience substantially higher rates of overall cancer mortality than other county groups. It is also the case that the rate of prostate cancer incidence, a core indicator, is worse among the county's men than men in the state overall, with particularly high rates for Black and Latino men in the county. And while the rate of cervical cancer incidence is barely worse in the county than the HP 2020 aspirational goal, the rate for White women in the county is markedly worse than the goal. Among related indicators, a smaller proportion of people are being screened for colorectal cancer at the county level than at the state level.

Figure 9, Cancer Mortality Rate (All Cancers), by Ethnicity



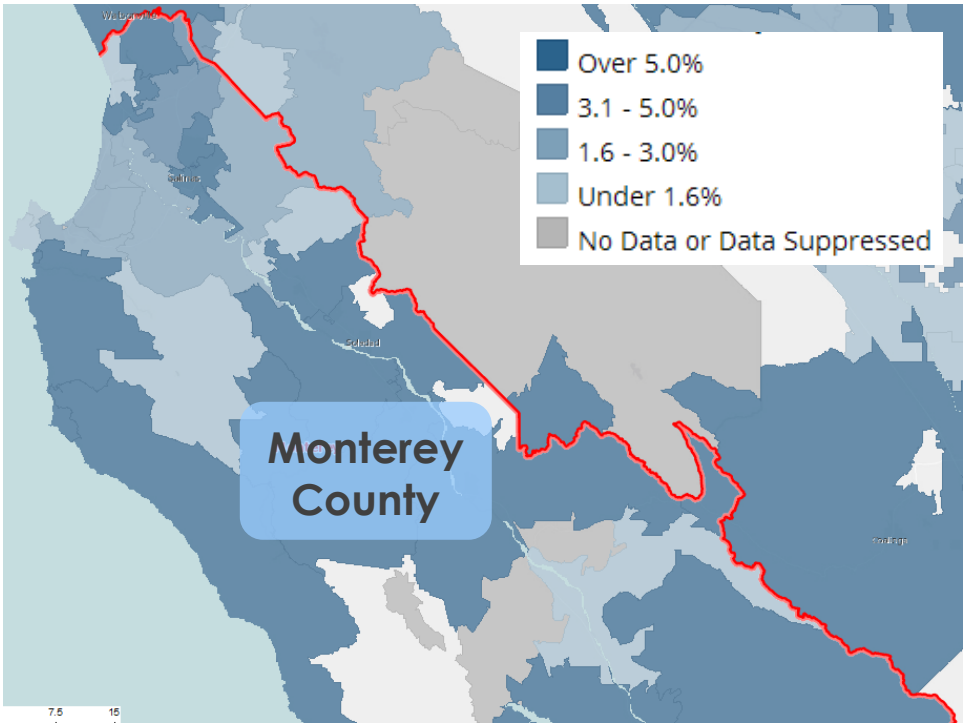
Source: California Department of Public Health, CDPH - Death Public Use Data. 2010-12.
Note: Rate per 100,000 population, age-adjusted to year 2000 standard.

Key informants did not directly discuss cancer, although several mentioned healthy lifestyles, a preventive factor for cancer. However, nearly one third of surveyed county adults indicated that cancer is a significant community health problem. These adults focused on the relationship between youth smoking and cancer. About one in 10 surveyed county youth indicated that cancer is a significant health concern facing their generation. One key informant suggested that hospitals such as Stanford and UCSF "sponsor or develop stronger partnerships with organizations in our county" to "meet the needs of families with special needs (i.e., pediatric oncology)."

Maternal/Infant Health

Maternal/infant health is a need in the county. The core indicator of lack of prenatal care is worse for mothers in the county than in the state overall. The teen birth rate is also higher in the county than the state, and is especially higher for Latinas. The county's rate of pertussis cases for infants younger than 3 months is double that of the state. Indicators related to this overall health need that missed benchmarks involved young children's education. Both the number of Head Start facilities per capita for children under 5 years and the percentage of preschool-aged children enrolled in preschool were lower in the county than at the state level.

Figure 10, Percent of New Mothers with Late or No Prenatal Care, by Zip Code



Source: Map, Community Commons 2017; data, California Department of Public Health (CDPH) - Birth Profiles by ZIP Code, 2011.

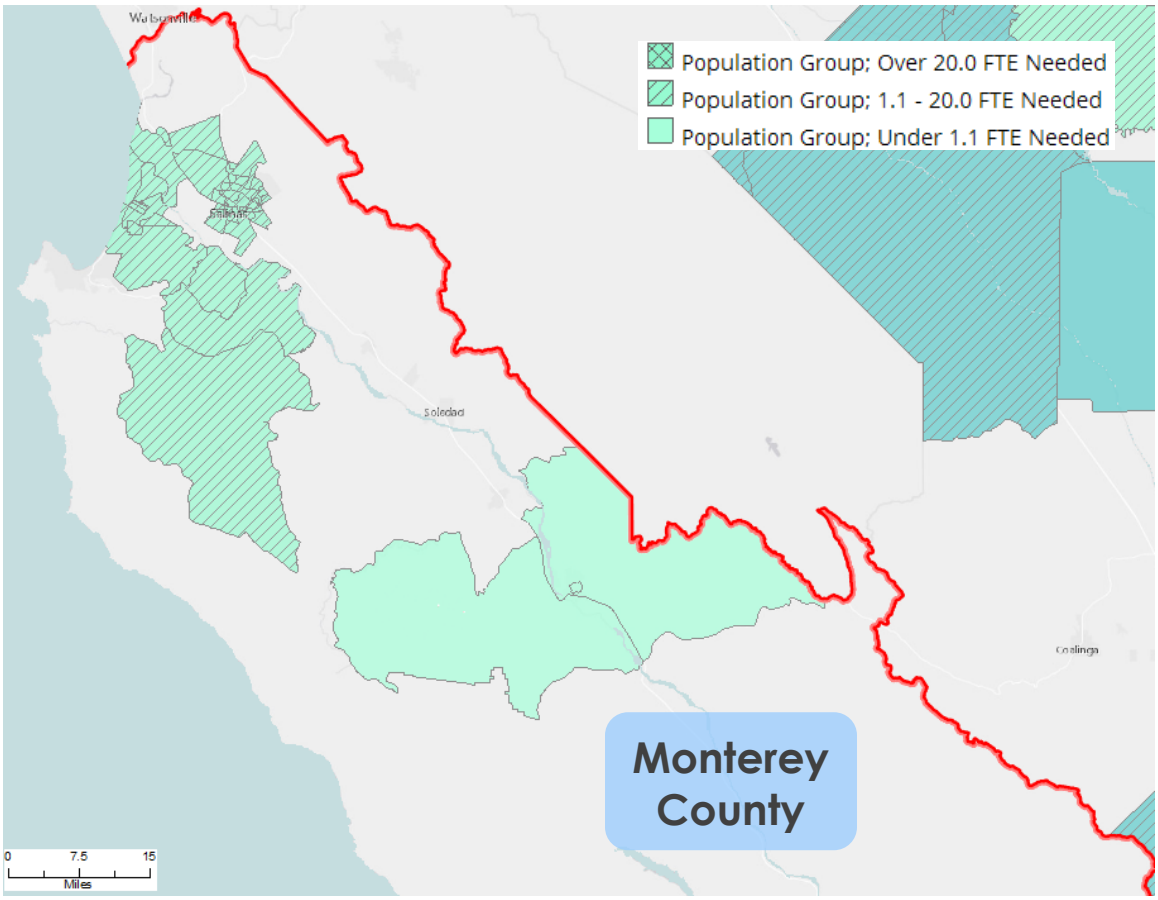
A key informant mentioned access to Medi-Cal as an issue for families with young children, especially those who move into the county from elsewhere. Another described "cultural norms surrounding women's healthcare" as a concern. One key informant also described "limited access to providers… particularly for issues that affect children." This key informant brought up other access issues that we address in the Access health need above. In general, key informants focused on the affordability of child care and on maternal education. The former issue was echoed by surveyed community members. Teen pregnancy was also mentioned by both some surveyed community members and a key informant, the latter mentioning the need for "quality sex education… beginning in middle school." However, more concerning was that nearly one in four surveyed adult community members reported that child abuse is a significant community health problem.

Oral Health

Oral (AKA dental) health is a need in the county mainly due to access issues. Several core indicators, including absence of dental insurance, lack of a recent dental exam (for youth), and population in a dental health professional shortage area, are all worse in the county than in the state. Latino youth are least likely among youth of all ethnicities to have had a recent dental exam. Affordability of dental care for youth, a related indicator, is also worse in the county than at the state level. Finally, the north-central part of the county has the greatest dental health professional shortage by population. In the map on the next page, Monterey County is the geographic area to the west and south of the red line.

Several key informants focused on dental care as a concern. There is a clear need for annual dental screenings and dental treatment for county children. In particular, key informants noted that it is a challenge for low-income families and migrant or farm workers to provide dental care for their children. It was stated that a lot of these children have teeth problems, and some of them need advanced care; just pulling the teeth isn't enough. One third of surveyed adult community members expressed that the lack of dental care is a significant community health need, while dental/oral health problems were reported as a need by one quarter of those surveyed.

Figure 11, Dental Care Health Professional Shortage Areas, by Census Tract



Source: Map, Community Commons 2017; data, U.S. Department of Health & Human Services, Health Resources and Services Administration, April 2016.

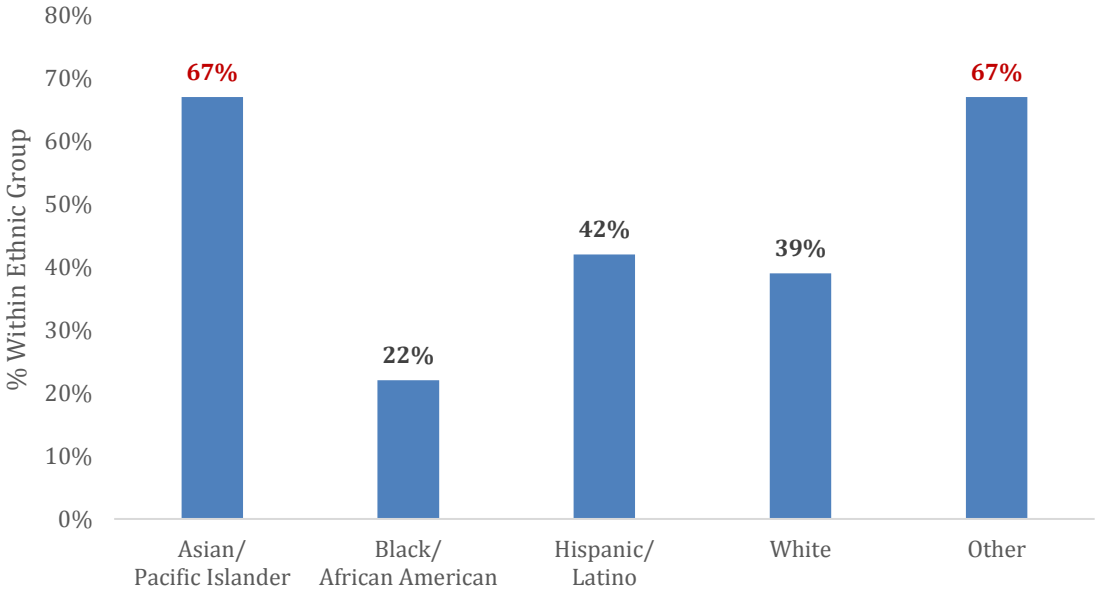
Infectious Diseases

Infectious diseases are a health need in the community. The core indicator of the rate of pertussis cases is higher in the county than in the state. A second core indicator, county tuberculosis incidence rate, is higher than the HP 2020 aspirational goal.[14] While another core indicator, early syphilis cases for males, is not worse in the county than the state, the county's Public Health Department notes that this indicator is trending up (i.e., getting worse). The rate of HIV prevalence, while not worse overall in the county than the state, is substantially worse for the county's Black population. Additional data from the county's Public Health Department suggests that there could be access-related

[14] Note that most, if not all, counties in California do not meet the HP 2020 goal with regard to tuberculosis incidence. Note also that, per the California Department of Public Health's Tuberculosis Control Branch, both the numerators and denominators for the calculation of county and state TB incidence rates include individuals who are incarcerated (Kanowitz, personal communication, February 28, 2017).

issues in getting from diagnosis to treatment so that HIV does not become full-blown AIDS, which statistics suggest are worst for the Asian/Pacific Islander population. The related indicator of lack of HIV screening is higher (worse) in the county than the state as well, and of concern for the county's Asian population. Finally, the related indicator of pneumonia vaccinations among the senior population is lower (worse) on the county level than the state overall.

Figure 12, Progression from HIV to AIDS within One Year of Diagnosis, by Ethnicity



Source: Monterey County Health Department, Public Health Bureau, 2014.

Key informants described the need for greater accessibility of needle exchange programs to prevent the transmission of diseases such as HIV and Hepatitis C.[13] Respondents also expressed concerns about improving sanitation for those who are on the street, which could additionally reduce disease transmission. Finally, key informants praised efforts to increase accessibility and affordability of flu shots. About one in five surveyed youth in the community mentioned that sexually-transmitted infections are a serious concern facing their generation, and some expressed concerns about other diseases, generally those that were in the news such as Ebola and measles.

Community Resources Potentially Available to Respond to Health Needs

SVMHS consulted Monterey County 2-1-1, which is maintained by the United Way,[15] and the January 2017 edition of SAM's GUIDE to Monterey County Family Resources[16] to identify community resources potentially available to respond to the health needs. SVMHS compiled these resources to create the list found in Attachment 8. As mentioned in Section V, key informants also contributed information about current assets and resources available to meet the health needs, and their information was also incorporated into the list of community resources in Attachment 8.

VIII. Conclusion

SVMHS worked with its consultants to meet the requirements of the federally required CHNA. By gathering secondary statistical and survey data and doing new primary research, SVMHS was able to understand the community's perception of health needs and prioritize health needs with an understanding of how each measures up to related benchmarks.

After making this CHNA report publicly available in 2017, our hospital will develop implementation plans based on this assessment.

IX. List of Attachments

1. IRS Checklist
2. Glossary
3. Secondary Data Sources
4. Data Indicators
5. Primary Data Collection Protocol
6. Health Needs Prioritization Scores: Breakdown by Criteria
7. Quantitative Data on Significant Identified Community Health Needs, in Priority Order
8. Community Assets & Resources

[15] http://www.unitedwaymcca.org/2-1-1.

[16] http://www.samsresources.com/SAM%27s%20GUIDE%202017%20FINAL.pdf.

Attachment 1. IRS Checklist 2017

Section §1.501(r)(3) of the Internal Revenue Service code describe the requirements of the CHNA.

Federal Requirements Checklist	Regulation Section Number	Report Section / Attachment
A. ACTIVITIES SINCE PREVIOUS CHNA(S)		
Describes the written comments received on the hospital's most recently conducted CHNA and most recently adopted implementation strategy.	(b)(5)(C)	Sec. IV [17]
Describes an evaluation of the impact of any actions that were taken, since the hospital facility finished conducting its immediately preceding CHNA, to address the significant health needs identified in the hospital facility's prior CHNA(s).	(b)(6)(F)	Sec. IV [17]
B. PROCESS & METHODS		
Background Information		
Identifies any parties with whom the facility collaborated in preparing the CHNA(s).	(b)(6)(F)(ii)	Sec. V
Identifies any third parties contracted to assist in conducting a CHNA.	(b)(6)(F)(ii)	Sec. V
Defines the community it serves, which: • Must take into account all patients without regard to whether (or how much) they or their insurers pay for care or whether they are eligible for assistance. • May take into account all relevant circumstances including the geographic area served by the hospital, target population(s), and principal functions. • May *not* exclude medically underserved, low-income, or minority populations who live in the geographic areas from which the hospital draws its patients.	(b)(i) (b)(3) (b)(6)(i)(A)	Sec. III
Describes how the community was determined.	(b)(6)(i)(A)	Sec. III
Describes demographics and other descriptors of the hospital service area.	(b)(3)	Sec. III
Health Needs Data Collection		
Describes **data and other information** used in the assessment:	(b)(6)(ii)	Sec. VI
a. Cites external source material (rather than describe the method of collecting the data).	(b)(6)(F)(ii)	Sec. VI Att. 3 & 4

[17] In 2013-14, SVMHS was involved in a community health needs assessment performed by the Monterey County Health Department. This is the first independent CHNA prepared by SVMHS.

Federal Requirements Checklist	Regulation Section Number	Report Section / Attachment
b. Describes methods of collecting and analyzing the data and information.	(b)(6)(ii)	Sec. VI Att. 5
Describes how it took into account input from persons who represent the broad interests of the community it serves in order to identify and prioritize health needs and identify resources potentially available to address those health needs.	(b)(1)(iii) (b)(5)(i) (b)(6)(F)(iii)	Sec. VI & VII Att. 5 & 6
Describes the medically underserved, low-income, or minority populations being represented by organizations or individuals that provide input.	(b)(6)(F)(iii)	Sec. VI & VII
a. At least one state, local, tribal, or regional governmental public health department (or equivalent department or agency) or a State Office of Rural Health.	(b)(5)(i)(A)	Sec. VI
b. Members of the following populations, or individuals serving or representing the interests of populations listed below. (Report includes the names of any organizations - names or other identifiers not required.)	(b)(5)(i)(B)	Sec. VI & VII
I. Medically underserved populations		
II. Low-income populations		
III. Minority populations	(b)(5)(i)(B)	
c. Additional sources (optional) – (e.g. healthcare consumers, advocates, nonprofit and community-based organizations, elected officials, school districts, healthcare providers and community health centers).	(b)(5)(ii)	Sec. VI
Describes how such input was provided (e.g., through focus groups, interviews or surveys).	(b)(6)(F)(iii)	Sec. VI Att. 5
Describes over what time period such input was provided and between what approximate dates.	(b)(6)(F)(iii)	Sec. VI
Summarizes the nature and extent of the organizations' input.	(b)(6)(F)(iii)	Sec. VI & VII Att. 5 & 6
C. CHNA NEEDS DESCRIPTION & PRIORITIZATION		
Health needs of a community include requisites for the improvement or maintenance of health status both in the community at large and in particular parts of the community (such as particular neighborhoods or populations experiencing health disparities).	(b)(4)	Sec. VII Att. 7
Prioritized description of significant health needs identified.	(b)(6)(i)(D)	Sec. VII Att. 7
Description of process and criteria used to identify certain health needs as significant and prioritizing those significant health needs.	(b)(6)(i)(D)	Sec. VI & VII Att. 6

Federal Requirements Checklist	Regulation Section Number	Report Section / Attachment
Description of the resources potentially available to address the significant health needs (such as organizations, facilities, and programs in the community, including those of the hospital facility.	(b)(4) (b)(6)(E)	Att. 8
D. FINALIZING THE CHNA		
CHNA is conducted in such taxable year or in either of the two taxable years immediately preceding such taxable year.	(a)1	Exec Sum Sec. VI
CHNA is a written report that is adopted for the hospital facility by an authorized body of the hospital facility (authorized body defined in §1.501(r)-1(b)(4)).	(b)(iv)	June 2017
Final, complete, and current CHNA report has been made widely available to the public until the subsequent two CHNAs are made widely available to the public. "Widely available on a web site" is defined in §1.501(r)-1(b)(29).	(b)(7)(i)(A)	June 2017
a. May not be a copy marked "Draft".	(b)(7)(ii)	
b. Posted conspicuously on website (either the hospital facility's website or a conspicuously-located link to a web site established by another entity).	(b)(7)(i)(A)	
c. Instructions for accessing CHNA report are clear.	(b)(7)(i)(A)	
d. Individuals with Internet access can access and print reports without special software, without payment of a fee, and without creating an account.	(b)(7)(i)(A)	
e. Individuals requesting a copy of the report(s) are provided the URL.	(b)(7)(i)(A)	
f. Makes a paper copy available for public inspection upon request and without charge at the hospital facility.	(b)(7)(i)(B)	

Attachment 2. Glossary

Abbreviation	Term	Description/Notes
ACA	Patient Protection and Affordable Care Act of 2010	Legislation enacted March 23, 2010 that includes requirements for all nonprofit hospitals to conduct a CHNA every three years or face an annual penalty.
AIDS	Acquired immune deficiency syndrome	Syndrome caused by HIV; the last stage of HIV infection, when the immune system can no longer fight off infections.
CARES	Center for Applied Research and Environmental Systems	University of Missouri institute responsible in part for developing the Community Commons.org data platform
CDC	Centers for Disease Control and Prevention	A federal agency under the DHHS focused on health research, prevention, and intervention.
CDPH	California Department of Public Health	
CHNA	Community Health Needs Assessment	
DHHS	United States Department of Health and Human Services	
ED	Emergency Department	
ER	Emergency Room	
FPL	Federal poverty level	An annual metric of income levels determined by DHHS.
Gini	Gini coefficient	A statistic that represents the distribution of income or wealth among an area's residents; a commonly used indicator of inequality,
IMC	Impact Monterey County	A collaborative of local nonprofits, businesses, public agencies, and the community working to improve life in Monterey County.

HIV	Human immunodeficiency virus	Sexually transmitted virus that can lead to AIDS.
HP 2020	Healthy People 2020	National, 10-year aspirational benchmarks set by federal agencies & finalized by an interagency workgroup under the auspices of the U.S. Office of Disease Prevention and Health Promotion, managed by DHHS.
IRS	Internal Revenue Service	A bureau of the U.S. Department of the Treasury, agency responsible for tax collection and tax law enforcement.
LGBTQ	Lesbian/ Gay/ Bisexual/ Transgender/ Questioning	
MC	Monterey County	
SVMHS	Salinas Valley Memorial Healthcare System	

Attachment 3. Secondary Data Sources and Dates

California Department of Education. 2012-2013.

California Department of Education. 2013.

California Department of Education, FITNESSGRAM®; Physical Fitness Testing. 2013-2014.

California Department of Health Care Services. September 2015.

California Department of Public Health (CDPH) – Birth Profiles by ZIP Code. 2011.

California Department of Public Health (CDPH) – Breastfeeding Statistics. 2012.

California Department of Public Health, County Health Status Profiles 2016.

California Department of Public Health (CDPH) – Death Public Use Data. University of Missouri, Center for Applied Research and Environmental Systems. 2010-2012.

California Department of Public Health, Immunization Branch. 2014-2015.

California Department of Public Health, Immunization Branch. 2015.

California Department of Public Health, STD Control Branch. 2011-2015.

California Department of Public Health, STD Control Branch. 2015.

California Department of Public Health (CDPH) – Tracking. 2005-2012.

California Department of Public Health, Tuberculosis Control Branch. 2014-2015.

California Department of Public Health (CDPH) Vital Statistics Death Statistical Master and Multiple Cause of Death files. 2013.

California Department of Public Health (CDPH) Vital Statistics Death Statistical Master Files. 2013.

California Office of Statewide Health Planning and Development, Emergency Department Data. 2014.

California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. 2011.

Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. 2006-2010.

Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. 2011-2012.

Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. US Department of Health & Human Services, Health Indicators Warehouse. 2005-2009.

Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. US Department of Health & Human Services, Health Indicators Warehouse. 2006-2012.

Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2013.

Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. US Department of Health & Human Services, Health Indicators Warehouse. 2014.

Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. US Department of Health & Human Services, Health Indicators Warehouse. 2013.

Centers for Disease Control and Prevention, National Environmental Public Health Tracking Network. 2012.

Centers for Disease Control and Prevention, National Vital Statistics System. Centers for Disease Control and Prevention, Wide Ranging Online Data for Epidemiologic Research. 2006-2010.

Centers for Disease Control and Prevention, National Vital Statistics System. University of Wisconsin Population Health Institute, County Health Rankings. 2011-2013.

Centers for Medicare and Medicaid Services. 2014.

Dartmouth College Institute for Health Policy & Clinical Practice. Dartmouth Atlas of Health Care. 2012.

Environmental Protection Agency, EPA Smart Location Database. 2011.

Federal Bureau of Investigation, FBI Uniform Crime Reports. 2010-2012.

Feeding America. 2013.

Monterey County Department of Social Services, Homeless Point-In-Time Census & Survey Comprehensive Report, 2015.

Monterey County Health Department, Public Health Bureau. 2014.

Multi-Resolution Land Characteristics Consortium, National Land Cover Database. 2011.

National Center for Education Statistics, NCES – Common Core of Data. 2013-2014.

National Institutes of Health, National Cancer Institute, Surveillance, Epidemiology, and End Results Program. State Cancer Profiles. 2008-2012.

National Oceanic and Atmospheric Administration, North America Land Data Assimilation System (NLDAS). 2014.

Nielsen, Nielsen Site Reports. 2014.

State of California, Department of Finance, E-1 Population Estimates for Cities, Counties, and the State. 2015.

University of California Center for Health Policy Research, California Health Interview Survey. 2009.

University of California Center for Health Policy Research, California Health Interview Survey. 2011-2012.

University of California Center for Health Policy Research, California Health Interview Survey. 2013-14.

University of Wisconsin Population Health Institute, County Health Rankings. 2012-2013.

University of Wisconsin Population Health Institute, County Health Rankings. 2016.

US Census Bureau, American Community Survey. 2010-2014.

US Census Bureau, American Housing Survey. 2011, 2013.

US Census Bureau, County Business Patterns. 2011.

US Census Bureau, County Business Patterns. 2012.

US Census Bureau, Decennial Census, ESRI Map Gallery. 2010.

US Census Bureau, Small Area Income & Poverty Estimates. 2013.

US Department of Agriculture, Economic Research Service, USDA – Food Access Research Atlas. 2010.

US Department of Agriculture, Economic Research Service, USDA – Food Environment Atlas. 2011.

US Department of Agriculture, Food & Nutrition Service, USDA – Child Nutrition Program. 2013.

US Department of Health & Human Services, Administration for Children and Families. 2014.

US Department of Health & Human Services, Center for Medicare & Medicaid Services, Provider of Services File. June 2016.

US Department of Health & Human Services, Health Resources and Services Administration, Health Resources and Services Administration. April 2016.

US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File. 2013.

US Department of Health and Human Services, Office of Disease Prevention and Health Promotion, HealthyPeople.gov, Healthy People 2020. http://www.healthypeople.gov. 2017.

US Department of Housing and Urban Development. 2015.

US Department of Labor, Bureau of Labor Statistics. October 2016.

US Drought Monitor. 2012-2014

Walk Score®. 2012.

Attachment 4. Data Indicators

Indicator	Indicator Variable	Data source
Absence of Dental Insurance Coverage	Percent Adults Without Dental Insurance	University of California Center for Health Policy Research, California Health Interview Survey. 2009.
Access to Mental Health Providers	Mental Health Care Provider Rate (Per 100,000 Population)	University of Wisconsin Population Health Institute, County Health Rankings. 2016.
Access to Primary Care	Primary Care Physicians, Rate per 100,000 Pop.	US DHHS, Health Resources and Services Administration, Area Health Resource File. 2013.
Air Quality - Ozone (O3)	Percentage of Days Exceeding Standards, Pop. Adjusted Average	Centers for Disease Control and Prevention, National Environmental Public Health Tracking Network. 2012.
Air Quality - Particulate Matter 2.5	Percentage of Days Exceeding Standards, Pop. Adjusted Average	Centers for Disease Control and Prevention, National Environmental Public Health Tracking Network. 2012.
Alcohol - Excessive Consumption	Estimated Adults Drinking Excessively (Age-Adjusted Percentage)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US DHHS, Health Indicators Warehouse. 2006-12.
Alcohol - Expenditures	Alcoholic Beverage Expenditures, Percentage of Total Food-At-Home Expenditures	Nielsen, Nielsen SiteReports. 2014.
Alzheimer's Disease Mortality Rate (age-adjusted)	Alzheimer's Disease Mortality Rate (age-	CDPH, County Health Status Profiles 2016.

Indicator	Indicator Variable	Data source
	adjusted) per 100,000 population	
Assisted Housing Units Rate	HUD-Assisted Units, Rate per 10,000 Housing Units	US, Department of Housing and Urban Development. 2015.
Asthma - Hospitalizations	Age-Adjusted Discharge Rate (Per 10,000 Pop.)	California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. Additional data analysis by CARES. 2011.
Asthma - Prevalence	Percent Adults with Asthma	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES. 2011-12.
Breast Cancer Incidence	Annual Breast Cancer Incidence Rate (Per 100,000 Pop.)	National Institutes of Health, National Cancer Institute, Surveillance, Epidemiology, and End Results Program. State Cancer Profiles. 2008-12.
Breastfeeding (Any)	Percentage of Mothers Breastfeeding (Any)	CDPH - Breastfeeding Statistics. 2012.
Breastfeeding (Exclusive)	Percentage of Mothers Breastfeeding (Exclusively)	CDPH - Breastfeeding Statistics. 2012.
Cancer Mortality Rate (All Types)	Cancer, Age-Adjusted Mortality Rate (per 100,000 Population)	CDPH - Death Public Use Data. 2010-12. CARES.
Cancer Screening - Mammogram	Percent Female Medicare Enrollees with Mammogram in Past 2 Year	Dartmouth College Institute for Health Policy & Clinical Practice, Dartmouth Atlas of Health Care. 2012.
Cancer Screening - Pap Test	Percent Adults Females Age 18+ with	Centers for Disease Control and Prevention, Behavioral Risk

Indicator	Indicator Variable	Data source
	Regular Pap Test(Age-Adjusted)	Factor Surveillance System. Accessed via the Health Indicators Warehouse. US DHHS Health Indicators Warehouse. 2006-12.
Cancer Screening - Sigmoid/Colonoscopy	Percent Adults Screened for Colon Cancer (Age-Adjusted)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US DHHS, Health Indicators Warehouse. 2006-12.
Cervical Cancer Incidence	Annual Cervical Cancer Incidence Rate (Per 100,000 Pop.)	National Institutes of Health, National Cancer Institute, Surveillance, Epidemiology, and End Results Program. State Cancer Profiles. 2008-12.
Change in Total Population	Percent Population Change, 2000-2010	US Census Bureau, Decennial Census. 2000 - 2010.
Children Eligible for Free/Reduced Price Lunch	Percent Students Eligible for Free or Reduced Price Lunch	National Center for Education Statistics, NCES - Common Core of Data. 2013-14.
Chronic Liver Disease and Cirrhosis Mortality Rate (age-adjusted)	Chronic Liver Disease and Cirrhosis Mortality Rate (age-adjusted) per 100,000 population	CDPH, County Health Status Profiles 2016.
Climate & Health - Canopy Cover	Population Weighted Percentage of Report Area Covered by Tree Canopy	Multi-Resolution Land Characteristics Consortium, National Land Cover Database 2011. Additional data analysis by CARES. 2011.
Climate & Health - Drought Severity	Percentage of Weeks in Drought	US Drought Monitor. 2012-14.

Indicator	Indicator Variable	Data source
Climate & Health - Heat Index Days	Percentage of Weather Observations with High Heat Index Values: %	National Oceanic and Atmospheric Administration, North America Land Data Assimilation System (NLDAS). Accessed via CDC WONDER. Additional data analysis by CARES. 2014.
Climate & Health - Heat Stress Events	Heat-related Emergency Department Visits, Rate per 100,000 Population	CDPH - Tracking. 2005-12.
Climate & Health - No Access to Air Conditioning	Percentage of Housing Units with No Air Conditioning	US Census Bureau, American Housing Survey. 2011, 2013.
Colon and Rectum Cancer Incidence	Annual Colon and Rectum Cancer Incidence Rate (Per 100,000 Pop.)	National Institutes of Health, National Cancer Institute, Surveillance, Epidemiology, and End Results Program. State Cancer Profiles. 2008-12.
Commute Over 60 Minutes	Percentage of Workers Commuting More than 60 Minutes	US Census Bureau, American Community Survey. 2010-14.
Commute to Work - Alone in Car	Percentage of Workers Commuting by Car, Alone	US Census Bureau, American Community Survey. 2010-14.
Commute to Work - Walking/Biking	Percentage Walking or Biking to Work	US Census Bureau, American Community Survey. 2010-14.
Cost Burdened Households Units	Percentage of Households where Housing Costs Exceed 30% of Income	US Census Bureau, American Community Survey. 2010-14.
Dental Care - Lack of Affordability (Youth)	Percent Population Age 5-17 Unable to Afford Dental Care	University of California Center for Health Policy Research,

Indicator	Indicator Variable	Data source
		California Health Interview Survey. 2009.
Diabetes Hospitalizations	Age-Adjusted Discharge Rate (Per 10,000 Pop.)	California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. Additional data analysis by CARES. 2011.
Diabetes Prevalence	Percent Adults with Diagnosed Diabetes(Age-Adjusted)	Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2013.
Drug-induced Mortality Rate (age-adjusted)	Death from Alcohol and/or Other Drugs, rate per 100,000 population	CDPH Vital Statistics Death Statistical Master and Multiple Cause of Death files. 2013.
Exposed to Unsafe Drinking Water	Percentage of Population Potentially Exposed to Unsafe Drinking Water	University of Wisconsin Population Health Institute, County Health Rankings. 2012-13.
Fast Food Restaurants	Fast Food Restaurants, Rate (Per 100,000 Population)	US Census Bureau, County Business Patterns. Additional data analysis by CARES. 2011.
Fatal Falls Rate, Age 50+	Unintentional - Fall, Death, age 50+, rate per 100,000 population	CDPH Vital Statistics Death Statistical Master Files. 2013.
Fatal Motor Vehicle Accident Rate	Motor Vehicle Accident, Age-Adjusted Mortality Rate (per 100,000 Population)	CARES and CDPH - Death Public Use Data. 2010-12.
Fatal Pedestrian Accident Rate	Pedestrian Accident, Age-Adjusted Mortality Rate (per 100,000 Population)	CARES and CDPH - Death Public Use Data. 2010-12.

Indicator	Indicator Variable	Data source
Fatal Unintentional Drowning Rate	Unintentional - Drowning/Submersion, Death, rate per 100,000 population	CDPH Vital Statistics Death Statistical Master Files. 2013.
Fatal Unintentional Poisoning Rate	Unintentional - Poisoning, Death, rate per 100,000 population	CDPH Vital Statistics Death Statistical Master Files. 2013.
Federally Qualified Health Centers	Federally Qualified Health Centers, Rate per 100,000 Population	US DHHS, Center for Medicare & Medicaid Services, Provider of Services File. Jun. 2016.
Female Population	Percent Female Population	US Census Bureau, American Community Survey. 2010-14.
Food Desert Population	Percent Population with Low Food Access	US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas. 2010.
Food Insecurity Rate	Percentage of the Population with Food Insecurity	Feeding, America, 2013.
Fruit/Vegetable Expenditures	Fruit / Vegetable Expenditures, Percentage of Total Food-At-Home Expenditures	Nielsen, Nielsen SiteReports. 2014.
Grocery Stores	Grocery Stores, Rate (Per 100,000 Population)	US Census Bureau, County Business Patterns. Additional data analysis by CARES. 2011.
Head Start Program Facilities Rate	Head Start Programs Rate (Per 10,000 Children Under Age 5)	US DHHS, Administration for Children and Families. 2014.
Heart Disease Prevalence	Percent Adults with Heart Disease	University of California Center for Health Policy Research,

Indicator	Indicator Variable	Data source
		California Health Interview Survey. 2011-12.
High Blood Pressure - Unmanaged	Percent Adults with High Blood Pressure Not Taking Medication	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES. 2006-10.
High School Graduation Rate (percent of cohort)	Cohort Graduation Rate	California Department of Education. 2013.
Hispanic Population	Percent Population Hispanic or Latino	US Census Bureau, American Community Survey. 2010-14.
Homeless Individuals	Homeless individuals as a percentage of total population	CA: U.S. Department of Housing and Urban Development, Office of Community Planning and Development, Annual Homeless Assessment Report (AHAR) to Congress. November 2015. MC: Monterey County Department of Social Services, Homeless Point-In-Time Census & Survey Comprehensive Report, 2015. Additional calculations by Actionable Insights, LLC, using state and county population statistics from State of California, Department of Finance, E-1 Population Estimates for Cities, Counties, and the State. 2015.
Homeless Individuals Who are Unsheltered	Unsheltered homeless individuals as a percentage of homeless population	CA: U.S. Department of Housing and Urban Development, Office of Community Planning and Development, Annual Homeless Assessment Report (AHAR) to Congress, November 2015.

Indicator	Indicator Variable	Data source
		MC: Monterey County Department of Social Services, Homeless Point-In-Time Census & Survey Comprehensive Report, 2015.
Homicide Rate	Homicide, Age-Adjusted Mortality Rate (per 100,000 Population)	CARES and CDPH - Death Public Use Data. 2010-12.
Households with No Vehicle	Percentage of Households with No Motor Vehicle	US Census Bureau, American Community Survey. 2010-14.
Income Inequality	Gini Index Value	US Census Bureau, American Community Survey. 2010-14.
Infant Mortality	Infant Mortality Rate (Per 1,000 Births)	Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. Centers for Disease Control and Prevention, Wide-Ranging Online Data for Epidemiologic Research. 2006-10.
Influenza/Pneumonia Mortality Rate (age-adjusted)	Influenza/Pneumonia Mortality Rate (age-adjusted), per 100,000 population	CDPH, County Health Status Profiles 2016.
Insurance - Population Receiving Medicaid	Percent of Insured Population Receiving Medicaid	US Census Bureau, American Community Survey. 2010-14.
Lack of a Consistent Source of Primary Care	Percentage Without Regular Doctor	University of California Center for Health Policy Research, California Health Interview Survey. 2011-12.

Indicator	Indicator Variable	Data source
Lack of Prenatal Care	Percent Mothers with Late or No Prenatal Care	CDPH - Birth Profiles by ZIP Code. 2011.
Lack of Social or Emotional Support	Percent Adults Without Adequate Social / Emotional Support (Age-Adjusted)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US DHHS, Health Indicators Warehouse. 2006-12.
Less than High School Diploma or Equivalent	Percent Population Age 25+ with No High School Diploma	US Census Bureau, American Community Survey. 2010-14.
Living in Health Professional Shortage Area – Dental Health Care	Percentage of Population Living in a dental health care HPSA	US DHHS, Health Resources and Services Administration, Health Resources and Services Administration. April 2016.
Living in Health Professional Shortage Area - Mental Health Care	Percentage of Population Living in a mental health care HPSA	US DHHS, Health Resources and Services Administration, Health Resources and Services Administration. April 2016.
Living in Health Professional Shortage Area - Primary Medical Health Care	Percentage of Population Living in a primary medical health care HPSA	US DHHS, Health Resources and Services Administration, Health Resources and Services Administration. April 2016.
Low Birth Weight	Percent Low Birth Weight Births	CDPH - Birth Profiles by ZIP Code. 2011.
Low Fruit/Vegetable Consumption (Adult)	Percent Adults with Inadequate Fruit / Vegetable Consumption	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US DHHS, Health Indicators Warehouse. 2005-09.

Indicator	Indicator Variable	Data source
Low Fruit/Vegetable Consumption (Youth)	Percent Population Age 2-13 with Inadequate Fruit/Vegetable Consumption	University of California Center for Health Policy Research, California Health Interview Survey. 2011-12.
Lung Cancer Incidence	Annual Lung Cancer Incidence Rate (Per 100,000 Pop.)	National Institutes of Health, National Cancer Institute, Surveillance, Epidemiology, and End Results Program. State Cancer Profiles. 2008-12.
Male Population	Percent Male Population	US Census Bureau, American Community Survey. 2010-14.
Median Age	Median Age	US Census Bureau, American Community Survey. 2010-14.
Medi-Cal Eligible Population	Total number of Medi-Cal eligible individuals.	California Department of Health Care Services. September 2015
Medicare Patients with Hemoglobin A1c Test	Percent Medicare Enrollees with Diabetes with Annual Exam	Dartmouth College Institute for Health Policy & Clinical Practice, Dartmouth Atlas of Health Care. 2012.
Mental Health - Depression Among Medicare Beneficiaries	Percentage of Medicare Beneficiaries with Depression	Centers for Medicare and Medicaid Services. 2014.
Mental Health - Needing Mental Health Care	Percentage with Poor Mental Health	University of California Center for Health Policy Research, California Health Interview Survey. 2013-14.
Mental Health - Poor Mental Health Days	Average Number of Mentally Unhealthy Days per Month	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. 2006-12.

Indicator	Indicator Variable	Data source
Mortality - Ischaemic Heart Disease	Heart Disease, Age-Adjusted Mortality Rate (per 100,000 Population)	CARES and CDPH - Death Public Use Data. 2010-12.
Mortality - Premature Death	Years of Potential Life Lost, Rate per 100,000 Population	Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. 2011-13. University of Wisconsin Population Health Institute, County Health Rankings.
Mortality - Stroke	Stroke, Age-Adjusted Mortality Rate (per 100,000 Population)	CARES and CDPH - Death Public Use Data. 2010-12.
No Recent Dental Exam (Adult)	Percent Adults Without Recent Dental Exam	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES. 2006-10.
No Recent Dental Exam (Youth)	Percent Youth Without Recent Dental Exam	University of California Center for Health Policy Research, California Health Interview Survey. 2013-14.
Non-fatal ED Visit, Violence Against Females Age 10+ by Partner	Non-fatal Emergency Department Visit, Violence Against Females (10+ years old) by Partner, per 100,000	California Office of Statewide Health Planning and Development, OSHPD, Emergency Department Data. 2014.
Non-fatal Substance Abuse ED Visit	Non-fatal Emergency Department Visit, Alcohol and/or Other Drugs, rate per 100,000 population	California Office of Statewide Health Planning and Development, OSHPD, Emergency Department Data. 2014.

Indicator	Indicator Variable	Data source
Obesity (Adult)	Percent Adults with BMI > 30.0 (Obese)	Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2013.
Obesity (Youth)	Percent Obese	California Department of Education, FITNESSGRAM® Physical Fitness Testing. 2013-14.
Overweight (Adult)	Percent Adults Overweight	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES. 2011-12.
Overweight (Youth)	Percent Overweight	California Department of Education, FITNESSGRAM® Physical Fitness Testing. 2013-14.
Park Access	Percent Population Within 1/2 Mile of a Park	US Census Bureau, Decennial Census. ESRI Map Gallery. 2010.
Percent in Car-Dependent Cities	Percent Population Living in Car Dependent (Almost Exclusively) Cities	Walk Score®. 2012.
Pertussis cases per 1,000 infants <3 months of age	Infant Pertussis cases <3 months of age (based on disease onset), rate per 1,000 population [provisional]	CDPH, Immunization Branch. 2014-2015.
Pertussis cases per 100,000	Pertussis rate per 100,000	CDPH, Immunization Branch. 2015.
Physical Inactivity (Adult)	Percent Population with no Leisure Time Physical Activity	Centers for Disease Control and Prevention, National Center for

Indicator	Indicator Variable	Data source
		Chronic Disease Prevention and Health Promotion. 2013.
Physical Inactivity (Youth)	Percent Physically Inactive	California Department of Education, FITNESSGRAM® Physical Fitness Testing. 2013-14.
Pneumonia Vaccinations (Age 65+)	Percent Population Age 65+ with Pneumonia Vaccination (Age-Adjusted)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US DHHS, Health Indicators Warehouse. 2006-12.
Poor Dental Health	Percent Adults with Poor Dental Health	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES. 2006-10.
Poor General Health	Percent Adults with Poor or Fair Health (Age-Adjusted)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US DHHS, Health Indicators Warehouse. 2006-12.
Population Age 0-4	Percent Population Age 0-4	US Census Bureau, American Community Survey. 2010-14.
Population Age 18-24	Percent Population Age 18-24	US Census Bureau, American Community Survey. 2010-14.
Population Age 25-34	Percent Population Age 25-34	US Census Bureau, American Community Survey. 2010-14.
Population Age 35-44	Percent Population Age 35-44	US Census Bureau, American Community Survey. 2010-14.

Indicator	Indicator Variable	Data source
Population Age 45-54	Percent Population Age 45-54	US Census Bureau, American Community Survey. 2010-14.
Population Age 5-17	Percent Population Age 5-17	US Census Bureau, American Community Survey. 2010-14.
Population Age 55-64	Percent Population Age 55-64	US Census Bureau, American Community Survey. 2010-14.
Population Age 65+	Percent Population Age 65+	US Census Bureau, American Community Survey. 2010-14.
Population in Limited English Households	Percent Linguistically Isolated Population	US Census Bureau, American Community Survey. 2010-14.
Population Receiving SNAP	Percent Population Receiving SNAP Benefits	US Census Bureau, Small Area Income & Poverty Estimates. 2013.
Population with Any Disability	Percent Population with a Disability	US Census Bureau, American Community Survey. 2010-14.
Population with Limited English Proficiency	Percent Population Age 5+ with Limited English Proficiency	US Census Bureau, American Community Survey. 2010-14.
Poverty - Children Below 100% FPL	Percent Population Under Age 18 in Poverty	US Census Bureau, American Community Survey. 2010-14.
Poverty - Population Below 100% FPL	Percent Population in Poverty	US Census Bureau, American Community Survey. 2010-14.
Poverty - Population Below 200% FPL	Percent Population with Income at or Below 200% FPL	US Census Bureau, American Community Survey. 2010-14.
Preventable Hospital Events	Age-Adjusted Discharge Rate (Per 10,000 Pop.)	California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. Additional data analysis by CARES. 2011.

Indicator	Indicator Variable	Data source
Progression from HIV to AIDS within 1 year of diagnosis	Percent of HIV-diagnosed population by ethnicity	Monterey County Health Department, Public Health Bureau. 2014.
Prostate Cancer Incidence	Annual Prostate Cancer Incidence Rate (Per 100,000 Pop.)	National Institutes of Health, National Cancer Institute, Surveillance, Epidemiology, and End Results Program. State Cancer Profiles. 2008-12.
Rape Rate	Rape Rate (Per 100,000 Pop.)	Federal Bureau of Investigation, FBI Uniform Crime Reports. Additional analysis by the National Archive of Criminal Justice Data. Accessed via the Inter-university Consortium for Political and Social Research. 2010-12.
Reading Below Proficiency	Percentage of Grade 4 ELA Test Score Not Proficient	California, Department, of, Education, 2012-13.
Robbery Rate	Robbery Rate (Per 100,000 Pop.)	Federal Bureau of Investigation, FBI Uniform Crime Reports. Additional analysis by the National Archive of Criminal Justice Data. Accessed via the Inter-university Consortium for Political and Social Research. 2010-12.
School Breakfast Program Participation	Average Daily School Breakfast Program Participation Rate	US Department of Agriculture, Food and Nutrition Service, USDA - Child Nutrition Program. 2013.
School Enrollment Age 3-4	Percentage of Population Age 3-4 Enrolled in School	US Census Bureau, American Community Survey. 2010-14.

Indicator	Indicator Variable	Data source
School Expulsions	Expulsion Rate	California Department of Education. 2013-14.
School Suspensions	Suspension Rate	California Department of Education. 2013-14.
Soft Drink Expenditures	Soda Expenditures, Percentage of Total Food-At-Home Expenditures	Nielsen, Nielsen SiteReports. 2014.
STD - Chlamydia	Chlamydia Infection Rate (Per 100,000 Pop.)	Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. US DHHS, Health Indicators Warehouse. 2014.
STD - Early Syphilis (Males)	Early Syphilis rate per 100,000 male population	CDPH, STD Control Branch. 2015.
STD - Gonorrhea	Gonorrhea Incidence Rate per 100,000 population	CDPH, STD Control Branch. 2011-2015.
STD - HIV Hospitalizations	Age-Adjusted Discharge Rate (Per 10,000 Pop.)	California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. Additional data analysis by CARES. 2011.
STD - HIV Prevalence	Population with HIV / AIDS, Rate (Per 100,000 Pop.)	Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. US DHHS, Health Indicators Warehouse. 2013.
STD - No HIV Screening	Percent Adults Never Screened for HIV / AIDS	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System.

Indicator	Indicator Variable	Data source
		Additional data analysis by CARES. 2011-12.
Substandard Housing Units	Percent Occupied Housing Units with One or More Substandard Conditions	US Census Bureau, American Community Survey. 2010-14.
Suicide Rate	Suicide, Age-Adjusted Mortality Rate (per 100,000 Population)	CARES and CDPH - Death Public Use Data. 2010-12.
TB incidence per 100,000	Tuberculosis Cases, Rates per 100,000 Population	CDPH, Tuberculosis Control Branch. 2014-2015.
Teen Births (Under Age 20)	Teen Birth Rate (Per 1,000 Female Pop. Under Age 20)	CDPH - Birth Profiles by ZIP Code. 2011.
Tobacco Expenditures	Cigarette Expenditures, Percentage of Total Household Expenditures	Nielsen, Nielsen SiteReports. 2014.
Tobacco Usage	Percent Population Smoking Cigarettes(Age-Adjusted)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US DHHS, Health Indicators Warehouse. 2006-12.
Total Population	Population Density (Per Square Mile)	US Census Bureau, American Community Survey. 2010-14.
Transit - Public Transit within 0.5 Miles	Percentage of Population within Half Mile of Public Transit	Environmental Protection Agency, EPA Smart Location Database. 2011.

Indicator	Indicator Variable	Data source
Transit - Road Network Density	Total Road Network Density (Road Miles per Acre)	Environmental Protection Agency, EPA Smart Location Database. 2011.
Unemployment Rate	Unemployment Rate	US Department of Labor, Bureau of Labor Statistics. 2016 - October.
Uninsured Population	Percent Uninsured Population	US Census Bureau, American Community Survey. 2010-14.
Vacant Housing Units	Vacant Housing Units, Percent	US Census Bureau, American Community Survey. 2010-14.
Violent Assault Rate	Assault Rate (Per 100,000 Pop.)	Federal Bureau of Investigation, FBI Uniform Crime Reports. Additional analysis by the National Archive of Criminal Justice Data. Accessed via the Inter-university Consortium for Political and Social Research. 2010-12.
Violent Crimes Rate	Violent Crime Rate (Per 100,000 Pop.)	Federal Bureau of Investigation, FBI Uniform Crime Reports. Additional analysis by the National Archive of Criminal Justice Data. Accessed via the Inter-university Consortium for Political and Social Research. 2010-12.
Walking/Biking/Skating to School	Percentage Walking/ Skating/ Biking to School	University of California Center for Health Policy Research, California Health Interview Survey. 2011-12.
WIC-Authorized Food Stores	WIC-Authorized Food Stores, Rate (Per 100,000 Population)	US Department of Agriculture, Economic Research Service, USDA - Food Environment Atlas. 2011.

Attachment 5. Primary Data Collection Protocol

Salinas Valley Memorial Healthcare System CHNA Key Informant Interview Protocol

Introductory Remarks — 3 min.

Introductions (*interviewer, notetaker if any*)

Why we're calling; what the project is about:

- We are helping Salinas Valley Memorial Healthcare System conduct a Community Health Needs Assessment, as required by the IRS.
- Identifying unmet health needs in our community, extending beyond patients.
- Ultimately, to invest in community health strategies that will lead to better health outcomes.

You were chosen to be interviewed for your particular perspective on health in your community.

What we'll do with the information you tell us today:

- Your responses will be summarized and your name will not be used to identify your comments.
- Notes and summary of all interviews will go to the hospital.
- The hospital will make decisions about which needs it can best address, and how it may collaborate with or complement other hospitals' community outreach work.

Our questions mainly relate to:

1. Health needs
2. Healthcare access in the post-Affordable Care Act environment
3. Other challenges contributing to health needs
4. Suggestions/solutions (both in terms of policies and in terms of local resources)

1. Background — 5 min.

First, please tell us a little about your current role and the organization you work for.

2. Health Needs — 15 min.

Next, we would like to get your opinion on the top health needs among those you serve.

a. In your opinion, which health needs do you believe are the most important to address among those you serve/your constituency?

b. In your opinion, what are the health needs that are not being met very well right now among those you serve/your constituency?

c. Are there any specific groups that have greater health needs, or special health needs?
   i. Differences by gender
   ii. Within specific ethnic groups
   iii. Among different age groups like seniors or children
   iv. Within different parts of the county
   v. Any other specific groups

If they identified more than 3 health needs, ask question d; if not, go on to section 3.

d. Which would you say are the most urgent or pressing of all the health needs that you've named?

3. Challenges: Access to healthcare – post-ACA — 10 min.

We would like to get your perspective on how access has changed in the post- Affordable Care Act environment.

a. Based on your observations and interactions with the clients you serve, to what extent are clients aware of how to obtain health care? **(Explain if needed: Where to find a clinic, how to make an appointment, etc.)**

b. To what extent are clients aware of how to obtain health insurance?

c. What barriers to access still exist? **(Focus on comparison pre- and post-ACA)**
   i. Is the same proportion still medically uninsured/under-insured?
   ii. Do more people or fewer people have a primary care physician?
   iii. Are people using the ER as primary care to the same degree?
   iv. Is the same proportion of the community facing difficulties affording health care?

4. Other Challenges — 10 min.

Are there any other drivers or barriers that are contributing to health needs? We will talk about solutions in just a minute.
Driver/barrier prompts if they are having trouble thinking of anything:

- Mental health and/or substance abuse issues
- SES (income, education)
- Housing
- Being victims of abuse, bullying, or crime
- Built environment incl. unsafe neighborhoods, lack of facilities/vendors, proximity to unhealthy things
- Transportation
- Policies/laws
- Cultural norms
- Stigma
- Lack of awareness/education

5. Suggestions/Improvements/Solutions — 15 min.

Now that we have discussed health needs and issues related to access to care, we are going to ask you about some possible solutions. **In order to maintain or improve the health of your community…**

a. Are there any policy changes you would recommend that could address these issues? Consider those that are readily achievable and politically feasible.

b. Are there existing resources available to address these needs? **If yes:** What are they? Why aren't people using them?

c. What other resources are needed?

d. Of the resources/solutions to improve health, which do you feel is the most significant improvement needed, second, and third?

Resource question prompts if they are having trouble thinking of anything:

- Specific new/expanded programs or services?
- Increase knowledge/understanding?
- Address underlying drivers like poverty, crime, education?
- Facilities (incl. hospitals/clinics)
- Infrastructure (transportation, technology, equipment)
- Staffing (incl. medical professionals)
- Information/educational materials
- Funding
- Collaborations and partnerships
- Expertise

Concluding Remarks — 2 min.

- Thanks for your time and sharing your perspective
- Notes and summary of discussions to client w/o your name attached
- Reminder about what will be done with the information
- Final CHNA report will be published by 3/31/17 on hospital's website

Attachment 6. Health Needs Prioritization Scores: Breakdown by Criteria

Health Need	Rank (1 = Highest Priority)	Overall Average Score (3 = Highest)	Average Scores of Prioritization Criteria Used by Group			
			Magnitude / Scale	Severity	Disparities/ Inequities	Community Priority
Access to & Delivery of Care	2	2.88	2.88	2.88	2.75	3.00
Behavioral Health	3	2.84	2.88	2.88	2.63	3.00
Cancers	7	2.00	2.13	2.25	1.63	2.00
Cardiovascular Disease/Stroke	6	2.50	2.75	2.25	2.00	3.00
Diabetes & Obesity	1	2.94	3.00	3.00	2.75	3.00
Economic Security	5	2.69	2.75	2.63	2.38	3.00
Infectious Diseases	10	1.41	1.75	1.38	1.50	1.00
Maternal/Infant Health	8	1.97	2.25	1.75	1.88	2.00
Oral Health	9	1.78	1.88	1.63	1.63	2.00
Violence & Preventable Injury	4	2.78	2.88	2.75	2.50	3.00

Definitions:

- **Magnitude/scale of the problem:** Rated based on the extent to which the health need affects a large number of people within the community.
- **Severity of the problem:** Rated based on how severe the need is (such as its potential to cause death or disability) and its degree of poor performance against the relevant benchmark(s).
- **Clear disparities or inequities exist:** Rated based on whether the health need disproportionately impacts the health status of one or more vulnerable population groups. Subgroups may be based on geography, languages, ethnicity, culture, citizenship status, economic status, sexual orientation, age, gender, or others.
- **Community priority:** The community prioritizes the health need over other health needs. Actionable Insights rated this criterion based on the frequency with which the key informants expressed strong concern about each health outcome during CHNA primary data collection, and the level of concern indicated by respondents to the IMC surveys.

Attachment 7. Quantitative Data on Significant Identified Community Health Needs, in Community Priority Order

1) Diabetes & Obesity

Below are core and related indicators for diabetes and obesity in Monterey County (MC), compared to California state benchmarks or Healthy People 2020 aspirational goals, whichever was more stringent. The desired direction ("desired") relative to the benchmark is indicated for comparison. Core indicators are shown in **bold**. Indicators shown in red are more than 5% (not five percentage points, but five percent) worse than the benchmark.

Table 5, Core and Related Indicator Data for Diabetes & Obesity

Indicators	MC	Bench mark	Desired ↑↓	More than 5% Worse
Overweight (Adult)	**37.7%**	**35.8%**	**Below (↓)**	**yes**
Obesity (Adult)	**22.1%**	**22.4%**	↓	**no**
Overweight (Youth)	**22.4%**	**19.3%**	↓	**yes**
Obesity (Youth)	**24.5%**	**19.0%**	↓	**yes**
Diabetes Prevalence (adults, age-adjusted)	**7.5%**	**8.3%**	↓	**no**
Diabetes Hospitalizations (age-adjusted discharge rate per 10,000 population)	**9.2**	**10.4**	↓	**no**
Low Fruit/Vegetable Consumption (Adult)	71.1%	71.5%	↓	no
Low Fruit/Vegetable Consumption (Youth)	44.5%	47.4%	↓	no
Fruit/Vegetable Expenditures	suppressed	14.1%	Above (↑)	N/A
Soft Drink Expenditures	suppressed	3.6%	↓	N/A
Fast Food Restaurants	64.6	74.5	↓	no
Grocery Stores	28.0	21.5	↑	no
WIC-Authorized Food Stores (per 100,000)	22.5	15.8	↑	no
Food Desert Population	15.9%	14.3%	↓	yes
Physical Inactivity (Adult)	17.2%	17.3%	↓	no
Physical Inactivity (Youth)	35.7%	35.9%	↓	no
Park Access	59.6%	58.6%	↑	no

Indicators	MC	Bench mark	Desired ↑↓	More than 5% Worse
Living in Car-Dependent Cities	no data	1.7%	↓	N/A
Breastfeeding (Any)	96.4%	93.0%	↑	no
Breastfeeding (Exclusive)	71.5%	64.8%	↑	no
School Breakfast Program Participation	no data	3.9%	↓	N/A
Commute >60 Min.	5.1%	10.4%	↓	no
Food Insecurity Rate	12.6%	15.0%	↓	no
Exposed to Unsafe Drinking Water	0.5%	2.7%	↓	no
Commute to Work - Walking/Biking	3.8%	3.8%	↑	no
Medicare Patients with Hemoglobin A1c Test	84.1%	81.5%	↑	no
Commute to Work - Alone in Car	70.9%	73.3%	↓	no
Walking/Biking/ Skating to School	37.9%	43.0%	↑	yes

Source: Data sources may be found in Attachments 3 & 4. Rates are per 100,000 population unless otherwise noted.

Certain indicators are available by ethnicity, which shows disparities in certain populations. Indicators in red are more than 5% worse for that ethnic group than the benchmark.

Table 6, Core and Related Indicator Data for Diabetes & Obesity by Ethnicity

Indicators	MC	Bench mark	White	Black	Asian Alone	Other	Multi Race	Hispanic /Latino (Any Race)
Overweight (Youth)	**22.4%**	**19.3%**	**19.1%**	**21.5%**	**20.4%**		**15.6%**	**23.6%**
Low Fruit/Vegetable Consumption (Youth)	44.5%	47.4%	43.8%	52.3%		21.5%		45.7%
Physical Inactivity (Youth)	35.7%	35.9%	33.4%	43.0%	31.2%		28.3%	51.1%
Breastfeeding (Any)	96.4%	93.0%	96.4%	88.6%	97.2%	85.7%	98.2%	96.5%
Breastfeeding (Exclusive)	71.5%	64.8%	86.8%	68.6%	79.0%	59.5%	82.4%	67.5%
Walking/Biking/Skating to School	37.9%	43.0%	31.5%	62.0%				42.7%

Source: Data sources may be found in Attachments 3 and 4. Note: "Asian Alone" does not include the Pacific Islander population.

2) Access to & Delivery of Care

Below are core and related indicators for access to and delivery of healthcare in MC, compared to California state benchmarks or Healthy People 2020 aspirational goals, whichever was more stringent. Core indicators are shown in **bold**. Indicators shown in red are more than 5% (not five percentage points, but five percent) worse than the benchmark.

Table 7, Core and Related Indicator Data for Access to & Delivery of Care

Indicators	MC	Bench mark	Desired ↑↓	More than 5% Worse
Access to Primary Care Rate	**61.8**	**78.5**	**Above (↑)**	**yes**
Poor General Health (age-adjusted)	**24.0%**	**18.4%**	**Below (↓)**	**yes**
Lack of Consistent Source of Primary Care	**22.3%**	**14.3%**	↓	**yes**
Access to Mental Health Care Providers Rate	**254.3**	**280.6**	↑	**yes**
Uninsured Population	20.9%	16.7%	↓	yes
Federally Qualified Health Centers Rate	4.3	2.4	↑	no
Living in Health Professional Shortage Area - Primary Care	53.4%	5.1%	↓	yes
Preventable Hospital Events (age-adjusted discharge rate per 10,000)	74.7	83.2	↓	no
Population with Any Disability	8.6%	10.3%	↓	no
Population Receiving Medicaid	28.2%	24.4%	↓	yes
Health Professional Shortage Area - Dental	27.5%	26.1%	↓	yes
Cancer Screening - Mammogram	63.5%	59.3%	↑	no
Cancer Screening - Pap Test	80.2%	78.3%	↑	no
Cancer Screening - Sigmoid/Colonoscopy	55.0%	57.9%	↑	yes

Source: Data sources may be found in Attachments 3 and 4. Rates are per 100,000 population unless otherwise noted.

Certain indicators are available by ethnicity, which shows disparities in certain populations. Indicators in red are more than 5% worse for that ethnic group than the benchmark.

Table 8, Core and Related Indicator Data for Access to & Delivery of Care by Ethnicity

Indicators	MC	Bench mark	White	Black	Asian Alone	Other	Multi Race	Hispanic /Latino (Any Race)
Lack of consistent source of primary care	**22.3%**	**14.3%**	**15.2%**	**18.2%**	**N/A**	**9.4%**	**N/A**	**28.6%**
Uninsured Population	20.9%	16.7%	10.6%	13.1%	14.2%	27.4%	17.2%	27.8%

Source: Data sources may be found in Attachments 3 and 4. Note: "Asian Alone" does not include the Pacific Islander population.

3) Behavioral Health

Below are core and related indicators for behavioral health (both mental health and substance use) in MC, compared to California state benchmarks or Healthy People 2020 aspirational goals, whichever was more stringent. Core indicators are shown in **bold**. Indicators shown in red are more than 5% (not five percentage points, but five percent) worse than the benchmark.

Table 9, Core and Related Indicator Data for Behavioral Health

Indicators	MC	Bench mark	Desired ↑↓	More than 5% Worse
Chronic Liver Disease and Cirrhosis Mortality Rate	**9.6**	**8.2 (HP)**	**Below (↓)**	**yes**
Non-fatal Substance Abuse ED Visit Rate	**545.6**	**455.2**	↓	**yes**
Drug-induced Mortality Rate	**12.4**	**11.3 (HP)**	↓	**yes**
Suicide Rate (age-adjusted)	**9.1**	**9.8**	↓	**no**
Average Days/Month with Poor Mental Health	**4.6**	**3.6**	↓	**yes**
Depression Among Medicare Beneficiaries	**13.1%**	**13.9%**	↓	**no**
Access to Mental Health Providers Rate	**254.3**	**280.6**	**Above (↑)**	**yes**
Needing Mental Health Care	**10.2%**	**15.9%**	↓	**no**
Tobacco Usage (age-adjusted)	12.1%	12.8%	↓	no
Tobacco Expenditures	suppressed	1.0%	↓	N/A
Alcohol - Excessive Consumption (adults, age-adjusted)	14.8%	17.2%	↓	no

Indicators	MC	Bench mark	Desired ↑↓	More than 5% Worse
Alcohol - Expenditures	suppressed	12.9%	↓	N/A
Lack of Social or Emotional Support (adults, age-adjusted)	27.2%	24.6%	↓	yes

Source: Data sources may be found in Attachments 3 & 4. Rates are per 100,000 population unless otherwise noted.

Certain indicators are available by ethnicity, which shows disparities in certain populations. Indicators in red are more than 5% worse for that ethnic group than the benchmark.

Table 10, Core and Related Indicator Data for Behavioral Health by Ethnicity

Indicators	MC	Bench mark	White	Black	Asian Alone	Other	Multi Race	Hispanic /Latino (Any Race)
Suicide Rate (age-adjusted)	9.1	9.8	**15.2**	**0.0**	**7.1**	N/A	**4.4**	**4.0**
Needing Mental Health Care	10.2%	15.9%	10.7%	52.4%	N/A	10.4%	N/A	9.1%

Source: Data sources may be found in Attachments 3 and 4. Note: "Asian Alone" does not include the Pacific Islander population. Rates are per 100,000 population unless otherwise noted.

4) Violence & Preventable Injury

Below are core and related indicators for violence and preventable injury in MC, compared to California state benchmarks or Healthy People 2020 aspirational goals, whichever was more stringent. Core indicators are shown in **bold**. Indicators shown in red are more than 5% (not five percentage points, but five percent) worse than the benchmark.

Table 11, Core and Related Indicator Data for Violence & Preventable Injury

Indicators	MC	Bench mark	Desired ↑↓	More than 5% Worse
Homicide Rate (age-adjusted)	**9.6**	**5.2**	**Below (↓)**	**yes**
Fatal Falls Rate, Age 50+	**16.4**	**17.1**	↓	**no**
Fatal Unintentional Poisoning Rate	**12.3**	**10.1**	↓	**yes**

Indicators	MC	Bench mark	Desired ↑↓	More than 5% Worse
Fatal Unintentional Drowning Rate	**suppressed**	**1.0**	↓	**N/A**
Fatal Motor Vehicle Accident Rate (age-adjusted)	**4.5**	**5.2**	↓	**no**
Fatal Pedestrian Accident Rate (age-adjusted)	**1.5**	**1.3 (HP)**	↓	**yes**
Non-fatal ED Visit, Violence Against Females Age 10+ by Partner	**12.3**	**9.1**	↓	**yes**
Violent Assault Rate	**286.2**	**249.4**	↓	**yes**
Robbery Rate	**146.9**	**149.5**	↓	**no**
All Violent Crimes Rate	464.3	425.0	↓	yes
Alcohol - Excessive Consumption (adults, age-adjusted)	14.8%	17.2%	↓	no
Alcohol - Expenditures	suppressed	12.9%	↓	N/A
Living in Car-Dependent Cities	no data	1.7%	↓	N/A
Rape Rate	21.4	21.0	↓	no
School Suspensions Rate (per 100 students)	4.2	4.0	↓	no
School Expulsions Rate (per 100 students)	0.05	0.05	↓	no

Source: Data sources may be found in Attachments 3 & 4. Rates are per 100,000 population unless otherwise noted.

Certain indicators are available by ethnicity, which shows disparities in certain populations. Indicators in red are more than 5% worse for that ethnic group than the benchmark.

Table 12, Core and Related Indicator Data for Violence & Preventable Injury by Ethnicity

Indicators	MC	Bench mark	White	Black	Asian Alone	Other	Multi Race	Hispanic /Latino (Any Race)
Homicide Rate (age-adjusted)	**9.6**	**5.2**	**3.5**	**12.0**	**4.5**	**N/A**	**1.1**	**12.0**
Fatal Motor Vehicle Accident Rate (age-adjusted)	**4.5**	**5.2**	**4.6**	**3.3**	**0.0**	**N/A**	**2.1**	**5.7**
Fatal Pedestrian Accident Rate (age-adjusted)	**1.5**	**1.3 (HP)**	**1.0**	**0.0**	**0.0**	**N/A**	**0.0**	**2.8**

Source: Data sources may be found in Attachments 3 and 4. Note: "Asian Alone" does not include the Pacific Islander population. Rates are per 100,000 population unless otherwise noted.

5) Economic Security

Below are core and related indicators for economic security (including income, education, and housing) in MC, compared to California state benchmarks or Healthy People 2020 aspirational goals, whichever was more stringent. Core indicators are shown in **bold**. Indicators shown in red are more than 5% (not five percentage points, but five percent) worse than the benchmark.

Table 13, Core and Related Indicator Data for Economic Security

Indicators	MC	Bench mark	Desired ↑↓	More than 5% Worse
Unemployment Rate	**5.5**	**5.3**	**Below (↓)**	**no**
Income Inequality (Gini Coefficient)	**0.46**	**0.48**	↓	**no**
Population Below 100% FPL	**17.2%**	**16.4%**	↓	**yes**
Population Below 200% FPL	**42.0%**	**36.4%**	↓	**yes**
Children Below 100% FPL	**25.6%**	**22.7%**	↓	**yes**
High School Graduation Rate	80.0	82.4 (HP)	Above (↑)	no
Homeless Individuals	0.53%	0.24%	↓	yes
Homeless Individuals Who are Unsheltered	70.6%	73.3%	↓	no
Reading Below Proficiency	49.0%	36.0%	↓	yes
Children Eligible for Free/Reduced Price Lunch	67.7%	58.1%	↓	yes
Population Receiving SNAP	11.5%	11.4%	↓	no
Population Receiving Medicaid	28.2%	24.4%	↓	yes
Less than High School Diploma (or Equivalent)	28.8%	18.5%	↓	yes
Uninsured Population	20.9%	16.7%	↓	yes
School Enrollment Age 3-4	40.1%	48.8%	↑	yes
Head Start Program Facilities Rate (per 10,000 children 0-5)	5.8	6.3	↑	yes
School Breakfast Program Participation	no data	3.9%	↓	N/A
Food Insecurity Rate	12.6%	15.0%	↓	no
Vacant Housing Units	10.4%	8.5%	↓	yes
Cost Burdened Households	46.5%	45.0%	↓	no
Substandard Housing Units	50.8%	47.5%	↓	yes

Indicators	MC	Bench mark	Desired ↑↓	More than 5% Worse
Assisted Housing Units Rate (per 10,000)	399.0	355.3	↓	yes
Commute Over 60 Minutes	5.1%	10.4%	↓	no
Households with No Vehicle	5.3%	7.8%	↓	no

Source: Data sources may be found in Attachments 3 and 4. Rates are per 100,000 population unless otherwise noted.

Certain indicators are available by ethnicity, which shows disparities in certain populations. Indicators in red are more than 5% worse for that ethnic group than the benchmark.

Table 14, Core and Related Indicator Data for Economic Security by Ethnicity

Indicators	MC	Bench mark	White	Black	Asian	Other	Multi Race	Hispanic /Latino (Any Race)
Population Below 100% FPL	**17.2%**	**16.4%**	**17.7%**	**19.4%**	**9.8%**	**18.3%**	**11.8%**	**23.1%**
Children Below 100% FPL	**25.6%**	**22.7%**	**8.2%**	**31.7%**	**7.3%**	**23.6%**	**10.6%**	**31.4%**
High School Graduation Rate (percent of cohort)	80.0%	82.4% (HP)	85.2%	80.8%	89.1%	84.6%	N/A	78.1%
Reading Below Proficiency	49.0%	36.0%	25.0%	47.3%	22.2%	N/A	N/A	56.0%
Less than High School Diploma or Equivalent	28.8%	18.5%	28.2%	16.5%	13.5%	52.0%	21.7%	51.9%
Uninsured Population	20.9%	16.7%	10.6%	13.1%	14.2%	27.4%	17.2%	27.8%

Source: Data sources may be found in Attachments 3 and 4.

6) Cardiovascular Disease/Stroke

Below are core and related indicators for cardiovascular disease/stroke in MC, compared to California state benchmarks or Healthy People 2020 aspirational goals, whichever was more stringent. Core indicators are shown in **bold**. Indicators shown in red are more than 5% (not five percentage points, but five percent) worse than the benchmark.

Table 15, Core and Related Indicator Data for Cardiovascular Disease/Stroke

Indicators	MC	Bench mark	Desired ↑↓	More than 5% Worse
Heart Disease Prevalence	**7.5%**	**6.3%**	**Below (↓)**	**yes**
Mortality Rate- Ischaemic Heart Disease (age-adjusted)	**129.4**	**100.8 (HP)**	↓	**yes**
Mortality Rate- Stroke (age-adjusted)	**38.3**	**37.4**	↓	**no**
High Blood Pressure - Unmanaged	32.5%	30.3%	↓	yes
Tobacco Usage	12.1%	12.8%	↓	no
Tobacco Expenditures	suppressed	1.0%	↓	N/A
Alcohol - Excessive Consumption (adults, age-adjusted)	14.8%	17.2%	↓	no
Alcohol - Expenditures	suppressed	12.9%	↓	N/A
Physical Inactivity (Adult)	17.2%	17.3%	↓	no
Physical Inactivity (Youth)	35.7%	35.9%	↓	no
Park Access	59.6%	58.6%	Above (↑)	no
Living in Car-Dependent Cities	no data	1.7%	↓	N/A
Overweight (Adult)	37.7%	35.8%	↓	yes
Obesity (Adult)	22.1%	22.4%	↓	no
Overweight (Youth)	22.4%	19.3%	↓	yes
Obesity (Youth)	24.5%	19.0%	↓	yes
Diabetes Prevalence (adults, age-adjusted)	7.5%	8.3%	↓	no
Diabetes Hospitalizations (age-adjusted discharge rate, per 10,000 population)	9.2	10.4	↓	no
Diabetes Management (Hemoglobin A1c Test)	84.1%	81.5%	↑	no

Source: Data sources may be found in Attachments 3 and 4. Rates are per 100,000 population unless otherwise noted.

Certain indicators are available by ethnicity, which shows disparities in certain populations. Indicators in red are more than 5% worse for that ethnic group than the benchmark.

Table 16, Core and Related Indicator Data for Cardiovascular Disease/Stroke by Ethnicity

Indicators	MC	Bench mark	White	Black	Asian Alone	Other	Multi Race	Hispanic /Latino (Any Race)
Heart Disease Prevalence	**7.5%**	**6.3%**	**11.6%**	**N/A**	**N/A**	**6.5%**	**N/A**	**5.0%**
Mortality Rate - Ischaemic Heart Disease	**129.4**	**100.8 (HP)**	**141.2**	**156.1**	**38.1**	**N/A**	**33.3**	**104.0**
Mortality Rate – Stroke (age-adjusted)	**38.3**	**37.4**	**39.9**	**45.6**	**0.0**	**N/A**	**13.2**	**33.9**
Physical Inactivity (Youth)	35.7%	35.9%	33.4%	43.0%	31.2%	N/A	28.3%	51.1%
Overweight (Youth)	22.4%	19.3%	19.1%	21.5%	20.4%	N/A	15.6%	23.6%

Source: Data sources may be found in Attachments 3 and 4. Note: "Asian Alone" does not include the Pacific Islander population. The ischaemic heart disease mortality rate for Pacific Islanders is also worse than the benchmark at 162.9. Rates are per 100,000 population unless otherwise noted.

7) Cancers

Below are core and related indicators for cancers in MC, compared to California state benchmarks or Healthy People 2020 aspirational goals, whichever was more stringent. Core indicators are shown in **bold**. Indicators shown in red are more than 5% (not five percentage points, but five percent) worse than the benchmark.

Table 17, Core and Related Indicator Data for Cancers

Indicators	MC	Bench mark	Desired ↑↓	More than 5% Worse
Breast Cancer Incidence Rate	**113.2**	**122.1**	**Below (↓)**	**no**
Cancer Mortality Rate (All Types) (age-adjusted)	**149.01**	**157.1**	↓	**no**
Cervical Cancer Incidence Rate	**7.2**	**7.1 (HP)**	↓	**no**
Colon and Rectum Cancer Incidence Rate	**29.3**	**38.7 (HP)**	↓	**no**
Prostate Cancer Incidence Rate	**156.2**	**126.9**	↓	**yes**
Lung Cancer Incidence Rate	**43.2**	**48.0**	↓	**no**
Alcohol - Excessive Consumption	14.8%	17.2%	↓	no
Alcohol - Expenditures	suppressed	12.9%	↓	N/A

Indicators	MC	Bench mark	Desired ↑↓	More than 5% Worse
Overweight (Adult)	37.7%	35.8%	↓	yes
Obesity (Adult)	22.1%	22.4%	↓	no
Cancer Screening - Mammogram	63.5%	59.3%	Above (↑)	no
Low Fruit/Vegetable Consumption (Adult)	71.1%	71.50%	↓	no
Fruit/Vegetable Expenditures	suppressed	14.1%	↑	N/A
Food Security - Food Desert Population	15.9%	14.3%	↓	yes
Tobacco Usage	12.1%	12.8%	↓	no
Tobacco Expenditures	suppressed	1.0%	↓	N/A
Cancer Screening - Pap Test (females ages 18+, age-adjusted)	80.2%	78.3%	↑	no
Physical Inactivity (Adult)	17.2%	17.3%	↓	no
Cancer Screening - Sigmoid/Colonoscopy (adults, age-adjusted)	55.0%	57.9%	↑	yes
Air Quality - Particulate Matter 2.5 (population-adjusted average)	0.0%	0.5%	↓	no

Source: Data sources may be found in Attachments 3 and 4. Rates are per 100,000 population unless otherwise noted.

Certain indicators are available by ethnicity, which shows disparities in certain populations. Indicators in red are more than 5% worse for that ethnic group than the benchmark.

Table 18, Core and Related Indicator Data for Cancers by Ethnicity

Indicators	MC	Bench mark	White	Black	Asian Alone	Other	Multi Race	Hispanic /Latino (Any Race)
Breast Cancer Incidence Rate	**113.2**	**122.1**	**119.0**	**104.7**	**92.9**	N/A	N/A	**85.2**
Cancer Mortality Rate (All Types) (age-adjusted)	**149.0**	**157.1**	**161.5**	**176.0**	**71.4**	N/A	**39.1**	**112.7**
Cervical Cancer Incidence Rate	**7.2**	**7.1 (HP)**	**7.5**	N/A	N/A	N/A	N/A	**6.7**
Colon and Rectum Cancer Incidence Rate	**29.3**	**38.7 (HP)**	**29.8**	**28.9**	**29.0**	N/A	N/A	**26.7**

Indicators	MC	Bench mark	White	Black	Asian Alone	Other	Multi Race	Hispanic /Latino (Any Race)
Prostate Cancer Incidence Rate	**156.2**	**126.9**	**141.4**	**145.6**	**87.3**	**N/A**	**N/A**	**156.5**
Lung Cancer Incidence Rate	**43.2**	**48.0**	**42.7**	**35.6**	**47.1**	**N/A**	**N/A**	**24.4**

Source: Data sources may be found in Attachments 3 and 4. Note: "Asian Alone" does not include the Pacific Islander population. Rates are per 100,000 population unless otherwise noted.

8) Maternal/Infant Health

Below are core and related indicators for maternal/infant health in MC, compared to California state benchmarks or Healthy People 2020 aspirational goals, whichever was more stringent. Core indicators are shown in **bold**. Indicators shown in red are more than 5% (not five percentage points, but five percent) worse than the benchmark.

Table 19, Core and Related Indicator Data for Maternal/Infant Health

Indicators	MC	Bench mark	Desired ↑↓	More than 5% Worse
Low Birth Weight	**5.6%**	**6.8%**	**Below (↓)**	**no**
Infant Mortality Rate (per 1,000 births)	**4.5**	**5.0**	↓	**no**
Pertussis cases of (per 1,000 infants aged <3 months)	**4.8**	**2.4**	↓	**yes**
Lack of Prenatal Care	**4.8%**	**3.1%**	↓	**yes**
Teen Births Rate (per 1,000 females under age 20)	**12.8**	**8.5**	↓	**yes**
Breastfeeding (Any)	96.4%	93.0%	Above (↑)	no
Breastfeeding (Exclusive)	71.5%	64.8%	↑	no
Head Start Program Rate (per 10,000 kids aged 0-5)	5.8	6.3	↑	yes
Education - School Enrollment Age 3-4	40.1%	48.8%	↑	yes
Food Security - Food Insecurity Rate	12.6%	15.0%	↓	no

Source: Data sources may be found in Attachments 3 and 4.

Certain indicators are available by ethnicity, which shows disparities in certain populations. Indicators in red are more than 5% worse for that ethnic group than the benchmark.

Table 20, Core and Related Indicator Data for Maternal/Infant Health by Ethnicity

Indicators	MC	Bench mark	White	Black	Asian Alone	Other	Multi Race	Hispanic / Latino (Any Race)
Infant Mortality Rate (per 1,000 births)	**4.5**	**5.0**	**4.4**	N/A	N/A	N/A	N/A	**4.3**
Breastfeeding (Any)	96.4%	93.0%	96.4%	88.6%	97.2%	85.7%	98.2%	96.5%
Breastfeeding (Exclusive)	71.5%	64.8%	86.8%	68.6%	79.0%	59.5%	82.4%	67.5%

Source: Data sources may be found in Attachments 3 and 4. Note: "Asian Alone" does not include the Pacific Islander population.

9) Oral Health

Below are core and related indicators for oral health in MC, compared to California state benchmarks or Healthy People 2020 aspirational goals, whichever was more stringent. Core indicators are shown in **bold**. Indicators shown in red are more than 5% (not five percentage points, but five percent) worse than the benchmark.

Table 21, Core and Related Indicator Data for Oral Health

Indicators	MC	Bench mark	Desired ↑↓	More than 5% Worse
Poor Dental Health	**9.4%**	**11.3%**	**Below (↓)**	**no**
No Recent Dental Exam (Adult)	**29.2%**	**30.5%**	↓	**no**
No Recent Exam (Youth)	**24.0%**	**18.5%**	↓	**yes**
Absence of Dental Insurance	**52.8%**	**40.9%**	↓	**yes**
Living in Health Professional Shortage Area - Dental Health Care	**27.5%**	**26.1%**	↓	**yes**
Soft Drink Expenditures	suppressed	3.6%	↓	N/A
Drinking Water Safety	0.5%	2.7%	↓	no
Dental Care - Lack of Affordability (Youth)	11.4%	6.3%	↓	yes

Source: Data sources may be found in Attachments 3 and 4.

Certain indicators are available by ethnicity, which shows disparities in certain populations. Indicators in red are more than 5% worse for that ethnic group than the benchmark.

Table 22, Core and Related Indicator Data for Oral Health by Ethnicity

Indicators	MC	Bench mark	White	Black	Asian Alone	Other	Multi Race	Hispanic / Latino (Any Race)
No Recent Dental Exam (Youth)	**24.0%**	**18.5%**	N/A	N/A	N/A	**15.7%**	N/A	**32.8%**
Absence of Dental Insurance	**52.8%**	**40.9%**	**43.9%**	N/A	**48.0%**	N/A	N/A	**48.6%**

Source: Data sources may be found in Attachments 3 and 4. Note: "Asian Alone" does not include the Pacific Islander population.

10) Infectious Diseases

Below are core and related indicators for infectious diseases in MC, compared to California state benchmarks or Healthy People 2020 aspirational goals, whichever was more stringent. Core indicators are shown in **bold**. Indicators shown in red are more than 5% (not five percentage points, but five percent) worse than the benchmark.

Table 23, Core and Related Indicator Data for Infectious Diseases

Indicators	MC	Bench mark	Desired ↑↓	More than 5% Worse
STD - Chlamydia	**397.1**	**459.2**	**Below (↓)**	**no**
STD - HIV Prevalence	**187.4**	**376.2**	↓	**no**
STD - HIV Hospitalizations (age-adjusted, per 10,000)	**0.7**	**2.0**	↓	**no**
STD - Early Syphilis (Males)	**20.5**	**20.8**	↓	**no**
STD - Gonorrhea	**70.0**	**138.9**	↓	**no**
TB incidence per 100,000	**3.7**	**1.0 (HP)**	↓	**yes**
Pertussis cases per 1,000 infants <3 months of age	**4.8**	**2.4**	↓	**yes**
Pertussis cases per 100,000	**17.4**	**11.6**	↓	**yes**
Influenza/Pneumonia Mortality Rate (age-adjusted)	**12.1**	**15.3**	↓	**no**

Indicators	MC	Bench mark	Desired ↑↓	More than 5% Worse
Pneumonia Vaccinations (Age 65+) (age-adjusted)	54.9%	63.4%	Above (↑)	yes
STD - No HIV Screening	69.7%	60.8%	↓	yes

Source: Data sources may be found in Attachments 3 & 4. Rates are per 100,000 population unless otherwise noted.

Certain indicators are available by ethnicity, which shows disparities in certain populations. Indicators in red are more than 5% worse for that ethnic group than the benchmark.

Table 24, Core and Related Indicator Data for Infectious Diseases by Ethnicity

Indicators	MC	Bench mark	White	Black	Asian Alone	Other	Multi Race	Hispanic /Latino (Any Race)
STD – HIV Prevalence	**187.4**	**376.2**	**171.3**	**946.3**	**N/A**	**N/A**	**N/A**	**166.4**
STD - No HIV Screening	69.7%	60.8%	52.4%	N/A	64.7%	N/A	N/A	55.0%

Source: Data sources may be found in Attachments 3 and 4. Note: "Asian Alone" does not include the Pacific Islander population. Rates are per 100,000 population unless otherwise noted.

Attachment 8. Community Assets & Resources

Monterey County is rich in health resources. This section lists facilities, clinics, and general resources available to the public to address health needs.

Existing Healthcare Facilities

- Natividad Medical Center
- Salinas Valley Memorial Healthcare System
- Community Hospital of the Monterey Peninsula
- George L. Mee Memorial Hospital

In addition to providing excellent clinical care to their members, non-profit hospitals in Monterey County invest in the community with a variety of strategies, including:

- Providing in-kind expertise, training and education for health professionals
- Financial assistance (charity care)
- Subsidies for qualified health services
- Covering unreimbursed Medi-Cal costs
- Community benefit grants for promising and evidence-based strategies that impact health needs identified through the CHNA

Existing Clinics

Many community healthcare clinics in Monterey County are funded in part by nonprofit hospitals, private donors, and healthcare districts. One of the largest networks of clinics in Monterey County is part of the County itself.

- Alisal Health Center[18]
- Clinica de Salud:
  - Mobile Medical Clinic
  - del Valle de Salinas (2 locations in Salinas, 1 each in Castroville, Pajaro, Watsonville, Soledad, Chualar, Greenfield, King City)
- Dr. Mohandas Free Clinic
- Laurel Clinics:[18]
  - Family Practice Clinic
  - Internal Medicine Clinic
  - Pediatrics Clinic
  - Women's Health Clinic
- Mee Hospital Memorial Clinics (4 locations in King City, 1 in Greenfield)
- Monterey Health Clinic at Marina[18]

[18] Operated by the Monterey County Health Department.

- Planned Parenthood – MarMonte (2 locations – Salinas and Seaside)
- Seaside Family Health Center[18]
  - RotaCare Clinic
- Seaside Community Health Clinic, operated by Salud Para La Gente

Other Existing Community Resources and Programs

On the following pages are lists of programs and resources available to meet each identified health need, which are listed alphabetically by health need:

Access to & Delivery of Care

All nonprofit hospitals provide charity care and cover the cost of unreimbursed Medi-Cal for underinsured patients.

- A.B. Ingham Medical Therapy Unit
- Access Support Network (ASN)
- Aging and Adult Services of Monterey County
- Big Sur Health Center: Health Care Services
- Breast & Cervical Cancer Treatment Program
- Casa de la Cultura
- Central California Alliance for Health:
  - Alliance Care In-Home Supportive Services (IHSS)
  - Medi-Cal Managed Care
  - Medi-Cal Access Program for Pregnant Women
- Central Coast Senior Services, Incorporated: In-Home Senior Services
- Central Coast Visiting Nurse Association & Hospice:
  - Home Health Program
  - Immunization Clinic
- Children's Hospice & Palliative Care Coalition (CHPCC)
- Clinica de Salud del Valle de Salinas
  - Child Healthcare
  - General Medical Services
  - Mobile Clinic
- Coastal Kids Home Care: Pediatric Home Health Care
- Community Benefits of Monterey County (CB):
  - MC Choice
  - Medicaid/Medi-Cal Program
- Community Homeless Solutions:
  - Mobile Outreach Services Team (MOST)
  - Respite Center Program

- CHOMP: General Hospital Services
- Covered California
- Dorothy's Place
- Dr. Mohandas Free Clinic
- Easter Seals Disability Services
- Every Woman Counts
- Family Planning Services: Family PACT Program
- George L Mee Memorial Hospital
- Heartland Hospice Care: Health Care
- Hospice of The Central Coast:
    - Health Care
    - Senior Services
- Impact Monterey County collaborative
- Jacob's Heart Children's Cancer Support Services
- MC-CHOICE
- Mee Memorial Hospital:
    - Clinics
    - Hospital
    - The Women's Center
- Military and Veteran's Affairs Office of Monterey County: VA Mobile Medical Team
- Monterey County Department of Social Services (DSS): Covered California Program
- Monterey County Health Department at Natividad Medical Center:
    - Laurel Family Practice Clinic
    - Laurel Internal Medicine Clinic
    - Laurel Pediatrics Clinic
- Monterey County Health Department Clinic Services Division:
    - Pediatrics
    - Primary Care
    - Women's Health Program
- Monterey County Health Department Environmental Health Division: Consumer Health Protection
- Monterey County Health Department:
    - Alisal Health Center
    - California Children Services (CCS)
    - Child Health & Disability Prevention Program (CHDP)
    - Comprehensive Perinatal Services Program
    - Monterey County Health Clinic at Marina

    - Seaside Family Health Center
- Monterey County Health Department: Immunization Clinics - Alisal Health Center & Seaside Family Health Center
- Monterey County Health Department Whole Person Care pilot
- Monterey County Prescribe Safe Initiative:
    - Pain Management Options
    - Patient Advocate
- Monterey Peninsula Unified School District: MPUSD Special Education Services
- Natividad Medical Center: Medical Health Care
- Natividad Medical Foundation: Support Services
- Partnership for Prescription Assistance
- Planned Parenthood
- Presumptive Eligibility Program for Pregnant Women
- Rotacare Free Clinic of Monterey Peninsula: Health Care
- Salinas Valley Memorial Healthcare System (SVMHS):
    - Hospital Services
    - Lifeline Medical Alert
- Salud Para La Gente:
    - Benefits Application Assistance
    - Clinics
    - Seaside Community Health Clinic
- San Andreas Regional Center
    - Developmental Case/Care Management
    - Developmental Disabilities Diagnostic and Evaluation Services
- Seaside Family Health Center: RotaCare Clinic
- Shelter Outreach Plus: MOST (Mobile Outreach Services)
- Social Security Administration (SSA): Medicare
- United States Department of Veterans Affairs: Outpatient Services
- United Way Monterey County (UWMC):
    - 2-1-1 Monterey County
    - Familywize Discount Card
- Veterans Administration Health Clinic of Monterey

Behavioral Health

- Active Seniors, Inc
- Alanon Support Groups
- Alateen Support Groups
- Alcoholics Anonymous, Monterey Bay Area & Salinas Valley

- Alisal Family Resource Center: Women's Health Counseling
- Alisal Union School District: Homeless Student Liaison
- Alliance on Aging
- Arms of Angels: Grief counseling after the loss of a loved one
- Army Substance Abuse Program: Army substance abuse program, outreach program
- Aspiranet: Family Services, Behavioral Health
- Beacon House: Chemical Dependency Treatment Program
- Big Sur Unified School District (BSUSD): Homeless Student Liaison
- Birth Network of Monterey County (BNOMC): Postpartum Warmline, Support Groups
- Breakthrough for Men: Breakthrough Workshops
- Bridge Restoration Ministry
- California State Department of Corrections and Rehabilitation: Offender Mentor Certification Program - Alcohol & Drug Counseling Certification
- Carmel Unified School District (CUSD): Homeless Student Liaison
- Catholic Charities of The Diocese of Monterey: Mental Health Services
- Celebrate Recovery
- Central Coast HIV/AIDS Services
- Children's Hospice & Palliative Care Coalition (CHPCC)
- Christine Marie's Star Riders: Therapeutic Horseback Riding
- City of Salinas: At Risk Youth Services
- Clinica de Salud del Valle de Salinas
- Community Homeless Solutions:
    - 12th Street Day Center
    - Mobile Outreach Services Team (MOST)
- Community Hospital of The Monterey Peninsula (CHOMP):
    - Grief Support Groups
    - Griefbusters
    - Outpatient Behavioral Health Services
    - OPIS Clinic
    - Substance Abuse Recovery Services
    - Crisis Intervention
    - Recovery Center Adult Services
- Community Human Services (CHS):
    - Anger Management Program
    - Drug and Alcohol Intervention Services for Youth (DAISY)
    - Elm House
    - Family Service Center
    - Family to Family

    - Genesis House substance abuse services
    - LGBT Counseling and Therapy Services (CATS)
    - Mental Health Services
    - Methadone Program
    - Outpatient Treatment Centers
    - Safe Place
    - SuperKids & SuperTeens
    - Off Main Clinic
    - Outpatient Mental Health Counseling
    - Safe Passage
- Compass Church:
    - Celebrate Recovery
    - New Hope Counseling
- Confidence Pregnancy Center of Salinas
- District Attorney, Victim/Witness Assistance Program
- Door to Hope:
    - Integrated Co-occurring Treatment (ICT)
    - Mentor Moms and Dads
    - Monterey County Screening Team for Assessment, Referral and Treatment (MCSTART)
    - Nueva Esperanza
    - Outpatient/Intensive Outpatient Program
    - Santa Lucia Group Home
    - Women's Residential Program
    - ICT (Integrated Co-occurring Treatment)
- Easter Seals Disability Services
- Epicenter
- First 5 Monterey County
- First Presbyterian Church: Celebrate Recovery
- First United Methodist Church of Salinas
- Fleet and Family Support Center: Military Family Counseling
- Gathering for Women: Homeless Women Service
- GLBT National Help Center
- Gonzales Unified School District: Homeless Student Liaison
- Greenfield Union School District (GUSD): Homeless Student Liaison
- Harmony at Home:
    - On-site Counseling
    - Sticks & Stones
    - Teen Enrichment Summer Camp
- Hartnell College: Successfully Parenting At-Risk Kids (SPARK)

- Hospice of The Central Coast: Grief Counseling
- Housing Resource Center
- Interim, Inc.:
    - Bridge House
    - Community Housing Program
    - Dual Recovery Services
    - Manzanita House
    - OMNI Resource Center
    - Outreach and Aftercare Services
    - Sandy Shores
    - Shelter Cove
    - Success Over Stigma (SOS)
    - MCHOME
- Impact Monterey County collaborative
- Jacob's Heart Children's Cancer Support Services
- King City Union School District (KCUSD): Homeless Student Liaison
- Mentor Moms & Dads: Foster & Adoptive Mentors
- Military One-Source Information & Referral Helpline
- Monterey County Behavioral Health:
    - Mental Health Hotlines
    - Mental Health Services
- Monterey County Behavioral Health Children and Adolescent Services:
    - Avanza
    - Family Partners
    - Home Partners
    - Mental Health Services
    - Safe School/Healthy Students
    - Services for Children
- Monterey County Department of Social Services:
    - Office of Aging & Adult Services
    - Senior Helpline
- Monterey County Health Department:
    - Behavioral Health, Adult Services
    - Children's Behavioral Health
    - Whole Person Care pilot
- Monterey County Probation Department:
    - Strengthening Families
    - Silver Star Resource Center
- Monterey County Rape Crisis Line
- Monterey Peninsula Unified School District (MPUSD):

    - High School Programs
    - Homeless Student Liaison
- Monterey Veterans Resource Center
- Mother to Baby California
- Narcotics Anonymous
- National Alliance on Mental Illness (NAMI):
    - Mental Health Advocacy
    - NAMI Family Support Group
- National Suicide Prevention Lifeline
- Natividad Medical Center
    - N.I.D.O. Clinic
    - Crisis Intervention
    - Behavioral Health Crisis Team
    - Crisis Team
- Natividad Medical Foundation: Support Services
- North Monterey County Unified School District (NMCUSD): Homeless Student Liaison
- Outreach Unlimited: Interfaith Homeless Emergency Lodging Program (I-HELP)
- Pacific Grove Police Department: Drug Abuse Resistance Education Program (DARE)
- Pacific Grove Unified School District: Homeless Student Liaison
- Pacific Stroke Association: Stroke Support Groups
- Pajaro Rescue Mission
- Partners for Peace:
    - Parent Project
    - STEP UP Mentoring
    - Strengthening Families Program (SFP)
- Peacock Acres, Inc.:
    - Incarceration to Success
    - Social Services
    - Path Plus of Monterey County
- Planned Parenthood Mar Monte: Teen Success
- PREP Monterey County
- Prevention and Recovery in Early Psychosis (PREP): Early Intervention Treatment
- Public Health Nursing, Monterey County Health Department: Teen Parenting Program
- Rancho Cielo:
    - Mentor Program

    - Youthbuild
    - Salinas Youth Corps
    - Silverstar Youth Program
- Reintegration Program (HVRP) and Female Veteran & Veterans with Families (FVVWF)
- Safe Place: Safe Place Program
- Salinas City Elementary School District: Homeless Student Liaison
- Salinas New Life Church of The Nazarene: Celebrate Recovery
- Salinas Union High School District (SUHSD): Homeless Student Liaison
- Salinas Valley Memorial Healthcare System (SVMHS):
    - Loss & Grief Support Group
    - Mended Hearts Support Group
    - Multiple Sclerosis Support Group
    - Postpartum and Perinatal Loss Support Group
    - Prostate Cancer Support Group
- Salvation Army of Salinas: Family Services
- San Antonio Union School District (SAUSD): Homeless Student Liaison
- San Ardo Union School District (SAUSD): Homeless Student Liaison
- Santa Lucia Group Home
- Santa Rita Union School District (SRUSD): Homeless Student Liaison
- Second Chance Youth Program:
    - Counseling
    - Crisis Intervention Services
    - Fuerzas Project Teen Parent Circle
    - Joven Noble con Palabra
    - Family & Youth Services
- Shine A Light Counseling Center: Counseling Services
- Shoreline Community Church:
    - Celebrate Recovery
    - Faith-based Counseling
- Soledad Unified School District (SUSD): Homeless Student Liaison
- SPARK
- Suicide Prevention Services of the Central Coast
- Suicide.org
- Sun Street Centers:
    - Driving Under the Influence Program
    - Men's Residential Center
    - Men's Transitional Housing Program
    - Outpatient Counseling Services
    - Outpatient Recovery Services

    - Prevention Program
    - Pueblo del Mar Family Recovery Community
    - Safe Teens Empowerment Project
    - Community Recovery & Resource Center in Salinas, Monterey & South County
    - Pueblo del Mar Family Recovery Community
    - Seven Suns Transitional Housing for Men
    - Sun Street Outpatient Counseling Services
- Sunrise House:
    - Crisis Line
    - Drug Abuse Counseling
    - Mental Health Services
    - Never Alone
    - Seven Challenges
- The Epicenter:
    - Education & Empowerment
    - Health and Wellness
- The Gathering Place for Women
- The Village Project, Inc.: Community Services
- Trevor Lifeline
- United Way Monterey County: 2-1-1 Monterey County
- Uplift Family Services: Therapeutic Behavioral Services (TBS)
- Valley Baptist Church: Sober Project
- Valley Health Associates
    - Drug and Alcohol Diversion Program
    - Methadone Detoxification Program
    - Methadone Maintenance Program
- Veterans Crisis Line
- Veterans Transition Center
- Victory Mission, Incorporated:
    - Homeless Support Services
    - Marriage and Family Counseling
- Victory Outreach Church: Youth Services
- Vocational Rehabilitation Specialist Inc (VRSI): Homeless Veterans
- Washington Union School District (WUSD): Homeless Student Liaison
- YWCA Monterey County:
    - YWCA Counseling Center
    - Counseling Services
    - Domestic Violence Crisis Line

Cancers

- American Cancer Society: Support Services
- Breathe California, Central Coast
- Cancer Information Service
- CHOMP: Comprehensive Cancer Center
- Every Woman Counts: Every Woman Counts Cancer Detection
- Look Good Feel Better (LGFB): Look Good Feel Better
- Natividad Medical Center: Breast Cancer Screening Program
- Salinas Valley Memorial Healthcare System (SVMHS): Cancer Support Group

Cardiovascular Disease/Stroke

- American Heart Association
- CHOMP: Tyler Heart Institute
- Impact Monterey County collaborative
- Monterey County Health Department initiatives that support a healthy and active lifestyle and healthy eating
- Natividad Medical Center: Stroke Rehabilitation Program
- Pacific Stroke Association: Stroke Support Groups
- SVMHS: Stroke Center
- Visionary Health Care Services

Diabetes & Obesity

- Alisal Family Resource Center: General Health Care Assistance Programs
- Parent nutrition cooking class
- Blind and Visually Impaired Center (BVIC): Disabilities Support Services for Blindness Caused by Diabetes and Other Conditions
- Casa de la Cultura
- Central California Alliance for Health
- Central Coast YMCA:
    - Health and Wellness
    - Sports
- CHOMP:
    - Diabetes & Nutrition Therapy Outpatient Program
    - Diabetes Support Groups
    - Nutrition Therapy Outpatient Program
- Community Benefits of Monterey County (CB): CalFresh

- Food Bank for Monterey County: The Family Market
- Impact Monterey County collaborative
- Just Run
- Monterey County Health Department:
    - Public Health Nursing
    - WIC - Women, Infants & Children Nutrition Program
    - Initiatives that support a healthy and active lifestyle and healthy eating
- Natividad Medical Center: Diabetes Education Center
- Pajaro Valley Community Health Trust: Diabetes Health Center
- Salinas Valley Memorial Healthcare System (SVMHS):
    - Health Education
    - Wellness Program
- Seaside Family Health Center:
    - RotaCare Clinic
    - RotaCare Clinic & Diabetes Clinic

Economic Security

- Alisal Family Resource Center - Family support group
- Army Community Service (ACS): Financial Readiness
- Army Emergency Relief
- Benefits Checkup
- Carmel Foundation
- Catholic Charities - Salinas
- Catholic Charities of The Diocese of Monterey: Family Supportive Services
- Central Coast Energy Services
- Central Coast HIV/AIDS Services
- CHISPA
- Community Benefits of Monterey County (CB):
    - CalFresh
    - CalWORKS Cash Assistance Program
- Community Homeless Solutions:
    - 12th Street Day Center
    - Mobile Outreach Services Team (MOST)
- Community Human Services (CHS):
    - Genesis House substance abuse services
    - Runaway and Homeless Youth Helpline
    - Safe Passage
- Door to Hope:

    - Santa Lucia Group Home
    - Women's Residential Program
- Dorothy's Place
- Financial Transitions Institute: Financial Assistance
- First 5 Monterey County
- First United Methodist Church of Salinas
- Fleet and Family Support Center: Military Financial Planning Assistance
- Food Bank for Monterey County
- For Kids Foundation Monterey Bay: Financial Assistance
- Gathering for Women: Homeless Women Service
- Goodwill Industries
- Housing Authority of Monterey County
- Housing Resource Center
- Impact Monterey County collaborative
- Interim, Incorporated:
    - Bridge House
    - Community Housing Program
    - Manzanita House
    - Sandy Shores
    - Shelter Cove
    - MCHOME
- Internal Revenue Service (IRS): Taxpayer Assistance
- Jacob's Heart Children's Cancer Support Services
- King City Union School District: King City Family Resource Center
- Lens Crafters
- Medicare
- Mid-Bay Emergency and Referral Center, Inc.: Utility Assistance
- Monterey Bay Economic Partnership
- Monterey County Department of Social Services:
    - CalFresh (Food Stamp) Program
    - Cash Aid - CalWORKS and the General Assistance Program
    - Community Benefits Branch
    - Office of Aging & Adult Services
- Monterey County Health Department:
    - California Children Services (CCS)
    - WIC - Women, Infants & Children Nutrition Program
- Monterey County Military & Veterans Affairs
- Monterey County Office of Education: MCOE Infant Development Program
- One Stop Career Center of Monterey County Youth Employment Program

- Outreach Unlimited: Interfaith Homeless Emergency Lodging Program (I-HELP)
- Pajaro Rescue Mission
- Pajaro Valley Unified School District: Pajaro Family Resource Center
- Partnership for Prescription Assistance
- Pass the Word Ministry
- Peacock Acres/Path Plus of Monterey County
- Rancho Cielo Youth Campus
- Salvation Army Monterey Peninsula Corps:
    - Frederiksen House - Temporary Emergency Shelter
    - Temporary Financial Assistance
- Salvation Army of Salinas: Family Services
- Salvation Army:
    - Casa de las Palmas
    - Good Samaritan Center
- Santa Lucia Group Home
- Seaside-Sand City Chamber of Commerce: Support Services
- Shelter Outreach Plus:
    - Emergency Shelters
    - Men in Transition
    - MOST (Mobile Outreach Services)
    - Women in Transition
    - Homeward Bound
- Social Security Administration
- Society of St. Vincent de Paul Thrift Store
- Sun Street Centers:
    - Men's Residential Center
    - Men's Transitional Housing Program
- Sunrise House: Teen Closet
- SVMHS: Tele-Care & Lifeline
- The Gathering Place for Women
- United Way Monterey County
    - 2-1-1 Monterey County
    - Volunteer Income Tax Assistance Program (VITA)
- Veterans Administration Health Clinic of Monterey
- Veterans Transition Center
- Victory Mission, Inc.: Homeless Support Services
- Vocational Rehabilitation Specialist Inc (VRSI): Homeless Veterans

Infectious Diseases

- Access Support Network (ASN)
- Central Coast HIV/AIDS Services
- Central Coast Visiting Nurse Association and Hospice (CCVNA): Immunization Clinic
- CHOMP: OPIS Clinic
- Community Human Services: Outpatient Mental Health Counseling C.A.T.S. Program
- Monterey County Health Department Clinic Services Division: Whooping Cough/Pertussis Vaccine
- Monterey County Health Department, Public Health Bureau Services:
    - Communicable Disease Program
    - Ebola Virus Disease
- Monterey County Health Department:
    - Child Health & Disability Prevention Program (CHDP)
    - Tuberculosis Case Management & Prevention Services
    - Immunization Clinics - Alisal Health Center & Seaside Family Health Center
- Natividad Medical Center:
    - N.I.D.O. Clinic
    - Certified Enrollment Entities
    - HIV Services

Maternal/Infant Health

- Avondale Early Education Center: Early Development Services. Inc.
- 1-877-BABY-SAFE
- Action Council of Monterey County. Inc.: Parents as Teachers
- Alisal Union School District: Alisal Family Resource Center
- Birth Network of Monterey County:
    - Postpartum Warmline
    - Support Groups
- Central California Alliance for Health: Medi-Cal Access Program for Pregnant Women
- Central Coast Multispecialty Medical Group: Fertility and Special Gynecological Services
- CHOMP: Family Birth Center
- Coastal Kids Home Care
- Compassion Pregnancy Center of The Monterey Bay: Health Care

- Confidence Pregnancy Center: Pregnancy Support
- Door to Hope:
    - MCSTART
    - Pathways to Safety
- Early Development Services. Inc.: Peninsula Center for Infant & Toddler Development
- First 5 Monterey County
- King City Union School District: King City Family Resource Center
- La Leche League of The Monterey Peninsula and Salinas: Breastfeeding Support Services
- Monterey County Department of Social Services Family and Children's Services (Child Protective Services)
- Monterey County Department of Social Services Family and Children's Services (Child Protective Services): Child Abuse Reporting Hotline
- Monterey County Early Start Program for Infants with Special Needs: Early Start Infant Program
- Monterey County Health Department at Natividad Medical Center: Laurel Pediatrics Clinic
- Monterey County Health Department Clinic Services Division:
    - Pediatrics
    - Women's Health Program
- Monterey County Health Department:
    - Comprehensive Perinatal Services Program
    - Public Health Nursing
    - WIC - Women, Infants & Children Nutrition Program
        - Breastfeeding Education and Breast Pump Equipment Loan Program
- Monterey County Office of Education:
    - Dads in Action
    - Early Head Start
    - MCOE Infant Development Program
- Monterey Peninsula Unified School District:
    - Cal-Safe Teen Parent Program
    - Community Family Resource Center
    - MPUSD Infant Development Program
- Mother to Baby California
- Natividad Medical Center: Outpatient Lactation Clinic
- Natividad Medical Foundation: Support Services
- North Monterey County Unified School District:
    - Castro Plaza Child & Family Resource Center
    - Central Bay Continuation High School

- Pacific Grove Adult School: Parents' Place
- Pajaro Valley Unified School District: Pajaro Family Resource Center
- Parenting Connection of Monterey County
- Parenting Connection of Monterey County:
  - Postpartum Support Groups
  - Postpartum Warmline
- Planned Parenthood
- Presumptive Eligibility Program for Pregnant Women
- Salinas Adult School Education Center:
  - Childbirth Education
  - Parent and Child Activity Classes
  - Parent Education
- Salinas Adult School: The Parent Center
- Salinas Union High School District: Mount Toro High School
- Salinas Valley Memorial Healthcare System (SVMHS): Breastfeeding Support Group
- San Andreas Regional Center
- Soledad Adult School
- SPARK

Oral Health

- Central Coast Pediatric Dental Group
- Clinica de Salud del Valle de Salinas:
  - Alvin Dental Clinic
  - Dental Care
- Monterey County Department of Social Services (DSS): Denti-Cal
- Natividad Medical Center: Emergency Room
- Salud Para la Gente:
  - Community Oral Health Services
  - Seaside Community Health Clinic

Violence & Preventable Injury

- 1-877-BABY-SAFE: Safely Surrendered Baby Law
- Alisal Family Resource Center: Women's Health Counseling
- Alternatives to Living in Violent Environments: A.L.I.V.E. for Men
- Asi Counseling and Professional Services Inc.: Domestic Violence Counseling
- Boys Town National Hotline

- Carmel Police Department: DARE Juvenile Diversion Program
- Child Abuse Prevention Council of Monterey County: Child Abuse Prevention Programs
- City of Salinas: At Risk Youth Services
- Community Alliance for Safety and Peace (CASP): CASP General Assembly Meeting
- Community Homeless Solutions:
  - Emergency Shelter for Women
  - Homeward Bound
- Community Human Services (CHS):
  - Anger Management Program
  - Pathways to Safety
  - Safe Passage
  - Safe Place
  - Domestic Violence/Anger Management Groups
  - Runaway and Homeless Youth Helpline
- Compass Church: New Hope Counseling
- District Attorney, Victim/Witness Assistance Program
- Door to Hope: Pathways to Safety
- Dorothy's Place: Women Alive
- Family and Children's Services of Monterey County (FCS):
  - 24 Hour Child Protective Services
  - Child Abuse Prevention Council
  - Pathway to Safety
- Family Service Agency of the Central Coast: Suicide Prevention Services of the Central Coast
- Fleet and Family Support Center: Sexual Assault Prevention and Response
- Franciscan Workers of Junipero Serra: Women Alive! Emergency Shelter
- Harmony at Home: Sticks & Stones
- Impact Monterey County collaborative
- Monterey County Department of Social Services Family and Children's Services (Child Protective Services)
- Monterey County Department of Social Services Family and Children's Services (Child Protective Services): Child Abuse Reporting Hotline
- Monterey County Department of Social Services:
  - Adult Protective Services Hotline
  - Senior Helpline
- Monterey County Probation Department: Family Violence Unit
- Monterey County Rape Crisis Line
- Mother to Baby California

- National Suicide Prevention Lifeline
- Natividad Medical Center Crisis Team
- Natividad Medical Foundation: Support Services
- Outreach Unlimited: Interfaith Homeless Emergency Lodge Program for Women (I-HELP)
- Pacific Grove Police Department: Police Services
- Partners for Peace:
  - Parent Project
  - STEP UP Mentoring
  - Strengthening Families Program (SFP)
- Peacock Acres, Inc: Incarceration to Success
- Rancho Cielo:
  - Silverstar Youth Program
  - Youth Services
- Restorative Justice Partners, Inc.: Victim Offender Reconciliation Program
- Safe Kids Monterey County: Child Safety Gun Locks
- Safe Place Program
- Sally P Archer Child Advocacy Center: Child Sexual Abuse Advocacy Program
- Salvation Army Monterey Peninsula Corps: Frederiksen House - Temporary Emergency Shelter
- Second Chance Youth Program:
  - Cara Y Corazon
  - Crisis Intervention Services
- Shelter Outreach Plus Emergency Shelters
- Suicide Prevention Services of the Central Coast
- Suicide.org
- Sunrise House:
  - 24-hour Crisis Line (831) 758-3302
  - Youth Alternative to Violence (YATV)
- The Village Project, Inc.: Community Services
- United Way Monterey County
  - 2-1-1 Monterey County
- Veterans Crisis Line
- Victory Mission, Inc.: Emergency Shelter
- YWCA:
  - Counseling Center
  - Domestic Violence Crisis Line
  - Lawson Safe House
  - School-Based Violence Prevention Program