

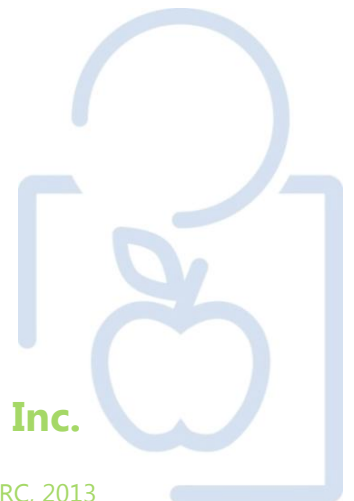
# 2013 PRC Community Health Needs Assessment

An Assessment of the Health of Residents of the  
Monterey Peninsula & Surrounding Communities

Sponsored by



Community Hospital of the Monterey Peninsula®



**Professional Research Consultants, Inc.**

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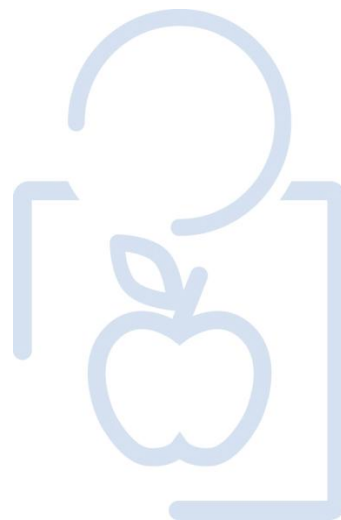
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# INTRODUCTION



# Project Overview

## Project Goals

This Community Health Needs Assessment, a follow-up to similar studies conducted in 2007 and 2010, is a systematic, data-driven approach to determining the health status, behaviors and needs of residents in the service area of Community Hospital of the Monterey Peninsula (CHOMP). Subsequently, this information may be used to inform decisions and guide efforts to improve community health and wellness.

A Community Health Needs Assessment provides information so that communities may identify issues of greatest concern and decide to commit resources to those areas, thereby making the greatest possible impact on community health status. This Community Health Needs Assessment will serve as a tool toward reaching three basic goals:

- **To improve residents' health status, increase their life spans, and elevate their overall quality of life.** A healthy community is not only one where its residents suffer little from physical and mental illness, but also one where its residents enjoy a high quality of life.
- **To reduce the health disparities among residents.** By gathering demographic information along with health status and behavior data, it will be possible to identify population segments that are most at-risk for various diseases and injuries. Intervention plans aimed at targeting these individuals may then be developed to combat some of the socio-economic factors which have historically had a negative impact on residents' health.
- **To increase accessibility to preventive services for all community residents.** More accessible preventive services will prove beneficial in accomplishing the first goal (improving health status, increasing life spans, and elevating the quality of life), as well as lowering the costs associated with caring for late-stage diseases resulting from a lack of preventive care.

This assessment was conducted on behalf of CHOMP by Professional Research Consultants, Inc. (PRC). PRC is a nationally-recognized healthcare consulting firm with extensive experience conducting Community Health Needs Assessments such as this in hundreds of communities across the United States since 1994.

## Methodology

This assessment incorporates data from both quantitative and qualitative sources. Quantitative data input includes primary research (the PRC Community Health Survey) and secondary research (vital statistics and other existing health-related data); these quantitative components allow for trending and comparison to benchmark data at the state and national levels. Qualitative data input includes primary research gathered through a series of Key Informant Focus Groups.

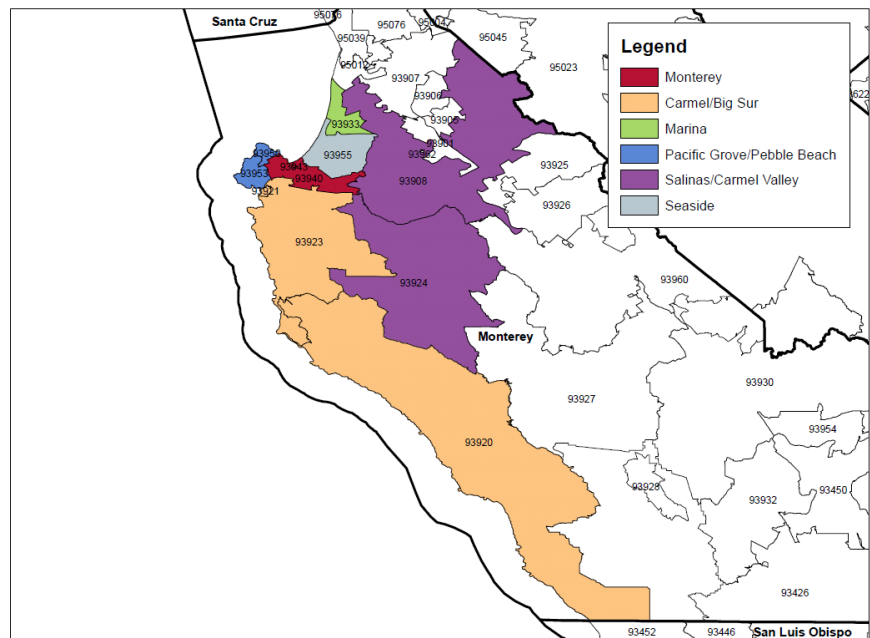
## PRC Community Health Survey

### Survey Instrument

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

### Community Defined for This Assessment

The study area for the survey effort (referred to as “CHOMP Service Area” in this report) includes each of the communities comprising the hospital’s service area, including Monterey, Carmel, Big Sur, Seaside, Marina, Pacific Grove, Pebble Beach, Salinas, and Carmel Valley. This community definition, determined based on the ZIP Codes of residence of recent CHOMP patients, is illustrated in the following map.



### Sample Approach & Design

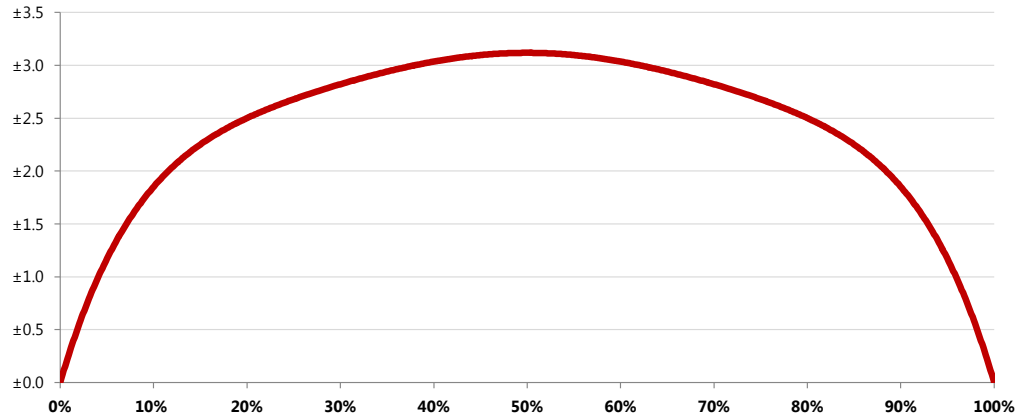
A precise and carefully executed methodology is critical in asserting the validity of the results gathered in the *PRC Community Health Survey*. Thus, to ensure the best representation of the population surveyed, a telephone interview methodology — one that incorporates both landline and cell phone interviews — was employed. The primary advantages of telephone interviewing are timeliness, efficiency and random-selection capabilities.

The sample design used for this effort consisted of a random sample of 1,000 individuals age 18 and older in the CHOMP Service Area, resulting in 234 surveys in Monterey, 127 in Carmel/Big Sur, 217 in Seaside, 147 in Marina, 143 in Pacific Grove/Pebble Beach, and 132 in Salinas/Carmel Valley (proportional to the population distribution). All administration of the surveys, data collection and data analysis was conducted by Professional Research Consultants, Inc. (PRC).

## Sampling Error

For statistical purposes, the maximum rate of error associated with a sample size of 1,000 respondents is  $\pm 3.1\%$  at the 95 percent level of confidence.

### Expected Error Ranges for a Sample of 997 Respondents at the 95 Percent Level of Confidence



- Note:
- The "response rate" (the percentage of a population giving a particular response) determines the error rate associated with that response. A "95 percent level of confidence" indicates that responses would fall within the expected error range on 95 out of 100 trials.
- Examples:
- If 10% of the sample of 997 respondents answered a certain question with a "yes," it can be asserted that between 8.1% and 11.9% ( $10\% \pm 1.9\%$ ) of the total population would offer this response.
  - If 50% of respondents said "yes," one could be certain with a 95 percent level of confidence that between 46.9% and 53.1% ( $50\% \pm 3.1\%$ ) of the total population would respond "yes" if asked this question.

## Sample Characteristics

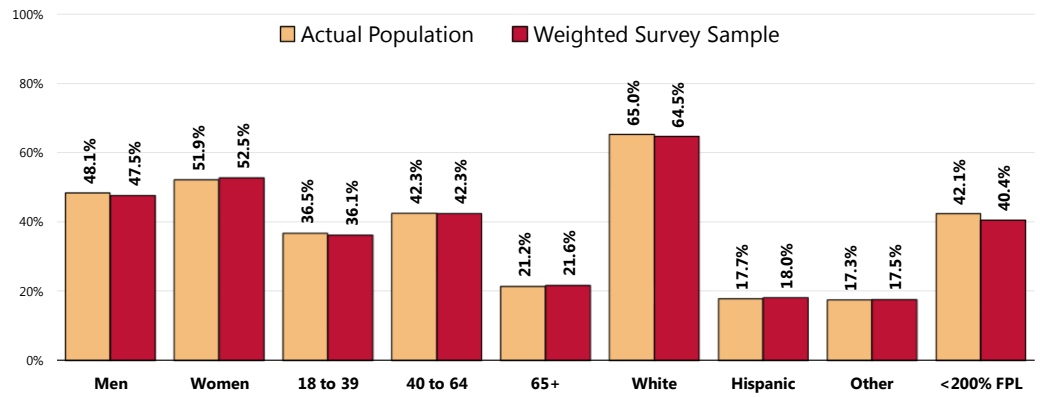
To accurately represent the population studied, PRC strives to minimize bias through application of a proven telephone methodology and random-selection techniques. And, while this random sampling of the population produces a highly representative sample, it is a common and preferred practice to "weight" the raw data to improve this representativeness even further. This is accomplished by adjusting the results of a random sample to match the geographic distribution and demographic characteristics of the population surveyed (poststratification), so as to eliminate any naturally occurring bias. Specifically, once the raw data are gathered, respondents are examined by key demographic characteristics (namely gender, age, race, ethnicity, and poverty status) and a statistical application package applies weighting variables that produce a sample which more closely matches the population for these characteristics. Thus, while the integrity of each individual's responses is maintained, one respondent's responses may contribute to the whole the same weight as, for example, 1.1 respondents. Another respondent, whose demographic characteristics may have been slightly oversampled, may contribute the same weight as 0.9 respondents.

The following chart outlines the characteristics of the CHOMP Service Area sample for key demographic variables, compared to actual population characteristics revealed in census data. [Note that the sample consisted solely of area residents age 18 and older; data on children were given by proxy by the person most responsible for that child's healthcare needs, and these children are not represented demographically in this chart.]



## Population & Sample Characteristics

(CHOMP Service Area, 2013)



Sources: • Census 2010, Summary File 3 (SF 3). U.S. Census Bureau.  
• 2013 PRC Community Health Survey, Professional Research Consultants, Inc.

Further note that the poverty descriptions and segmentation used in this report are based on administrative poverty thresholds determined by the US Department of Health & Human Services. These guidelines define poverty status by household income level and number of persons in the household (*e.g., the 2013 guidelines place the poverty threshold for a family of four at \$23,550 annual household income or lower*). In sample segmentation: “<200% FPL” refers to community members living in a household with incomes up to 199% of the federal poverty level; “200-399% FPL” refers to households with incomes at twice the poverty level and earning up to 399% of poverty threshold; and “400%+ FPL” refers to those households living on incomes which are four times or more the federal poverty level.

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

### Key Informant Focus Groups

As part of this Community Health Needs Assessment, two focus groups were held on June 20, 2013. Focus group participants included 28 local key informants: physicians, a public health representative, other health professionals, social service providers, business leaders and other community leaders.

A list of recommended participants for the focus groups was provided by Community Hospital of the Monterey Peninsula. Potential participants were chosen because of their ability to identify primary concerns of the populations with whom they work, as well as of the community overall. Focus group candidates were first contacted by letter to request their participation. Follow-up phone calls were then made to ascertain whether or not they would be able to attend. Confirmation calls were placed the day before the groups were scheduled to insure a reasonable turnout.

Final participation included representatives of the organizations outlined in the following tables. Through this process, input was gathered from a representative of public health, as well as several individuals whose organizations work with low-income, minority (including African American, Hispanic, Asian Americans/Pacific Islanders, and undocumented residents), or other medically underserved populations (specifically,

elderly, the uninsured/ underinsured, mentally ill, homeless residents, and Medical/Medicare recipients.)

Key Informant Focus Group: Health Providers	Populations Served		
	Medically Underserved	Low-Income Residents	Minority Populations
Thursday, June 20th, 7:30 to 9:30 AM			
Organizations Represented			
Monarch Cove			
Natividad Medical Center	X	X	X
Central Coast Visiting Nurse Association and Hospice	X	X	X
Community Hospital of the Monterey Peninsula	X	X	X
Monterey Integrated Sports & Pain Association	X	X	X
Rotacare	X	X	X
Peninsula Primary Care	X	X	X
Office of Sharon M. Wesley, M.D.	X	X	X
Marina Health Clinic			
Big Sur Health Center	X	X	X
Monterey Bay Urgent Care Center	X	X	
Seaside Family Heart Center	X	X	X

Key Informant Focus Group: Other Community Leaders	Populations Served		
	Medically Underserved	Low-Income Residents	Minority Populations
Thursday, June 20th, Noon to 2:00 PM			
Organizations Represented			
Central California Alliance for Health			
Monterey County Department of Social Services			
American Cancer Society	X	X	X
Central Coast Seniors Services, Inc.			
Monterey County Health Department	X	X	X
Tanimura & Antle			
Monterey County Office of Education	X	X	X
Franciscan Workers of Junipero Serra			
Chamber of Commerce, Monterey Peninsula			
Monterey Police Department			
Alzheimer's Association	X	X	X
Community Partnership for Youth		X	X

Audio from the focus groups sessions was recorded, from which verbatim comments in this report are taken. There are no names connected with the comments, as participants were asked to speak candidly and assured of confidentiality.

*NOTE: These findings represent qualitative rather than quantitative data. The groups were designed to gather input from participants regarding their opinions and perceptions of the health of the residents in the area. Thus, these findings are based on perceptions, not facts.*

### Public Health, Vital Statistics & Other Data

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

- Centers for Disease Control & Prevention
- National Center for Health Statistics
- State of California Department of Justice
- California Department of Public Health
- US Census Bureau
- US Department of Health and Human Services
- US Department of Justice, Federal Bureau of Investigation

Note that secondary data reflect county-level data (Monterey County).

## Benchmark Data

### Trending

A similar survey was administered in the service area in 2007 and 2010 by PRC on behalf of Community Hospital of the Monterey Peninsula. Trending data, as revealed by comparison to prior survey results, are provided throughout this report whenever available. Historical data for secondary data indicators are also included for the purposes of trending.

### California Risk Factor Data

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

### Nationwide Risk Factor Data

Nationwide risk factor data, which are also provided in comparison charts, are taken from the *2011 PRC National Health Survey*; the methodological approach for the national study is identical to that employed in this assessment, and these data may be generalized to the US population with a high degree of confidence. National-level vital statistics are also provided for comparison of secondary data indicators.

### Healthy People 2020



Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. The Healthy People initiative is grounded in the principle that setting national objectives and monitoring progress can motivate action. For three decades, Healthy People has

established benchmarks and monitored progress over time in order to:

- Encourage collaborations across sectors.
- Guide individuals toward making informed health decisions.
- Measure the impact of prevention activities.

Healthy People 2020 is the product of an extensive stakeholder feedback process that is unparalleled in government and health. It integrates input from public health and prevention experts, a wide range of federal, state and local government officials, a consortium of more than 2,000 organizations, and perhaps most importantly, the public. More than 8,000 comments were considered in drafting a comprehensive set of Healthy People 2020 objectives.

### Information Gaps

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

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

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

# Summary of Findings

## Significant Health Needs of the Community

The following “areas of opportunity” represent the significant health needs of the community, based on the information gathered through this Community Health Needs Assessment and the guidelines set forth in *Healthy People 2020*. From these data, opportunities for health improvement exist in the area with regard to the following health issues (see also the summary tables presented in the following section).

Areas of Opportunity Identified Through This Assessment	
<b>Access to Health Services</b>	<ul style="list-style-type: none"> <li>• Lack of Insurance — [vs. US]</li> <li>• Insurance Instability — [vs. US; Trend]</li> <li>• Cost as a Barrier to Doctor Visits — [vs. US]</li> <li>• Access to Children’s Healthcare — [vs. US]</li> <li>• Access to healthcare ranked as the #1 top concern among focus group participants; they emphasized:               <ul style="list-style-type: none"> <li>○ Insurance Status</li> <li>○ Poverty</li> <li>○ Physician Recruitment</li> <li>○ Geography/Transportation</li> <li>○ Language</li> </ul> </li> <li>• <i>Note that Seaside and Marina residents frequently reported greater difficulty accessing healthcare services than those in other parts of the CHOMP Service Area.</i></li> </ul>
<b>Chronic Pain &amp; Disabling Conditions</b>	<ul style="list-style-type: none"> <li>• Activity Limitations — [vs. US; Trend]</li> <li>• Osteoporosis — [Trend]</li> <li>• Chronic Neck Pain — [vs. US]</li> </ul>
<b>Chronic Kidney Disease</b>	<ul style="list-style-type: none"> <li>• Kidney Disease Deaths — [vs. CA; Trend]</li> </ul>
<b>Dementias</b>	<ul style="list-style-type: none"> <li>• Alzheimer’s Disease Deaths — [Trend]</li> </ul>
<b>Educational &amp; Community-Based Programs</b>	<ul style="list-style-type: none"> <li>• Attending Health Promotion Events — [vs. US]</li> <li>• Health education and prevention ranked as the #3 top concern among focus group participants; they emphasized:               <ul style="list-style-type: none"> <li>○ Health Literacy</li> <li>○ Prevention Not Valued</li> </ul> </li> </ul>
<b>Heart Disease &amp; Stroke</b>	<ul style="list-style-type: none"> <li>• Hypertension Prevalence — [vs. CA; Trend]</li> <li>• Chronic disease management (heart disease, obesity, diabetes) ranked as the #4 top concern among focus group participants.</li> </ul>
<b>Immunization &amp; Infectious Diseases</b>	<ul style="list-style-type: none"> <li>• Pertussis Incidence — [vs. US]</li> <li>• Tuberculosis Incidence — [vs. US]</li> </ul>
<b>Injury &amp; Violence Prevention</b>	<ul style="list-style-type: none"> <li>• Firearm-Related Deaths — [vs. CA; vs. US; Trend]</li> <li>• Homicides — [vs. CA; vs. US; Trend]</li> <li>• Violent Crime Rate — [vs. CA; vs. US]</li> </ul>
<b>Maternal/Infant Health &amp; Family Planning</b>	<ul style="list-style-type: none"> <li>• Lack of Prenatal Care — [vs. CA; Trend]</li> <li>• Births to Teenagers — [vs. CA; vs. US]</li> </ul>

— continued next page —

## Areas of Opportunity (continued)

<b>Mental Health &amp; Mental Disorders</b>	<ul style="list-style-type: none"> <li>• Chronic Depression — [vs. US; Trend]</li> <li>• Suicides — [Trend]</li> <li>• ADD/ADHD Prevalence — [Trend]</li> <li>• Mental health ranked as the #2 top concern among focus group participants; they emphasized:             <ul style="list-style-type: none"> <li>○ Current System Is Fragmented</li> <li>○ Stigma</li> <li>○ Language Barriers</li> </ul> </li> <li>• <i>Depression and mental health status indicators suggest that Seaside and Marina residents might have greater unaddressed mental health needs.</i></li> </ul>
<b>Nutrition, Physical Activity &amp; Weight</b>	<ul style="list-style-type: none"> <li>• Obesity Prevalence — [Trend]</li> <li>• Chronic disease management (heart disease, obesity, diabetes) ranked as the #4 top concern among focus group participants.</li> <li>• <i>Overweight/obesity prevalence is highest in Seaside and Marina; physical activity indicators are also least favorable in the Seaside community.</i></li> </ul>
<b>Oral Health</b>	<ul style="list-style-type: none"> <li>• Lack of Dental Insurance — [vs. US; Trend]</li> <li>• <i>Seaside residents also report low utilization of dental care services.</i></li> </ul>
<b>Sexually Transmitted Diseases</b>	<ul style="list-style-type: none"> <li>• Chlamydia Incidence — [Trend]</li> <li>• Syphilis Incidence — [Trend]</li> </ul>
<b>Substance Abuse</b>	<ul style="list-style-type: none"> <li>• Cirrhosis/Liver Disease Deaths — [vs. US; Trend]</li> <li>• Drug-Induced Deaths — [Trend]</li> <li>• <i>Chronic drinking is particularly high in the Salinas/Carmel Valley communities, whereas Seaside residents are more likely to report illicit drug use.</i></li> </ul>
<b>Tobacco Use</b>	<ul style="list-style-type: none"> <li>• <i>Seaside residents report a relatively high prevalence of cigarette smoking.</i></li> </ul>

## Summary Tables: Comparisons With Benchmark Data

The following tables provide an overview of indicators in the CHOMP Service Area, including comparisons among the individual communities, as well as trend data. These data are grouped to correspond with the Focus Areas presented in Healthy People 2020.

### Reading the Summary Tables

- In the following charts, CHOMP Service Area results are shown in the larger, blue column.
- The green columns [to the left of the CHOMP Service Area column] provide comparisons among the six communities, identifying differences for each as “better than” (☀️), “worse than” (🌑), or “similar to” (☁️) the combined opposing areas.
- The columns to the right of the CHOMP Service Area column provide trending, as well as comparisons between the CHOMP Service Area and any available state and national findings, and Healthy People 2020 targets. Again, symbols indicate whether the service area compares favorably (☀️), unfavorably (🌑), or comparably (☁️) to these external data.

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

### TREND SUMMARY

(Current vs. Baseline Data)

#### Survey Data Indicators:

Trends for survey-derived indicators represent significant changes since 2007. *Note that survey data reflect the ZIP Code-defined CHOMP Service Area.*

#### Other (Secondary) Data

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

*Note that secondary data reflect county-level data (Monterey County).*

Access to Health Services	Each Sub-Area vs. Others						CHOMP Service Area	CHOMP vs. Benchmarks			
	Monterey	Carmel/Big Sur	Seaside	Marina	Pac Grv/Pebble Bch	Salinas/Carmel Valley		vs. CA	vs. US	vs. HP2020	TREND
% [Age 18-64] Lack Health Insurance	17.5	17.5	32.9	18.4	8.8	15.7	<b>20.1</b>	21.5	14.9	0.0	19.7
% [65+] With Medicare Supplement Insurance							<b>86.6</b>		75.5		80.3
% [Insured] Insurance Covers Prescriptions	93.6	93.8	90.7	95.4	98.1	97.1	<b>94.6</b>		93.9		94.4
% [Insured] Went Without Coverage in Past Year	9.9	4.3	18.5	17.8	3.9	3.6	<b>10.1</b>		4.8		7.1
% Difficulty Accessing Healthcare in Past Year (Composite)	28.6	38.8	52.4	47.3	38.1	37.4	<b>40.3</b>		37.3		39.5
% Inconvenient Hrs Prevented Dr Visit in Past Year	7.0	12.3	15.8	15.4	13.4	6.8	<b>11.7</b>		14.3		16.3
% Cost Prevented Getting Prescription in Past Year	11.1	10.1	20.0	22.9	14.2	9.6	<b>14.9</b>		15.0		15.2
% Cost Prevented Physician Visit in Past Year	11.6	10.3	29.7	24.3	15.6	11.9	<b>17.8</b>		14.0		19.4
% Difficulty Getting Appointment in Past Year	14.6	15.4	10.1	10.1	12.1	12.9	<b>12.5</b>		16.5		14.3
% Difficulty Finding Physician in Past Year	9.2	9.5	15.0	7.2	7.3	8.7	<b>9.8</b>		10.7		12.2
% Transportation Hindered Dr Visit in Past Year	5.7	4.3	13.8	10.8	3.2	3.9	<b>7.5</b>		7.7		6.4
% Skipped Prescription Doses to Save Costs	14.5	7.2	17.9	18.0	13.4	19.1	<b>15.3</b>		14.8		14.5

Access to Health Services (continued)	Each Sub-Area vs. Others					
	Monterey	Carmel/ Big Sur	Seaside	Marina	Pac Grv/ Pebble Bch	Salinas/ Carmel Valley
% Difficulty Getting Child's Healthcare in Past Year						
% [Age 18+] Have a Specific Source of Ongoing Care	78.0	78.1	65.6	70.8	82.5	78.8
% Have Had Routine Checkup in Past Year	62.7	67.4	57.6	68.1	69.0	64.0
% Child Has Had Checkup in Past Year						
% Two or More ER Visits in Past Year	6.4	2.2	10.5	12.8	4.1	3.9
% Rate Local Healthcare "Fair/Poor"	10.4	15.0	13.2	9.2	4.5	17.3
<p>Note: In the green section, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.</p>						













CHOMP Service Area	CHOMP vs. Benchmarks			TREND
	vs. CA	vs. US	vs. HP2020	
7.1		1.9		7.1
75.0		76.3	95.0	73.0
64.1		67.3		65.1
84.6		87.0		85.6
7.1		6.5		5.4
11.4		15.3		19.5
<p> better     similar     worse</p>				








Arthritis, Osteoporosis & Chronic Back Conditions	Each Sub-Area vs. Others					
	Monterey	Carmel/ Big Sur	Seaside	Marina	Pac Grv/ Pebble Bch	Salinas/ Carmel Valley
% [50+] Arthritis/Rheumatism	32.6	31.9	37.8	47.7	26.6	19.6
% [50+] Osteoporosis	14.4	15.0	14.8	9.8	11.4	8.1
% Sciatica/Chronic Back Pain	17.7	22.0	21.7	24.8	22.8	24.0

CHOMP Service Area	CHOMP vs. Benchmarks			TREND
	vs. CA	vs. US	vs. HP2020	
32.0		35.4		29.4
12.4		11.4	5.3	8.2
21.7		21.5		21.7





































Each Sub-Area vs. Others

Arthritis, Osteoporosis & Chronic Back Conditions (cont.)	Monterey	Carmel/ Big Sur	Seaside	Marina	Pac Grv/ Pebble Bch	Salinas/ Carmel Valley
% Migraine/Severe Headaches	 11.5	 10.7	 15.3	 17.4	 15.1	 9.6
% Chronic Neck Pain	 8.1	 9.9	 12.1	 11.9	 12.9	 11.4
<p>Note: In the green section, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.</p>						

CHOMP Service Area	CHOMP vs. Benchmarks			TREND
	vs. CA	vs. US	vs. HP2020	
13.4		 16.9		 13.9
10.9		 8.3		 10.0
<p> better     similar     worse</p>				

Each Sub-Area vs. Others

Cancer	Monterey	Carmel/ Big Sur	Seaside	Marina	Pac Grv/ Pebble Bch	Salinas/ Carmel Valley
Cancer (Age-Adjusted Death Rate)						
Lung Cancer (Age-Adjusted Death Rate)						
Prostate Cancer (Age-Adjusted Death Rate)						
Female Breast Cancer (Age-Adjusted Death Rate)						
Colorectal Cancer (Age-Adjusted Death Rate)						
% Skin Cancer	 8.3	 12.8	 2.5	 3.5	 11.1	 13.7
% Cancer (Other Than Skin)	 7.1	 10.5	 3.5	 9.9	 8.5	 5.7







CHOMP Service Area	CHOMP vs. Benchmarks			TREND
	vs. CA	vs. US	vs. HP2020	
138.7	 158.2	 174.2	 160.6	 159.8
33.8	 37.6	 50.5	 45.5	
21.2	 22.0	 22.3	 21.2	
19.5	 21.6	 22.3	 20.6	
10.0	 14.7	 16.1	 14.5	
8.0	 5.8	 8.1		 6.8
7.2	 5.8	 5.5		 5.8











Cancer (continued)	Each Sub-Area vs. Others					
	Monterey	Carmel/ Big Sur	Seaside	Marina	Pac Grv/ Pebble Bch	Salinas/ Carmel Valley
% [Men 50+] Prostate Exam in Past 2 Years						
% [Women 50-74] Mammogram in Past 2 Years						
% [Women 21-65] Pap Smear in Past 3 Years	 86.1	 91.2	 80.5	 80.7	 92.0	 80.4
% [Age 50+] Sigmoid/Colonoscopy Ever	 71.2	 81.4	 70.1	 73.9	 69.7	 71.9
% [Age 50+] Blood Stool Test in Past 2 Years	 31.0	 35.6	 29.3	 34.4	 27.3	 20.8
% [Age 50-75] Colorectal Cancer Screening	 64.0	 72.8	 64.7	 75.3	 63.4	 62.7
Note: In the green section, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.						

CHOMP Service Area	CHOMP vs. Benchmarks			TREND
	vs. CA	vs. US	vs. HP2020	
68.3		 70.5		 80.5
77.0	 81.4	 79.9	 81.1	 81.3
84.4	 80.8	 84.7	 93.0	 88.4
73.0	 61.5	 72.0		 69.4
29.7	 27.0	 28.3		 34.1
66.7			 70.5	
better     similar     worse				







Chronic Kidney Disease	Each Sub-Area vs. Others					
	Monterey	Carmel/ Big Sur	Seaside	Marina	Pac Grv/ Pebble Bch	Salinas/ Carmel Valley
Kidney Disease (Age-Adjusted Death Rate)						
Note: In the green section, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.						







CHOMP Service Area	CHOMP vs. Benchmarks			TREND
	vs. CA	vs. US	vs. HP2020	
9.4	 8.6	 15.2		 7.0
better     similar     worse				






Diabetes	Each Sub-Area vs. Others					
	Monterey	Carmel/ Big Sur	Seaside	Marina	Pac Grv/ Pebble Bch	Salinas/ Carmel Valley
Diabetes Mellitus (Age-Adjusted Death Rate)						
% Diabetes/High Blood Sugar	 7.7	 5.8	 11.6	 13.8	 12.4	 8.1
<p>Note: In the green section, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.</p>						

CHOMP Service Area	CHOMP vs. Benchmarks			
	vs. CA	vs. US	vs. HP2020	TREND
17.4	 20.3	 21.3	 19.6	 20.0
9.9	 8.9	 10.1		 8.5
<p> better     similar     worse</p>				

Dementias, Including Alzheimer's Disease	Each Sub-Area vs. Others					
	Monterey	Carmel/ Big Sur	Seaside	Marina	Pac Grv/ Pebble Bch	Salinas/ Carmel Valley
Alzheimer's Disease (Age-Adjusted Death Rate)						
<p>Note: In the green section, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.</p>						

CHOMP Service Area	CHOMP vs. Benchmarks			
	vs. CA	vs. US	vs. HP2020	TREND
17.0	 29.2	 25.0		 15.1
<p> better     similar     worse</p>				

Educational & Community-Based Programs	Each Sub-Area vs. Others					
	Monterey	Carmel/ Big Sur	Seaside	Marina	Pac Grv/ Pebble Bch	Salinas/ Carmel Valley
% Attended Health Event in Past Year	 18.6	 19.3	 12.2	 20.5	 18.1	 20.1
<p>Note: In the green section, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.</p>						

CHOMP Service Area	CHOMP vs. Benchmarks			
	vs. CA	vs. US	vs. HP2020	TREND
17.7		 22.2		 16.0
<p> better     similar     worse</p>				

Environmental Health	Each Sub-Area vs. Others					
	Monterey	Carmel/ Big Sur	Seaside	Marina	Pac Grv/ Pebble Bch	Salinas/ Carmel Valley
% Illness/Symptoms in Past Yr from Indoor Air	 15.1	 6.4	 24.3	 20.7	 11.2	 10.5
% Illness/Symptoms in Past Yr from Outdoor Air	 4.8	 0.6	 8.7	 11.6	 7.6	 6.9
% Mold in the Home	 9.0	 8.7	 6.8	 5.4	 11.3	 3.7
Note: In the green section, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.						

CHOMP Service Area	CHOMP vs. Benchmarks			TREND
	vs. CA	vs. US	vs. HP2020	
15.6				 17.0
6.8				 7.9
7.6				 10.7
better     similar     worse				







Family Planning	Each Sub-Area vs. Others					
	Monterey	Carmel/ Big Sur	Seaside	Marina	Pac Grv/ Pebble Bch	Salinas/ Carmel Valley
% Births to Teenagers						
Note: In the green section, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.						






CHOMP Service Area	CHOMP vs. Benchmarks			TREND
	vs. CA	vs. US	vs. HP2020	
11.6	 9.0	 9.9		 12.1
better     similar     worse				

General Health Status	Each Sub-Area vs. Others					
	Monterey	Carmel/ Big Sur	Seaside	Marina	Pac Grv/ Pebble Bch	Salinas/ Carmel Valley
% "Fair/Poor" Physical Health	 11.8	 13.3	 15.9	 25.9	 13.4	 13.9
% Activity Limitations	 18.2	 27.8	 18.7	 25.2	 28.7	 21.6
Note: In the green section, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.						





































CHOMP Service Area	CHOMP vs. Benchmarks			TREND
	vs. CA	vs. US	vs. HP2020	
15.5	 18.7	 16.8		 14.5
22.5	 21.3	 17.0		 18.6
better     similar     worse				































Each Sub-Area vs. Others

Hearing & Other Sensory or Communication Disorders	Monterey	Carmel/ Big Sur	Seaside	Marina	Pac Grv/ Pebble Bch	Salinas/ Carmel Valley
% Deafness/Trouble Hearing	 6.6	 4.5	 12.2	 11.1	 13.5	 10.1
<p>Note: In the green section, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.</p>						

CHOMP Service Area	CHOMP vs. Benchmarks			TREND
	vs. CA	vs. US	vs. HP2020	
9.7		 9.6		 9.9
	 better	 similar	 worse	

Each Sub-Area vs. Others

Heart Disease & Stroke	Monterey	Carmel/ Big Sur	Seaside	Marina	Pac Grv/ Pebble Bch	Salinas/ Carmel Valley
Diseases of the Heart (Age-Adjusted Death Rate)						
Stroke (Age-Adjusted Death Rate)						
% Heart Disease (Heart Attack, Angina, Coronary Disease)	 5.0	 5.9	 4.0	 7.1	 6.9	 5.9
% Stroke	 0.9	 7.2	 1.0	 2.5	 3.0	 2.4
% Blood Pressure Checked in Past 2 Years	 89.5	 98.5	 87.8	 93.3	 97.8	 97.2
% Told Have High Blood Pressure (Ever)	 31.2	 33.7	 28.1	 33.8	 35.5	 40.1
% [HBP] Taking Action to Control High Blood Pressure						
% Cholesterol Checked in Past 5 Years	 87.1	 90.1	 82.7	 85.0	 97.2	 89.8
% Told Have High Cholesterol (Ever)	 36.3	 29.3	 27.2	 28.9	 35.8	 33.9

CHOMP Service Area	CHOMP vs. Benchmarks			TREND
	vs. CA	vs. US	vs. HP2020	
137.0	 168.2	 184.6	 152.7	 197.3
37.2	 39.2	 40.2	 33.8	 60.2
5.6		 6.1		 5.3
2.5	 2.2	 2.7		 1.9
93.1		 94.7	 94.9	 94.1
33.0	 27.8	 34.3	 26.9	 27.1
93.6		 89.1		 91.2
88.0	 75.5	 90.7	 82.1	 83.6
31.9	 36.0	 31.4	 13.5	 33.2

Heart Disease & Stroke (continued)	Each Sub-Area vs. Others					
	Monterey	Carmel/ Big Sur	Seaside	Marina	Pac Grv/ Pebble Bch	Salinas/ Carmel Valley
% [HBC] Taking Action to Control High Blood Cholesterol	93.4	91.8	88.6	93.3	97.2	88.3
% 1+ Cardiovascular Risk Factor	73.2	71.1	84.0	87.4	78.2	83.0
Note: In the green section, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.						







CHOMP Service Area	CHOMP vs. Benchmarks			TREND
	vs. CA	vs. US	vs. HP2020	
92.2		89.1	88.5	
79.4	86.3		77.5	
better     similar     worse				













HIV	Each Sub-Area vs. Others					
	Monterey	Carmel/ Big Sur	Seaside	Marina	Pac Grv/ Pebble Bch	Salinas/ Carmel Valley
% [Age 18-44] HIV Test in the Past Year						
Note: In the green section, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.						













CHOMP Service Area	CHOMP vs. Benchmarks			TREND
	vs. CA	vs. US	vs. HP2020	
23.5		19.9	16.9	28.4
better     similar     worse				























Immunization & Infectious Diseases	Each Sub-Area vs. Others					
	Monterey	Carmel/ Big Sur	Seaside	Marina	Pac Grv/ Pebble Bch	Salinas/ Carmel Valley
Pertussis per 100,000						
% [Age 65+] Flu Shot in Past Year						
% [High-Risk 18-64] Flu Shot in Past Year						
% [Age 65+] Pneumonia Vaccine Ever						

CHOMP Service Area	CHOMP vs. Benchmarks			TREND
	vs. CA	vs. US	vs. HP2020	
14.3	15.4	6.3		4.6
74.7	57.2	71.6	90.0	66.7
46.5		52.5	90.0	28.1
66.2	68.1	68.1	90.0	67.7

Immunization & Infectious Diseases (continued)	Each Sub-Area vs. Others					
	Monterey	Carmel/ Big Sur	Seaside	Marina	Pac Grv/ Pebble Bch	Salinas/ Carmel Valley
% [High-Risk 18-64] Pneumonia Vaccine Ever						
Tuberculosis Incidence per 100,000						
% Ever Vaccinated for Hepatitis B	 46.2	 21.5	 39.5	 47.4	 32.2	 40.1
Note: In the green section, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.						

CHOMP Service Area	CHOMP vs. Benchmarks			
	vs. CA	vs. US	vs. HP2020	TREND
23.4		 32.0	 60.0	 27.9
5.0	 6.4	 3.6	 1.0	 8.7
38.9		 38.4		 35.9
 better  similar  worse				

Injury & Violence Prevention	Each Sub-Area vs. Others					
	Monterey	Carmel/ Big Sur	Seaside	Marina	Pac Grv/ Pebble Bch	Salinas/ Carmel Valley
Unintentional Injury (Age-Adjusted Death Rate)						
Motor Vehicle Crashes (Age-Adjusted Death Rate)						
% "Always" Wear Seat Belt	 97.4	 96.2	 93.5	 91.5	 97.1	 96.4
% Child [Age 0-17] "Always" Uses Seat Belt/Car Seat						
% Child [Age 5-17] "Always" Wears Bicycle Helmet						
Firearm-Related Deaths (Age-Adjusted Death Rate)						
% Firearm in Home	 14.8	 16.4	 15.5	 15.3	 17.4	 45.6

CHOMP Service Area	CHOMP vs. Benchmarks			
	vs. CA	vs. US	vs. HP2020	TREND
30.1	 28.9	 38.2	 36.0	 32.6
9.4	 8.8	 11.9	 12.4	 14.9
95.3	 97.7	 85.3	 92.4	 93.2
94.0		 91.6		 97.1
72.4		 35.3		 67.9
11.7	 8.1	 10.2	 9.2	 9.0
19.6		 37.9		 22.3

Each Sub-Area vs. Others

Injury & Violence Prevention (continued)	Each Sub-Area vs. Others					
	Monterey	Carmel/ Big Sur	Seaside	Marina	Pac Grv/ Pebble Bch	Salinas/ Carmel Valley
% [Homes With Children] Firearm in Home						
% [Homes With Firearms] Weapon(s) Unlocked & Loaded						
Homicide (Age-Adjusted Death Rate)						
Violent Crime per 100,000						
% Victim of Violent Crime in Past 5 Years	 1.5	 0.0	 2.8	 7.3	 3.2	 0.9
Domestic Violence Offenses per 100,000						
% Ever Threatened With Violence by Intimate Partner	 0.3	 11.5	 14.6	 15.9	 13.5	 6.1
% Victim of Domestic Violence (Ever)	 10.0	 16.4	 14.0	 17.7	 12.6	 6.2
<p>Note: In the green section, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.</p>						

CHOMP Service Area	CHOMP vs. Benchmarks			TREND
	vs. CA	vs. US	vs. HP2020	
14.5		 34.4		 17.1
12.4		 16.9		 13.3
10.3	 5.6	 5.6	 5.5	 6.2
489.1	 441.2	 407.3		 485.7
2.6		 1.6		 3.5
484.3	 439.4			 538.6
11.9		 11.7		 10.1
12.7		 13.5		 11.0
<p> better     similar     worse</p>				



Each Sub-Area vs. Others

Maternal, Infant & Child Health	Monterey	Carmel/ Big Sur	Seaside	Marina	Pac Grv/ Pebble Bch	Salinas/ Carmel Valley
% Late or No Prenatal Care						
% of Low Birthweight Births						
Infant Death Rate						
<p>Note: In the green section, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.</p>						






CHOMP Service Area	CHOMP vs. Benchmarks			TREND
	vs. CA	vs. US	vs. HP2020	
4.4	3.2			3.4
5.8	6.8	8.2	7.8	5.8
5.0	5.1	6.5	6.0	5.9
<p> better     similar     worse</p>				

















































Each Sub-Area vs. Others




















Mental Health & Mental Disorders	Monterey	Carmel/ Big Sur	Seaside	Marina	Pac Grv/ Pebble Bch	Salinas/ Carmel Valley
% "Fair/Poor" Mental Health	7.8	6.8	15.5	18.0	7.6	10.3
% Major Depression	9.4	6.7	7.0	10.0	6.3	10.7
% Symptoms of Chronic Depression (2+ Years)	31.6	25.9	38.6	34.2	21.4	26.4
Suicide (Age-Adjusted Death Rate)						
% [Those With Major Depression] Seeking Help						
% Typical Day Is "Extremely/Very" Stressful	7.5	9.7	8.0	9.6	10.0	8.4

CHOMP Service Area	CHOMP vs. Benchmarks			TREND
	vs. CA	vs. US	vs. HP2020	
11.2		11.7		9.6
8.4		11.7		9.0
30.6		26.5		25.0
10.4	10.3	11.8	10.2	9.2
86.5		82.0	75.1	78.9
8.7		11.5		9.9

Mental Health & Mental Disorders (continued)	Each Sub-Area vs. Others					
	Monterey	Carmel/ Big Sur	Seaside	Marina	Pac Grv/ Pebble Bch	Salinas/ Carmel Valley
% Child [Age 5-17] Takes Prescription for ADD/ADHD						
Note: In the green section, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.						

CHOMP Service Area	CHOMP vs. Benchmarks			TREND
	vs. CA	vs. US	vs. HP2020	
8.1		 6.5	 3.0	
 better  similar  worse				

Nutrition & Weight Status	Each Sub-Area vs. Others					
	Monterey	Carmel/ Big Sur	Seaside	Marina	Pac Grv/ Pebble Bch	Salinas/ Carmel Valley
% Eat 5+ Servings of Fruit or Vegetables per Day	 55.7	 57.0	 44.7	 55.3	 52.5	 63.8
% Medical Advice on Nutrition in Past Year	 45.7	 34.5	 37.8	 46.5	 45.5	 46.5
% Healthy Weight (BMI 18.5-24.9)	 46.9	 52.2	 26.5	 29.3	 40.9	 40.9
% Overweight	 51.6	 45.0	 72.1	 69.8	 57.5	 57.1
% Obese	 16.2	 9.3	 27.8	 35.4	 24.1	 19.4
% Medical Advice on Weight in Past Year	 24.0	 16.5	 23.8	 29.7	 25.3	 25.2
% [Overweights] Counseled About Weight in Past Year	 34.5	 24.6	 30.6	 36.3	 41.7	 34.7
% [Obese Adults] Counseled About Weight in Past Year						
% [Overweights] Trying to Lose Weight Both Diet/Exercise	 42.6	 35.4	 37.1	 51.4	 34.8	 49.2

CHOMP Service Area	CHOMP vs. Benchmarks			TREND
	vs. CA	vs. US	vs. HP2020	
54.1		 48.8	 53.9	
42.8		 41.9	 39.6	
39.0		 31.7	 33.9	
59.4	 60.2	 66.9	 56.1	
22.2	 23.8	 28.5	 30.6	
24.2		 25.7	 21.4	
33.9		 30.9		
51.0		 47.4	 31.8	
41.8		 38.6	 35.6	

Each Sub-Area vs. Others

Nutrition & Weight Status (continued)	Each Sub-Area vs. Others					
	Monterey	Carmel/ Big Sur	Seaside	Marina	Pac Grv/ Pebble Bch	Salinas/ Carmel Valley
% Children [Age 5-17] Overweight						
% Children [Age 5-17] Obese						
<p>Note: In the green section, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.</p>						

CHOMP Service Area	CHOMP vs. Benchmarks			TREND
	vs. CA	vs. US	vs. HP2020	
33.2		30.7	25.5	
15.0	18.9	14.6	12.1	
<p> better     similar     worse</p>				

Each Sub-Area vs. Others

Oral Health	Each Sub-Area vs. Others					
	Monterey	Carmel/ Big Sur	Seaside	Marina	Pac Grv/ Pebble Bch	Salinas/ Carmel Valley
% [Age 18+] Dental Visit in Past Year	69.9	76.0	61.1	65.1	77.0	78.6
% Child [Age 2-17] Dental Visit in Past Year						
% Have Dental Insurance	53.6	45.7	48.0	52.0	56.6	52.8
<p>Note: In the green section, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.</p>						

CHOMP Service Area	CHOMP vs. Benchmarks			TREND
	vs. CA	vs. US	vs. HP2020	
70.2	69.6	66.9	49.0	72.5
85.9		79.2	49.0	85.3
51.5		60.8		60.0
<p> better     similar     worse</p>				

Each Sub-Area vs. Others

Physical Activity	Each Sub-Area vs. Others					
	Monterey	Carmel/ Big Sur	Seaside	Marina	Pac Grv/ Pebble Bch	Salinas/ Carmel Valley
% [Employed] Job Entails Mostly Sitting/Standing						
% No Leisure-Time Physical Activity	15.4	10.4	23.0	22.7	12.0	10.7

CHOMP Service Area	CHOMP vs. Benchmarks			TREND
	vs. CA	vs. US	vs. HP2020	
54.5		63.2		60.9
16.4	19.1	28.7	32.6	19.6

Physical Activity (continued)	Each Sub-Area vs. Others					
	Monterey	Carmel/ Big Sur	Seaside	Marina	Pac Grv/ Pebble Bch	Salinas/ Carmel Valley
% Meeting Physical Activity Guidelines	55.8	62.0	44.4	57.0	53.3	59.1
% Moderate Physical Activity	29.2	46.9	24.1	36.2	33.6	33.5
% Vigorous Physical Activity	44.4	44.2	34.4	43.3	33.8	43.1
% Medical Advice on Physical Activity in Past Year	46.8	40.3	46.7	44.8	47.8	55.5
% Child [Age 5-17] Watches TV 3+ Hours per Day						
% Child [Age 5-17] Uses Computer 3+ Hours per Day						
% Child [Age 5-17] 3+ Hours per Day of Total Screen Time						
	Note: In the green section, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.					

CHOMP Service Area	CHOMP vs. Benchmarks			TREND
	vs. CA	vs. US	vs. HP2020	
54.4		42.7	53.6	
32.6		23.9	31.6	
40.4		34.8	40.2	
46.9		47.8	46.9	
14.2		19.7		
14.3		9.9		
35.2		43.4		
	better	similar	worse	

Respiratory Diseases	Each Sub-Area vs. Others					
	Monterey	Carmel/ Big Sur	Seaside	Marina	Pac Grv/ Pebble Bch	Salinas/ Carmel Valley
CLRD (Age-Adjusted Death Rate)						
Pneumonia/Influenza (Age-Adjusted Death Rate)						

CHOMP Service Area	CHOMP vs. Benchmarks			TREND
	vs. CA	vs. US	vs. HP2020	
31.8	38.1	43.2	36.3	
10.7	17.9	16.4	18.6	

Respiratory Diseases (continued)	Each Sub-Area vs. Others					
	Monterey	Carmel/ Big Sur	Seaside	Marina	Pac Grv/ Pebble Bch	Salinas/ Carmel Valley
% Nasal/Hay Fever Allergies	24.9	34.3	26.5	31.3	31.7	30.4
% Sinusitis	12.8	15.8	8.6	18.0	19.7	12.8
% Chronic Lung Disease	11.4	5.8	12.9	11.9	10.9	2.6
% [Adult] Currently Has Asthma	10.3	11.6	4.7	13.3	6.6	3.1
% [Child 0-17] Currently Has Asthma						
<p>Note: In the green section, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.</p>						

CHOMP Service Area	CHOMP vs. Benchmarks			TREND
	vs. CA	vs. US	vs. HP2020	
29.1		27.3		26.1
14.0		19.4		14.6
9.9		8.4		7.6
8.3	8.4	7.5		6.9
4.6		6.8		2.9
<p> better     similar     worse</p>				

Sexually Transmitted Diseases	Each Sub-Area vs. Others					
	Monterey	Carmel/ Big Sur	Seaside	Marina	Pac Grv/ Pebble Bch	Salinas/ Carmel Valley
Gonorrhea Incidence per 100,000						
Primary & Secondary Syphilis Incidence per 100,000						
Chlamydia Incidence per 100,000						
Hepatitis B Incidence per 100,000						

CHOMP Service Area	CHOMP vs. Benchmarks			TREND
	vs. CA	vs. US	vs. HP2020	
21.6	69.9	101.0		40.7
1.3	5.8	4.5		0.8
344.8	417.5	429.6		287.5
0.1	0.4	1.2		0.6

Each Sub-Area vs. Others

Sexually Transmitted Diseases (continued)	Monterey	Carmel/ Big Sur	Seaside	Marina	Pac Grv/ Pebble Bch	Salinas/ Carmel Valley
% [Unmarried 18-64] 3+ Sexual Partners in Past Year						
% [Unmarried 18-64] Using Condoms						
<p>Note: In the green section, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.</p>						

CHOMP Service Area	CHOMP vs. Benchmarks			TREND
	vs. CA	vs. US	vs. HP2020	
5.7		7.1		12.3
35.2		18.9		38.3
<p> better     similar     worse</p>				

Each Sub-Area vs. Others

Substance Abuse	Monterey	Carmel/ Big Sur	Seaside	Marina	Pac Grv/ Pebble Bch	Salinas/ Carmel Valley
Cirrhosis/Liver Disease (Age-Adjusted Death Rate)						
% Current Drinker	 64.1	 70.6	 55.7	 44.9	 63.0	 69.0
% Chronic Drinker (Average 2+ Drinks/Day)	 4.3	 8.3	 7.1	 1.4	 7.2	 12.4
% Binge Drinker (Single Occasion - 5+ Drinks Men, 4+ Women)	 16.1	 9.9	 19.4	 10.9	 13.5	 20.7
% Drinking & Driving in Past Month	 1.8	 1.9	 1.3	 0.0	 4.4	 4.1
% Driving Drunk or Riding with Drunk Driver	 4.9	 3.3	 6.0	 2.7	 4.8	 6.0
Drug-Induced Deaths (Age-Adjusted Death Rate)						
% Illicit Drug Use in Past Month	 2.1	 0.7	 5.8	 1.9	 0.0	 5.2

CHOMP Service Area	CHOMP vs. Benchmarks			TREND
	vs. CA	vs. US	vs. HP2020	
10.6	11.3	9.2	8.2	9.8
60.7	57.1	58.8		61.7
6.4	6.2	5.6		8.6
15.4	18.6	16.7	24.3	16.3
2.1		3.5		3.0
4.7		5.5		6.3
10.7	11.2	12.7	11.3	8.8
2.8		1.7	7.1	4.4

**Substance Abuse (continued)**

**Each Sub-Area vs. Others**

	Monterey	Carmel/ Big Sur	Seaside	Marina	Pac Grv/ Pebble Bch	Salinas/ Carmel Valley
% Ever Sought Help for Alcohol or Drug Problem	3.3	2.1	7.1	2.5	3.6	1.8
<p>Note: In the green section, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.</p>						

CHOMP Service Area	CHOMP vs. Benchmarks			TREND
	vs. CA	vs. US	vs. HP2020	
3.7		3.9		4.6
<p> better     similar     worse</p>				













**Tobacco Use**








**Each Sub-Area vs. Others**

	Monterey	Carmel/ Big Sur	Seaside	Marina	Pac Grv/ Pebble Bch	Salinas/ Carmel Valley
% Current Smoker	9.1	8.8	20.1	15.7	5.9	14.9
% Someone Smokes at Home	3.9	4.0	12.3	9.3	4.6	6.2
% [Non-Smokers] Someone Smokes in the Home	2.6	4.4	6.9	6.9	3.5	5.8
% [Household With Children] Someone Smokes in the Home						
% [Smokers] Received Advice to Quit Smoking						
% [Smokers] Have Quit Smoking 1+ Days in Past Year						
% Smoke Cigars	3.0	4.4	1.0	4.6	3.6	3.5
% Use Smokeless Tobacco	0.6	3.8	1.7	0.0	1.2	6.2
<p>Note: In the green section, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.</p>						

CHOMP Service Area	CHOMP vs. Benchmarks			TREND
	vs. CA	vs. US	vs. HP2020	
12.8	13.6	16.6	12.0	13.9
6.9		13.6		10.3
4.9		5.7		3.9
7.5		12.1		9.1
58.5		63.7		54.4
70.1		56.2	80.0	51.0
3.1		4.2	0.2	3.5
2.0		2.8	0.3	2.2
<p> better     similar     worse</p>				

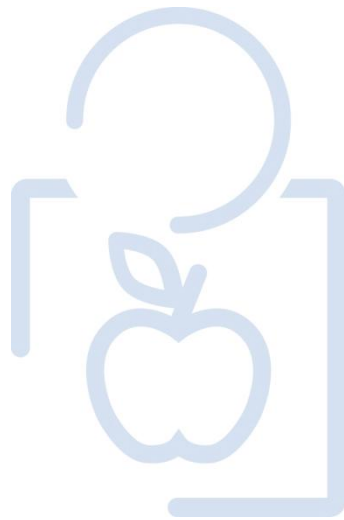
Each Sub-Area vs. Others

Vision	Monterey	Carmel/ Big Sur	Seaside	Marina	Pac Grv/ Pebble Bch	Salinas/ Carmel Valley
% Blindness/Trouble Seeing	 8.4	 6.9	 7.2	 7.5	 9.7	 6.4
% Eye Exam in Past 2 Years	 60.0	 64.5	 45.3	 58.6	 64.3	 61.1
<p>Note: In the green section, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.</p>						

CHOMP Service Area	CHOMP vs. Benchmarks			TREND
	vs. CA	vs. US	vs. HP2020	
7.7	 6.9	 10.0		
58.0	 57.5	 60.9		
<p>  better                          similar                          worse                 </p>				



# GENERAL HEALTH STATUS



# Overall Health Status

The initial inquiry of the PRC Community Health Survey asked respondents the following:

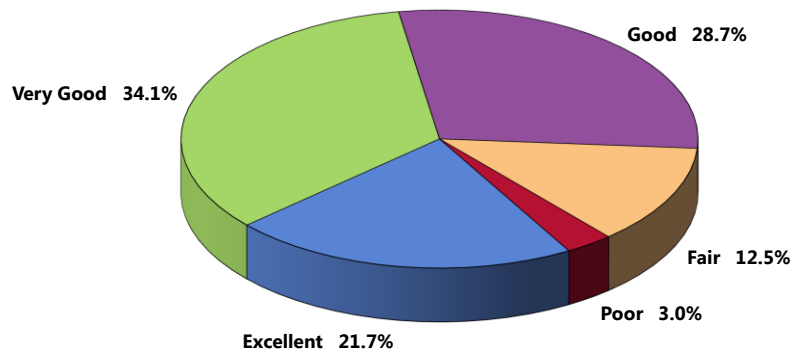
*"Would you say that in general your health is: excellent, very good, good, fair or poor?"*

## Self-Reported Health Status

**A total of 55.8% of CHOMP Service Area adults rate their overall health as "excellent" or "very good."**

- Another 28.7% gave "good" ratings of their overall health.

**Self-Reported Health Status**  
(CHOMP Service Area, 2013)



Sources: • 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 5]  
Notes: • Asked of all respondents.

**However, 15.5% of CHOMP Service Area adults believe that their overall health is "fair" or "poor."**

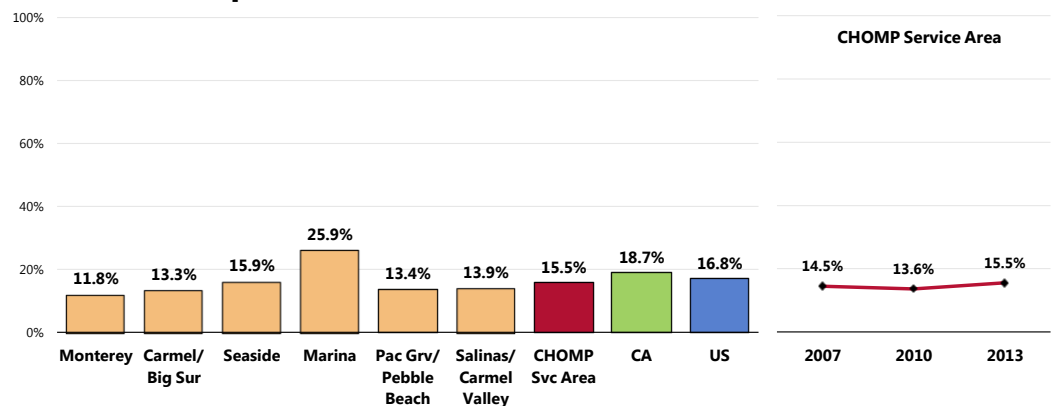
- Better than statewide findings.
- Comparable to the national percentage.
- Unfavorably high in the Marina community.
- ☒ No statistically significant change has occurred when comparing "fair/poor" overall health reports to previous survey results in the service area.

### NOTE:

- Differences noted in the text represent significant differences determined through statistical testing.
- Where sample sizes permit, community-level data are provided.

☒ Trends are measured against baseline data – i.e., the earliest year that data are available or that is presented in this report.

## Experience "Fair" or "Poor" Overall Health



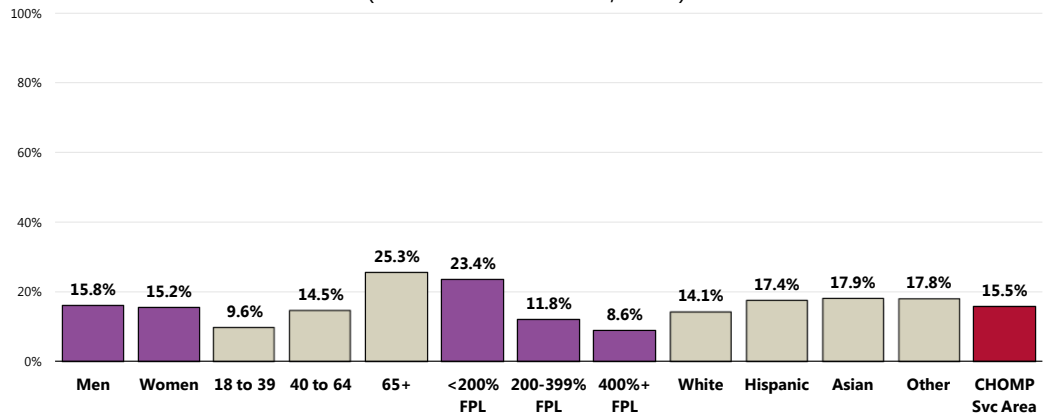
Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 5]  
• Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2011 California data.  
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.  
Notes: • Asked of all respondents.

Adults more likely to report experiencing “fair” or “poor” overall health include:

- 👥 Seniors (note the positive correlation with age).
- 👥 Residents living at lower incomes (note the negative correlation with income).
- 👥 Other differences within demographic groups, as illustrated in the following chart, are not statistically significant.

Charts throughout this report (such as that here) detail survey findings among key demographic groups – namely by gender, age groupings, income (based on poverty status), and race/ethnicity.

### Experience “Fair” or “Poor” Overall Health (CHOMP Service Area, 2013)



Sources: • 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 5]

- Notes:
- Asked of all respondents.
  - Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., “White” reflects non-Hispanic White respondents).
  - Income categories reflect respondent’s household income as a ratio to the federal poverty level (FPL) for their household size. “<200% FPL” includes households with incomes up to 199% of the federal poverty level; “200-399% FPL” includes households with incomes between 200% and 399% of the federal poverty level; and “400%+ FPL” includes those households with incomes at 400% or more the federal poverty level.

## Activity Limitations

An individual can get a disabling impairment or chronic condition at any point in life. Compared with people without disabilities, people with disabilities are more likely to:

- Experience difficulties or delays in getting the health care they need.
- Not have had an annual dental visit.
- Not have had a mammogram in past 2 years.
- Not have had a Pap test within the past 3 years.
- Not engage in fitness activities.
- Use tobacco.
- Be overweight or obese.
- Have high blood pressure.
- Experience symptoms of psychological distress.
- Receive less social-emotional support.
- Have lower employment rates.

There are many social and physical factors that influence the health of people with disabilities. The following three areas for public health action have been identified, using the International Classification of Functioning, Disability, and Health (ICF) and the three World Health Organization (WHO) principles of action for addressing health determinants.

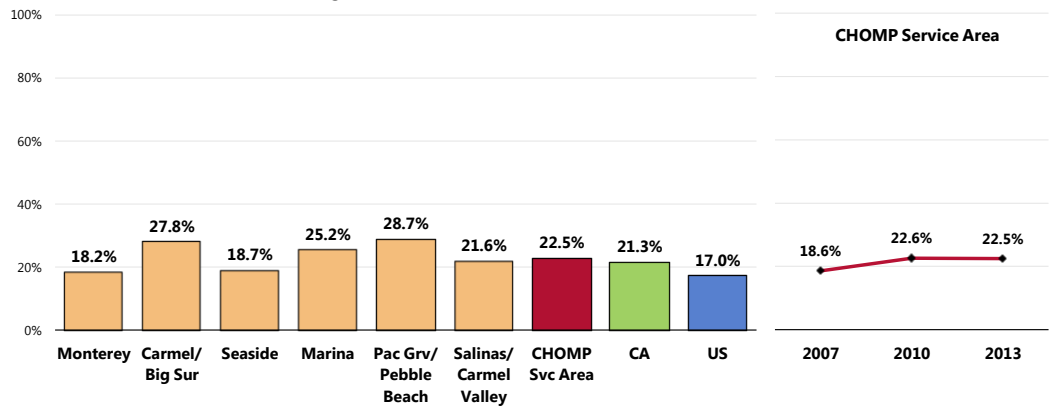
- **Improve the conditions of daily life** by: encouraging communities to be accessible so all can live in, move through, and interact with their environment; encouraging community living; and removing barriers in the environment using both physical universal design concepts and operational policy shifts.
- **Address the inequitable distribution of resources among people with disabilities and those without disabilities** by increasing: appropriate health care for people with disabilities; education and work opportunities; social participation; and access to needed technologies and assistive supports.
- **Expand the knowledge base and raise awareness about determinants of health for people with disabilities** by increasing: the inclusion of people with disabilities in public health data collection efforts across the lifespan; the inclusion of people with disabilities in health promotion activities; and the expansion of disability and health training opportunities for public health and health care professionals.

– Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

### **A total of 22.5% of CHOMP Service Area adults are limited in some way in some activities due to a physical, mental or emotional problem.**

- Similar to the prevalence statewide.
- Less favorable than the national prevalence.
- Statistically similar by community.
- ▣ Marks a statistically significant increase in activity limitations since 2007.

## Limited in Activities in Some Way Due to a Physical, Mental or Emotional Problem



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 117]  
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2011 California data.  
 • 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes: • Asked of all respondents.

### RELATED ISSUE:

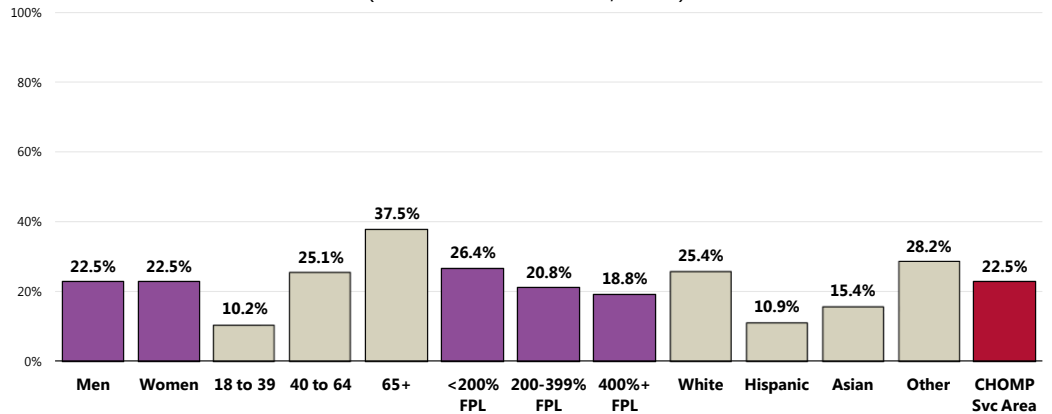
See also  
*Potentially Disabling  
 Conditions in the Death,  
 Disease & Chronic  
 Conditions* section of this  
 report.

In looking at responses by key demographic characteristics, note the following:

- 👤 Adults age 40 and older are much more often limited in activities (note the positive correlation with age).
- 👤 Note also the negative correlation with income.
- 👤 Non-Hispanic Whites and residents of "Other" races (e.g., Black, Native American, self-identified "mixed" race, etc.) are more likely to report activity limitations.

## Limited in Activities in Some Way Due to a Physical, Mental or Emotional Problem

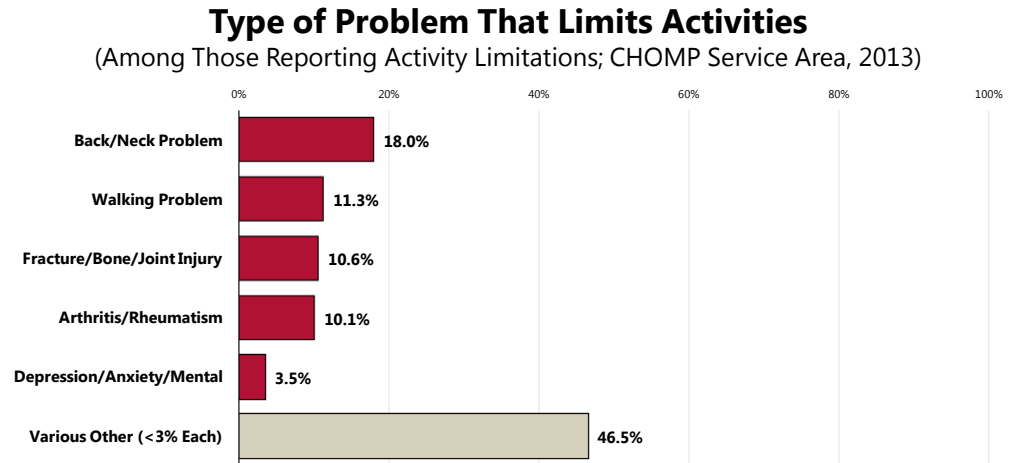
(CHOMP Service Area, 2013)



Sources: • 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 117]  
 Notes: • Asked of all respondents.  
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "<200% FPL" includes households with incomes up to 199% of the federal poverty level; "200-399% FPL" includes households with incomes between 200% and 399% of the federal poverty level; and "400%+ FPL" includes those households with incomes at 400% or more the federal poverty level.

Among persons reporting activity limitations, these are most often attributed to musculoskeletal issues, such as back/neck problems, difficulty walking, fractures or bone/joint injuries, or arthritis/rheumatism.

Depression and other mental health issues were also noted with some frequency, as shown.



Sources: • 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 118]  
Notes: • Asked of those respondents reporting activity limitations.

# Mental Health & Mental Disorders

Mental health is a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with challenges. Mental health is essential to personal well-being, family and interpersonal relationships, and the ability to contribute to community or society. Mental disorders are health conditions that are characterized by alterations in thinking, mood, and/or behavior that are associated with distress and/or impaired functioning. Mental disorders contribute to a host of problems that may include disability, pain, or death. Mental illness is the term that refers collectively to all diagnosable mental disorders.

Mental disorders are among the most common causes of disability. The resulting disease burden of mental illness is among the highest of all diseases. According to the national Institute of Mental Health (NIMH), in any given year, an estimated 13 million American adults (approximately 1 in 17) have a seriously debilitating mental illness. Mental health disorders are the leading cause of disability in the United States and Canada, accounting for 25% of all years of life lost to disability and premature mortality. Moreover, suicide is the 11<sup>th</sup> leading cause of death in the United States, accounting for the deaths of approximately 30,000 Americans each year.

Mental health and physical health are closely connected. Mental health plays a major role in people's ability to maintain good physical health. Mental illnesses, such as depression and anxiety, affect people's ability to participate in health-promoting behaviors. In turn, problems with physical health, such as chronic diseases, can have a serious impact on mental health and decrease a person's ability to participate in treatment and recovery.

The existing model for understanding mental health and mental disorders emphasizes the interaction of social, environmental, and genetic factors throughout the lifespan. In behavioral health, researchers identify: **risk factors**, which predispose individuals to mental illness; and **protective factors**, which protect them from developing mental disorders. Researchers now know that the prevention of mental, emotional, and behavioral (MEB) disorders is inherently interdisciplinary and draws on a variety of different strategies. Over the past 20 years, research on the prevention of mental disorders has progressed. The understanding of how the brain functions under normal conditions and in response to stressors, combined with knowledge of how the brain develops over time, has been essential to that progress. The major areas of progress include evidence that:

- MEB disorders are common and begin early in life.
- The greatest opportunity for prevention is among young people.
- There are multiyear effects of multiple preventive interventions on reducing substance abuse, conduct disorder, antisocial behavior, aggression, and child maltreatment.
- The incidence of depression among pregnant women and adolescents can be reduced.
- School-based violence prevention can reduce the base rate of aggressive problems in an average school by 25 to 33%.
- There are potential indicated preventive interventions for schizophrenia.
- Improving family functioning and positive parenting can have positive outcomes on mental health and can reduce poverty-related risk.
- School-based preventive interventions aimed at improving social and emotional outcomes can also improve academic outcomes.
- Interventions targeting families dealing with adversities, such as parental depression or divorce, can be effective in reducing risk for depression among children and increasing effective parenting.
- Some preventive interventions have benefits that exceed costs, with the available evidence strongest for early childhood interventions.
- Implementation is complex, and it is important that interventions be relevant to the target audiences.

In addition to advancements in the prevention of mental disorders, there continues to be steady progress in treating mental disorders as new drugs and stronger evidence-based outcomes become available.

– Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

## Mental Health Status

### Self-Reported Mental Health Status

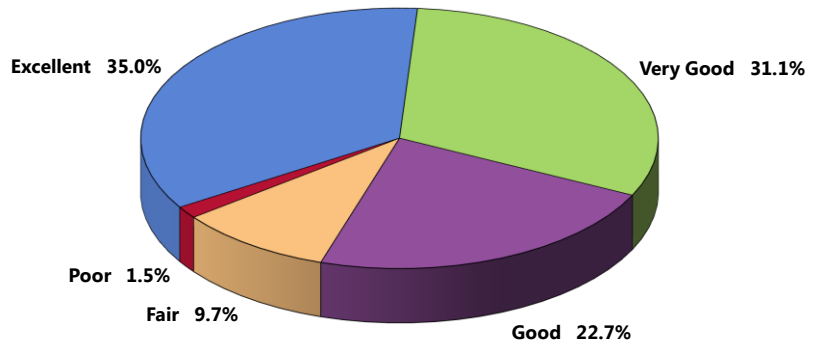
**A total of 66.1% of CHOMP Service Area adults rate their overall mental health as "excellent" or "very good."**

- Another 22.7% gave "good" ratings of their own mental health status.

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

### Self-Reported Mental Health Status

(CHOMP Service Area, 2013)

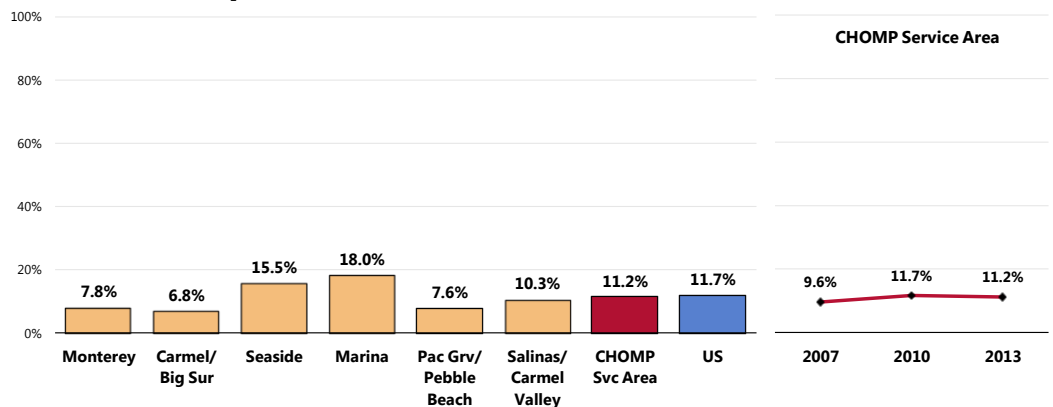


Sources: • 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 113]  
Notes: • Asked of all respondents.

**A total of 11.2% of CHOMP Service Area adults, however, believe that their overall mental health is "fair" or "poor."**

- Similar to the "fair/poor" response reported nationally.
- Lowest in Monterey and Carmel/Big Sur; unfavorably high in Seaside and Marina.
- ☒ Statistically unchanged over time.

### Experience "Fair" or "Poor" Mental Health



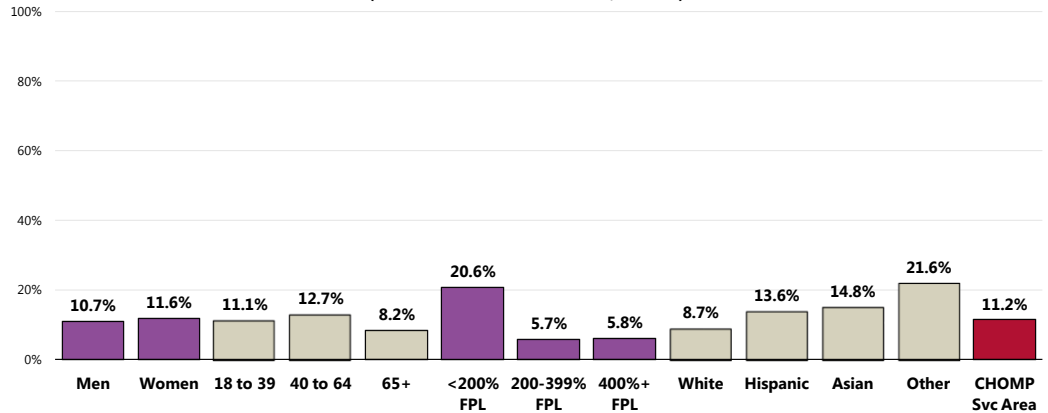
Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 113]  
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.  
Notes: • Asked of all respondents.



👥 Residents with lower incomes, and those of “Other” races are much more likely to report “fair/poor” mental health than their demographic counterparts.

👥 Adults under the age of 65 are also more likely to report “fair/poor” mental health than are older adults.

## Experience “Fair” or “Poor” Mental Health (CHOMP Service Area, 2013)



Sources: • 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 113]  
 Notes: • Asked of all respondents.  
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., “White” reflects non-Hispanic White respondents).  
 • Income categories reflect respondent’s household income as a ratio to the federal poverty level (FPL) for their household size. “<200% FPL” includes households with incomes up to 199% of the federal poverty level; “200-399% FPL” includes households with incomes between 200% and 399% of the federal poverty level; and “400%+ FPL” includes those households with incomes at 400% or more the federal poverty level.

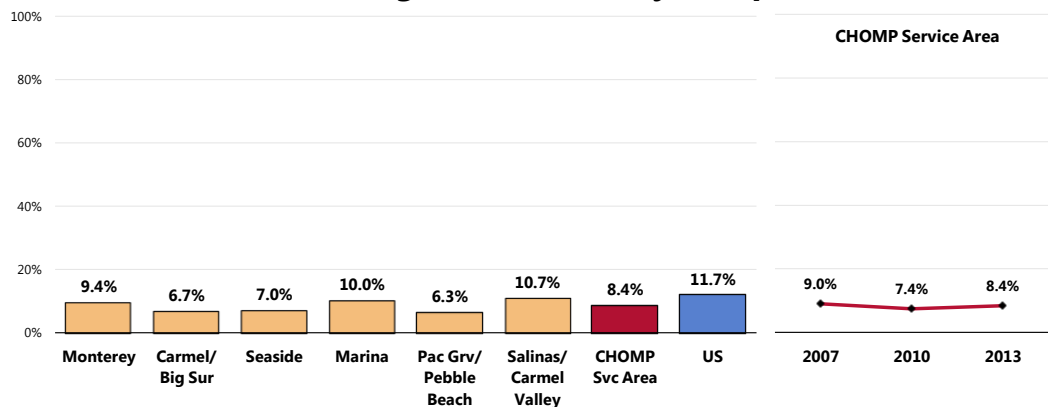
## Depression

### Major Depression

**A total of 8.4% of CHOMP Service Area adults have been diagnosed with major depression by a physician.**



- Better than the national finding.
- Statistically similar by community.
- 📊 Statistically unchanged over time.

## Have Been Diagnosed With Major Depression

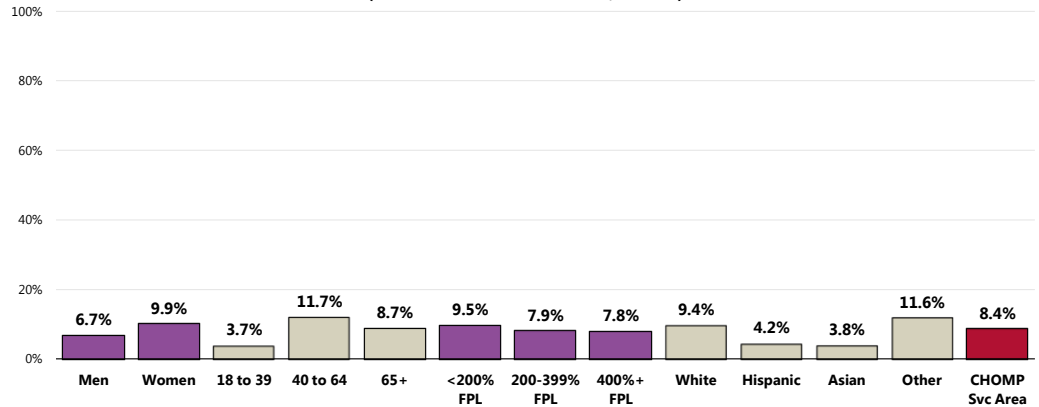


Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 33]  
 • 2011 PRC National Health Survey, Professional Research Consultants, Inc.  
 Notes: • Asked of all respondents.

The prevalence of major depression is notably higher among:

-  Adults age 40 and older.
-  Whites and "Other" races.

### Have Been Diagnosed With Major Depression (CHOMP Service Area, 2013)



Sources: 


- 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 33]

  
 Notes: 

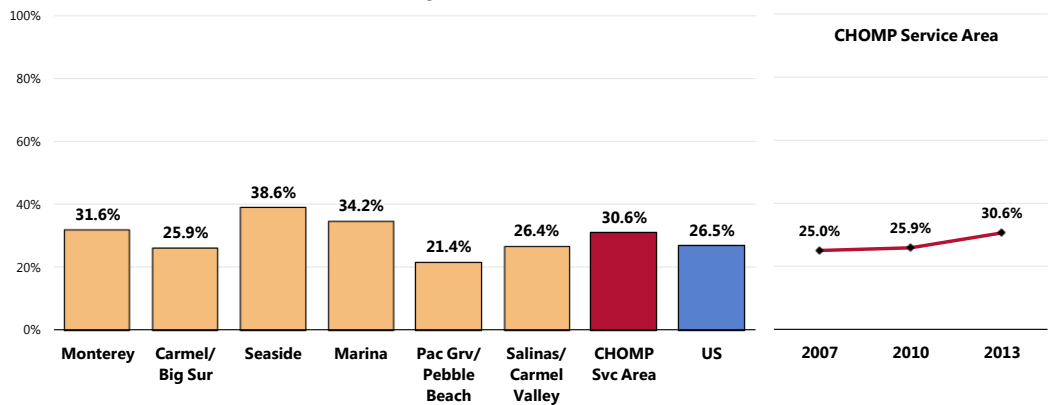
- Asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "<200% FPL" includes households with incomes up to 199% of the federal poverty level; "200-399% FPL" includes households with incomes between 200% and 399% of the federal poverty level; and "400%+ FPL" includes those households with incomes at 400% or more the federal poverty level.

### Symptoms of Chronic Depression

**A total of 30.6% of CHOMP Service Area adults have had two or more years in their lives when they felt depressed or sad on most days, although they may have felt okay sometimes (chronic depression).**

- Less favorable than national findings.
- Particularly high in Seaside; lowest in Pacific Grove/Pebble Beach.
-  Marks a significant increase in symptoms of chronic depression since 2007.

### Have Experienced Symptoms of Chronic Depression





Sources: 

- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 114]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

  
 Notes: 

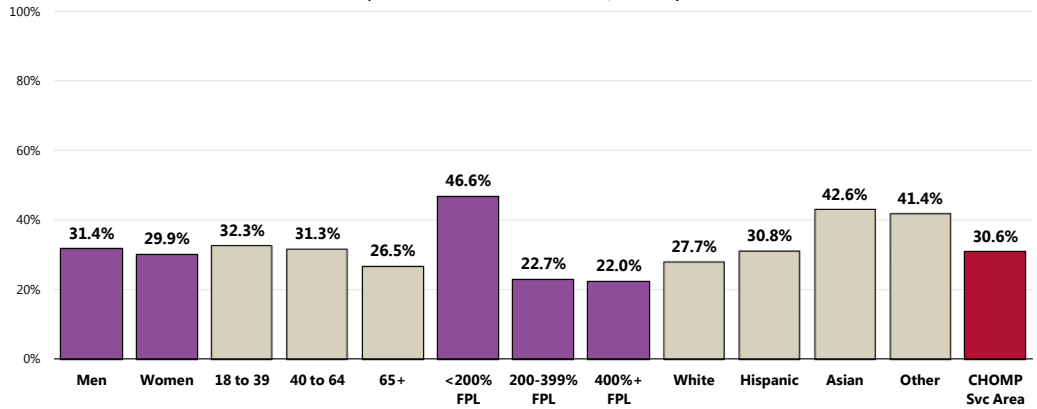
- Asked of all respondents.

Note that the prevalence of chronic depression is notably higher among:

-  Adults with lower incomes.
-  Asians and "Other" races.

## Have Experienced Symptoms of Chronic Depression

(CHOMP Service Area, 2013)



Sources: • 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 114]

Notes: • Asked of all respondents.

• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).

• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "<200% FPL" includes households with incomes up to 199% of the federal poverty level; "200-399% FPL" includes households with incomes between 200% and 399% of the federal poverty level; and "400%+ FPL" includes those households with incomes at 400% or more the federal poverty level.

## Stress

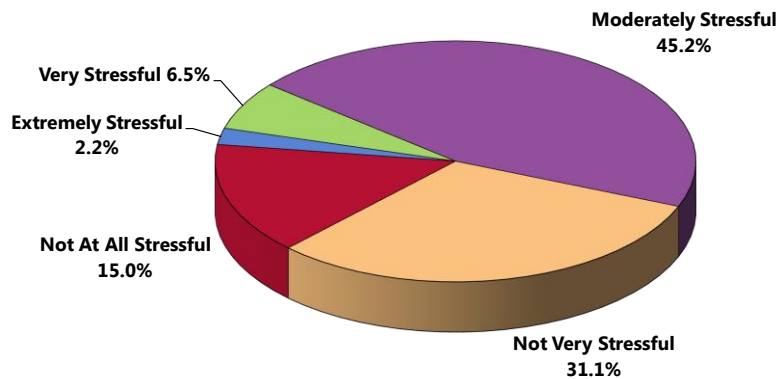
RELATED ISSUE:  
See also *Substance Abuse* in  
the **Modifiable  
Health Risks** section  
of this report.

Nearly one-half of CHOMP Service Area adults considers their typical day to be "not very stressful" (31.1%) or "not at all stressful" (15.0%).

- Another 45.2% of survey respondents characterize their typical day as "moderately stressful."

## Perceived Level of Stress On a Typical Day

(CHOMP Service Area, 2013)



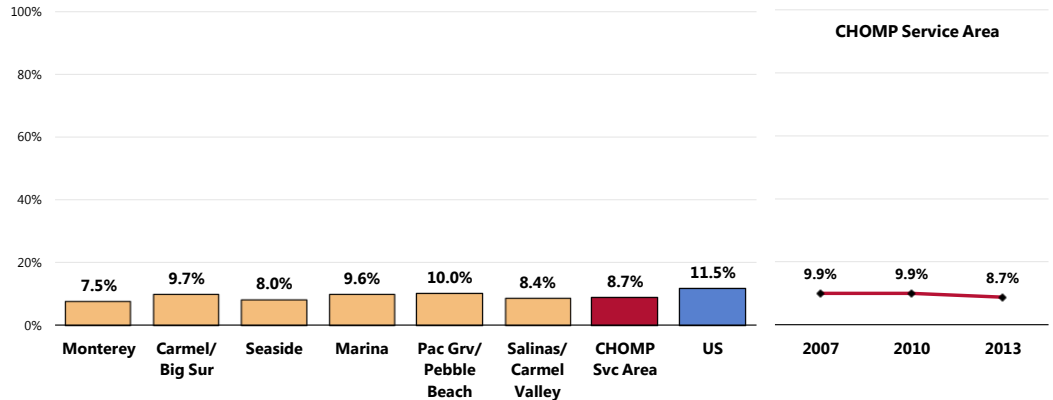
Sources: • 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 115]

Notes: • Asked of all respondents.

In contrast, 8.7% of CHOMP Service Area adults experience “very” or “extremely” stressful days on a regular basis.

- More favorable than national findings.
- No significant difference among individual communities.
- ☒ Statistically similar to previous survey findings.

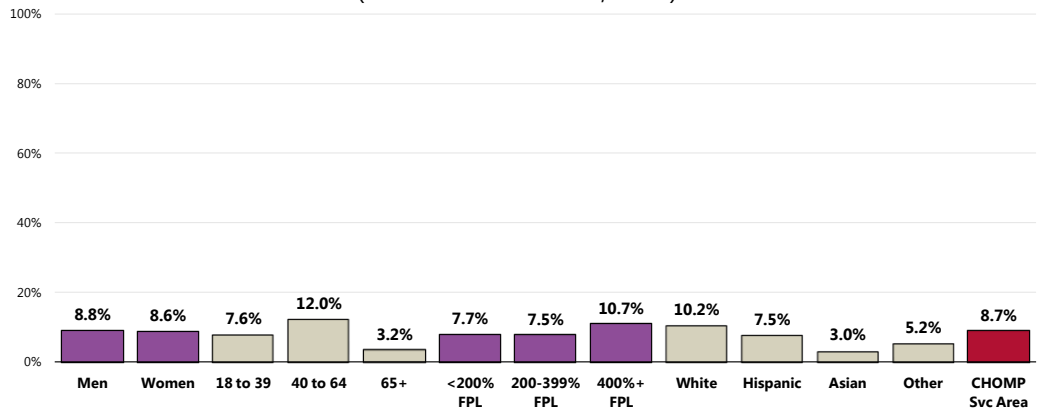
### Perceive Most Days As “Extremely” or “Very” Stressful



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 115]  
 • 2011 PRC National Health Survey, Professional Research Consultants, Inc.  
 Notes: • Asked of all respondents.

☺ Note that high stress levels are more prevalent among adults age 40 to 64, those with higher incomes, and Whites.

### Perceive Most Days as “Extremely” or “Very” Stressful (CHOMP Service Area, 2013)

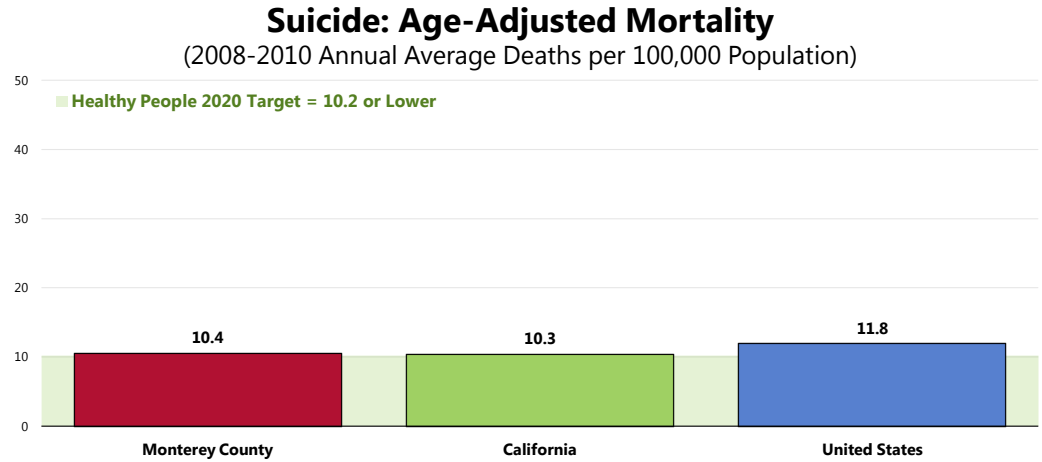


Sources: • 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 115]  
 Notes: • Asked of all respondents.  
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., “White” reflects non-Hispanic White respondents).  
 • Income categories reflect respondent’s household income as a ratio to the federal poverty level (FPL) for their household size. “<200% FPL” includes households with incomes up to 199% of the federal poverty level, “200-399% FPL” includes households with incomes between 200% and 399% of the federal poverty level, and “400%+ FPL” includes those households with incomes at 400% or more the federal poverty level.


## Suicide

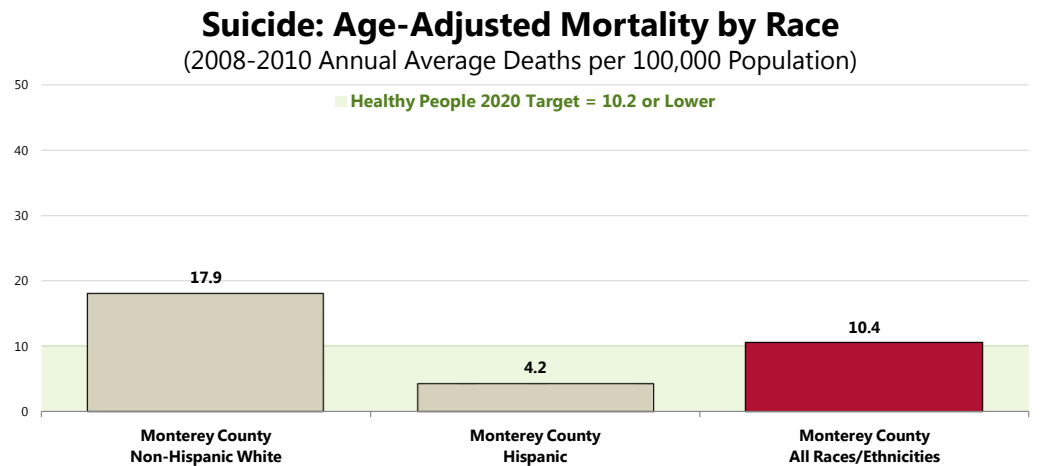
Between 2008 and 2010, there was an annual average age-adjusted suicide rate of 10.4 deaths per 100,000 population in Monterey County.

- Almost identical to the statewide rate.
- Just below the national rate.
- Similar to the Healthy People 2020 target of 10.2 or lower.



- Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2013.
  - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective MHMD-1]
- Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
  - Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
  - Local, state and national data are simple three-year averages.

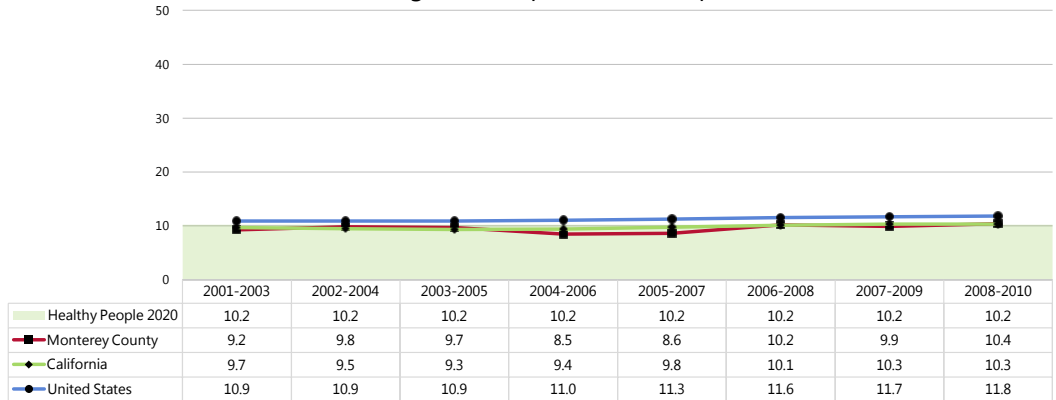
 The suicide rate in Monterey County is dramatically higher among Non-Hispanic Whites than among Hispanics (breakouts among other races not available).



- Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2013.
  - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective MHMD-1]
- Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
  - Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
  - Local, state and national data are simple three-year averages.

☒ The county's suicide rate has overall trended upward, echoing the state and national trends.

### Suicide: Age-Adjusted Mortality Trends (Annual Average Deaths per 100,000 Population)



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2013.  
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective MHMD-1]  
 Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).  
 • Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.  
 • Local, state and national data are simple three-year averages.

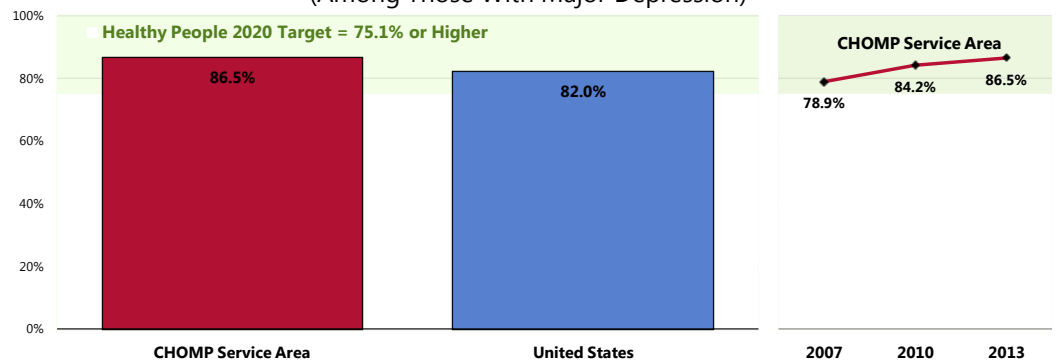
## Mental Health Treatment

Among adults with diagnosed depression, 86.5% acknowledge that they have sought professional help for a mental or emotional problem.

- Similar to national findings.
- Satisfies the Healthy People 2020 target of 75.1% or higher.
- ☒ The increase over time is not statistically significant, given the smaller sample sizes for this indicator (adults with major depression).

“Diagnosed depression” includes respondents reporting a past diagnosis of major depression by a physician.

### Have Sought Professional Help for a Mental or Emotional Problem (Among Those With Major Depression)



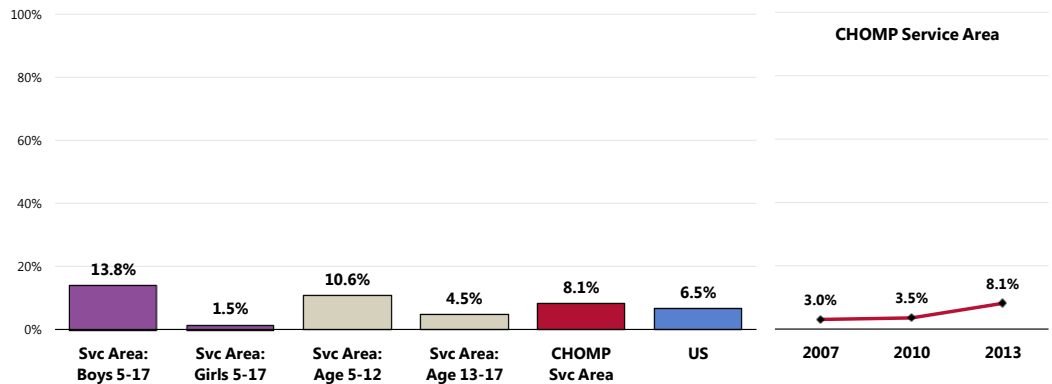
Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 139]  
 • 2011 PRC National Health Survey, Professional Research Consultants, Inc.  
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective MHMD-9.2]  
 Notes: • Asked of those respondents with major depression diagnosed by a physician.  
 • Trend data represent those adults with “recognized depression,” including those who have been diagnosed with major depression OR have experienced 2+ years of depression at some point in their lives.

## Children & ADD/ADHD

Among CHOMP Service Area adults with children age 5 to 17, 8.1% report that their child takes medication for ADD/ADHD.

- Statistically similar to the national prevalence.
- ▣ Marks a significant increase over time.
- 👤 Highest in boys and in younger children.

### Child Takes Medication for ADD/ADHD (Among Parents of Children 5-17)



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 132]  
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes: • Asked of all respondents with children age 5-17 at home.

### Related Focus Group Findings: Mental Health

Focus group members discussed the fragmented mental health system and the limited services available to residents, with focus on:

- System is broken, fragmented, absent, and incomplete
- Monterey County Behavioral Health
- Need case management services
- Stigma
- Language

During the focus groups, issues surrounding mental health services arose several times. Respondents describe the **mental health system in Monterey County as broken, fragmented, absent, and incomplete**. There is high demand for juvenile psychiatric services, but few resources exist for the community's adolescent population.

Attendees worry because financial constraints impact the agencies that provide these services. **Monterey County Behavioral Health** provides care to low income and Medicaid recipients, but is currently overwhelmed with the need and patients may have a several-month waiting period before appointments are available. In addition, the county system will only accept certain diagnoses. For Medicare recipients, finding a provider that will accept that insurance can be very difficult.

Participants do feel that the county system has begun to move toward a more integrated approach by combining behavioral healthcare into their primary care clinics. Key informants would like to see a coordinated system between private providers and the county. Currently, agencies do not work together and do not follow up after referrals, as a respondent describes:

*"This is where I mean it would be nice in mental health if there's a partnership between the County and the private sector and they really looked at how we can best provide mental health services for Monterey County period versus the fact it goes back to my original statement, mental health is really a turf battle. If you can bat the patient to another facility or another clinician, you shut the door on them as fast as you can and go out of sight out of mind, which is really unfortunate." — Healthcare Provider*

Respondents believe that in general, mentally ill residents have lower health knowledge, are less likely to participate in preventative healthcare, and may not follow through or attend appointments. Intensive **case management services** could help those mentally ill patients to live more productive lives. A key informant explains:

*"The key is these clients need to be seen, they need to be shepherded into the system. And unfortunately, and again I'm not bashing the county, but the county if somebody stops coming to their appointments it kind of goes well they're not interested. And so these are actually the clients we need to be going out and getting and saying you got to come to your appointment rather than saying well they're not interested. Mentally ill people don't self-motivate to go to an appointment. They don't self-motivate to take care of themselves. They don't self-motivate to watch their diet and things like that." — Healthcare Provider*

Participants also agree that **stigma** impacts residents' willingness to access behavioral healthcare:

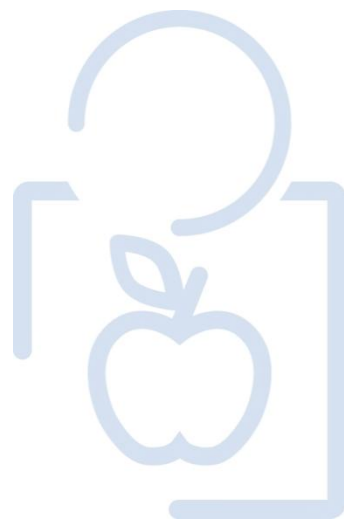
*"Well within our society, the culture that we live in, it's a barrier for a lot of people to access services. I know we're always trying to send messages out in different ways using different mediums just to increase awareness about mental health and the message is that it affects everybody and anybody can deal with challenges, but that still holds a lot of people back from accessing services and the fear of being labeled, the fear of being discriminated because of a diagnosis or a specific challenge that they're facing. We are still behavioral health. We're still working quite diligently to eradicate that, but we've quite a long ways to go." — Community Leader*

Access to mental health services is also impacted by **language**. Those residents who do not speak English well may not have any options. Participants think that additional bilingual psychiatrists and interpreters are needed. A healthcare provider explains the importance of bilingual services:

*"Language is another issue. Those appointments are really critical that you speak Spanish. Getting an interpreter, someone that can actually communicate how the patient is feeling and what the patient needs, you lose some of that. And so we have, really hard to find someone that is bilingual." — Healthcare Provider*



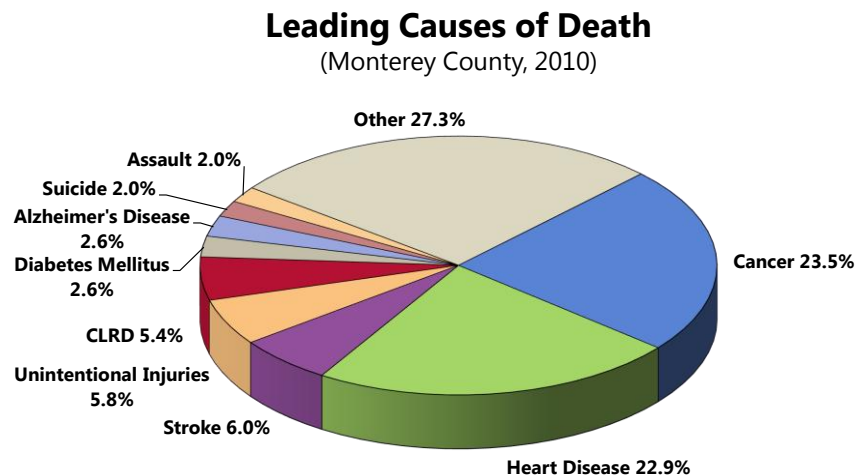
# DEATH, DISEASE & CHRONIC CONDITIONS



# Leading Causes of Death

## Distribution of Deaths by Cause

Together, cancers and cardiovascular disease (heart disease and stroke) accounted for just over 50% of all deaths in Monterey County in 2010.



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2013.  
Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).  
• CLRD is chronic lower respiratory disease.

## Age-Adjusted Death Rates for Selected Causes

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

Furthermore, in order to compare localities without undue bias toward younger or older populations, the common convention is to adjust the data to some common baseline age distribution. Use of these “age-adjusted” rates provides the most valuable means of gauging mortality against benchmark data, as well as *Healthy People 2020* targets.

The following chart outlines 2008-2010 annual average age-adjusted death rates per 100,000 population for selected causes of death in Monterey County.

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

**Age-adjusted mortality rates in Monterey County (2008-2010) are worse than national rates for firearm-related deaths, cirrhosis/liver disease deaths, and homicides.**

Of the causes outlined in the following chart for which Healthy People 2020 objectives have been established, Monterey County rates fail to satisfy the related goals for stroke deaths, firearm-related deaths, homicides, and cirrhosis/liver disease deaths.

**Age-Adjusted Death Rates for Selected Causes**  
(2008-2010 Deaths per 100,000)

	Monterey County	California	US	HP2020
<b>Malignant Neoplasms (Cancers)</b>	138.7	158.2	174.2	160.6
<b>Diseases of the Heart</b>	137.0	168.2	184.6	152.7*
<b>Cerebrovascular Disease (Stroke)</b>	37.2	39.2	40.2	33.8
<b>Chronic Lower Respiratory Disease (CLRD)</b>	31.8	38.1	43.2	n/a
<b>Unintentional Injuries</b>	30.1	28.9	38.2	36
<b>Diabetes Mellitus</b>	17.4	20.3	21.3	19.6*
<b>Alzheimer's Disease</b>	17.0	29.2	25.0	n/a
<b>Firearm-Related</b>	11.7	8.1	10.2	9.2
<b>Pneumonia/Influenza</b>	10.7	17.9	16.4	n/a
<b>Drug-Induced</b>	10.7	11.2	12.7	11.3
<b>Cirrhosis/Liver Disease</b>	10.6	11.3	9.2	8.2
<b>Intentional Self-Harm (Suicide)</b>	10.4	10.3	11.8	10.2
<b>Homicide/Legal Intervention</b>	10.3	5.6	5.6	5.5
<b>Kidney Diseases</b>	9.4	8.6	15.2	n/a
<b>Motor Vehicle Deaths</b>	9.4	8.8	11.9	12.4

- Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2013.
  - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov>.
- Note:
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population and coded using ICD-10 codes.
  - \*The Healthy People 2020 Heart Disease target is adjusted to account for all diseases of the heart; the Diabetes target is adjusted to reflect only diabetes mellitus-coded deaths.
  - Local, state and national data are simple three-year averages.

**Related Focus Group Findings: Chronic Disease**

All participants agree that chronic disease conditions persist in the community. Focus group participants mentioned the following chronic health ailments which continue to affect the community: hypertension, diabetes, congestive heart failure, chronic obstructive pulmonary disease, and asthma.

# Cardiovascular Disease

Heart disease is the leading cause of death in the United States, with stroke following as the third leading cause. Together, heart disease and stroke are among the most widespread and costly health problems facing the nation today, accounting for more than \$500 billion in healthcare expenditures and related expenses in 2010 alone. Fortunately, they are also among the most preventable.

The leading modifiable (controllable) risk factors for heart disease and stroke are:

- High blood pressure
- High cholesterol
- Cigarette smoking
- Diabetes
- Poor diet and physical inactivity
- Overweight and obesity

The risk of Americans developing and dying from cardiovascular disease would be substantially reduced if major improvements were made across the US population in diet and physical activity, control of high blood pressure and cholesterol, smoking cessation, and appropriate aspirin use.

The burden of cardiovascular disease is disproportionately distributed across the population. There are significant disparities in the following based on gender, age, race/ethnicity, geographic area, and socioeconomic status:

- Prevalence of risk factors
- Access to treatment
- Appropriate and timely treatment
- Treatment outcomes
- Mortality

Disease does not occur in isolation, and cardiovascular disease is no exception. Cardiovascular health is significantly influenced by the physical, social, and political environment, including: maternal and child health; access to educational opportunities; availability of healthy foods, physical education, and extracurricular activities in schools; opportunities for physical activity, including access to safe and walkable communities; access to healthy foods; quality of working conditions and worksite health; availability of community support and resources; and access to affordable, quality healthcare.

– Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

## Age-Adjusted Heart Disease & Stroke Deaths

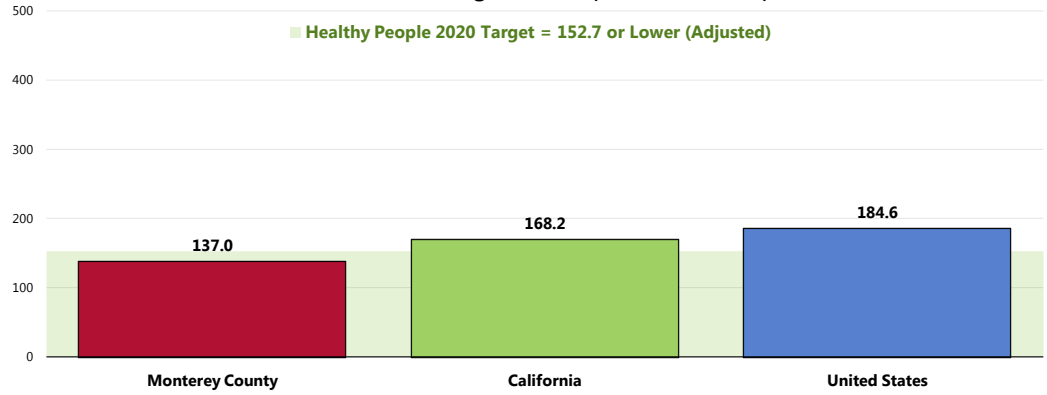
### Heart Disease Deaths

**Between 2008 and 2010 there was an annual average age-adjusted heart disease mortality rate of 137.0 deaths per 100,000 population in Monterey County.**

- Lower than the statewide rate.
- Lower than the national rate.
- Satisfies the Healthy People 2020 target (as adjusted to account for all diseases of the heart).

The greatest share of cardiovascular deaths is attributed to heart disease.

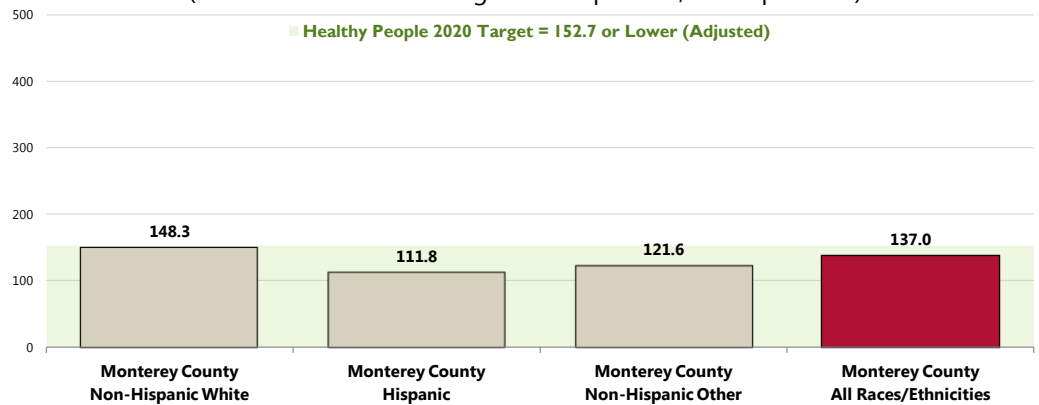
## Heart Disease: Age-Adjusted Mortality (2008-2010 Annual Average Deaths per 100,000 Population)



- Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2013.
  - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective HDS-2]
- Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
  - Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
  - Local, state and national data are simple three-year averages.
  - The Healthy People 2020 Heart Disease target is adjusted to account for all diseases of the heart.

👤 By race/ethnicity, the heart disease mortality rate is notably higher among Non-Hispanic Whites when compared with Hispanics and adults of “Other” races in Monterey County.

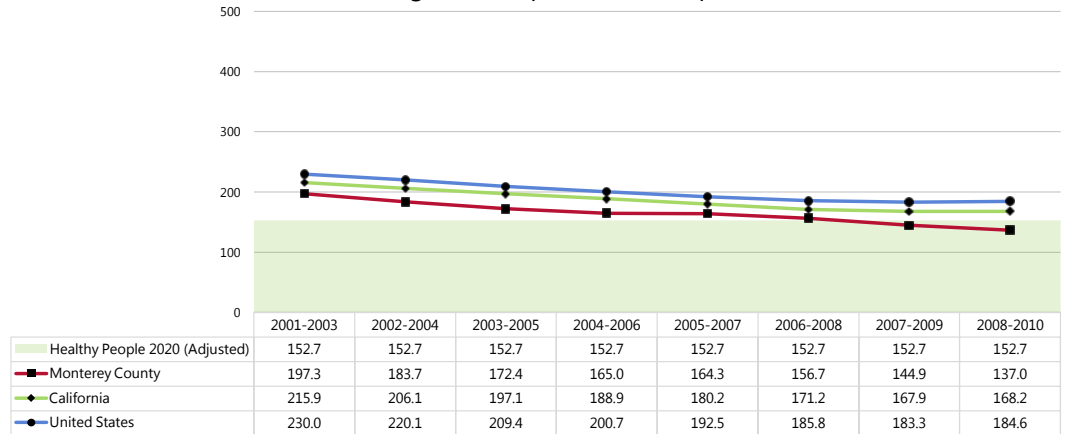
## Heart Disease: Age-Adjusted Mortality by Race (2008-2010 Annual Average Deaths per 100,000 Population)



- Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2013.
  - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective HDS-2]
- Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
  - Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
  - Local, state and national data are simple three-year averages.
  - The Healthy People 2020 Heart Disease target is adjusted to account for all diseases of the heart.

☒ The county's heart disease mortality rate has decreased, echoing the decreasing trends across California and the US overall.

## Heart Disease: Age-Adjusted Mortality Trends (Annual Average Deaths per 100,000 Population)



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2013.  
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective HDS-2]  
 Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).  
 • Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.  
 • Local, state and national data are simple three-year averages.  
 • The Healthy People 2020 Heart Disease target is adjusted to account for all diseases of the heart.

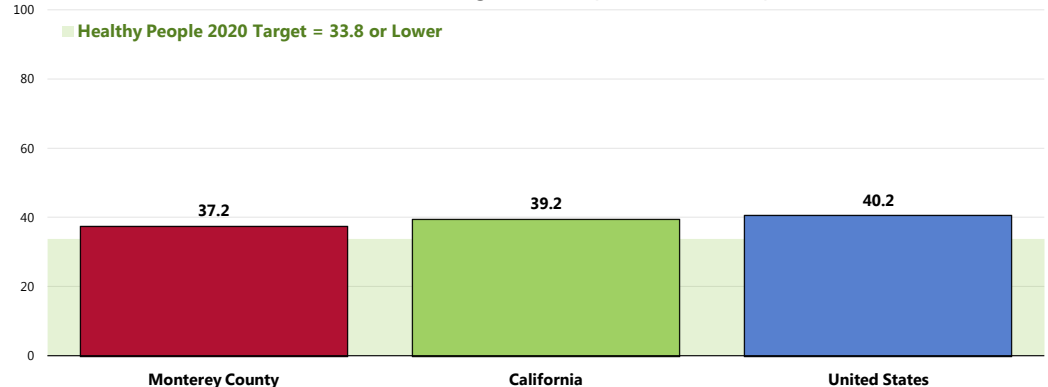
## Stroke Deaths

Between 2008 and 2010, there was an annual average age-adjusted stroke mortality rate of 37.2 deaths per 100,000 population in Monterey County.

- More favorable than the California rate.
- More favorable than the national rate.
- Fails to satisfy the Healthy People 2020 target of 33.8 or lower.

## Stroke: Age-Adjusted Mortality

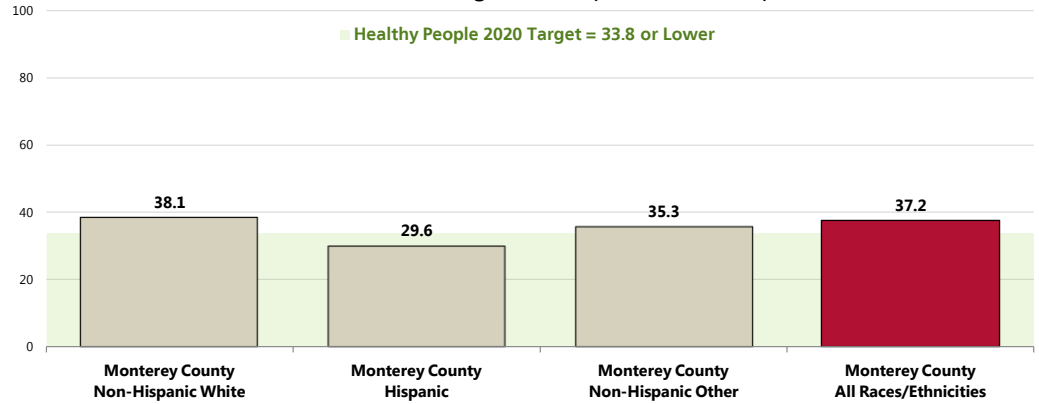
(2008-2010 Annual Average Deaths per 100,000 Population)



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2013.  
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective HDS-3]  
 Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).  
 • Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.  
 • Local, state and national data are simple three-year averages.

Stroke mortality is lowest among Hispanics in Monterey County.

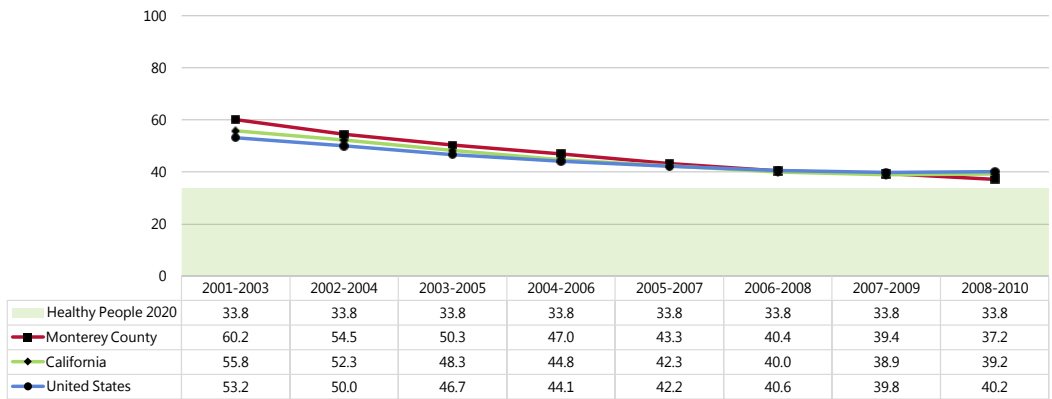
### Stroke: Age-Adjusted Mortality by Race (2008-2010 Annual Average Deaths per 100,000 Population)



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2013.  
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective HDS-3]  
 Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).  
 • Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.  
 • Local, state and national data are simple three-year averages.

The stroke mortality rate has declined in recent years, in keeping with the trends reported across California and the US overall.

### Stroke: Age-Adjusted Mortality Trends (Annual Average Deaths per 100,000 Population)



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2013.  
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective HDS-3]  
 Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).  
 • Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.  
 • Local, state and national data are simple three-year averages.

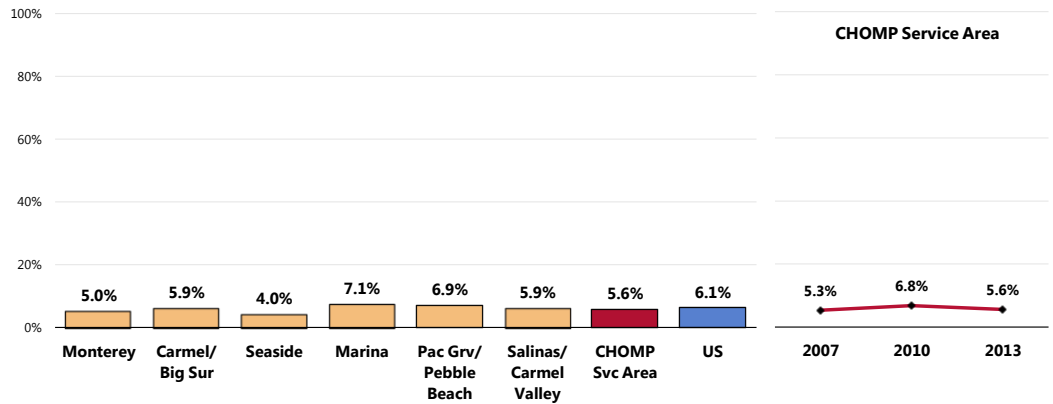
# Prevalence of Heart Disease & Stroke

## Prevalence of Heart Disease

**A total of 5.6% of surveyed adults report that they suffer from or have been diagnosed with heart disease, such as coronary heart disease, angina or heart attack.**

- Similar to the national prevalence.
- Similar by community.
- ☒ Statistically unchanged over time.

### Prevalence of Heart Disease

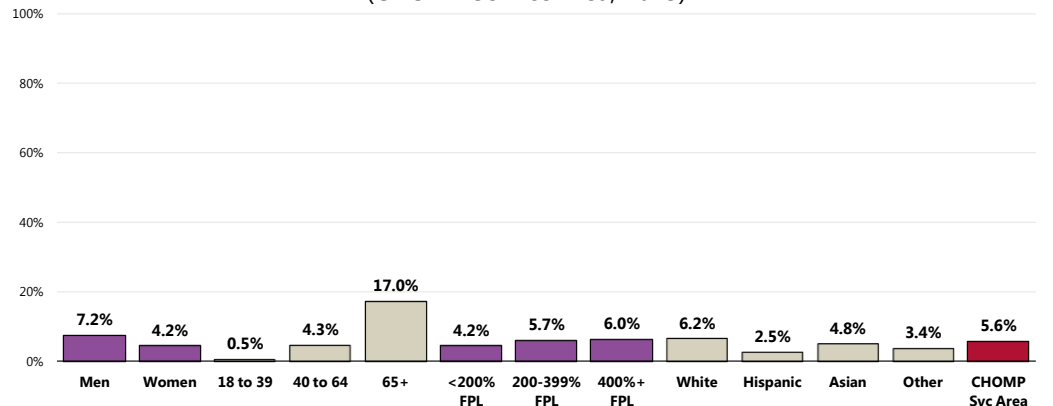


Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 140]  
 ● 2011 PRC National Health Survey, Professional Research Consultants, Inc.  
 Notes: ● Asked of all respondents.

Adults more likely to have been diagnosed with chronic heart disease include:

- ☒ Men.
- ☒ Seniors (age 65+).
- ☒ Whites.

### Prevalence of Heart Disease (CHOMP Service Area, 2013)



Sources: ● 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 140]  
 Notes: ● Asked of all respondents.  
 ● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
 ● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "<200% FPL" includes households with incomes up to 199% of the federal poverty level; "200-399% FPL" includes households with incomes between 200% and 399% of the federal poverty level; and "400%+ FPL" includes those households with incomes at 400% or more the federal poverty level.

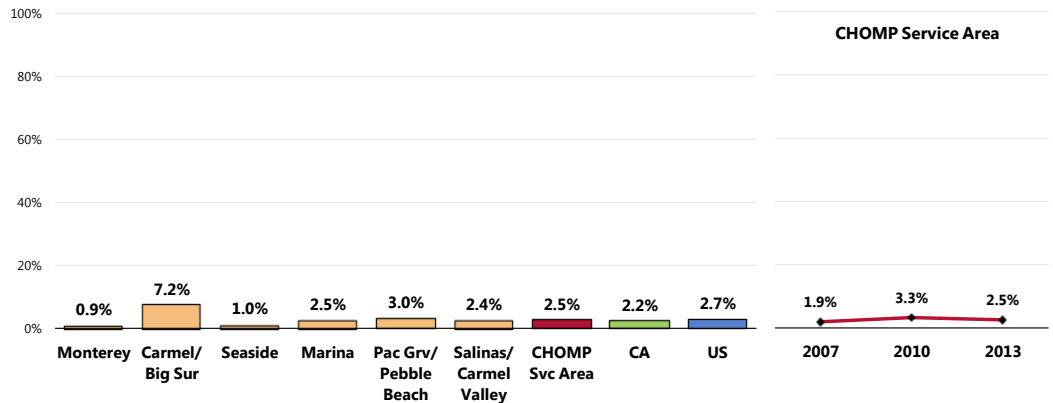


## Prevalence of Stroke

**A total of 2.5% of surveyed adults report that they suffer from or have been diagnosed with cerebrovascular disease (a stroke).**

- Similar to statewide findings.
- Similar to national findings.
- Lower in Monterey and Seaside; unfavorably high in Carmel/Big Sur.
- 📊 Statistically unchanged over time.

### Prevalence of Stroke



Sources:
 

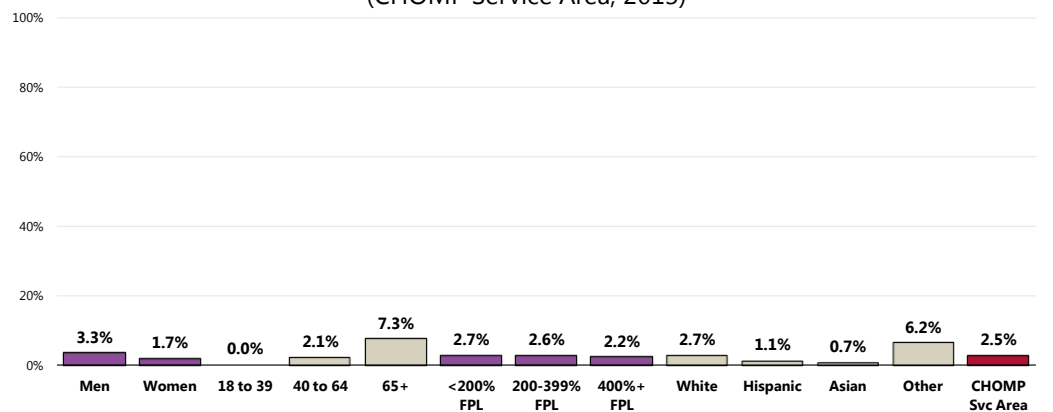
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 40]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2011 California data.

 Notes:
 

- Asked of all respondents.

👥 Note the positive correlation between age and stroke prevalence in the service area.

### Prevalence of Stroke (CHOMP Service Area, 2013)



Sources:
 

- 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 40]

 Notes:
 

- Asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "<200% FPL" includes households with incomes up to 199% of the federal poverty level; "200-399% FPL" includes households with incomes between 200% and 399% of the federal poverty level; and "400%+ FPL" includes those households with incomes at 400% or more the federal poverty level.

## Cardiovascular Risk Factors

Controlling risk factors for heart disease and stroke remains a challenge. High blood pressure and cholesterol are still major contributors to the national epidemic of cardiovascular disease. High blood pressure affects approximately 1 in 3 adults in the United States, and more than half of Americans with high blood pressure do not have it under control. High sodium intake is a known risk factor for high blood pressure and heart disease, yet about 90% of American adults exceed their recommendation for sodium intake.

– Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

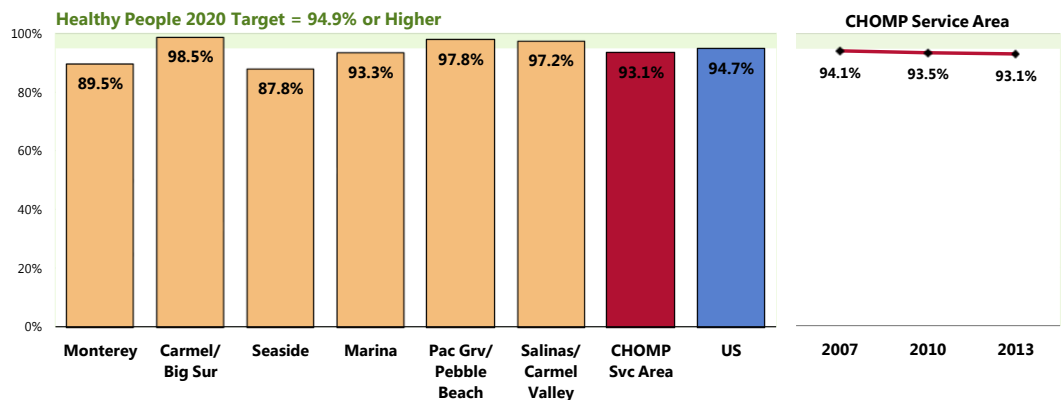
### Hypertension (High Blood Pressure)

#### High Blood Pressure Testing

**A total of 93.1% of CHOMP Service Area adults have had their blood pressure tested within the past two years.**

- Similar to national findings.
  - Fails to satisfy the Healthy People 2020 target (94.9% or higher).
  - Higher in Carmel/Big Sur, Pacific Grove/Pebble Beach, and Salinas/Carmel Valley; unfavorably low in Seaside.
- 📈 No significant change over time.

#### Have Had Blood Pressure Checked in the Past Two Years



Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 48]  
● 2011 PRC National Health Survey, Professional Research Consultants, Inc.  
● US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective HDS-4]  
Notes: ● Asked of all respondents.

#### Prevalence of Hypertension

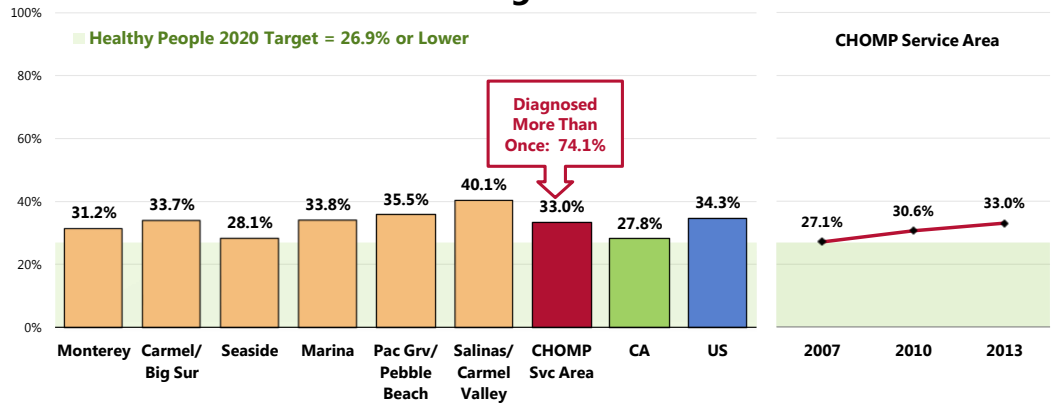
**A total of 33.0% of adults have been told at some point that their blood pressure was high.**

- Less favorable than the California prevalence.
- Similar to the national prevalence.
- Fails to satisfy the Healthy People 2020 target (26.9% or lower).
- No significant difference in results by community.

📈 Denotes a significant increase over time.

👥 Among hypertensive adults, 74.1% have been diagnosed with high blood pressure more than once.

## Prevalence of High Blood Pressure



Sources:
 

- PRC Community Health Surveys, Professional Research Consultants, Inc. [Items 46, 141]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2011 California data.
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective HDS-5.1]

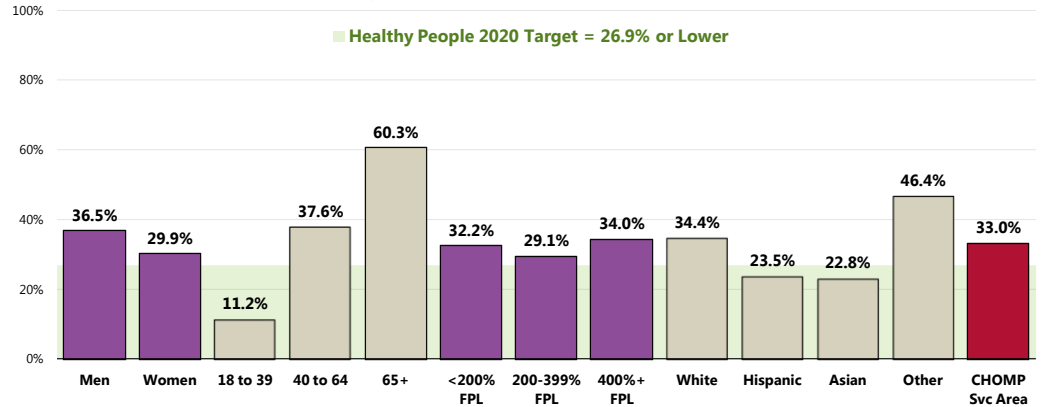
 Notes:
 

- Asked of all respondents.

Hypertension diagnoses are higher among:

- 👤 Men.
- 👤 Adults age 40 and older, and especially those age 65+.
- 👤 White adults and "Other" race adults in the service area.

## Prevalence of High Blood Pressure (CHOMP Service Area, 2013)



Sources:
 

- 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 141]
- US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective HDS-5.1]

 Notes:
 

- Asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "<200% FPL" includes households with incomes up to 199% of the federal poverty level; "200-399% FPL" includes households with incomes between 200% and 399% of the federal poverty level; and "400%+ FPL" includes those households with incomes at 400% or more the federal poverty level.

## Hypertension Management

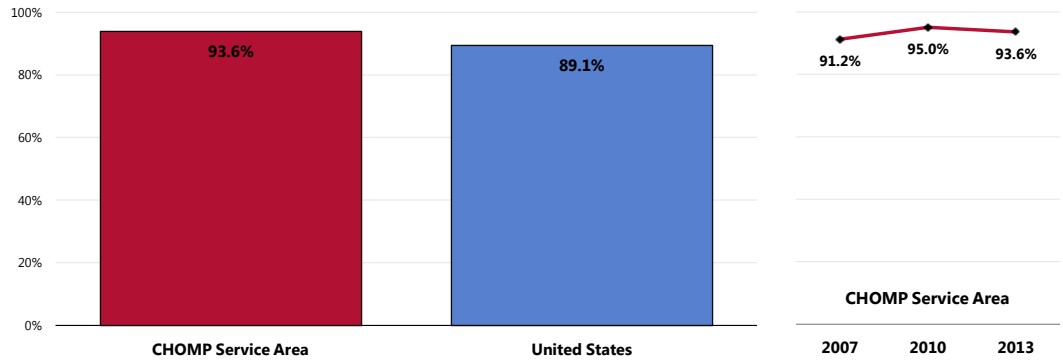
Respondents reporting high blood pressure were further asked:

*"Are you currently taking any action to help control your high blood pressure, such as taking medication, changing your diet, or exercising?"*

**Among respondents who have been told that their blood pressure was high, 93.6% report that they are currently taking actions to control their condition.**

- Similar to national findings.
- ☒ Statistically unchanged since 2007.

### Taking Action to Control Hypertension (Among Adults With High Blood Pressure)



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 47]  
 • 2011 PRC National Health Survey, Professional Research Consultants, Inc.  
 Notes: • Asked of all respondents who have been diagnosed with high blood pressure.  
 • In this case, the term "action" refers to medication, change in diet, and/or exercise.

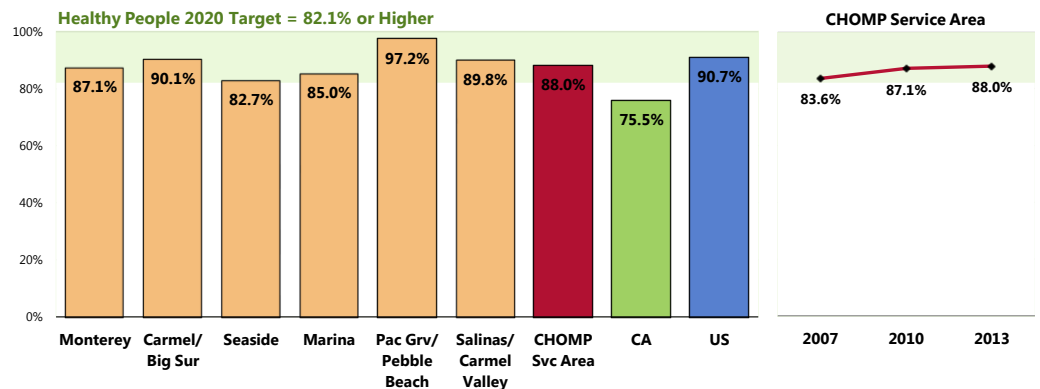
## High Blood Cholesterol

### Blood Cholesterol Testing

**88.0% of service area adults had their blood cholesterol checked in the past 5 years.**

- More favorable than California findings.
- Comparable to the national findings.
- Satisfies the Healthy People 2020 target (82.1% or higher).
- Lower in Seaside; higher in Pacific Grove/Pebble Beach.
- ☒ Denotes a statistically significant increase since 2007.

### Have Had Blood Cholesterol Levels Checked in the Past Five Years

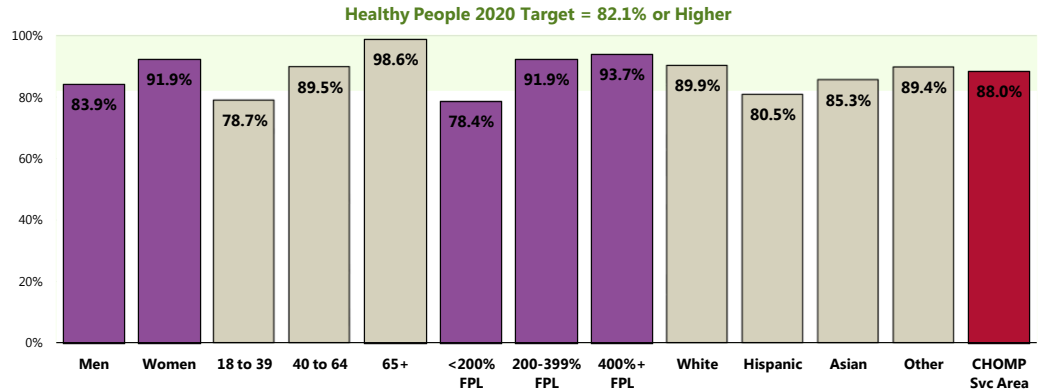


Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 51]  
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2011 California data.  
 • 2011 PRC National Health Survey, Professional Research Consultants, Inc.  
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective HDS-6]  
 Notes: • Asked of all respondents.

The following demographic segments report lower screening levels:

- 👤 Men.
- 👤 Adults under age 65, and especially those under 40 (note the positive correlation with age).
- 👤 Residents with lower incomes.
- 👤 Hispanic adults and Asian adults.

### Have Had Blood Cholesterol Levels Checked in the Past Five Years (CHOMP Service Area, 2013)



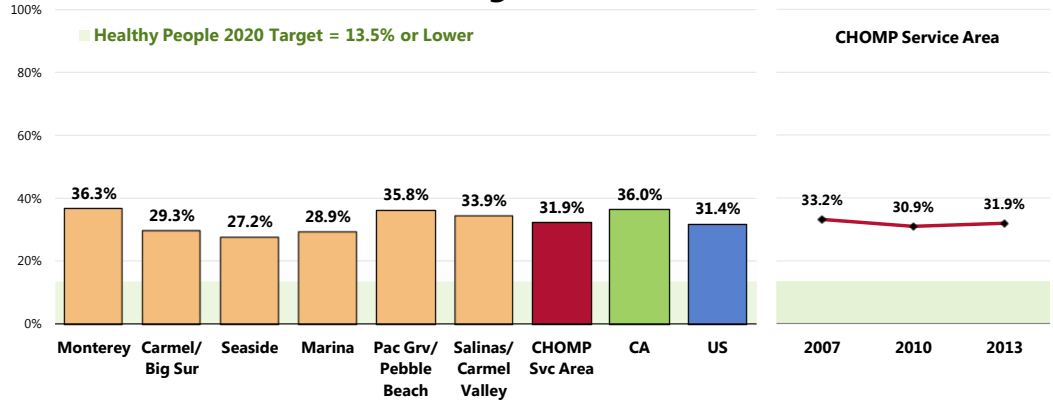
Sources: • 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 51]  
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective HD5-6]  
 Notes: • Asked of all respondents.  
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "<200% FPL" includes households with incomes up to 199% of the federal poverty level; "200-399% FPL" includes households with incomes between 200% and 399% of the federal poverty level; and "400%+ FPL" includes those households with incomes at 400% or more the federal poverty level.

#### Self-Reported High Blood Cholesterol

**A total of 31.9% of adults have been told by a health professional that their cholesterol level was high.**

- More favorable than the California findings.
- Almost identical to the national prevalence.
- More than twice the Healthy People 2020 target (13.5% or lower).
- No significant difference by community.
- 📊 Statistically unchanged since 2007.

## Prevalence of High Blood Cholesterol



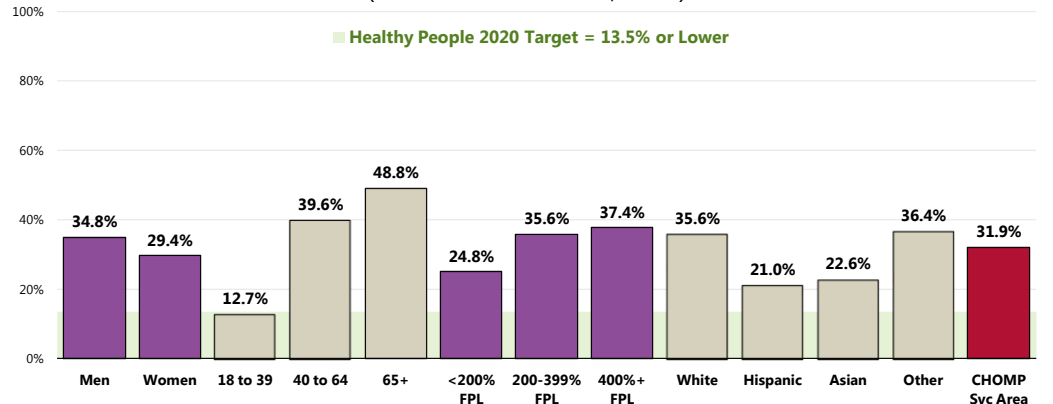
- Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 142]
  - Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2011 California data.
  - 2011 PRC National Health Survey, Professional Research Consultants, Inc.
  - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective HDS-7]
- Notes:
- Asked of all respondents.
  - \*The California data reflects those adults who have been tested for high cholesterol and who have been diagnosed with it.

Note that 17.0% of CHOMP Service Area adults report not having high blood cholesterol, but: 1) have never had their blood cholesterol levels tested; 2) have not been screened in the past 5 years; or 3) do not recall when their last screening was. For these individuals, current prevalence is unknown.

- Note the positive correlation between age and high blood cholesterol.
- Note the higher prevalence among upper-income adults.
- Whites and "Other" race adults report a higher prevalence.
- Keep in mind that "unknowns" are relatively high in men, young adults, lower-income residents, Hispanics and Asians.

## Prevalence of High Blood Cholesterol

(CHOMP Service Area, 2013)



- Sources:
- 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 142]
  - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective HDS-7]
- Notes:
- Asked of all respondents.
  - Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
  - Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "<200% FPL" includes households with incomes up to 199% of the federal poverty level; "200-399% FPL" includes households with incomes between 200% and 399% of the federal poverty level; and "400%+ FPL" includes those households with incomes at 400% or more the federal poverty level.

## High Cholesterol Management

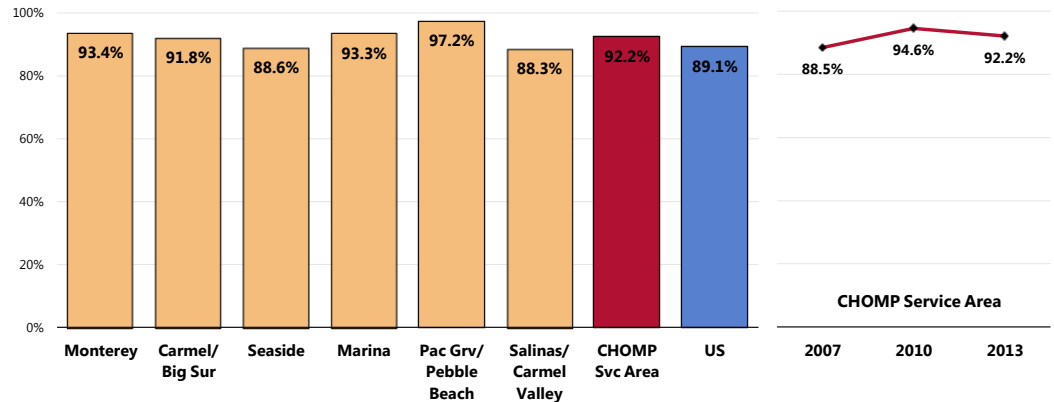
Respondents reporting high cholesterol were further asked:

*“Are you currently taking any action to help control your high cholesterol, such as taking medication, changing your diet, or exercising?”*

**Among adults who have been told that their blood cholesterol was high, 92.2% report that they are currently taking actions to control their cholesterol levels.**

- Comparable to that found nationwide.
- Favorably high in the Pacific Grove/Pebble Beach communities.
- ☒ Statistically unchanged over time.

### Taking Action to Control High Blood Cholesterol Levels (Among Adults with High Cholesterol)



Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 50]  
 ● 2011 PRC National Health Survey, Professional Research Consultants, Inc.  
 Notes: ● Asked of all respondents who have been diagnosed with high blood cholesterol levels.  
 ● In this case, the term "action" refers to medication, change in diet, and/or exercise.

Individual level risk factors which put people at increased risk for cardiovascular diseases include:

- High Blood Pressure
- High Blood Cholesterol
- Tobacco Use
- Physical Inactivity
- Poor Nutrition
- Overweight/Obesity
- Diabetes

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

Three health-related behaviors contribute markedly to cardiovascular disease:

**Poor nutrition.** People who are overweight have a higher risk for cardiovascular disease. Almost 60% of adults are overweight or obese. To maintain a proper body weight, experts recommend a well-balanced diet which is low in fat and high in fiber, accompanied by regular exercise.

**Lack of physical activity.** People who are not physically active have twice the risk for heart disease of those who are active. More than half of adults do not achieve recommended levels of physical activity.

**Tobacco use.** Smokers have twice the risk for heart attack of nonsmokers. Nearly one-fifth of all deaths from cardiovascular disease, or about 190,000 deaths a year nationally, are smoking-related. Every day, more than 3,000 young people become daily smokers in the US

Modifying these behaviors is critical both for preventing and for controlling cardiovascular disease. Other steps that adults who have cardiovascular disease should take to reduce their risk of death and disability include adhering to treatment for high blood pressure and cholesterol, using aspirin as appropriate, and learning the symptoms of heart attack and stroke.

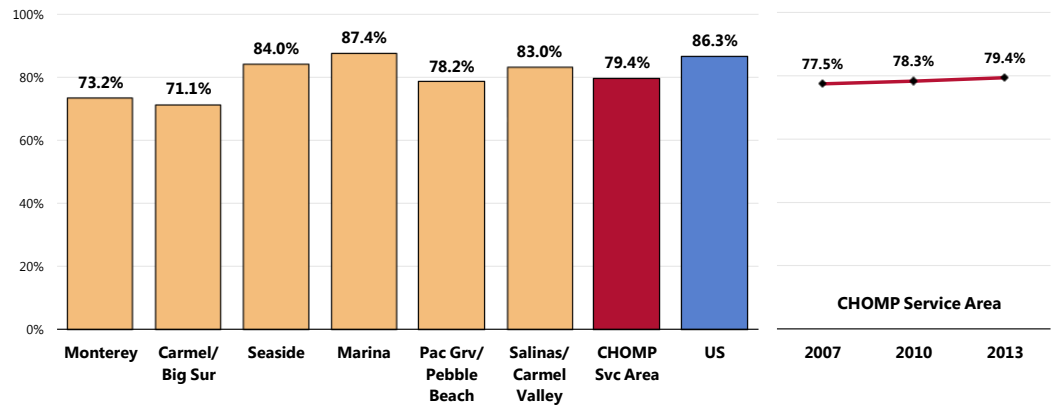
– National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention

## Total Cardiovascular Risk

In all, 79.4% of CHOMP Service Area adults report one or more cardiovascular risk factors, such as being overweight, smoking cigarettes, being physically inactive, or having high blood pressure or cholesterol.

- Notably lower than national findings.
- Higher in Seaside and Marina; lower in Monterey and Carmel/Big Sur.
- ☒ Statistically similar to previous survey findings.

### Present One or More Cardiovascular Risks or Behaviors



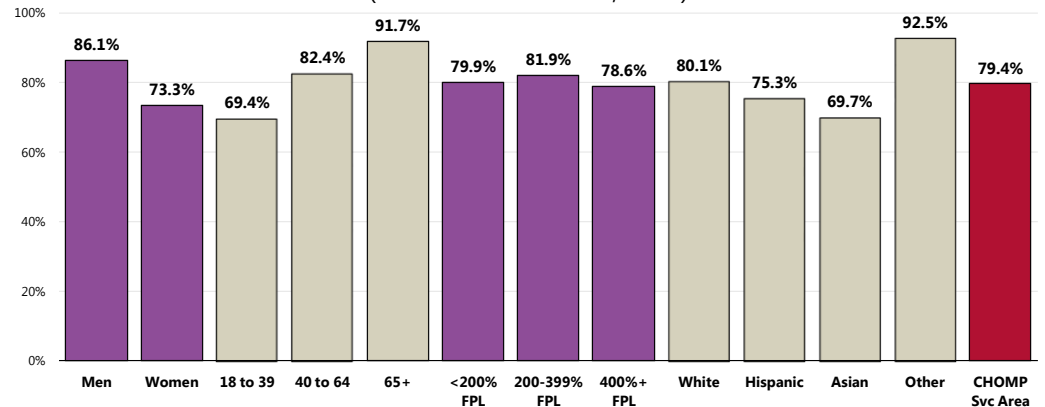
Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 143]  
 ● 2011 PRC National Health Survey, Professional Research Consultants, Inc.  
 Notes: ● Asked of all respondents.  
 ● Cardiovascular risk is defined as exhibiting one or more of the following: 1) no leisure-time physical activity; 2) regular/occasional cigarette smoking; 3) hypertension; 4) high blood cholesterol; and/or 5) being overweight/obese.

Adults more likely to exhibit cardiovascular risk factors include:

- 👤 Men.
- 👤 Adults age 40 and older, and especially seniors.
- 👤 Adults of "Other" races.

RELATED ISSUE:  
 See also  
*Nutrition & Overweight,  
 Physical Activity & Fitness  
 and Tobacco Use* in the  
**Modifiable Health Risk**  
 section of this report.

### Present One or More Cardiovascular Risks or Behaviors (CHOMP Service Area, 2013)



Sources: ● 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 143]  
 Notes: ● Asked of all respondents.  
 ● Cardiovascular risk is defined as exhibiting one or more of the following: 1) no leisure-time physical activity; 2) regular/occasional cigarette smoking; 3) hypertension; 4) high blood cholesterol; and/or 5) being overweight/obese.  
 ● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
 ● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "<200% FPL" includes households with incomes up to 199% of the federal poverty level; "200-399% FPL" includes households with incomes between 200% and 399% of the federal poverty level; and "400%+ FPL" includes those households with incomes at 400% or more the federal poverty level.



# Cancer

Continued advances in cancer research, detection, and treatment have resulted in a decline in both incidence and death rates for all cancers. Among people who develop cancer, more than half will be alive in five years. Yet, cancer remains a leading cause of death in the United States, second only to heart disease.

Many cancers are preventable by reducing risk factors such as: use of tobacco products; physical inactivity and poor nutrition; obesity; and ultraviolet light exposure. Other cancers can be prevented by getting vaccinated against human papillomavirus and hepatitis B virus. In the past decade, overweight and obesity have emerged as new risk factors for developing certain cancers, including colorectal, breast, uterine corpus (endometrial), and kidney cancers. The impact of the current weight trends on cancer incidence will not be fully known for several decades. Continued focus on preventing weight gain will lead to lower rates of cancer and many chronic diseases.

Screening is effective in identifying some types of cancers (see US Preventive Services Task Force [USPSTF] recommendations), including:

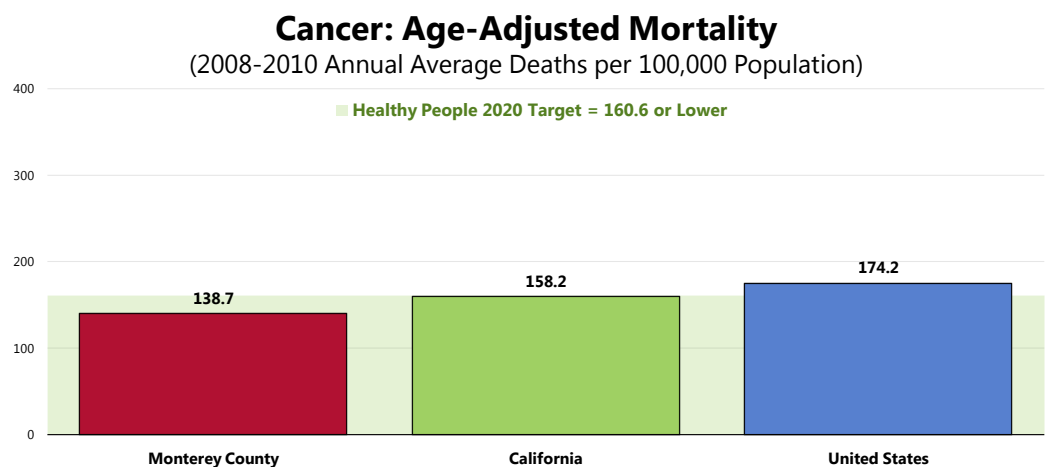
- Breast cancer (using mammography)
  - Cervical cancer (using Pap tests)
  - Colorectal cancer (using fecal occult blood testing, sigmoidoscopy, or colonoscopy)
- Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

## Age-Adjusted Cancer Deaths

### All Cancer Deaths

**Between 2008 and 2010, there was an annual average age-adjusted cancer mortality rate of 138.7 deaths per 100,000 population in Monterey County.**

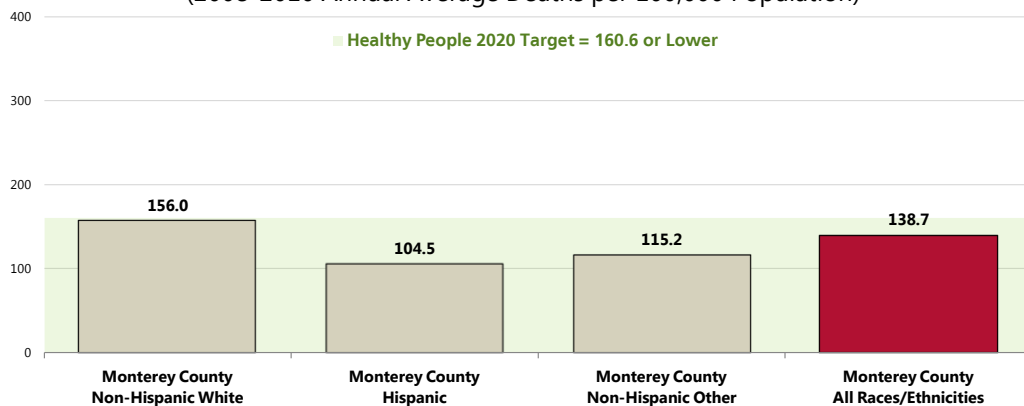
- More favorable than the statewide rate.
- More favorable than the national rate.
- Satisfies the Healthy People 2020 target of 160.6 or lower.



- Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2013.
  - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective C-1]
- Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
  - Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
  - Local, state and national data are simple three-year averages.

👥 The county's cancer mortality rate is notably higher among Non-Hispanic Whites.

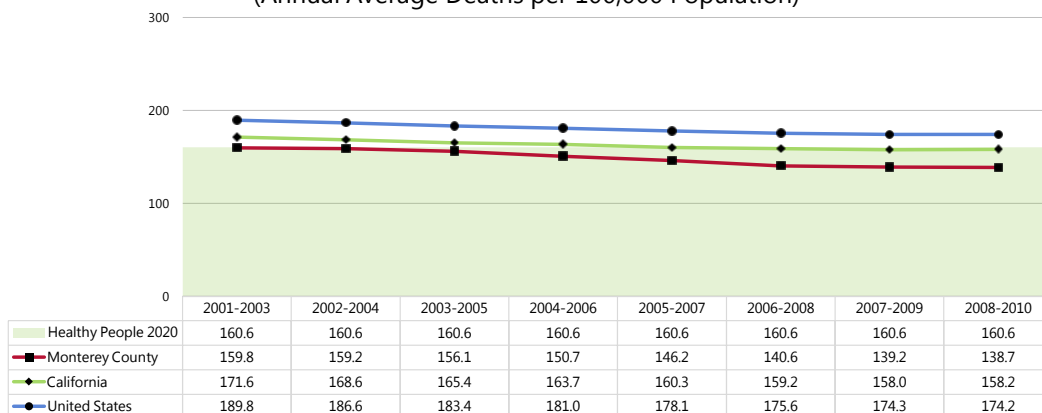
### Cancer: Age-Adjusted Mortality by Race (2008-2010 Annual Average Deaths per 100,000 Population)



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2013.  
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective C-1]  
 Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).  
 • Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.  
 • Local, state and national data are simple three-year averages.

📉 Cancer mortality has decreased over the past decade in Monterey County; the same trend is apparent both statewide and nationwide.

### Cancer: Age-Adjusted Mortality Trends (Annual Average Deaths per 100,000 Population)



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2013.  
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective C-1]  
 Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).  
 • Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.  
 • State and national data are simple three-year averages.

## Cancer Deaths by Site

**Lung cancer is the leading cause of cancer deaths in Monterey County.**

**Other leading sites include prostate cancer among men, breast cancer among women, and colorectal cancer (both genders).**

As can be seen in the following chart (referencing 2008-2010 annual average age-adjusted death rates):

- The Monterey County **lung cancer** death rate is lower than both the state and national rates.

- The county's **prostate cancer** death rate is similar to both the state and national rates.
- The **female breast cancer** death rate is lower than both the California and US rates.
- The **colorectal cancer** death rate is lower than both the state and national rates.

Note that each of the Monterey County cancer death rates detailed below satisfies the related Healthy People 2020 target (the prostate cancer rate is statistically similar).

### Age-Adjusted Cancer Death Rates by Site (2008-2010 Annual Average Deaths per 100,000 Population)

	Monterey County	California	US	HP2020
<b>Lung Cancer</b>	<b>33.8</b>	<b>37.6</b>	<b>50.5</b>	<b>45.5</b>
<b>Prostate Cancer</b>	<b>21.2</b>	<b>22.0</b>	<b>22.3</b>	<b>21.2</b>
<b>Female Breast Cancer</b>	<b>19.5</b>	<b>21.6</b>	<b>22.3</b>	<b>20.6</b>
<b>Colorectal Cancer</b>	<b>10.0</b>	<b>14.7</b>	<b>16.1</b>	<b>14.5</b>

Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2013.  
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov>

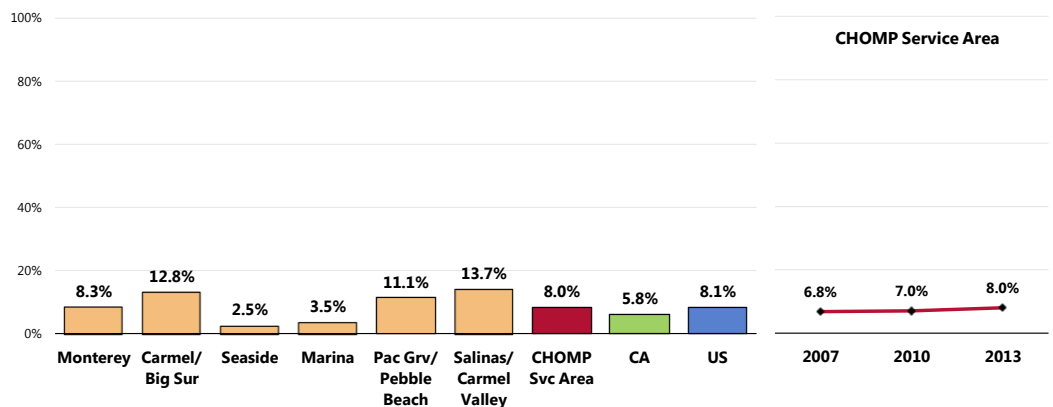
## Prevalence of Cancer

### Skin Cancer

**A total of 8.0% of surveyed CHOMP Service Area adults report having been diagnosed with skin cancer.**

- Less favorable than the California average.
- Comparable to the US figure.
- Lowest in Seaside and Marina; highest in Salinas/Carmel Valley.
- The prevalence of skin cancer has remained statistically unchanged over time.

### Prevalence of Skin Cancer



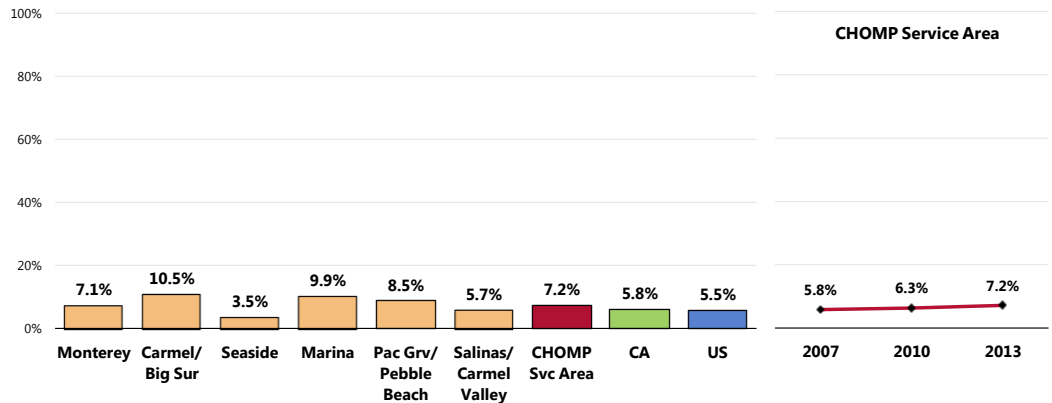
Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 31]  
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2011 California data.  
 • 2011 PRC National Health Survey, Professional Research Consultants, Inc.  
 Notes: • Asked of all respondents.

## Other Cancer

**A total of 7.2% of respondents have been diagnosed with some type of (non-skin) cancer.**

- Similar to the state prevalence.
- Similar to the national prevalence.
- Particularly low in Seaside.
- ☒ The prevalence of cancer has not changed significantly over time.

### Prevalence of Cancer (Other Than Skin Cancer)



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 30]  
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2011 California data.  
 • 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes: • Asked of all respondents.

### Cancer Risk

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

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

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

### Cancer Screenings

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

Screening levels in the community were measured in the PRC Community Health Survey relative to four cancer sites: prostate cancer (prostate-specific antigen testing and digital rectal examination); female breast cancer (mammography); cervical cancer (Pap smear testing); and colorectal cancer (sigmoidoscopy and fecal occult blood testing).

RELATED ISSUE:  
 See also  
*Nutrition & Overweight,  
 Physical Activity &  
 Fitness and Tobacco Use*  
 in the **Modifiable  
 Health Risk** section of  
 this report.

## Prostate Cancer Screenings

The US Preventive Services Task Force (USPSTF) concludes that the current evidence is insufficient to assess the balance of benefits and harms of prostate cancer screening in men younger than age 75 years.

Rationale: Prostate cancer is the most common nonskin cancer and the second-leading cause of cancer death in men in the United States. The USPSTF found convincing evidence that prostate-specific antigen (PSA) screening can detect some cases of prostate cancer.

In men younger than age 75 years, the USPSTF found inadequate evidence to determine whether treatment for prostate cancer detected by screening improves health outcomes compared with treatment after clinical detection.

The USPSTF found convincing evidence that treatment for prostate cancer detected by screening causes moderate-to-substantial harms, such as erectile dysfunction, urinary incontinence, bowel dysfunction, and death. These harms are especially important because some men with prostate cancer who are treated would never have developed symptoms related to cancer during their lifetime.

There is also adequate evidence that the screening process produces at least small harms, including pain and discomfort associated with prostate biopsy and psychological effects of false-positive test results.

The USPSTF recommends against screening for prostate cancer in men age 75 years or older.

Rationale: In men age 75 years or older, the USPSTF found adequate evidence that the incremental benefits of treatment for prostate cancer detected by screening are small to none.

Given the uncertainties and controversy surrounding prostate cancer screening in men younger than age 75 years, a clinician should not order the PSA test without first discussing with the patient the potential but uncertain benefits and the known harms of prostate cancer screening and treatment. Men should be informed of the gaps in the evidence and should be assisted in considering their personal preferences before deciding whether to be tested.

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

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

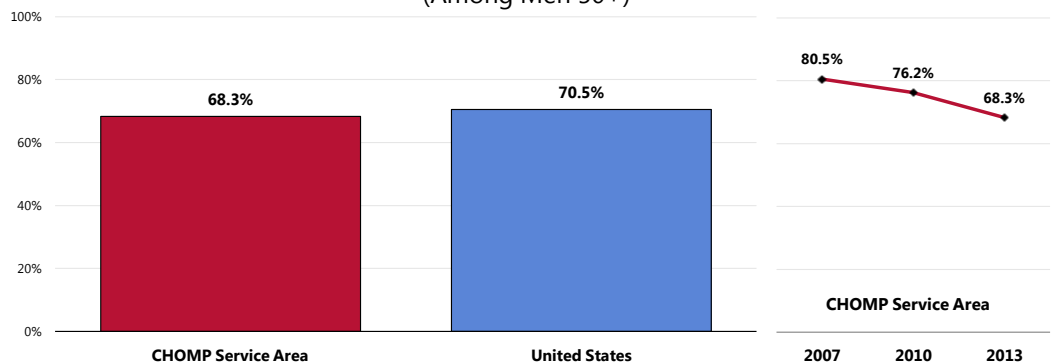
### PSA Testing and/or Digital Rectal Examination

**Among men age 50 and older, more than two-thirds (68.1%) have had a PSA (prostate-specific antigen) test and/or a digital rectal examination for prostate problems within the past two years.**

- Similar to national findings.
- ▨ Marks a significant decrease since 2007.

Note: Due to recent (2008) changes in clinical recommendations against routine PSA testing, it is anticipated that testing levels will begin to decline.

### Have Had a Prostate Screening in the Past Two Years (Among Men 50+)



Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 147]  
● 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes: ● Asked of all male respondents 50 and older.

## Female Breast Cancer Screening

The US Preventive Services Task Force (USPSTF) recommends screening mammography, with or without clinical breast examination (CBE), every 1-2 years for women age 40 and older.

*Rationale:* The USPSTF found fair evidence that mammography screening every 12-33 months significantly reduces mortality from breast cancer. Evidence is strongest for women age 50-69, the age group generally included in screening trials. For women age 40-49, the evidence that screening mammography reduces mortality from breast cancer is weaker, and the absolute benefit of mammography is smaller, than it is for older women. Most, but not all, studies indicate a mortality benefit for women undergoing mammography at ages 40-49, but the delay in observed benefit in women younger than 50 makes it difficult to determine the incremental benefit of beginning screening at age 40 rather than at age 50.

The absolute benefit is smaller because the incidence of breast cancer is lower among women in their 40s than it is among older women. The USPSTF concluded that the evidence is also generalizable to women age 70 and older (who face a higher absolute risk for breast cancer) if their life expectancy is not compromised by comorbid disease. The absolute probability of benefits of regular mammography increase along a continuum with age, whereas the likelihood of harms from screening (false-positive results and unnecessary anxiety, biopsies, and cost) diminish from ages 40-70. The balance of benefits and potential harms, therefore, grows more favorable as women age. The precise age at which the potential benefits of mammography justify the possible harms is a subjective choice. The USPSTF did not find sufficient evidence to specify the optimal screening interval for women age 40-49.

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

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

### Mammography

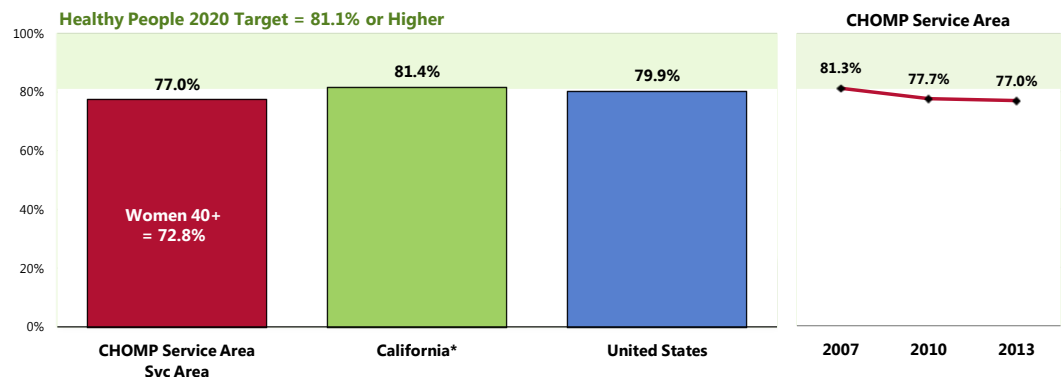
**Among women age 50-74, 77.0% had a mammogram within the past two years.**

- Similar to statewide findings (which represent all women 50+).
- Similar to national findings.
- Similar to the Healthy People 2020 target (81.1% or higher).

📊 Statistically unchanged since 2007.

👥 Among women 40+, 72.8% had a mammogram in the past two years.

### Have Had a Mammogram in the Past Two Years (Among Women 50-74)



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Items 144-145]  
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2010 California data.  
 • 2011 PRC National Health Survey, Professional Research Consultants, Inc.  
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective C-17]

Notes: • Reflects female respondents 50-74.  
 • \*Note that state data reflects all women 50 and older (vs. women 50-74 in local, US and Healthy People data).

## Cervical Cancer Screenings

The US Preventive Services Task Force (USPSTF) strongly recommends screening for cervical cancer in women who have been sexually active and have a cervix.

*Rationale:* The USPSTF found good evidence from multiple observational studies that screening with cervical cytology (Pap smears) reduces incidence of and mortality from cervical cancer. Direct evidence to determine the optimal starting and stopping age and interval for screening is limited. Indirect evidence suggests most of the benefit can be obtained by beginning screening within 3 years of onset of sexual activity or age 21 (whichever comes first) and screening at least every 3 years. The USPSTF concludes that the benefits of screening substantially outweigh potential harms.

The USPSTF recommends against routinely screening women older than age 65 for cervical cancer if they have had adequate recent screening with normal Pap smears and are not otherwise at high risk for cervical cancer.

*Rationale:* The USPSTF found limited evidence to determine the benefits of continued screening in women older than 65. The yield of screening is low in previously screened women older than 65 due to the declining incidence of high-grade cervical lesions after middle age. There is fair evidence that screening women older than 65 is associated with an increased risk for potential harms, including false-positive results and invasive procedures. The USPSTF concludes that the potential harms of screening are likely to exceed benefits among older women who have had normal results previously and are not otherwise at high risk for cervical cancer.

The USPSTF recommends against routine Pap smear screening in women who have had a total hysterectomy for benign disease.

*Rationale:* The USPSTF found fair evidence that the yield of cytologic screening is very low in women after hysterectomy and poor evidence that screening to detect vaginal cancer improves health outcomes. The USPSTF concludes potential harms of continued screening after hysterectomy are likely to exceed benefits.

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

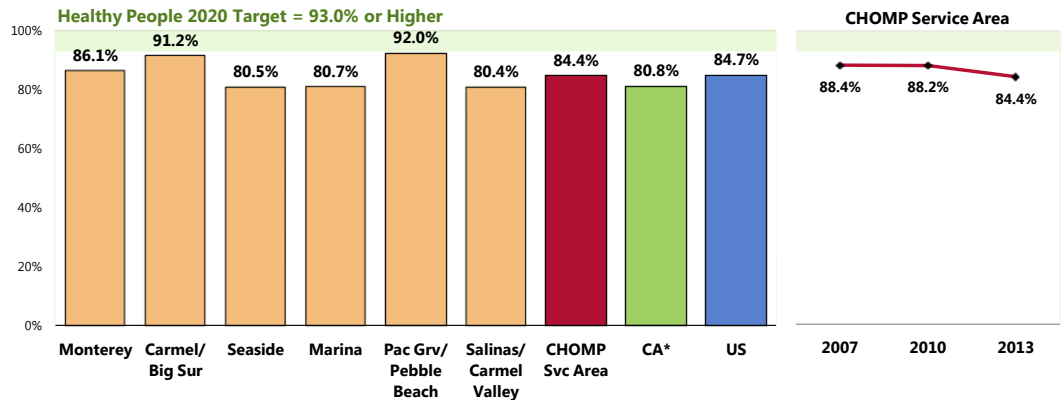
Note that other organizations (e.g., American Cancer Society, American Academy of Family Physicians, American College of Physicians, National Cancer Institute) may have slightly different screening guidelines.

### Pap Smear Testing

**Among women age 21 to 65, 84.4% had a Pap smear within the past three years.**

- Better than California findings (which includes all women 18+).
- Nearly identical to national findings.
- Fails to satisfy the Healthy People 2020 target (93% or higher).
- Highest among women in the Pacific Grove/Pebble Beach communities.
- ☒ Statistically unchanged since 2007.

### Have Had a Pap Smear in the Past Three Years (Among Women 21-65)



Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 146]  
 ● Behavioral Risk Factor Surveillance System Survey Data, Atlanta, Georgia, United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2010 California data.  
 ● 2011 PRC National Health Survey, Professional Research Consultants, Inc.  
 ● US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective C-15]

Notes: ● Reflects female respondents age 21 to 65.  
 ● \*Note that the California percentage represents all women age 18 and older.

## Colorectal Cancer Screenings

The USPSTF recommends screening for colorectal cancer using fecal occult blood testing, sigmoidoscopy, or colonoscopy in adults, beginning at age 50 years and continuing until age 75 years.

The evidence is convincing that screening for colorectal cancer with fecal occult blood testing, sigmoidoscopy, or colonoscopy detects early-stage cancer and adenomatous polyps. There is convincing evidence that screening with any of the three recommended tests (FOBT, sigmoidoscopy, colonoscopy) reduces colorectal cancer mortality in adults age 50 to 75 years. Follow-up of positive screening test results requires colonoscopy regardless of the screening test used.

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

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

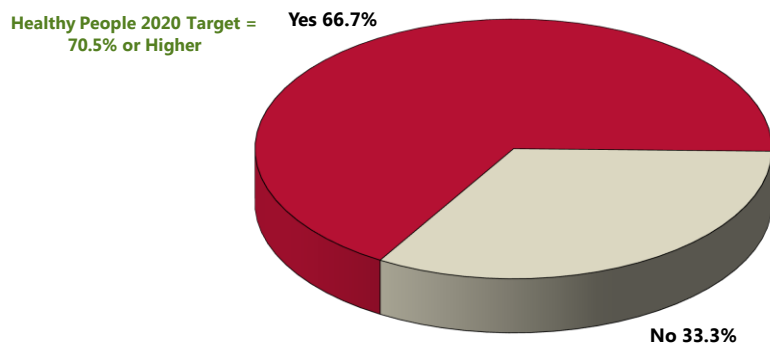
### Colorectal Cancer Screening

**Among adults age 50-75, 66.7% have had an appropriate colorectal cancer screening (fecal occult blood testing within the past year and/or sigmoidoscopy/ colonoscopy [lower endoscopy] within the past 10 years).**

- Similar to the Healthy People 2020 target (70.5% or higher).

### Have Had a Colorectal Cancer Screening

(Among CHOMP Service Area Adults 50-75, 2013)



- Sources:
- 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 150]
  - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective C-16]
- Notes:
- Asked of all respondents age 50 through 75.
  - In this case, the term "colorectal screening" refers to adults age 50-75 receiving a FOBT (fecal occult blood test) in the past year and/or a lower endoscopy (sigmoidoscopy/colonoscopy) in the past 10 years.

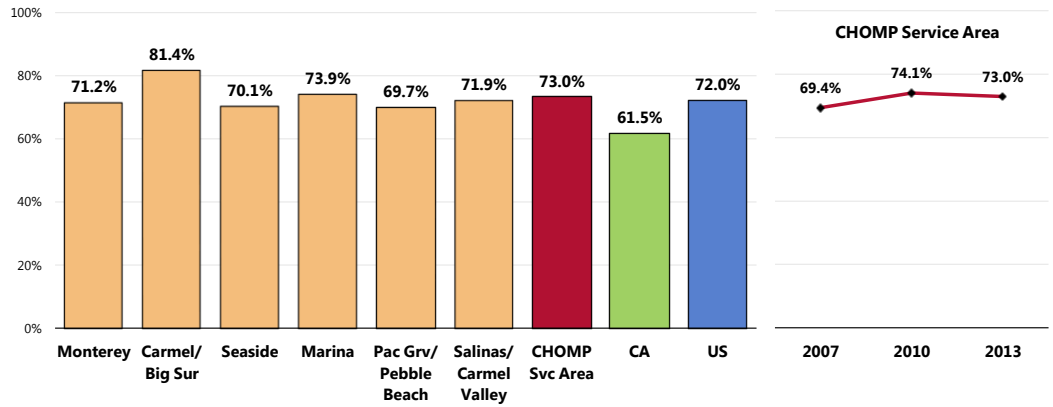
### Lower Endoscopy

**Among adults age 50 and older, nearly three-fourths (73.0%) have had a lower endoscopy (sigmoidoscopy or colonoscopy) at some point in their lives.**

- More favorable than California findings.
- Similar to national findings.
- Highest in Carmel/Big Sur.
- ☒ Statistically similar to previous survey findings.



## Have Ever Had a Lower Endoscopy Exam (Among Adults 50+)



Sources:
 

- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 148]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC). 2010 California data.
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

 Notes:
 

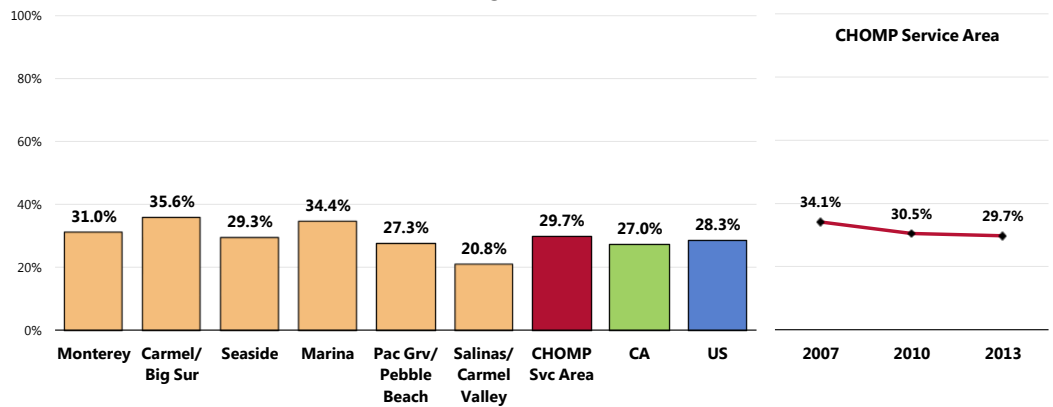
- Asked of all respondents 50+.
- Lower endoscopy includes either sigmoidoscopy or colonoscopy.

## Blood Stool Testing

**Among adults age 50 and older, 29.7% have had a blood stool test (aka "fecal occult blood test") within the past two years.**

- Comparable to California findings.
- Comparable to national findings.
- Lower in Salinas/Carmel Valley.
- 📊 Statistically unchanged since 2007.

## Have Had a Blood Stool Test in the Past Two Years (Among Adults 50+)



Sources:
 

- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 149]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC). 2010 California data.
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

 Notes:
 

- Asked of all respondents 50+.

# Respiratory Disease

Asthma and chronic obstructive pulmonary disease (COPD) are significant public health burdens. Specific methods of detection, intervention, and treatment exist that may reduce this burden and promote health.

Asthma is a chronic inflammatory disorder of the airways characterized by episodes of reversible breathing problems due to airway narrowing and obstruction. These episodes can range in severity from mild to life threatening. Symptoms of asthma include wheezing, coughing, chest tightness, and shortness of breath. Daily preventive treatment can prevent symptoms and attacks and enable individuals who have asthma to lead active lives.

COPD is a preventable and treatable disease characterized by airflow limitation that is not fully reversible. The airflow limitation is usually progressive and associated with an abnormal inflammatory response of the lung to noxious particles or gases (typically from exposure to cigarette smoke). Treatment can lessen symptoms and improve quality of life for those with COPD.

Several additional respiratory conditions and respiratory hazards, including infectious agents and occupational and environmental exposures, are covered in other areas of Healthy People 2020. Examples include tuberculosis, lung cancer, acquired immunodeficiency syndrome (AIDS), pneumonia, occupational lung disease, and smoking. Sleep Health is now a separate topic area of Healthy People 2020.

Currently in the United States, more than 23 million people have asthma. Approximately 13.6 million adults have been diagnosed with COPD, and an approximately equal number have not yet been diagnosed. The burden of respiratory diseases affects individuals and their families, schools, workplaces, neighborhoods, cities, and states. Because of the cost to the healthcare system, the burden of respiratory diseases also falls on society; it is paid for with higher health insurance rates, lost productivity, and tax dollars. Annual healthcare expenditures for asthma alone are estimated at \$20.7 billion.

**Asthma.** The prevalence of asthma has increased since 1980. However, deaths from asthma have decreased since the mid-1990s. The causes of asthma are an active area of research and involve both genetic and environmental factors.

Risk factors for asthma currently being investigated include:

- Having a parent with asthma
- Sensitization to irritants and allergens
- Respiratory infections in childhood
- Overweight

Asthma affects people of every race, sex, and age. However, significant disparities in asthma morbidity and mortality exist, in particular for low-income and minority populations. Populations with higher rates of asthma include: children; women (among adults) and boys (among children); African Americans; Puerto Ricans; people living in the Northeast United States; people living below the Federal poverty level; and employees with certain exposures in the workplace.

While there is not a cure for asthma yet, there are diagnoses and treatment guidelines that are aimed at ensuring that all people with asthma live full and active lives.

– Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

[NOTE: COPD was changed to chronic lower respiratory disease (CLRD) with the introduction of ICD-10 codes. CLRD is used in vital statistics reporting, but COPD is still widely used and commonly found in surveillance reports.]

## Age-Adjusted Respiratory Disease Deaths

### Chronic Lower Respiratory Disease Deaths (CLRD)

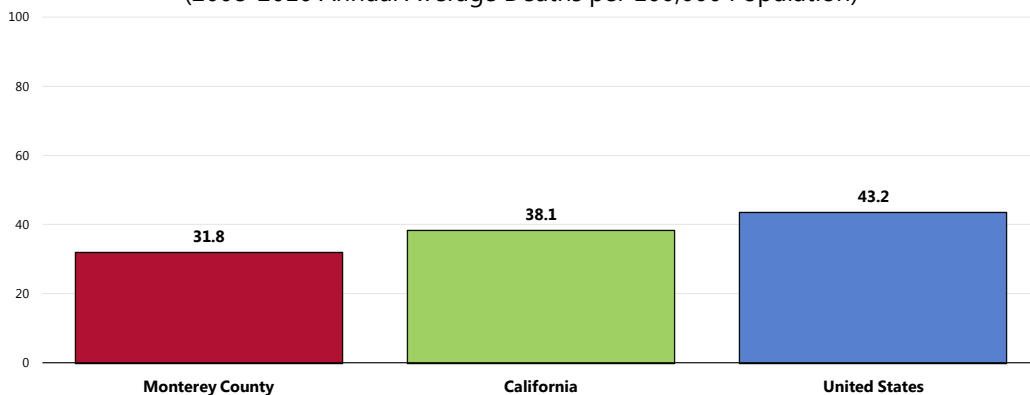
Note: COPD was changed to chronic lower respiratory disease (CLRD) in 1999 with the introduction of ICD-10 codes. CLRD is used in vital statistics reporting, but COPD is still widely used and commonly found in surveillance reports.

Between 2008 and 2010, there was an annual average age-adjusted CLRD mortality rate of 31.8 deaths per 100,000 population in Monterey County.

- Lower than found statewide.
- Lower than the national rate.

### CLRD: Age-Adjusted Mortality

(2008-2010 Annual Average Deaths per 100,000 Population)

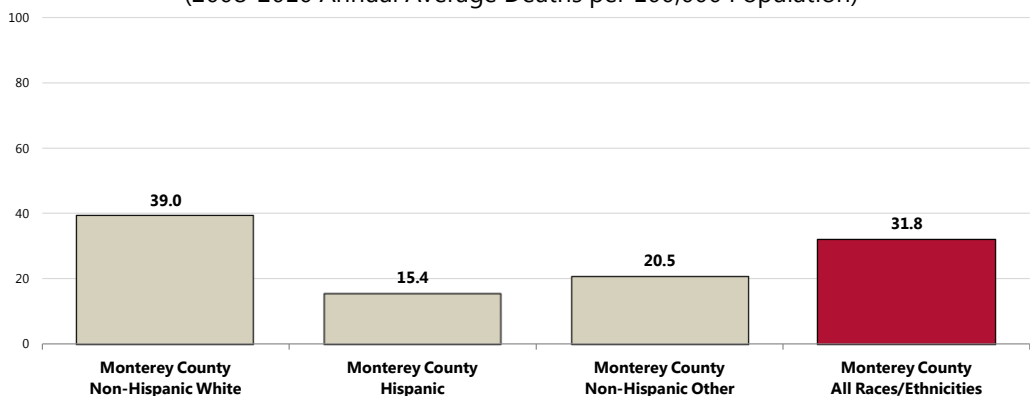


- Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2013.
- Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
  - Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
  - Local, state and national data are simple three-year averages.
  - CLRD is chronic lower respiratory disease.

👤 CLRD mortality in Monterey County is notably higher among Non-Hispanic Whites.

### CLRD: Age-Adjusted Mortality by Race

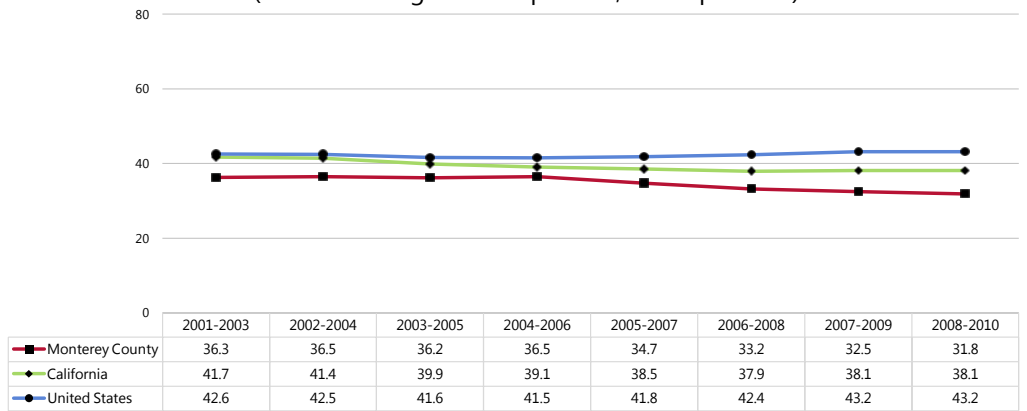
(2008-2010 Annual Average Deaths per 100,000 Population)



- Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2013.
- Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
  - Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
  - Local, state and national data are simple three-year averages.
  - CLRD is chronic lower respiratory disease.

CLRD mortality in the county has decreased in the most recent reporting periods.

### CLRD: Age-Adjusted Mortality Trends (Annual Average Deaths per 100,000 Population)



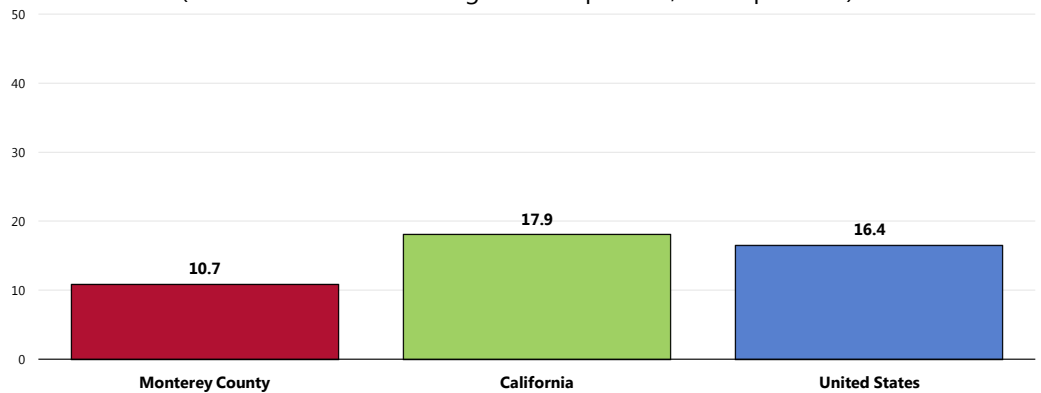
Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2013.  
 Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).  
 • Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.  
 • State and national data are simple three-year averages.  
 • CLRD is chronic lower respiratory disease.

### Pneumonia/Influenza Deaths

Between 2008 and 2010, there was an annual average age-adjusted pneumonia influenza mortality rate of 10.7 deaths per 100,000 population in Monterey County.

- Lower than found statewide.
- Lower than the national rate.

### Pneumonia/Influenza: Age-Adjusted Mortality (2008-2010 Annual Average Deaths per 100,000 Population)

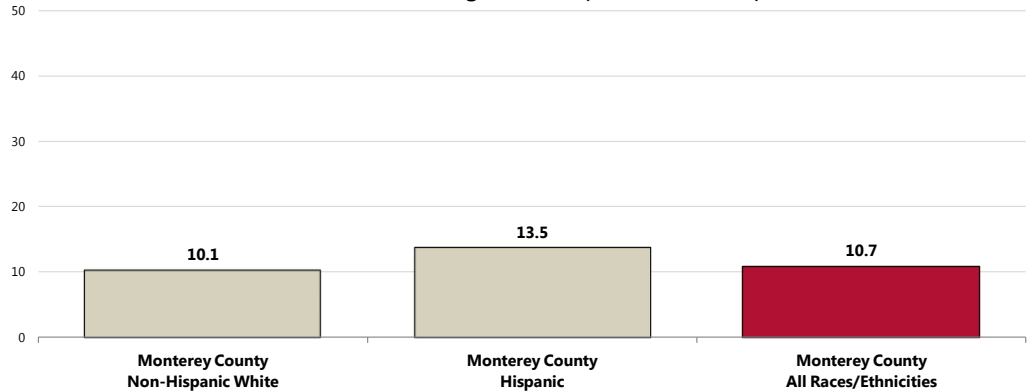


Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2013.  
 Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).  
 • Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.  
 • Local, state and national data are simple three-year averages.

For prevalence of vaccinations for pneumonia and influenza, see also "Immunization & Infectious Disease."

👥 The Monterey County pneumonia/influenza mortality rate is slightly higher among Hispanics than among Whites.

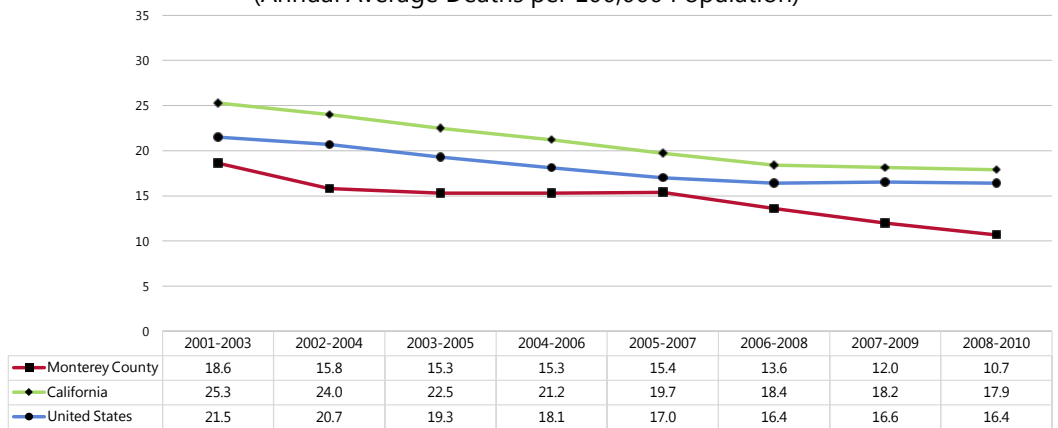
### Pneumonia/Influenza: Age-Adjusted Mortality by Race (2008-2010 Annual Average Deaths per 100,000 Population)



Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2013.  
 Notes: ● Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).  
 ● Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.  
 ● Local, state and national data are simple three-year averages.

📉 Note the decreasing trend in pneumonia/influenza deaths for Monterey County, in keeping with the state and national trends.

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



Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2013.  
 Notes: ● Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).  
 ● Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.  
 ● State and national data are simple three-year averages.

Survey respondents were next asked to indicate whether they suffer from or have been diagnosed with various respiratory conditions, including asthma, nasal/hay fever allergies, sinusitis, and/ or chronic lung disease.

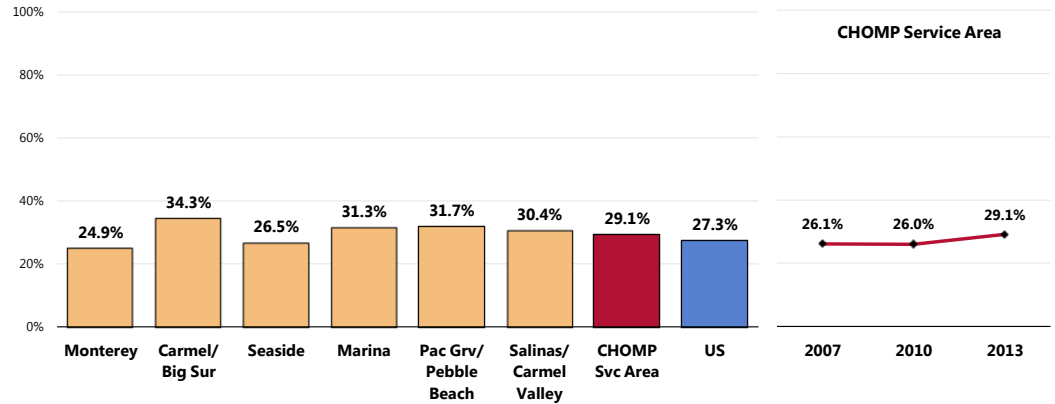
## Prevalence of Respiratory Conditions

### Nasal/Hay Fever Allergies

According to survey data, nearly 3 in 10 (29.1%) CHOMP Service Area adults currently suffer from or have been diagnosed with nasal/hay fever allergies.

- Similar to the national prevalence.
- Statistically similar by community.
- 📈 Statistically unchanged over time.

### Prevalence of Nasal/Hay Fever Allergies



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 35]  
 • 2011 PRC National Health Survey, Professional Research Consultants, Inc.

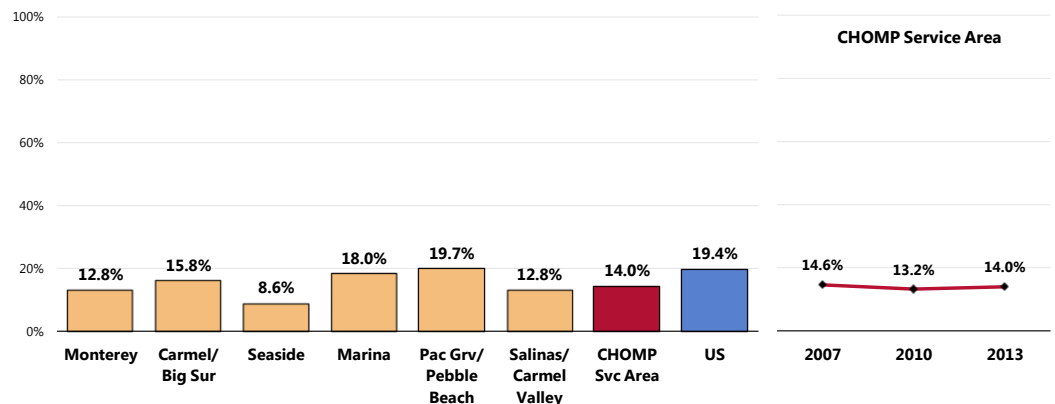
Notes: • Asked of all respondents.

### Sinusitis

A total of 14.0% of CHOMP Service Area adults suffer from sinusitis.

- More favorable than the national prevalence.
- Statistically low in the Seaside community.
- 📈 Unchanged over time.

### Prevalence of Sinusitis



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 34]  
 • 2011 PRC National Health Survey, Professional Research Consultants, Inc.

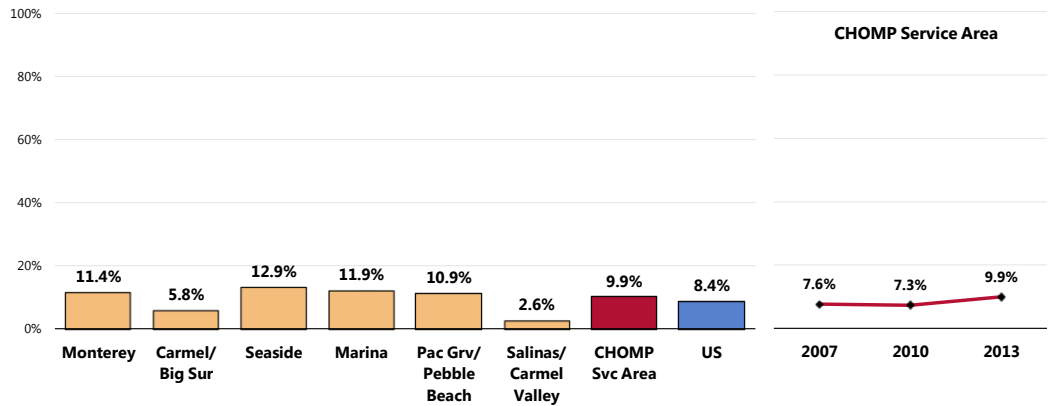
Notes: • Asked of all respondents.

## Chronic Lung Disease

**A total of 9.9% of CHOMP Service Area adults suffer from chronic lung disease.**

- Similar to the national prevalence.
- Lowest in Carmel/Big Sur and in Salinas/Carmel Valley.
- ▣ Similar to previous survey findings.

### Prevalence of Chronic Lung Disease



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 25]  
 • 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes: • Asked of all respondents.

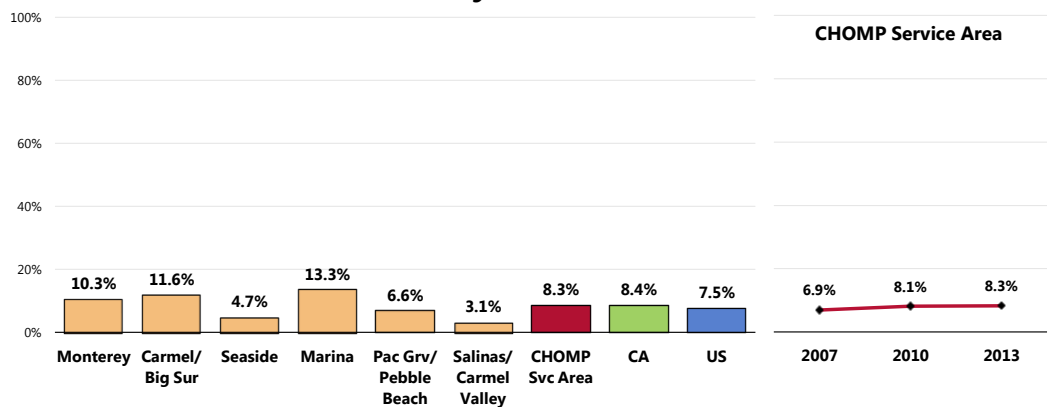
## Asthma

### Adults

**A total of 8.3% of CHOMP Service Area adults currently suffer from asthma.**

- Nearly identical to the statewide prevalence.
- Similar to the national prevalence.
- Lowest in Seaside and Salinas/Carmel Valley.
- ▣ Statistically unchanged over time.

### Currently Have Asthma





Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 151]  
 • 2011 PRC National Health Survey, Professional Research Consultants, Inc.

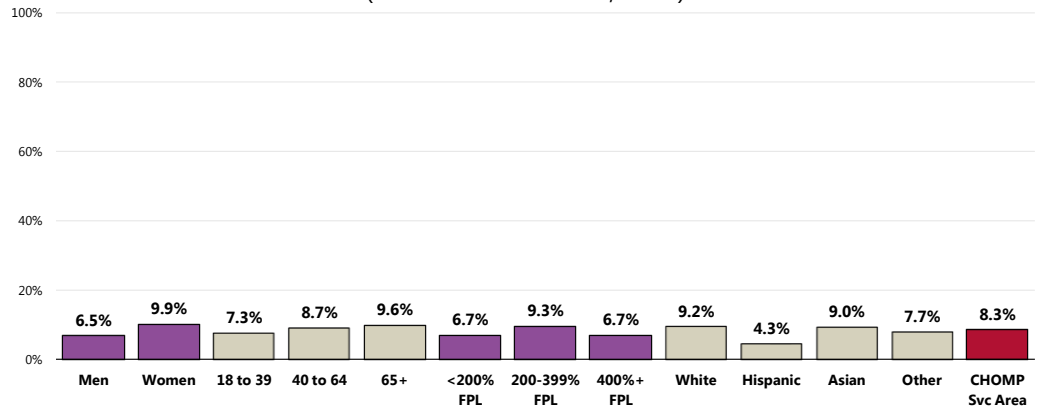
• Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2011 California data.

Notes: • Asked of all respondents.

The following adults are more likely to suffer from asthma:

-  Women.
-  White adults.



### Currently Have Asthma (CHOMP Service Area, 2013)



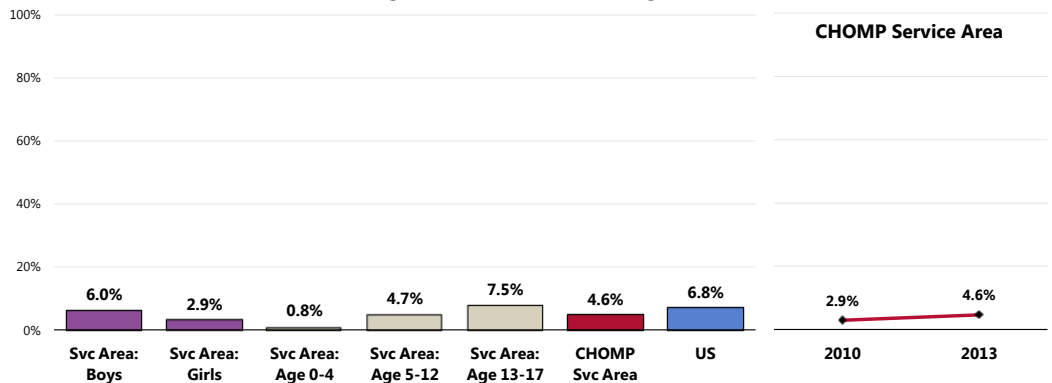
Sources: • 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 151]  
 Notes: • Asked of all respondents.  
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "<200% FPL" includes households with incomes up to 199% of the federal poverty level; "200-399% FPL" includes households with incomes between 200% and 399% of the federal poverty level; and "400%+ FPL" includes those households with incomes at 400% or more the federal poverty level.

### Children

**Among CHOMP Service Area children under age 18, 4.6% currently have asthma.**

- Comparable to national findings.
-  Higher in boys and increasing with age.
-  Statistically unchanged from 2010 survey findings.

### Child Currently Has Asthma (Among Parents of Children Age 0-17)



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 152]  
 • 2011 PRC National Health Survey, Professional Research Consultants, Inc.  
 Notes: • Asked of all respondents with children 0 to 17 in the household.



# Injury & Violence

Injuries and violence are widespread in society. Both unintentional injuries and those caused by acts of violence are among the top 15 killers for Americans of all ages. Many people accept them as “accidents,” “acts of fate,” or as “part of life.” However, most events resulting in injury, disability, or death are predictable and preventable.

Injuries are the leading cause of death for Americans ages 1 to 44, and a leading cause of disability for all ages, regardless of sex, race/ethnicity, or socioeconomic status. More than 180,000 people die from injuries each year, and approximately 1 in 10 sustains a nonfatal injury serious enough to be treated in a hospital emergency department.

Beyond their immediate health consequences, injuries and violence have a significant impact on the well-being of Americans by contributing to:

- Premature death
- Disability
- Poor mental health
- High medical costs
- Lost productivity

The effects of injuries and violence extend beyond the injured person or victim of violence to family members, friends, coworkers, employers, and communities.

Numerous factors can affect the risk of unintentional injury and violence, including individual behaviors, physical environment, access to health services (ranging from pre-hospital and acute care to rehabilitation), and social environment (from parental monitoring and supervision of youth to peer group associations, neighborhoods, and communities).

Interventions addressing these social and physical factors have the potential to prevent unintentional injuries and violence. Efforts to prevent unintentional injury may focus on:

- Modifications of the environment
- Improvements in product safety
- Legislation and enforcement
- Education and behavior change
- Technology and engineering

Efforts to prevent violence may focus on:

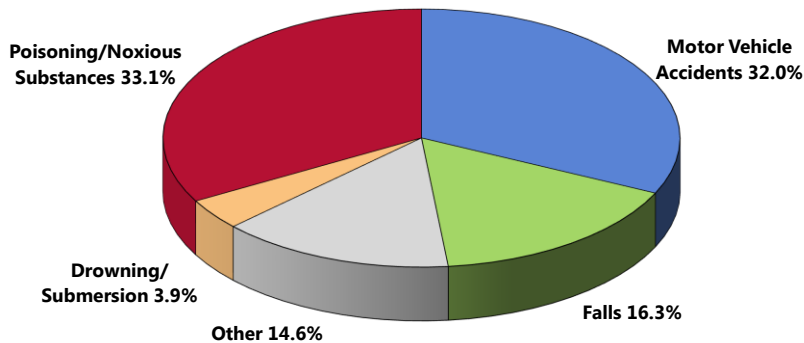
- Changing social norms about the acceptability of violence
- Improving problem-solving skills (for example, parenting, conflict resolution, coping)
- Changing policies to address the social and economic conditions that often give rise to violence

– Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

## Leading Causes of Accidental Death

**Poisoning, motor vehicle accidents, falls, and drowning/submersion accounted for over 85% of accidental deaths in Monterey County between 2008 and 2010.**

## Leading Causes of Accidental Death (Monterey County, 2008-2010)



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2013.  
Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).

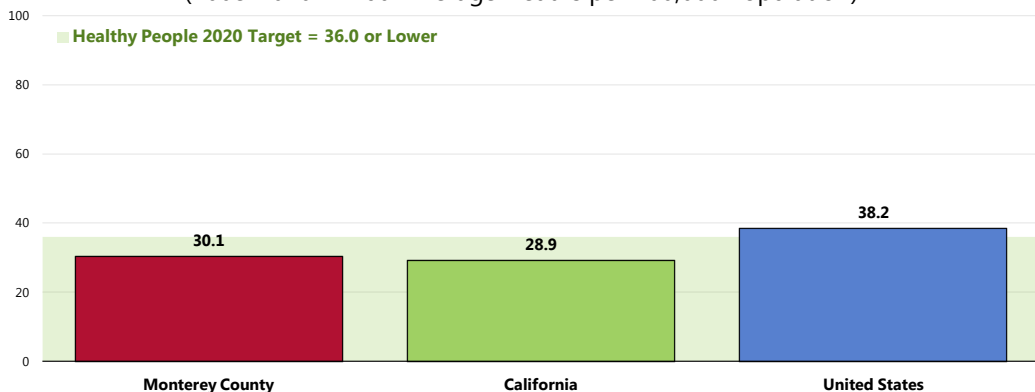
## Unintentional Injury

### Age-Adjusted Unintentional Injury Deaths

**Between 2008 and 2010, there was an annual average age-adjusted unintentional injury mortality rate of 30.1 deaths per 100,000 population in Monterey County.**

- Similar to the California rate.
- Lower than the national rate.
- Satisfies the Healthy People 2020 target (36.0 or lower).

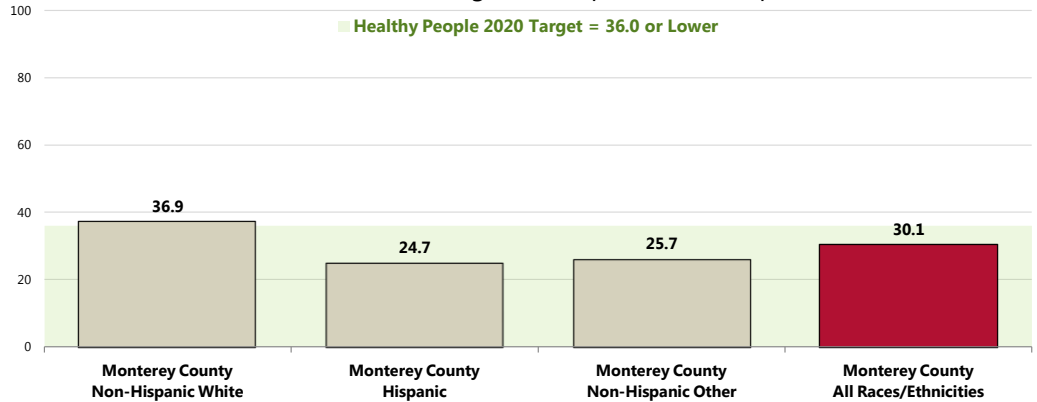
### Unintentional Injuries: Age-Adjusted Mortality (2008-2010 Annual Average Deaths per 100,000 Population)



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2013.  
• US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective IVP-11]  
Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).  
• Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.  
• Local, state and national data are simple three-year averages.

👥 The mortality rate is notably higher among Non-Hispanic Whites when compared with Hispanics and “Other” races in the county.

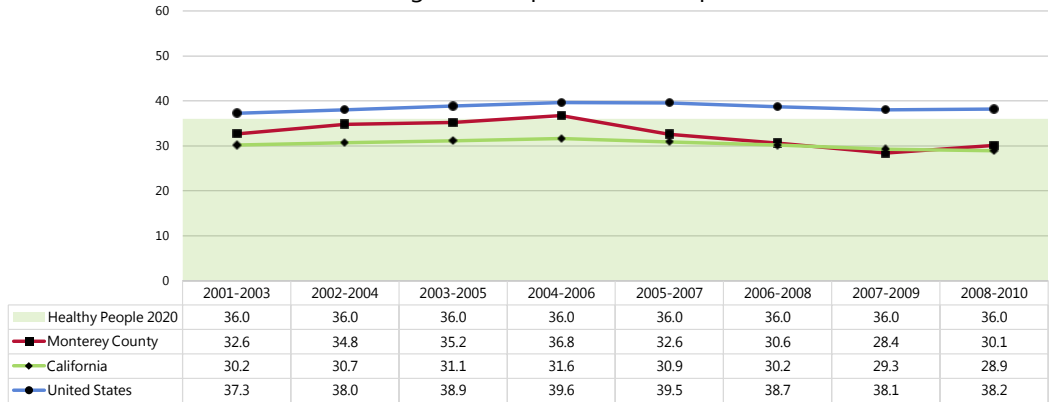
### Unintentional Injuries: Age-Adjusted Mortality by Race (2008-2010 Annual Average Deaths per 100,000 Population)



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2013.  
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective IVP-11]  
 Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).  
 • Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.  
 • Local, state and national data are simple three-year averages.

📈 After rising in the early 2000s, the unintentional injury mortality rate in Monterey County has since declined. Statewide and national trends have been more stable.

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



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2013.  
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective IVP-11]  
 Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).  
 • Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.  
 • Local, state and national data are simple three-year averages.

## Motor Vehicle Safety

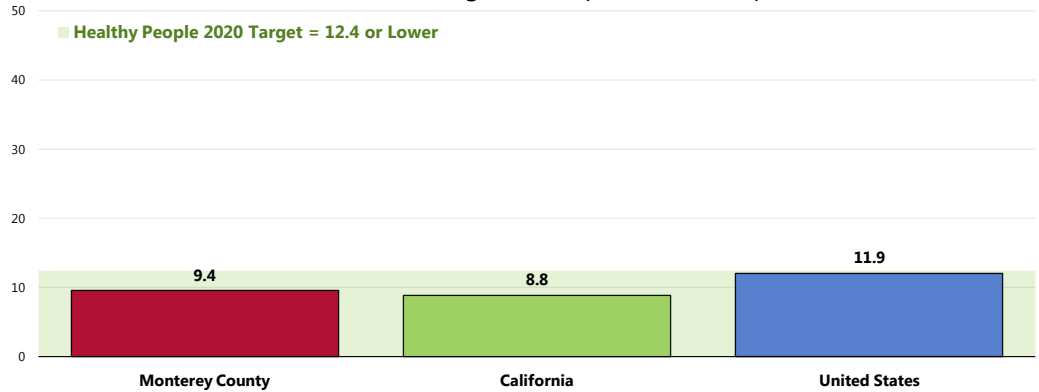
### Age-Adjusted Motor-Vehicle Related Deaths

**Between 2008 and 2010, there was an annual average age-adjusted motor vehicle crash mortality rate of 9.4 deaths per 100,000 population in Monterey County.**

- Higher than found statewide.
- Lower than found nationally.
- Satisfies the Healthy People 2020 target (12.4 or lower).

### Motor Vehicle Crashes: Age-Adjusted Mortality

(2008-2010 Annual Average Deaths per 100,000 Population)



Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2013.

● US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective IVP-13.1]

Notes: ● Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).

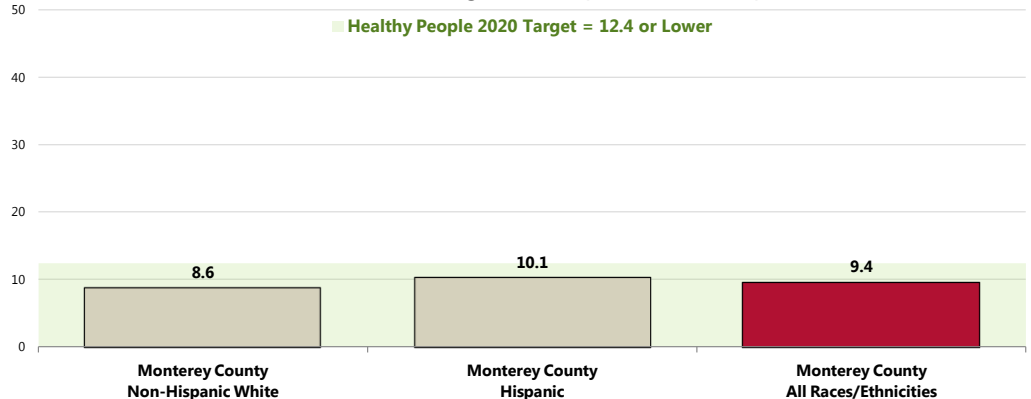
● Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.

● Local, state and national data are simple three-year averages.

👤 The county's motor vehicle crash mortality rate is higher among Hispanics than among Non-Hispanic Whites.

### Motor Vehicle Crashes: Age-Adjusted Mortality by Race

(2008-2010 Annual Average Deaths per 100,000 Population)



Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2013.

● US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective IVP-13.1]

Notes: ● Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).

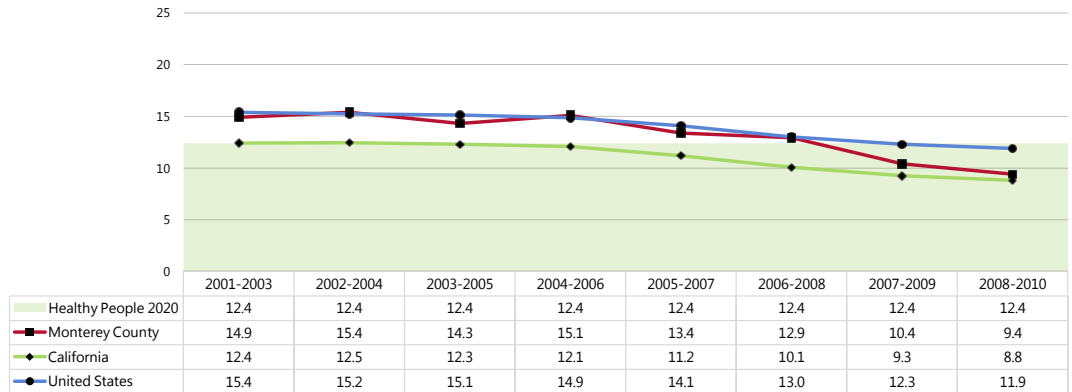
● Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.

● Local, state and national data are simple three-year averages.

☒ The motor vehicle crash mortality rate in Monterey County decreased over the past decade, in keeping with state and national trends.

## Motor Vehicle Crashes: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2013.  
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective IVP-13.1]  
 Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).  
 • Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.  
 • Local, state and national data are simple three-year averages.

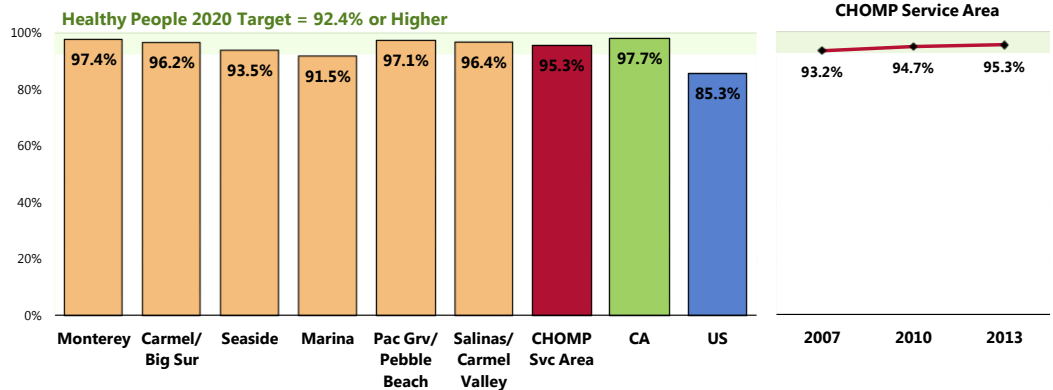
### Seat Belt Usage - Adults

**Most CHOMP Service Area adults (95.3%) report “always” wearing a seat belt when driving or riding in a vehicle.**

- Lower than the state prevalence.
- Higher than the percentage found nationally.
- Satisfies the Healthy People 2020 target of 92.4% or higher.
- Highest in Monterey.

☒ Marks a statistically significant increase over time.

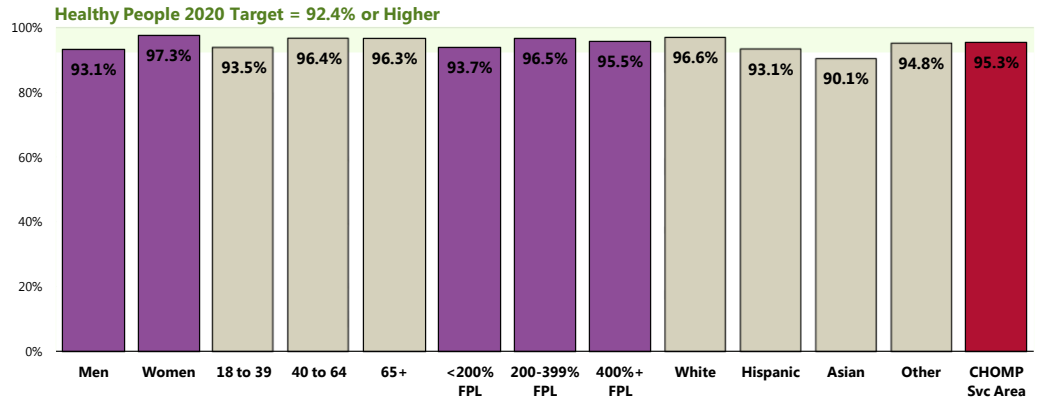
## “Always” Wear a Seat Belt When Driving or Riding in a Vehicle



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 55]  
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC). 2011 California data.  
 • 2011 PRC National Health Survey, Professional Research Consultants, Inc.  
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective IPV-15]  
 Notes: • Asked of all respondents.

Men in the service area are less likely to report consistent seat belt usage.

## “Always” Wear a Seat Belt When Driving or Riding in a Vehicle (CHOMP Service Area, 2013)



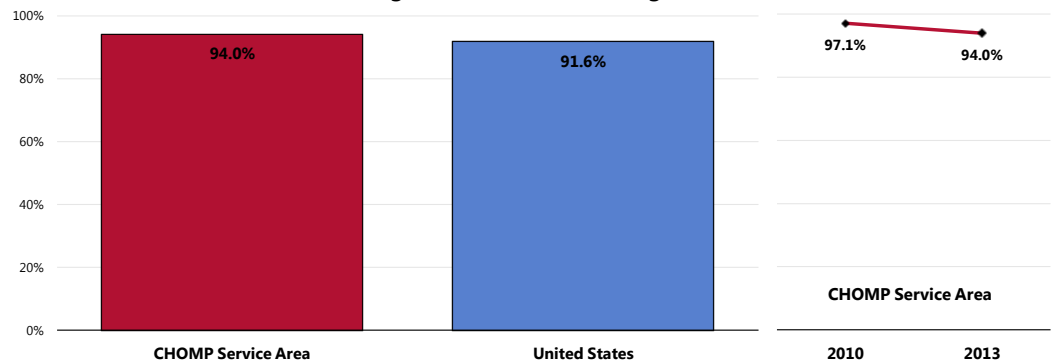
Sources: • 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 55]  
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective IPV-15]  
 Notes: • Asked of all respondents.  
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "<200% FPL" includes households with incomes up to 199% of the federal poverty level; "200-399% FPL" includes households with incomes between 200% and 399% of the federal poverty level; and "400%+ FPL" includes those households with incomes at 400% or more the federal poverty level.

### Seat Belt Usage - Children

**A full 94.0% of CHOMP Service Area parents report that their child (age 0 to 17) “always” wears a seat belt (or appropriate car seat for younger children) when riding in a vehicle.**

- Statistically similar to what is found nationally.
- ☒ Statistically unchanged since 2010.

## Child “Always” Wears a Seat Belt or Appropriate Restraint When Riding in a Vehicle (Among Parents of Children Age 0-17)



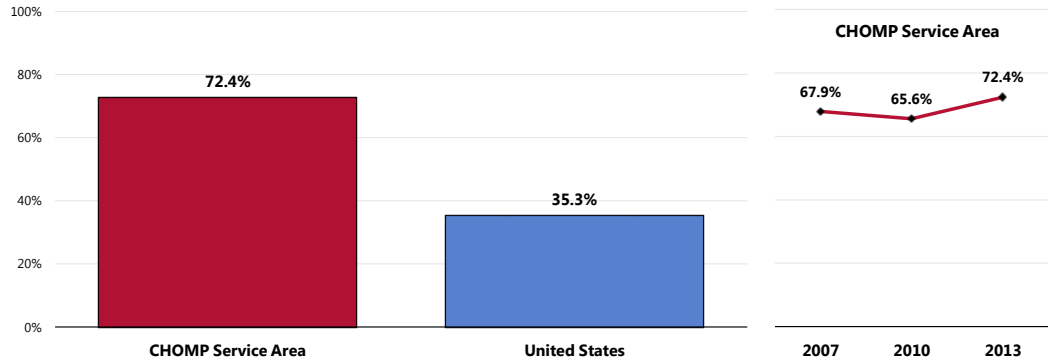
Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 133]  
 • 2011 PRC National Health Survey, Professional Research Consultants, Inc.  
 Notes: • Asked of all respondents with children 0 to 17 in the household.

## Bicycle Safety

**Over 7 in 10 CHOMP Service Area children age 5 to 17 (72.4%) are reported to “always” wear a helmet when riding a bicycle.**

- Over twice the national prevalence.
- 📊 Statistically unchanged over time.

### Child “Always” Wears a Helmet When Riding a Bicycle (Among Parents of Children Age 5-17)



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 136]  
 • 2011 PRC National Health Survey, Professional Research Consultants, Inc.  
 Notes: • Asked of all respondents with children age 5 to 17 at home.

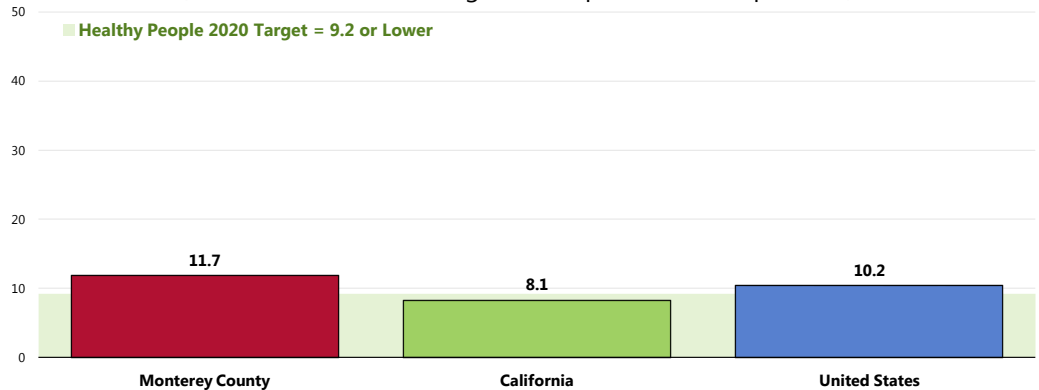
## Firearm Safety

### Age-Adjusted Firearm-Related Deaths

**Between 2008 and 2010, there was an annual average age-adjusted rate of 11.7 deaths per 100,000 population due to firearms in Monterey County.**

- Higher than found statewide.
- Higher than found nationally.
- Fails to satisfy the Healthy People 2020 objective (9.2 or lower).

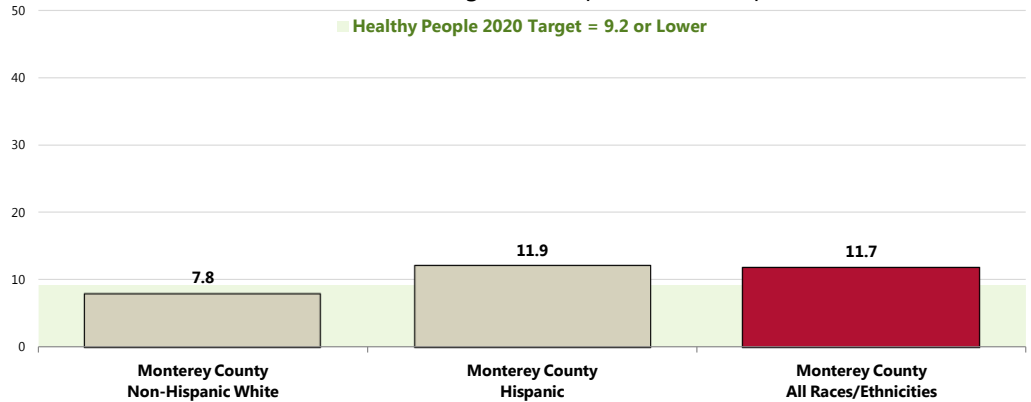
### Firearms-Related Deaths: Age-Adjusted Mortality (2008-2010 Annual Average Deaths per 100,000 Population)



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2013.  
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective IVP-30]  
 Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).  
 • Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.  
 • Local, state and national data are simple three-year averages.

👤 The county's firearm-related mortality rate is higher among Hispanics than among Non-Hispanic Whites.

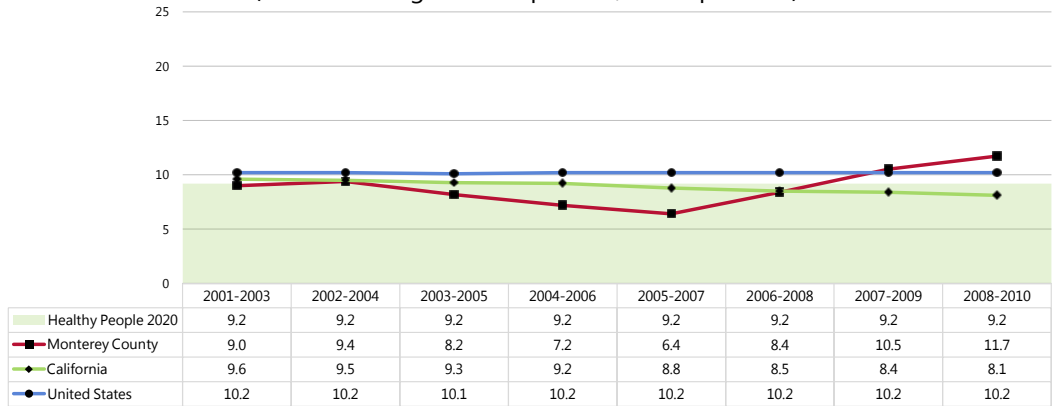
### Firearms-Related Deaths: Age-Adjusted Mortality by Race (2008-2010 Annual Average Deaths per 100,000 Population)



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2013.  
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective IVP-30]  
 Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).  
 • Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.  
 • Local, state and national data are simple three-year averages.

📉 The firearms-related mortality rate in Monterey County declined in the early 2000s, but has since increased sharply.

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



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2013.  
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective IVP-30]  
 Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).  
 • Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.  
 • Local, state and national data are simple three-year averages.



## Presence of Firearms in Homes

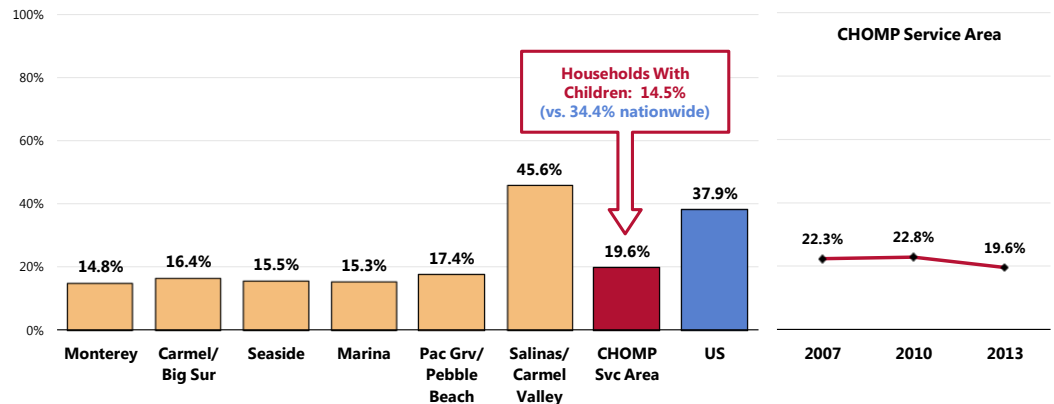
### Overall, one-fifth (19.6%) of CHOMP Service Area adults has a firearm kept in or around their home.

Survey respondents were further asked about the presence of weapons in the home:

*“Are there any firearms now kept in or around your home, including those kept in a garage, outdoor storage area, truck, or car? For the purposes of this inquiry, ‘firearms’ include pistols, shotguns, rifles, and other types of guns, but do NOT include starter pistols, BB guns, or guns that cannot fire.”*

- Much lower than the national prevalence.
- Particularly high in Salinas/Carmel Valley; lowest in Monterey.
- ☒ Statistically similar to that reported in 2007.
- 👤 Among CHOMP Service Area households with children, 14.5% have a firearm kept in or around the house (well below that reported nationally).
- ☒ The prevalence of firearms in households with children has not changed significantly over time (not shown).

### Have a Firearm Kept in or Around the Home



Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Items 59, 153]

● 2011 PRC National Health Survey, Professional Research Consultants, Inc.

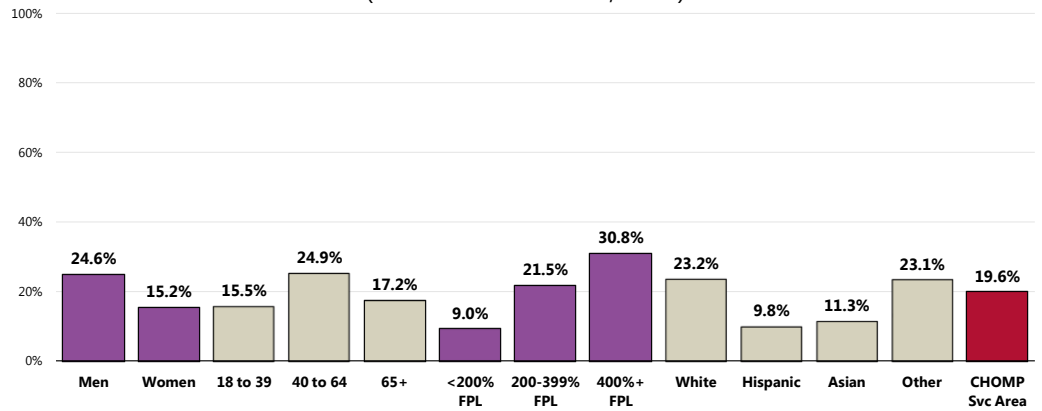
Notes:

- Asked of all respondents.
- In this case, firearms include pistols, shotguns, rifles, and other types of guns; this does not include starter pistols, BB guns, or guns that cannot fire.

Reports of firearms in or around the home are more prevalent among the following respondent groups:

- 👤 Men.
- 👤 Adults age 40 to 64.
- 👤 Higher-income households.
- 👤 Whites and “Other” race respondents.

## Have a Firearm Kept in or Around the House (CHOMP Service Area, 2013)

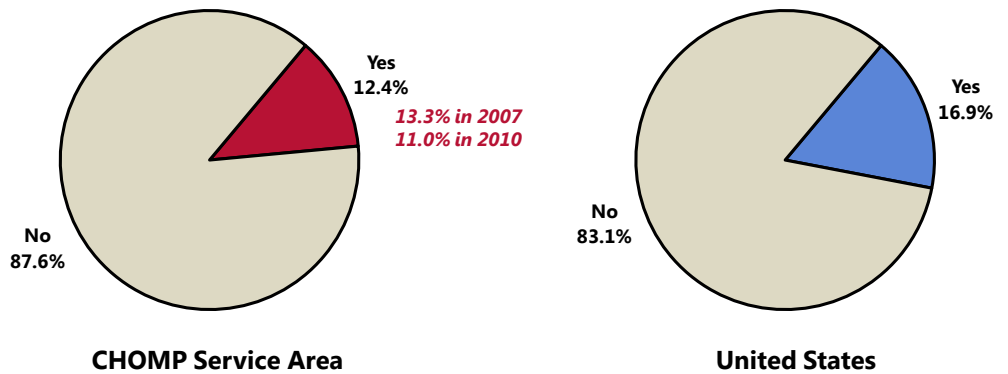


Sources: • 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 59]  
 Notes: • Asked of all respondents.  
 • In this case, firearms include pistols, shotguns, rifles, and other types of guns; this does not include starter pistols, BB guns, or guns that cannot fire.  
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "<200% FPL" includes households with incomes up to 199% of the federal poverty level; "200-399% FPL" includes households with incomes between 200% and 399% of the federal poverty level; and "400%+ FPL" includes those households with incomes at 400% or more the federal poverty level.

**Among CHOMP Service Area households with firearms, 12.4% report that there is at least one weapon that is kept unlocked and loaded.**

- Statistically similar to what is found nationally.
- ☒ Statistically similar to what was reported locally in 2007.

## Household Has An Unlocked, Loaded Firearm (Among Respondents Reporting a Firearm in or Around the Home)



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 154]  
 • 2011 PRC National Health Survey, Professional Research Consultants, Inc.  
 Notes: • Asked of all respondents with a firearm in or around the home.  
 • In this case, firearms include pistols, shotguns, rifles, and other types of guns; this does not include starter pistols, BB guns, or guns that cannot fire.

# Intentional Injury (Violence)

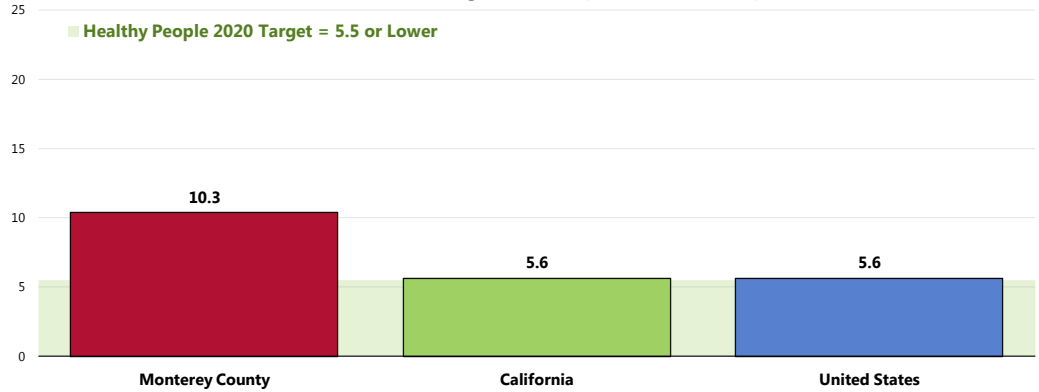
## Age-Adjusted Homicide Deaths

Between 2008 and 2010, there was an annual average age-adjusted homicide rate of 10.3 deaths per 100,000 population in Monterey County.

- Less favorable than the rate found statewide.
- Less favorable than the national rate.
- Fails to satisfy the Healthy People 2020 target of 5.5 or lower.

RELATED ISSUE:  
See also *Suicide* in the **Mental Health & Mental Disorders** section of this report.

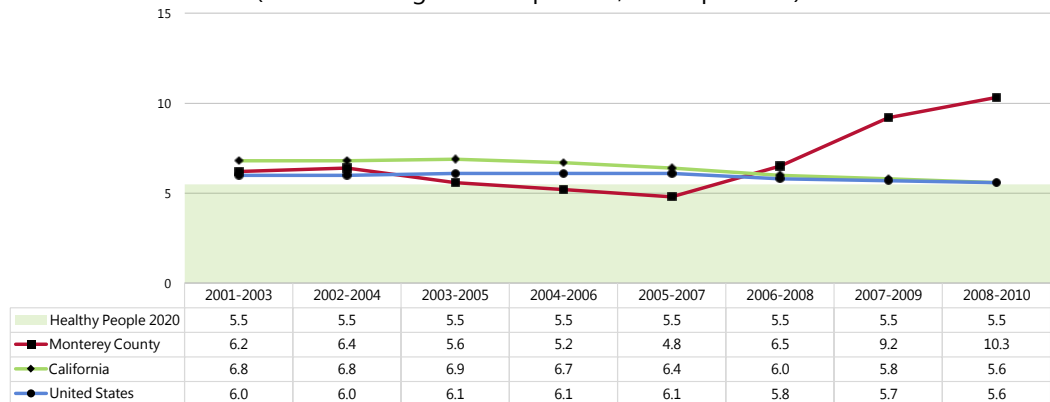
### Homicide: Age-Adjusted Mortality (2008-2010 Annual Average Deaths per 100,000 Population)



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2013.  
• US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective IPV-29]  
Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).  
• Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.  
• Local, state and national data are simple three-year averages.

☒ The county's homicide rate has more than doubled in recent years (from 2005-2007 to 2008-2010), in contrast to the decreasing trends reported statewide and nationwide.

### Homicide: Age-Adjusted Mortality Trends (Annual Average Deaths per 100,000 Population)



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2013.  
• US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective IPV-29]  
Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).  
• Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.  
• Local, state and national data are simple three-year averages.

## Violent Crime

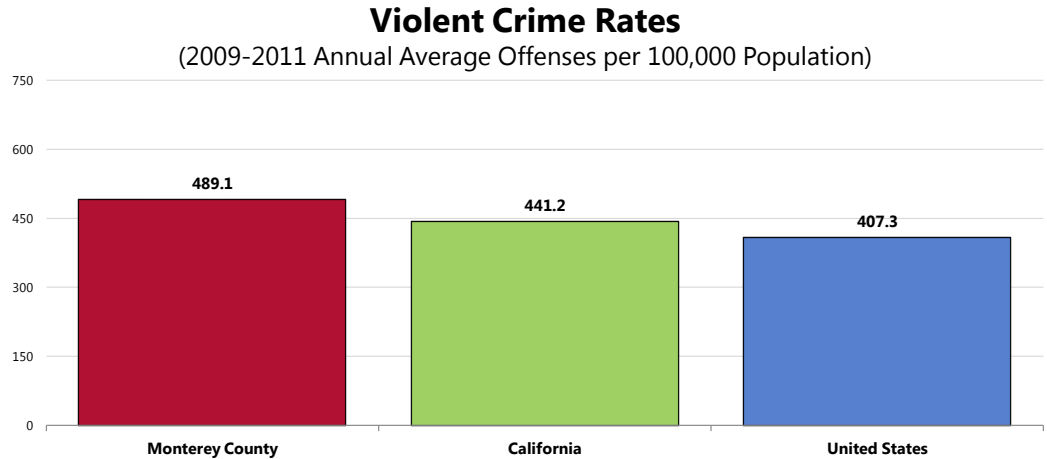
Violent crime is composed of four offenses (FBI Index offenses): murder and non-negligent manslaughter; forcible rape; robbery; and aggravated assault.

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

### Violent Crime Rates

**Between 2009 and 2011, there was an annual average violent crime rate of 489.1 offenses per 100,000 population in Monterey County.**

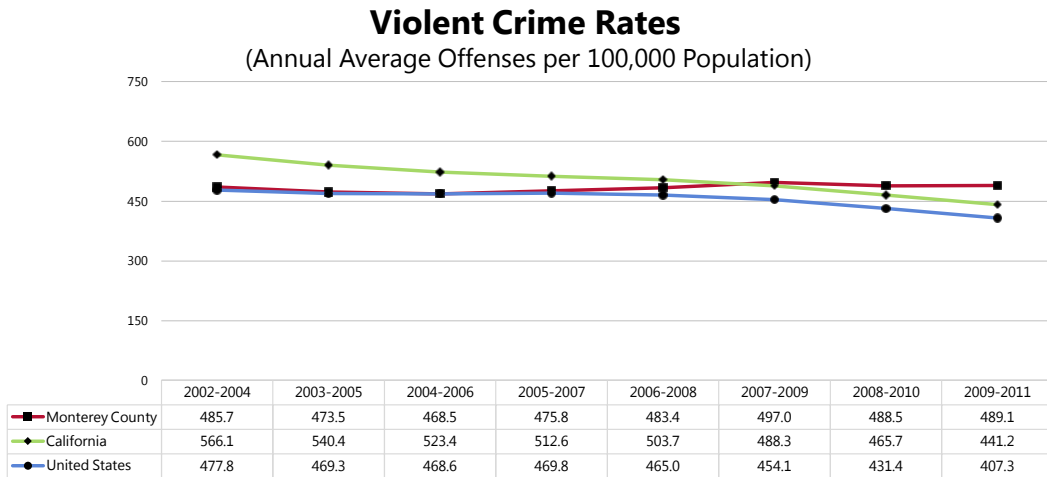
- Higher than the California rate for the same period.
- Higher than the national rate.



Sources: • State of California Department of Justice, Criminal Justice Statistics Center  
 • US Department of Justice, Federal Bureau of Investigation

Notes: • Rates are offenses per 100,000 population among agencies reporting.

The county's crime rate has not shown a clear trend over the past decade, while California and the US report downward trends during this period.



Sources: • State of California Department of Justice, Criminal Justice Statistics Center  
 • US Department of Justice, Federal Bureau of Investigation

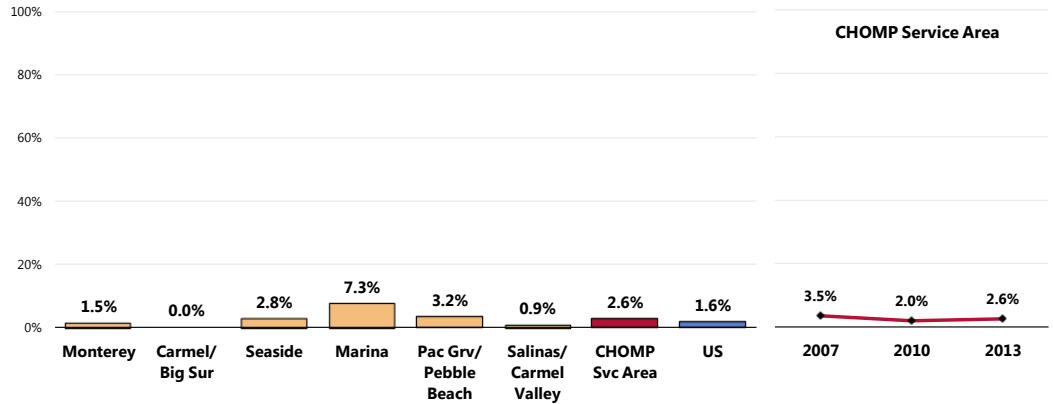
Notes: • Rates are offenses per 100,000 population among agencies reporting.

## Self-Reported Violence

**A total of 2.6% of CHOMP Service Area adults acknowledge being the victim of a violent crime in the past five years.**

- Statistically similar to national findings.
- Lowest in Carmel/Big Sur and Salinas/Carmel Valley; unfavorably high in Marina.
- ☒ Statistically unchanged over time.

### Victim of a Violent Crime in the Past Five Years

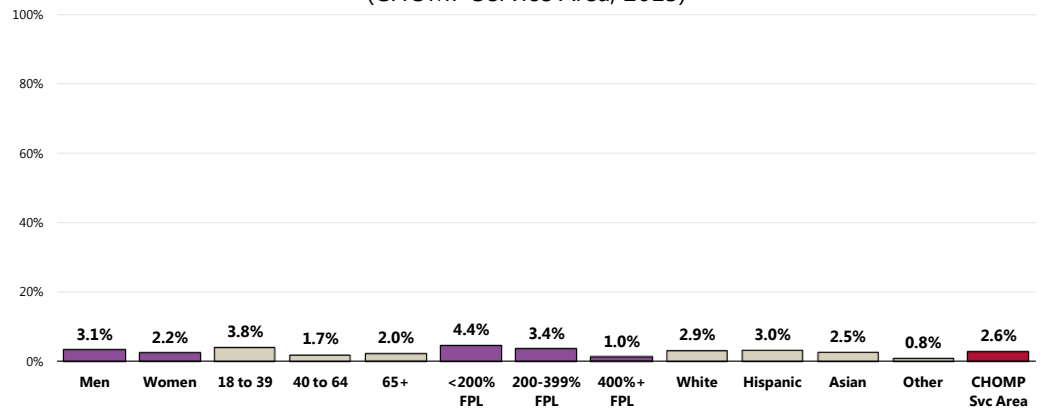


Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 56]  
 • 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes: • Asked of all respondents.

👥 Reports of violence are higher among residents living in the lower income categories.

### Victim of a Violent Crime in the Past Five Years (CHOMP Service Area, 2013)



Sources: • 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 56]

Notes: • Asked of all respondents.

- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "<200% FPL" includes households with incomes up to 199% of the federal poverty level; "200-399% FPL" includes households with incomes between 200% and 399% of the federal poverty level; and "400%+ FPL" includes those households with incomes at 400% or more the federal poverty level.

## Family Violence

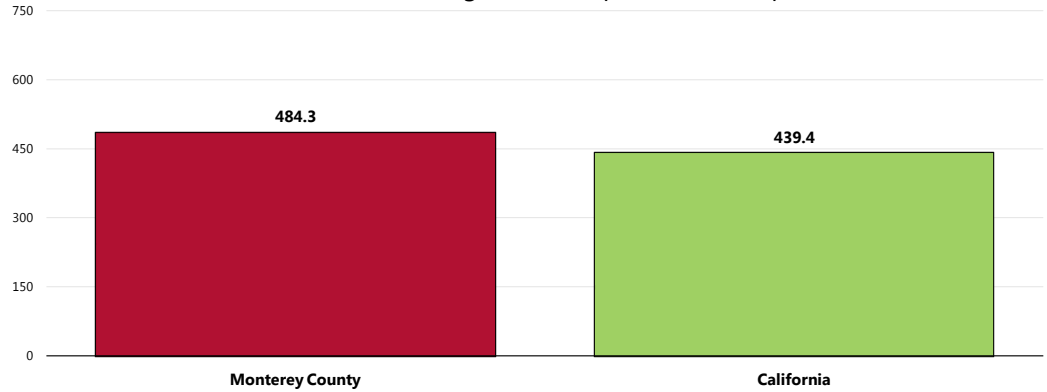
Between 2009 and 2011, there was an annual average domestic violence rate of 484.3 offenses per 100,000 population in Monterey County.

- Higher than the California rate for the same period.

Keep in mind that these data only reflect those incidents reported to law enforcement (offenses).

### Domestic Violence Rates

(2009-2011 Annual Average Offenses per 100,000 Population)

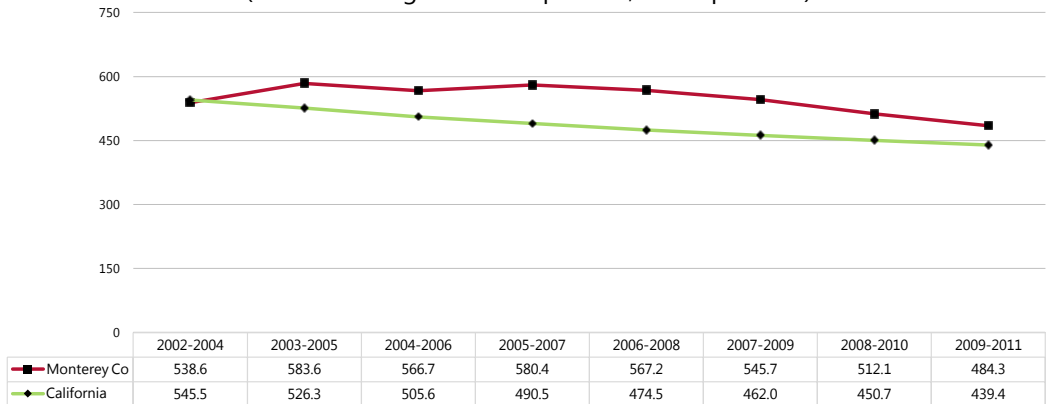


Sources: State of California Department of Justice, Criminal Justice Statistics Center  
 Notes: Rates are domestic calls for assistance per 100,000 population.

- The county's domestic violence rate decreased over the past decade, in keeping with the state trend.

### Domestic Violence Rates

(Annual Average Offenses per 100,000 Population)



Sources: State of California Department of Justice, Criminal Justice Statistics Center  
 Notes: Rates are domestic calls for assistance per 100,000 population.

Respondents were told:

*"By an intimate partner, I mean any current or former spouse, boyfriend, or girlfriend. Someone you were dating, or romantically or sexually intimate with would also be considered an intimate partner."*

## Self-Reported Family Violence

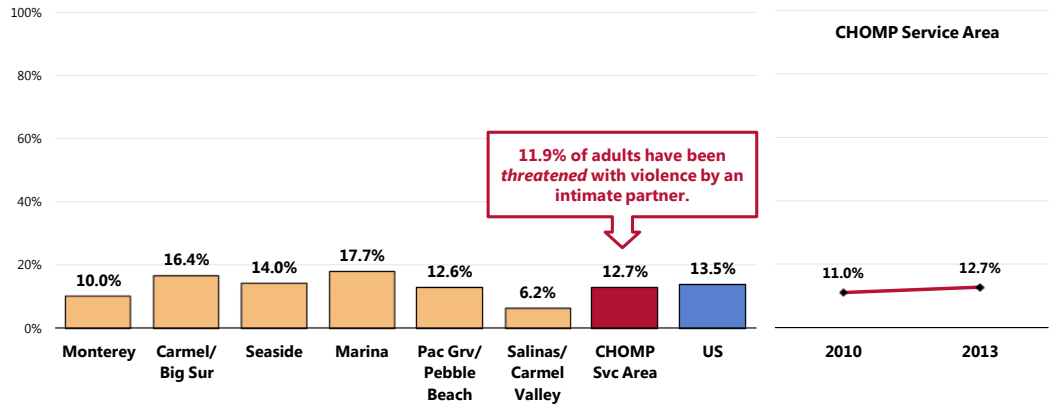
A total of 11.9% of CHOMP Service Area adults report that they have ever been threatened with physical violence by an intimate partner.

- Similar to that reported nationally.

**A total of 12.7% of respondents acknowledge that they have ever been hit, slapped, pushed, kicked, or otherwise hurt by an intimate partner.**

- Comparable to national findings.
- Lowest in Salinas/Carmel Valley.
- ☒ Statistically unchanged from 2010 survey results.

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

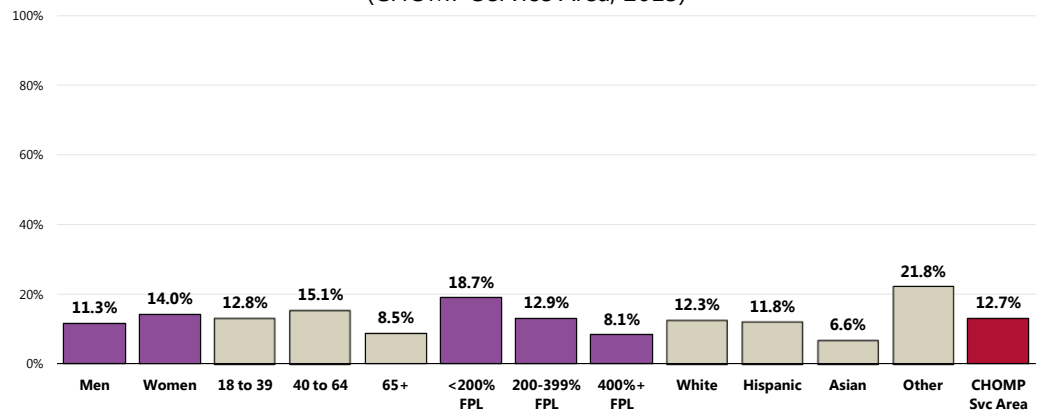


Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Items 57-58]  
 ● 2011 PRC National Health Survey, Professional Research Consultants, Inc.  
 Notes: ● Asked of all respondents.

Reports of domestic violence are also notably higher among:

- 👥 Adults between the ages of 40 and 64.
- 👥 Those with lower incomes.
- 👥 Adults of "Other" races.

### Have Ever Been Hit, Slapped, Pushed, Kicked, or Hurt in Any Way by an Intimate Partner (CHOMP Service Area, 2013)



Sources: ● 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 58]  
 Notes: ● Asked of all respondents.  
 ● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
 ● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "<200% FPL" includes households with incomes up to 199% of the federal poverty level; "200-399% FPL" includes households with incomes between 200% and 399% of the federal poverty level; and "400%+ FPL" includes those households with incomes at 400% or more the federal poverty level.

## Related Focus Group Findings: Violence

Many focus group participants are concerned with violence in the community, discussing these issues:

- Violence
  - *Bullying*
  - *Gang-related*
- Need for additional prevention programs

According to participants, **violence** is a concern for the community and the perception of violence is also a challenge for the community. A major contributor to violence in the community is alcohol and drug use. Attendees worry that violence (or the perception of violence) inhibits families' ability to participate in outdoor activities.

Key informants agree that violence can include things that go unreported, domestic violence, bullying, or be gang-related. **Bullying** occurs both in the classrooms and online, which worries respondents because it creates an "undertone of violence and cruelty" that negatively impacts the youth:

*"I do a survey every year with my classes, so we surveyed over 200 people this last semester, half of whom we were surveying on school violence and the other half on community violence. I have very high numbers on people scared to go to school. We did a survey in King City. The cyber bullying and the comments that kids are getting from their peers at school, even if it's not homicide, it's scary." — Community Leader*

**Gang-related violence** also impacts the community. Focus group members express concern for East Salinas, King City, Seaside and Greenfield. Many young males (14-25) die prematurely due to gang-related incidents. This type of violence is also perpetuated generationally; one community leader describes an example of this:

*I just watched a video yesterday of a gang member taking his two-year-old daughter to a local store and as he's walking her through the store he's talking about using gang slang about how 'We're rolling as two. There's a gangster over here' and 'Bang, bang, bang', and the little girl is going 'Bang, bang, bang'. He was videotaping how he's teaching his daughter, which is just amazing." — Community Leader*

Attendees believe that the community needs more **prevention programs**. These programs could work to improve safety and lower the number of violent acts committed in the area.



# Diabetes

Diabetes mellitus occurs when the body cannot produce or respond appropriately to insulin. Insulin is a hormone that the body needs to absorb and use glucose (sugar) as fuel for the body's cells. Without a properly functioning insulin signaling system, blood glucose levels become elevated and other metabolic abnormalities occur, leading to the development of serious, disabling complications. Many forms of diabetes exist; the three common types are Type 1, Type 2, and gestational diabetes.

Effective therapy can prevent or delay diabetic complications. However, almost 25% of Americans with diabetes mellitus are undiagnosed, and another 57 million Americans have blood glucose levels that greatly increase their risk of developing diabetes mellitus in the next several years. Few people receive effective preventative care, which makes diabetes mellitus an immense and complex public health challenge.

Diabetes mellitus affects an estimated 23.6 million people in the United States and is the 7th leading cause of death. Diabetes mellitus:

- Lowers life expectancy by up to 15 years.
- Increases the risk of heart disease by 2 to 4 times.
- Is the leading cause of kidney failure, lower limb amputations, and adult-onset blindness.

In addition to these human costs, the estimated total financial cost of diabetes mellitus in the US in 2007 was \$174 billion, which includes the costs of medical care, disability, and premature death.

The rate of diabetes mellitus continues to increase both in the United States and throughout the world. Due to the steady rise in the number of persons with diabetes mellitus, and possibly earlier onset of type 2 diabetes mellitus, there is growing concern about the possibility that the increase in the number of persons with diabetes mellitus and the complexity of their care might overwhelm existing healthcare systems.

People from minority populations are more frequently affected by type 2 diabetes. Minority groups constitute 25% of all adult patients with diabetes in the US and represent the majority of children and adolescents with type 2 diabetes.

Lifestyle change has been proven effective in preventing or delaying the onset of type 2 diabetes in high-risk individuals.

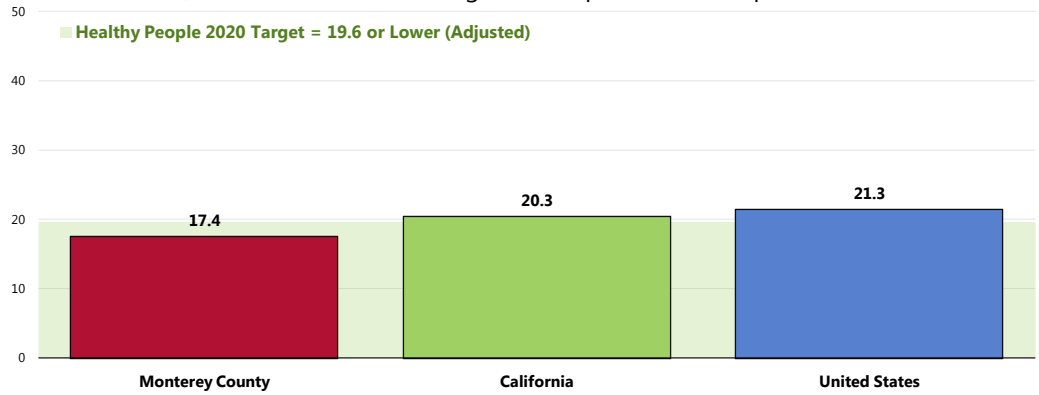
– Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

## Age-Adjusted Diabetes Deaths


**Between 2008 and 2010, there was an annual average age-adjusted diabetes mortality rate of 17.4 deaths per 100,000 population in Monterey County.**

- More favorable than that found statewide.
- More favorable than the national rate.
- Satisfies the Healthy People 2020 target (19.6 or lower).

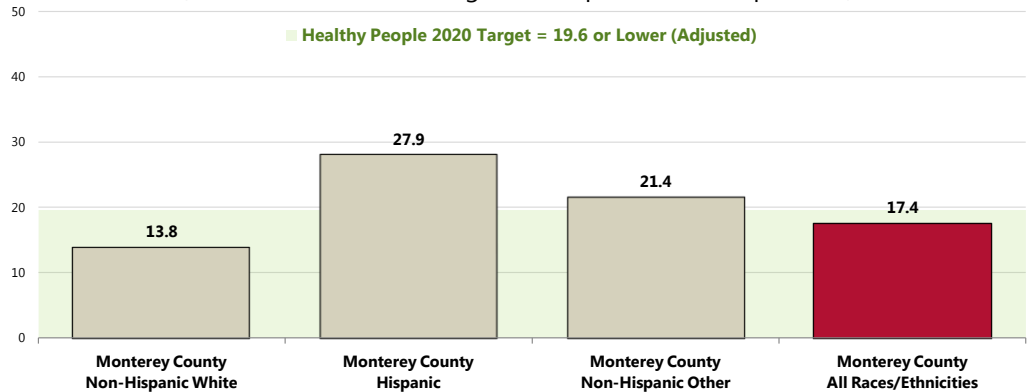
## Diabetes: Age-Adjusted Mortality (2008-2010 Annual Average Deaths per 100,000 Population)



- Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2013.
  - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective D-3]
- Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
  - Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
  - Local, state and national data are simple three-year averages.
  - The Healthy People 2020 target for Diabetes is adjusted to account for only diabetes mellitus coded deaths.

 The county's diabetes mortality rate is notably higher among Hispanics than among Non-Hispanic Whites and "Other" races.

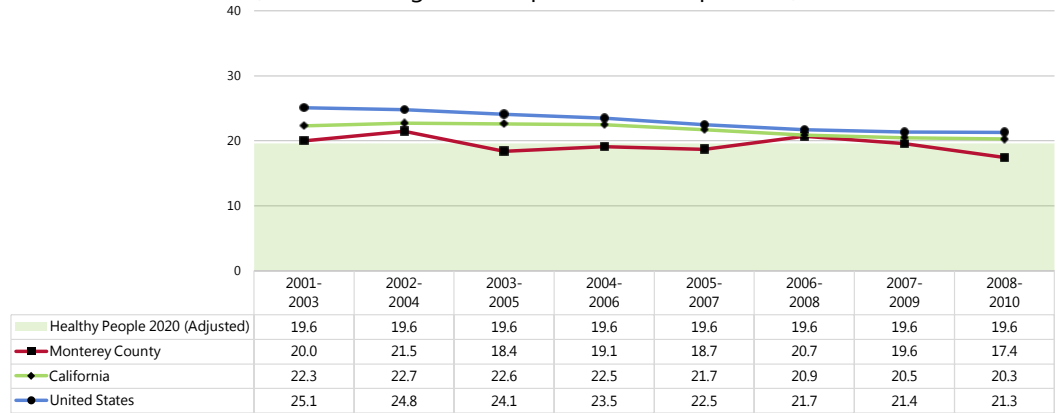
## Diabetes: Age-Adjusted Mortality by Race (2008-2010 Annual Average Deaths per 100,000 Population)



- Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2013.
  - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective D-3]
- Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
  - Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
  - The Healthy People 2020 target for Diabetes is adjusted to account for only diabetes mellitus coded deaths.

Diabetes mortality has decreased overall in Monterey County in the past decade. Across California and the US, diabetes mortality decreased as well.

### Diabetes: Age-Adjusted Mortality Trends (Annual Average Deaths per 100,000 Population)



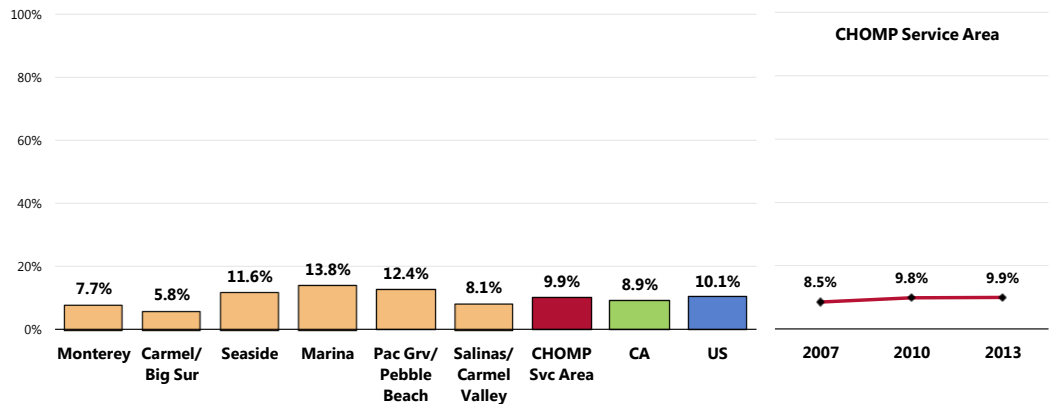
Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2013.  
 US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective D-3]  
 Notes: Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).  
 Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.  
 Local, state and national data are simple three-year averages.  
 The Healthy People 2020 target for Diabetes is adjusted to account for only diabetes mellitus coded deaths.

### Prevalence of Diabetes

According to survey data, a total of 9.9% of CHOMP Service Area adults report having been diagnosed with diabetes.

- Similar to the proportion statewide.
- Similar to the national proportion.
- Lowest in Carmel/Big Sur.
- ☒ Statistically unchanged since 2007.

### Prevalence of Diabetes

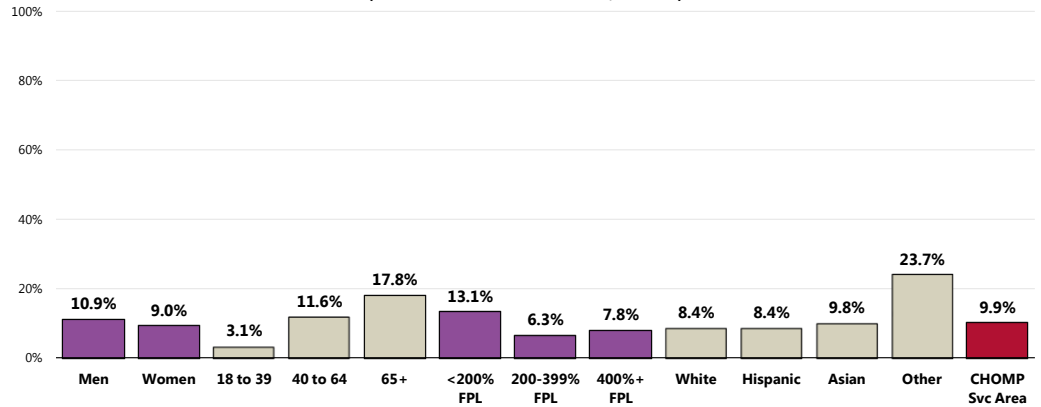


Sources: PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 43]  
 2011 PRC National Health Survey, Professional Research Consultants, Inc.  
 Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2011 California data.  
 Notes: Asked of all respondents.  
 Local and national data exclude gestation diabetes (occurring only during pregnancy).

👥 A higher prevalence of diabetes is reported among lower-income residents and adults of “Other” races in the service area.

👥 Note also the positive correlation between diabetes and age (with 17.8% of seniors with diabetes).

### Prevalence of Diabetes (CHOMP Service Area, 2013)

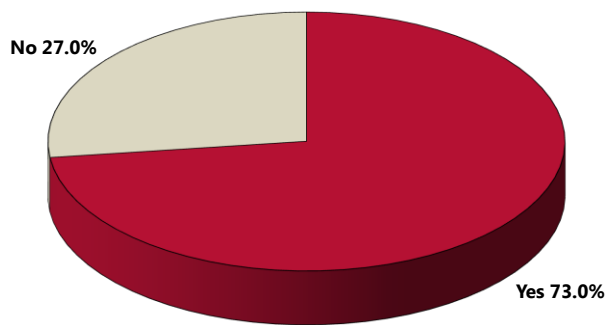


Sources: • 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 43]  
 Notes: • Asked of all respondents.  
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., “White” reflects non-Hispanic White respondents).  
 • Income categories reflect respondent’s household income as a ratio to the federal poverty level (FPL) for their household size. “<200% FPL” includes households with incomes up to 199% of the federal poverty level; “200-399% FPL” includes households with incomes between 200% and 399% of the federal poverty level; and “400%+ FPL” includes those households with incomes at 400% or more the federal poverty level.  
 • Excludes gestation diabetes (occurring only during pregnancy).

### Diabetes Treatment

Among adults with diabetes, most (73.0%) are currently taking insulin or some type of medication to manage their condition.

### Taking Insulin or Other Medication for Diabetes (Among CHOMP Service Area Diabetics)



Sources: • 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 44]  
 Notes: • Asked of all diabetic respondents.

# Alzheimer's Disease

Dementia is the loss of cognitive functioning—thinking, remembering, and reasoning—to such an extent that it interferes with a person's daily life. Dementia is not a disease itself, but rather a set of symptoms. Memory loss is a common symptom of dementia, although memory loss by itself does not mean a person has dementia. Alzheimer's disease is the most common cause of dementia, accounting for the majority of all diagnosed cases.

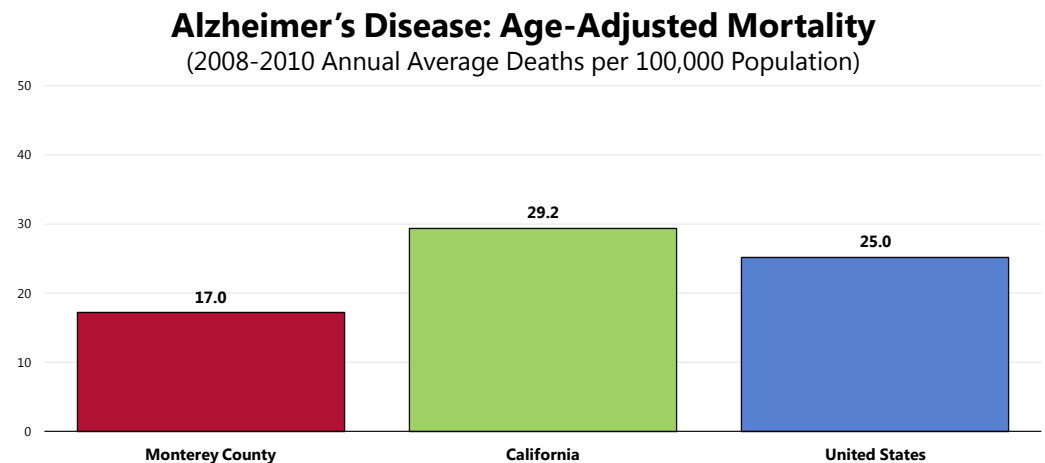
Alzheimer's disease is the 6<sup>th</sup> leading cause of death among adults age 18 years and older. Estimates vary, but experts suggest that up to 5.1 million Americans age 65 years and older have Alzheimer's disease. These numbers are predicted to more than double by 2050 unless more effective ways to treat and prevent Alzheimer's disease are found.

– Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

## Age-Adjusted Alzheimer's Disease Deaths

**Between 2008 and 2010, there was an annual average age-adjusted Alzheimer's disease mortality rate of 17.0 deaths per 100,000 population in Monterey County.**

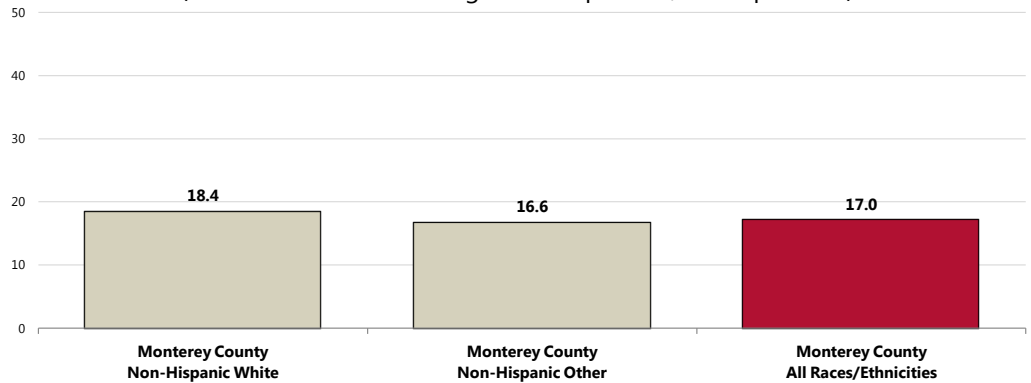
- More favorable than the statewide rate.
- More favorable than the national rate.



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2013.  
Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).  
• Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.  
• Local, state and national data are simple three-year averages.

👥 The Alzheimer's disease mortality rate appears somewhat higher among Non-Hispanic Whites.

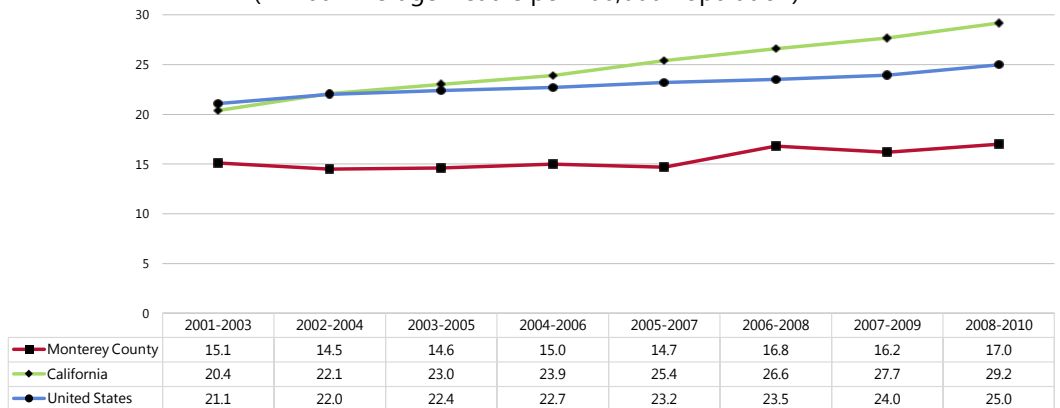
### Alzheimer's Disease: Age-Adjusted Mortality by Race (2008-2010 Annual Average Deaths per 100,000 Population)



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2013.  
 Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).  
 • Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.  
 • Local, state and national data are simple three-year averages.

📈 The Alzheimer's disease mortality rate in Monterey County increased over the past decade. Across California and the US, rates have increased steadily in recent years.

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



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2013.  
 Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).  
 • Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.

# Kidney Disease

Chronic kidney disease and end-stage renal disease are significant public health problems in the United States and a major source of suffering and poor quality of life for those afflicted. They are responsible for premature death and exact a high economic price from both the private and public sectors. Nearly 25% of the Medicare budget is used to treat people with chronic kidney disease and end-stage renal disease.

Genetic determinants have a large influence on the development and progression of chronic kidney disease. It is not possible to alter a person's biology and genetic determinants; however, environmental influences and individual behaviors also have a significant influence on the development and progression of chronic kidney disease. As a result, some populations are disproportionately affected. Successful behavior modification is expected to have a positive influence on the disease.

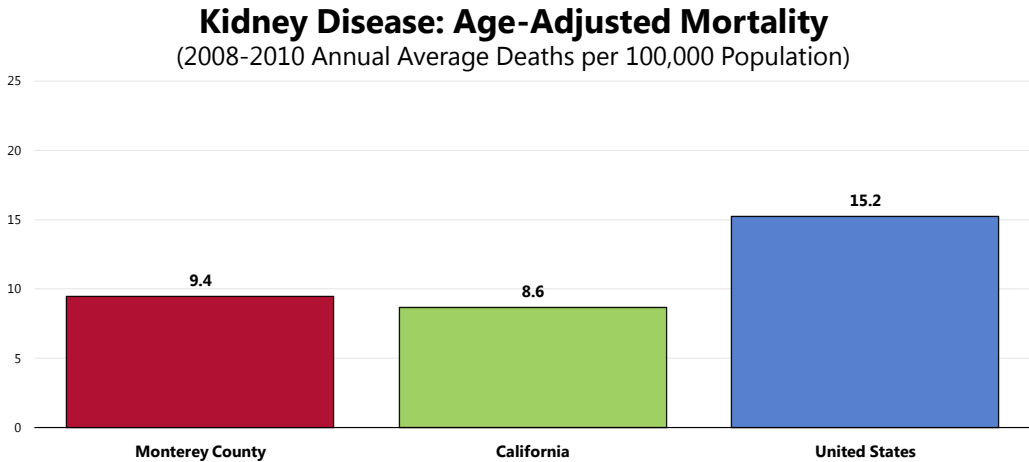
Diabetes is the most common cause of kidney failure. The results of the Diabetes Prevention Program (DPP) funded by the national Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) show that moderate exercise, a healthier diet, and weight reduction can prevent development of type 2 diabetes in persons at risk.

- Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

## Age-Adjusted Kidney Disease Deaths

**Between 2008 and 2010 there was an annual average age-adjusted kidney disease mortality rate of 9.4 deaths per 100,000 population in Monterey County.**

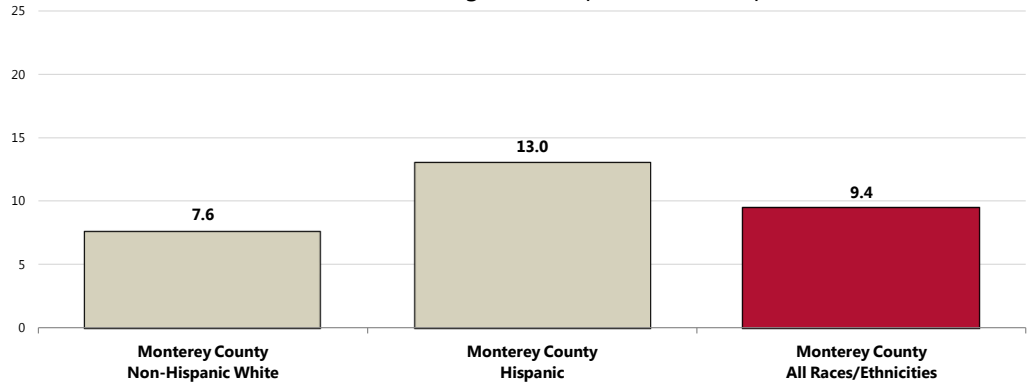
- Just above the rate found statewide.
- Below the national rate.



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2013.  
Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).  
• Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.  
• Local, state and national data are simple three-year averages.

👥 The kidney disease mortality rate in Monterey County is much higher in the Hispanic population.

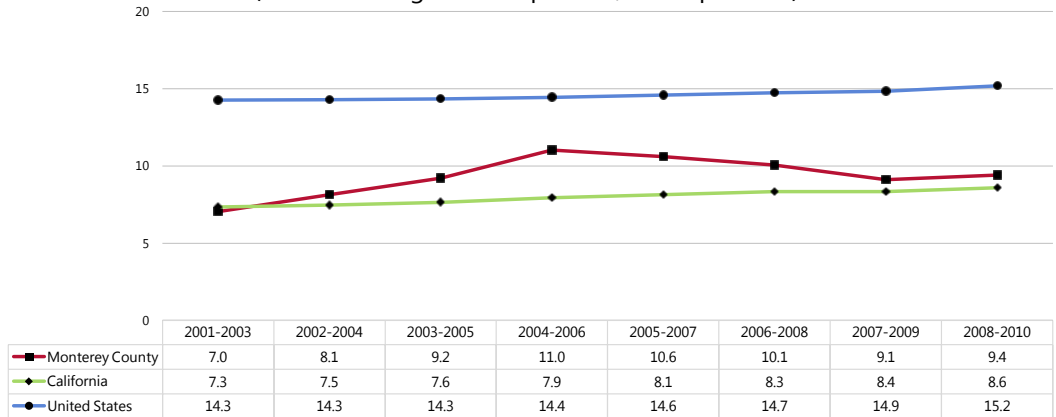
### Kidney Disease: Age-Adjusted Mortality by Race (2008-2010 Annual Average Deaths per 100,000 Population)



Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2013.  
 Notes: ● Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).  
 ● Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.  
 ● Local, state and national data are simple three-year averages.

📈 Although fluctuating, the Monterey County kidney disease death rate increased more than it decreased over the past decade. State and national rates rose steadily over the past several years.

### Kidney Disease: Age-Adjusted Mortality Trends (Annual Average Deaths per 100,000 Population)



Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2013.  
 Notes: ● Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).  
 ● Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.  
 ● State and national data are simple three-year averages.



# Potentially Disabling Conditions

There are more than 100 types of arthritis. Arthritis commonly occurs with other chronic conditions, such as diabetes, heart disease, and obesity. Interventions to treat the pain and reduce the functional limitations from arthritis are important, and may also enable people with these other chronic conditions to be more physically active. Arthritis affects 1 in 5 adults and continues to be the most common cause of disability. It costs more than \$128 billion per year. All of the human and economic costs are projected to increase over time as the population ages. There are interventions that can reduce arthritis pain and functional limitations, but they remain underused. These include: increased physical activity; self-management education; and weight loss among overweight/obese adults.

Osteoporosis is a disease marked by reduced bone strength leading to an increased risk of fractures (broken bones). In the United States, an estimated 5.3 million people age 50 years and older have osteoporosis. Most of these people are women, but about 0.8 million are men. Just over 34 million more people, including 12 million men, have low bone mass, which puts them at increased risk for developing osteoporosis. Half of all women and as many as 1 in 4 men age 50 years and older will have an osteoporosis-related fracture in their lifetime.

Chronic back pain is common, costly, and potentially disabling. About 80% of Americans experience low back pain in their lifetime. It is estimated that each year:

- 15%-20% of the population develop protracted back pain.
- 2-8% have chronic back pain (pain that lasts more than 3 months).
- 3-4% of the population is temporarily disabled due to back pain.
- 1% of the working-age population is disabled completely and permanently as a result of low back pain.

Americans spend at least \$50 billion each year on low back pain. Low back pain is the:

- 2<sup>nd</sup> leading cause of lost work time (after the common cold).
- 3<sup>rd</sup> most common reason to undergo a surgical procedure.
- 5<sup>th</sup> most frequent cause of hospitalization.

Arthritis, osteoporosis, and chronic back conditions all have major effects on quality of life, the ability to work, and basic activities of daily living.

– Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

## Arthritis, Osteoporosis, & Chronic Pain

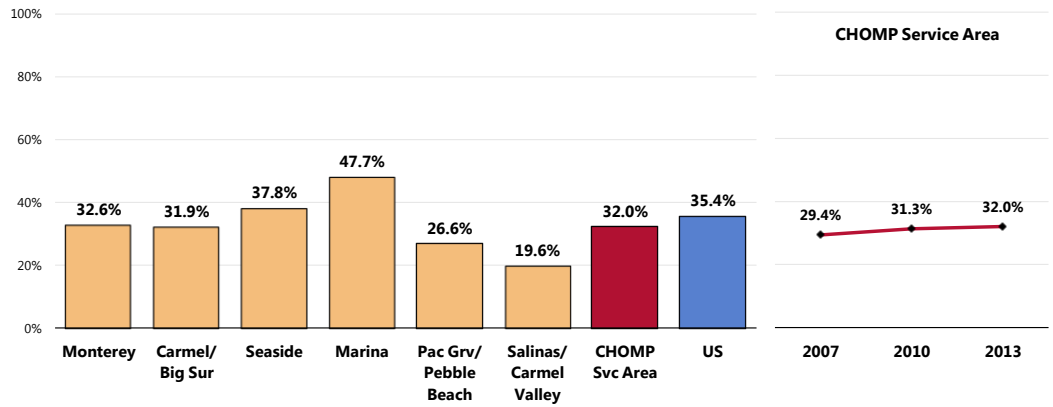
### Prevalence of Arthritis/Rheumatism

**Nearly one-third (32.0%) of CHOMP Service Area adults age 50 and older reports suffering from arthritis or rheumatism.**

- Comparable to that found nationwide.
- Lowest in Salinas/Carmel Valley; highest in Marina.
- ☒ The prevalence of arthritis/rheumatism is similar to that reported in 2007.

RELATED ISSUE:  
See also *Activity Limitations* in  
the **General Health Status**  
section of this report.

## Prevalence of Arthritis/Rheumatism (Among Adults 50+)



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 157]  
 • 2011 PRC National Health Survey, Professional Research Consultants, Inc.

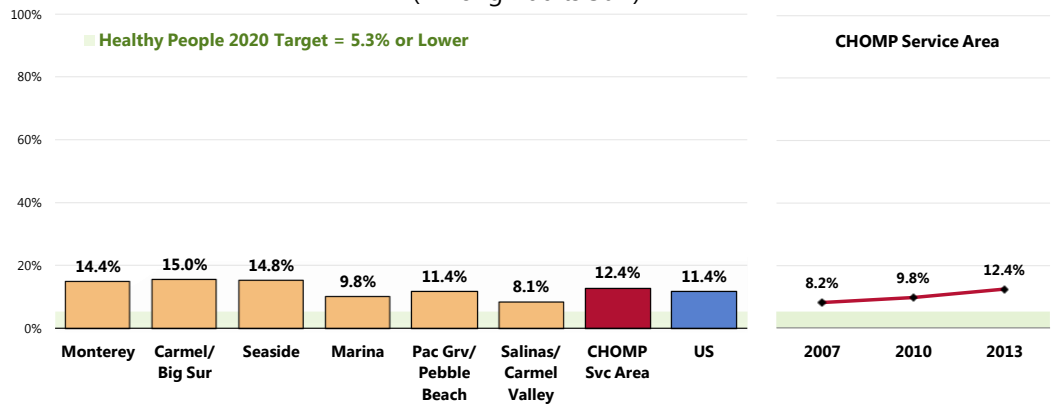
Notes: • Reflects respondents 50 and older.

## Prevalence of Osteoporosis

**A total of 12.4% of survey respondents age 50 and older have osteoporosis.**

- Similar to that found nationwide.
- Fails to satisfy the Healthy People 2020 target of 5.3% or lower.
- No significant differences by community.
- ☒ Denotes a significant increase over time.

## Prevalence of Osteoporosis (Among Adults 50+)



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 158]  
 • 2011 PRC National Health Survey, Professional Research Consultants, Inc.

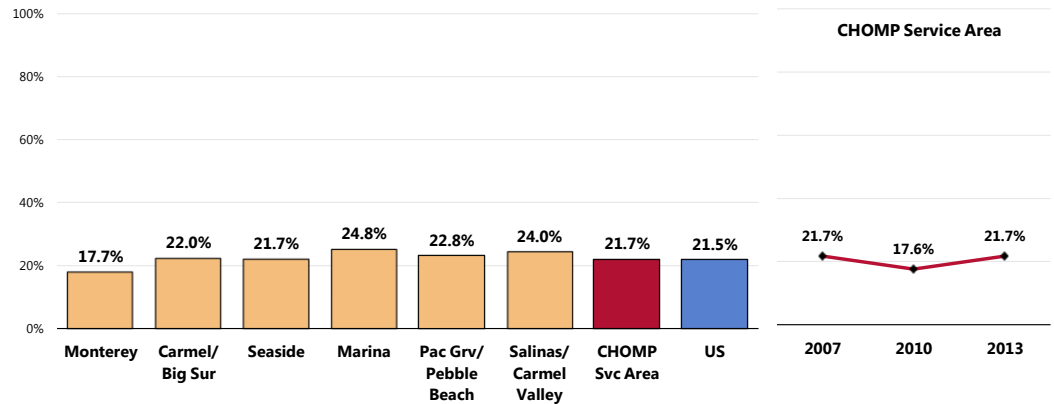
• US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective AOCBC-10]  
 Notes: • Reflects respondents 50 and older.

## Prevalence of Sciatica/Chronic Back Pain

**A total of 21.7% of survey respondents suffer from chronic back pain or sciatica.**

- Nearly identical to that found nationwide.
- No significant difference by community.
- ☒ Identical to the 2007 prevalence, but a significant increase from 2010 findings.

### Prevalence of Sciatica/Chronic Back Pain



Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 29]  
● 2011 PRC National Health Survey, Professional Research Consultants, Inc.

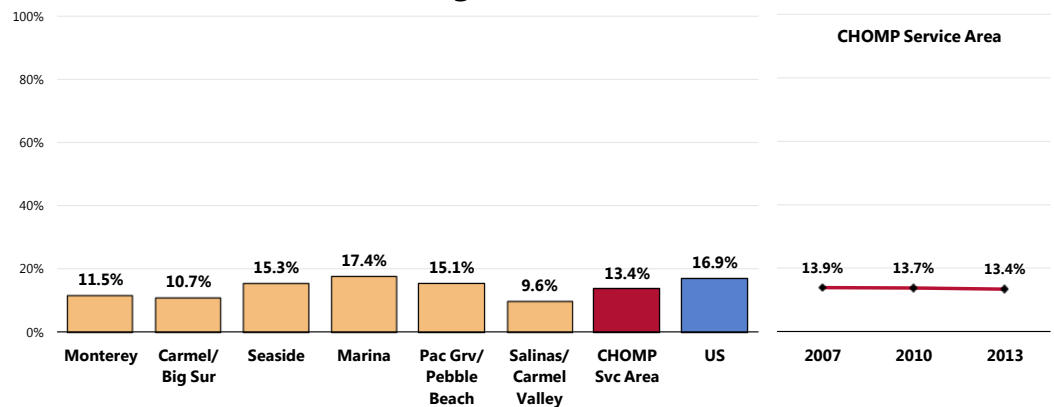
Notes: ● Asked of all respondents.

## Prevalence of Migraines/Severe Headaches

**A total of 13.4% of survey respondents report suffering from migraines or severe headaches.**

- Better than that found nationwide.
- Findings by community are statistically similar.
- ☒ No significant change over time in the service area.

### Prevalence of Migraines/Severe Headaches



Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 36]  
● 2011 PRC National Health Survey, Professional Research Consultants, Inc.

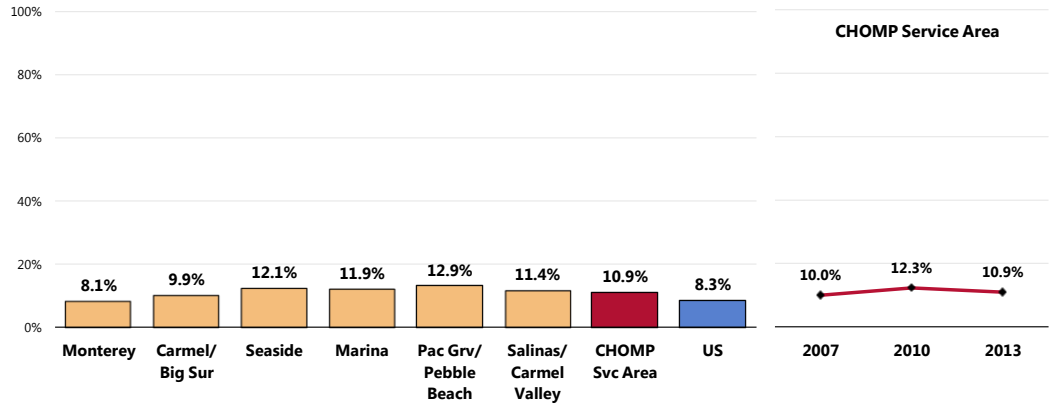
Notes: ● Asked of all respondents.

## Prevalence of Chronic Neck Pain

**A total of 10.9% of survey respondents currently suffer from chronic neck pain.**

- Higher than that found nationwide.
- Statistically similar by community.
- ☒ Statistically unchanged since 2007.

### Prevalence of Chronic Neck Pain



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 37]  
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes: • Asked of all respondents.

## Vision & Hearing Impairment

Vision is an essential part of everyday life, influencing how Americans of all ages learn, communicate, work, play, and interact with the world. Yet millions of Americans live with visual impairment, and many more remain at risk for eye disease and preventable eye injury.

The eyes are an important, but often overlooked, part of overall health. Despite the preventable nature of some vision impairments, many people do not receive recommended screenings and exams. A visit to an eye care professional for a comprehensive dilated eye exam can help to detect common vision problems and eye diseases, including diabetic retinopathy, glaucoma, cataract, and age-related macular degeneration.

These common vision problems often have no early warning signs. If a problem is detected, an eye care professional can prescribe corrective eyewear, medicine, or surgery to minimize vision loss and help a person see his or her best.

Healthy vision can help to ensure a healthy and active lifestyle well into a person's later years. Educating and engaging families, communities, and the nation is critical to ensuring that people have the information, resources, and tools needed for good eye health.

– Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

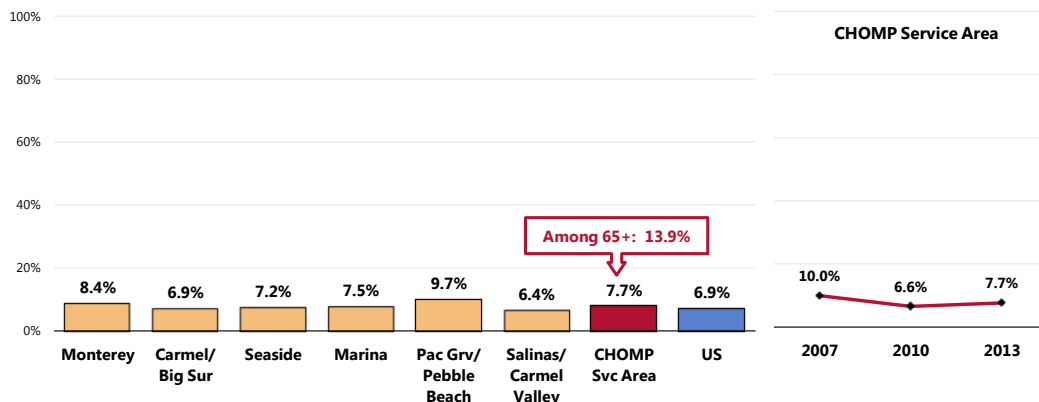
### Vision Trouble

**A total of 7.7% of CHOMP Service Area adults are blind, or have trouble seeing even when wearing corrective lenses.**

- Comparable to that found nationwide.
- Comparable findings by community.
- ☒ Statistically unchanged over time.
- 👥 Among CHOMP Service Area adults age 65 and older, 13.9% have vision trouble.

RELATED ISSUE:  
See also *Vision Care* in the **Access to Health Services** section of this report.

### Prevalence of Blindness/Trouble Seeing



Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 26]  
● 2011 PRC National Health Survey, Professional Research Consultants, Inc.  
Notes: ● Asked of all respondents.

## Hearing Trouble

An impaired ability to communicate with others or maintain good balance can lead many people to feel socially isolated, have unmet health needs, have limited success in school or on the job. Communication and other sensory processes contribute to our overall health and well-being. Protecting these processes is critical, particularly for people whose age, race, ethnicity, gender, occupation, genetic background, or health status places them at increased risk.

Many factors influence the numbers of Americans who are diagnosed and treated for hearing and other sensory or communication disorders, such as social determinants (social and economic standings, age of diagnosis, cost and stigma of wearing a hearing aid, and unhealthy lifestyle choices). In addition, biological causes of hearing loss and other sensory or communication disorders include: genetics; viral or bacterial infections; sensitivity to certain drugs or medications; injury; and aging.

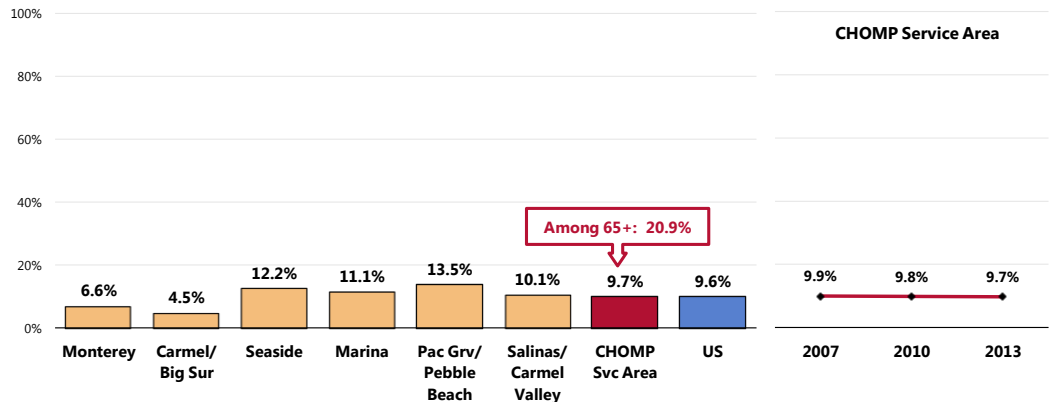
As the nation's population ages and survival rates for medically fragile infants and for people with severe injuries and acquired diseases improve, the prevalence of sensory and communication disorders is expected to rise.

– Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

### In all, 9.7% of CHOMP Service Area adults report being deaf or having difficulty hearing.

- Almost identical to that found nationwide.
- Favorably low in Monterey and Carmel/Big Sur.
- ☒ Unchanged over time.
- 👥 Among CHOMP Service Area adults age 65 and older, 20.9% have partial or complete hearing loss.

### Prevalence of Deafness/Trouble Hearing



Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 27]  
● 2011 PRC National Health Survey, Professional Research Consultants, Inc.  
Notes: ● Asked of all respondents.

# Environmental Health

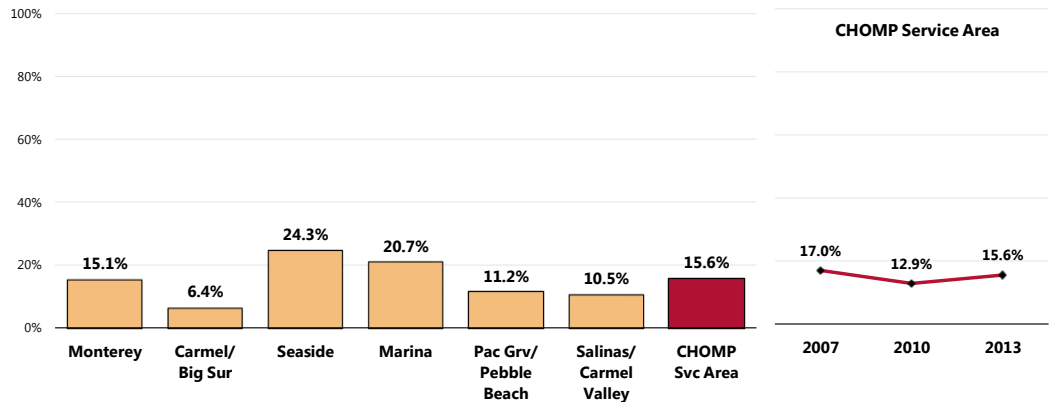
Things like dust, mold, smoke, and chemicals inside the home or office can cause poor indoor air quality. In the past 12 months, have you had an illness or symptom that you think was caused by something in the air inside a home, office, or other building?

## Indoor Air Pollution

A total of 15.6% of CHOMP Service Area adults report having an illness or symptoms in the past year believed to be caused by indoor air contaminants.

- Unfavorably high in Seaside; lowest in Carmel/Big Sur and Salinas/Carmel Valley.
- ☒ Statistically unchanged since 2007.

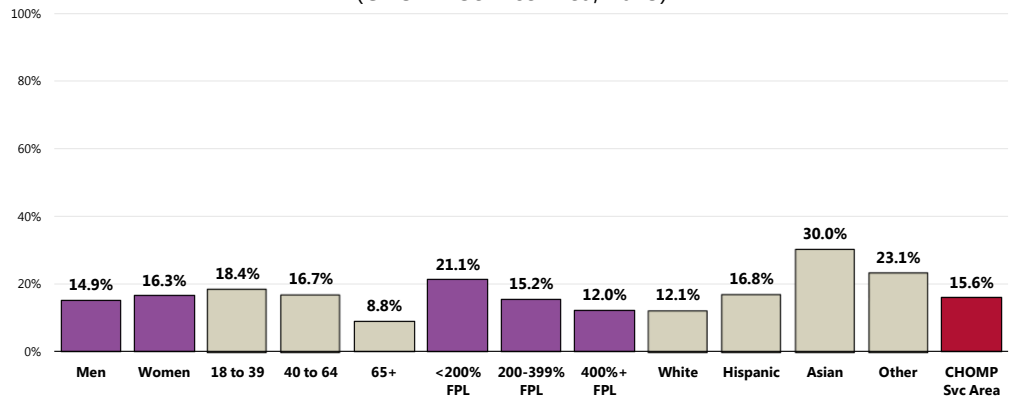
### Had an Illness or Symptoms in the Past Year Believed to be Caused by Indoor Air Contaminants



Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 52]  
 Notes: ● Asked of all respondents.

- ☺ A higher prevalence of indoor air illness is reported among adults under age 65, Asians, and "Other" race adults.
- ☺ Note also the negative correlation between income and indoor air-related illness or symptoms.

### Had an Illness or Symptoms in the Past Year Believed to be Caused by Indoor Air Contaminants (CHOMP Service Area, 2013)



Sources: ● 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 52]  
 Notes: ● Asked of all respondents.  
 ● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
 ● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "<200% FPL" includes households with incomes up to 199% of the federal poverty level; "200-399% FPL" includes households with incomes between 200% and 399% of the federal poverty level; and "400%+ FPL" includes those households with incomes at 400% or more the federal poverty level.

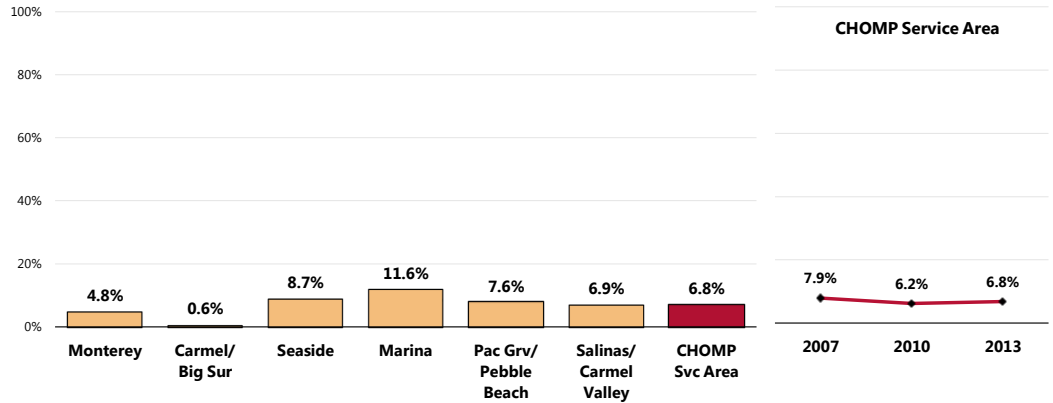
## Outdoor Air Pollution

Things like smog, automobile exhaust, and chemicals can cause outdoor pollution. In the past 12 months, have you had an illness or symptom that you think was caused by pollution in the air outdoors?

**Fewer residents (6.8%) report having an illness or symptoms in the past year believed to be caused by outdoor pollution.**

- Highest in Marina; lowest in Carmel/Big Sur.
- ☒ Statistically unchanged since 2007.

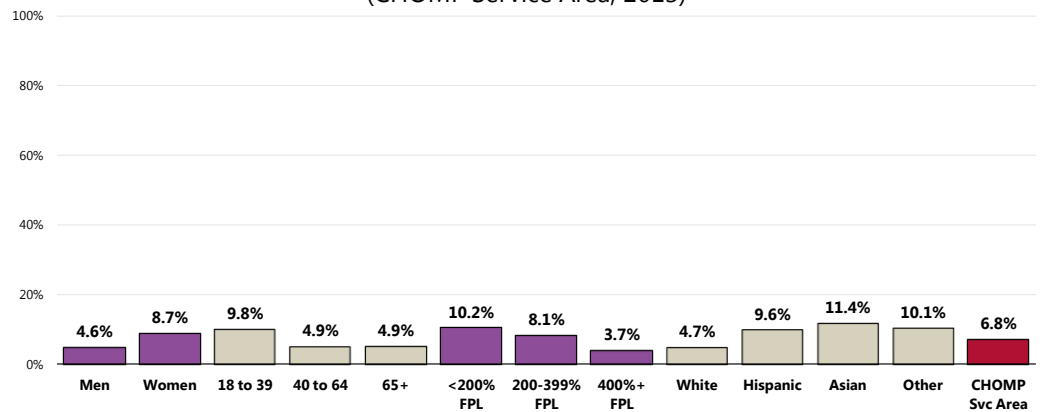
### Had an Illness or Symptoms in the Past Year Believed to be Caused by Outdoor Air Contaminants



Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 53]  
 Notes: ● Asked of all respondents.

- 👥 Adults more likely to report illness or symptoms related to outdoor air include women, young adults, and Non-White adults.
- 👥 Note also the negative correlation with income.

### Had an Illness or Symptoms in the Past Year Believed to be Caused by Outdoor Air Contaminants (CHOMP Service Area, 2013)



Sources: ● 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 53]  
 Notes: ● Asked of all respondents.  
 ● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
 ● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "<200% FPL" includes households with incomes up to 199% of the federal poverty level; "200-399% FPL" includes households with incomes between 200% and 399% of the federal poverty level; and "400%+ FPL" includes those households with incomes at 400% or more the federal poverty level.

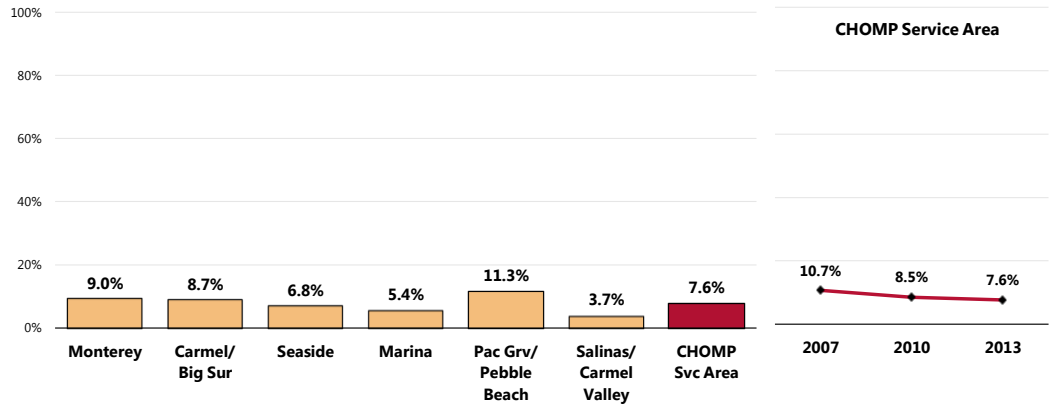


## Mold in the Home

Of survey respondents, 7.6% report having an area of mold in the home greater than the size of a dollar bill.

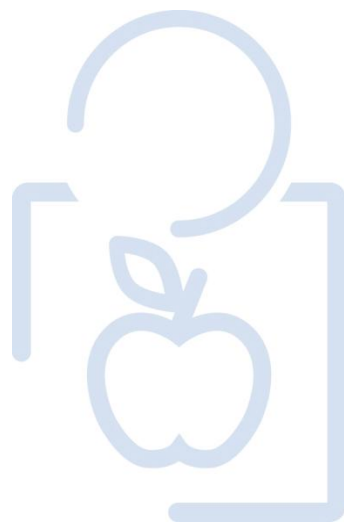
- Favorably low in Salinas/Carmel Valley.
- ▣ Marks a significant decrease over time.

### Have an Area of Mold in the Home Greater Than the Size of a Dollar Bill



Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 54]  
Notes: ● Asked of all respondents.

# INFECTIOUS DISEASE



# Vaccine-Preventable Conditions

The increase in life expectancy during the 20<sup>th</sup> century is largely due to improvements in child survival; this increase is associated with reductions in infectious disease mortality, due largely to immunization. However, infectious diseases remain a major cause of illness, disability, and death. Immunization recommendations in the United States currently target 17 vaccine-preventable diseases across the lifespan.

People in the US continue to get diseases that are vaccine-preventable. Viral hepatitis, influenza, and tuberculosis (TB) remain among the leading causes of illness and death across the nation and account for substantial spending on the related consequences of infection.

The infectious disease public health infrastructure, which carries out disease surveillance at the national, state, and local levels, is an essential tool in the fight against newly emerging and re-emerging infectious diseases. Other important defenses against infectious diseases include:

- Proper use of vaccines
- Antibiotics
- Screening and testing guidelines
- Scientific improvements in the diagnosis of infectious disease-related health concerns

Vaccines are among the most cost-effective clinical preventive services and are a core component of any preventive services package. Childhood immunization programs provide a very high return on investment. For example, for each birth cohort vaccinated with the routine immunization schedule, society:

- Saves 33,000 lives.
- Prevents 14 million cases of disease.
- Reduces direct healthcare costs by \$9.9 billion.
- Saves \$33.4 billion in indirect costs.

– Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

## Measles, Mumps, Rubella

**According to the California Department of Public Health, only one case of mumps was reported in Monterey County in 2012** (no cases of measles or rubella were reported between 2010 and 2012).

## Pertussis

**Between 2009 and 2011, the annual average pertussis incidence rate (new cases per year) was 14.3 cases per 100,000 population in Monterey County.**

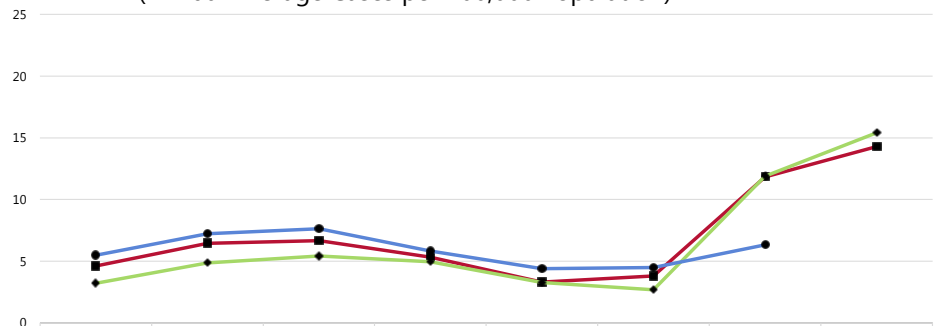
- Below the California incidence rate.
- Well above the national incidence rate for the latest (2008-2010) reporting period.
- ☒ Incidence has increased dramatically in recent years (since 2009), echoing the California trend.

"Incidence rate" or "case rate" is the number of new cases of a disease occurring during a given period of time.

It is usually expressed as cases per 100,000 population per year.

## Pertussis Incidence

(Annual Average Cases per 100,000 Population)



	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008	2007-2009	2008-2010	2009-2011
Monterey County	4.6	6.4	6.7	5.3	3.3	3.8	11.8	14.3
California	3.2	4.9	5.4	5.0	3.3	2.7	11.9	15.4
United States	5.5	7.2	7.6	5.8	4.4	4.5	6.3	

Sources: ● California Department of Public Health.  
 ● Centers for Disease Control and Prevention, National Center for Health Statistics.  
 Notes: ● Rates are annual average new cases per 100,000 population.

# Influenza & Pneumonia Vaccination

Acute respiratory infections, including pneumonia and influenza, are the 8th leading cause of death in the nation, accounting for 56,000 deaths annually. Pneumonia mortality in children fell by 97% in the last century, but respiratory infectious diseases continue to be leading causes of pediatric hospitalization and outpatient visits in the US. On average, influenza leads to more than 200,000 hospitalizations and 36,000 deaths each year. The 2009 H1N1 influenza pandemic caused an estimated 270,000 hospitalizations and 12,270 deaths (1,270 of which were of people younger than age 18) between April 2009 and March 2010.

– Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

## Flu Vaccinations

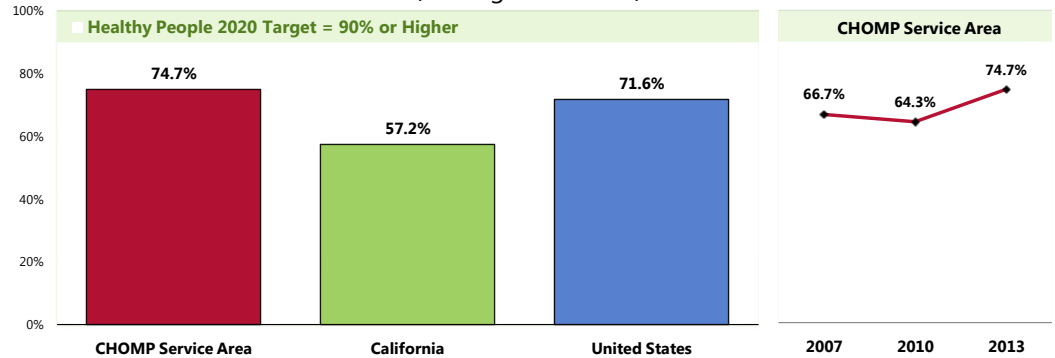
**Among CHOMP Service Area seniors, 74.7% received a flu shot (or FluMist®) within the past year.**

- Higher than the California finding.
- Comparable to the national finding.
- Fails to satisfy the Healthy People 2020 target (90% or higher).
- ☒ Marks a statistically significant increase since 2007.

FluMist® is a vaccine that is sprayed into the nose to help protect against influenza; it is an alternative to traditional flu shots.

### Have Had a Flu Vaccination in the Past Year

(Among Adults 65+)



Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 159]  
 ● 2011 PRC National Health Survey, Professional Research Consultants, Inc.  
 ● Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2011 California data.  
 ● US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective IID-12.7]  
 Notes: ● Reflects respondents 65 and older.  
 ● Includes FluMist as a form of vaccination.

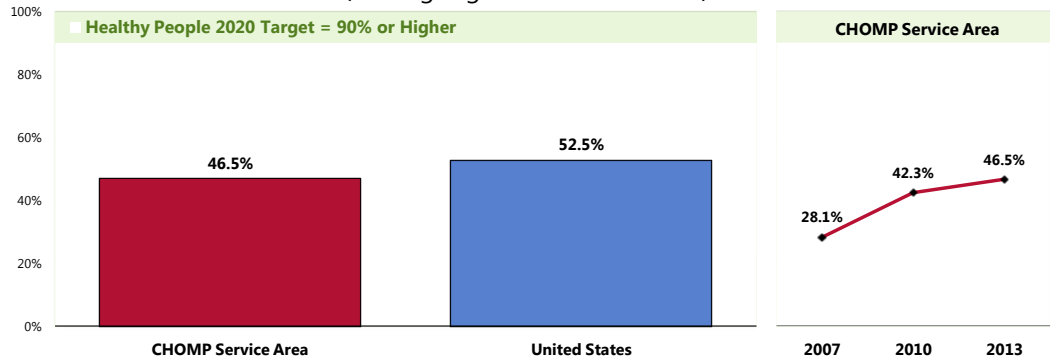
## High-Risk Adults

**A total of 46.5% of high-risk adults age 18 to 64 received a flu vaccination (flu shot or FluMist®) within the past year.**

- Similar to national findings.
- Far from satisfying the Healthy People 2020 target (90% or higher).
- ☒ Marks a statistically significant increase over time.

“High-risk” includes adults who report having been diagnosed with heart disease, diabetes or respiratory disease.

## Have Had a Flu Vaccination in the Past Year (Among High-Risk Adults 18-64)



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 160]  
 • 2011 PRC National Health Survey, Professional Research Consultants, Inc.  
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective IID-12.6]

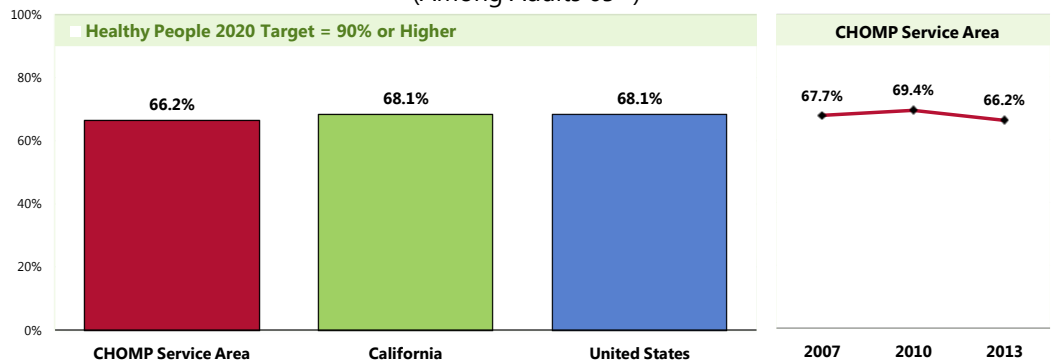
Notes: • Reflects high-risk respondents age 18-64.  
 • "High-Risk" includes adults age 18 to 64 who have been diagnosed with heart disease, diabetes or respiratory disease.  
 • Includes FluMist as a form of vaccination.

## Pneumonia Vaccination

**Among adults age 65 and older, 66.2% have received a pneumonia vaccination at some point in their lives.**

- Similar to the California finding.
- Similar to the national finding.
- Fails to satisfy the Healthy People 2020 target of 90% or higher.
- ☒ Statistically unchanged over time.

## Have Ever Had a Pneumonia Vaccine (Among Adults 65+)



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 161]  
 • 2011 PRC National Health Survey, Professional Research Consultants, Inc.  
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2011 California data.  
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective IID-13.1]

Notes: • Reflects respondents 65 and older.

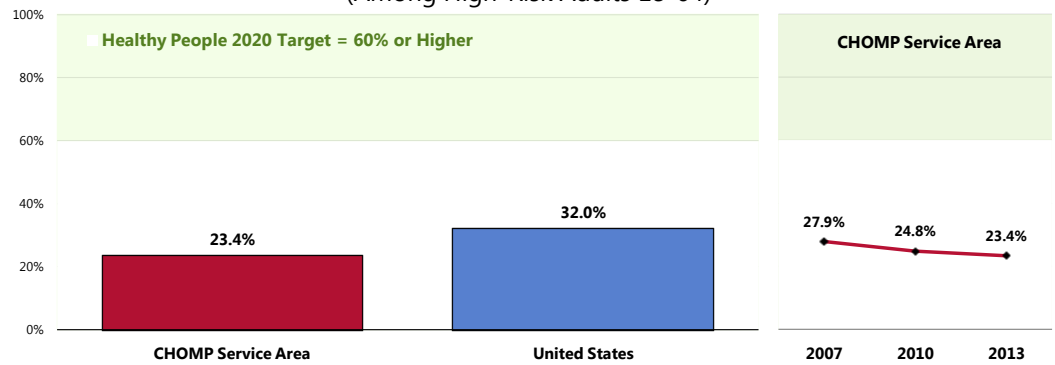
## High-Risk Adults

“High-risk” includes adults who report having been diagnosed with heart disease, diabetes or respiratory disease.

**A total of 23.4% of high-risk adults age 18 to 64 have ever received a pneumonia vaccination.**

- Comparable to national findings.
- Fails to satisfy the Healthy People 2020 target (60% or higher).
- ☒ The decrease over time is not statistically significant.

### Have Ever Had a Pneumonia Vaccine (Among High-Risk Adults 18-64)



Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 162]  
● 2011 PRC National Health Survey, Professional Research Consultants, Inc.  
● US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective IID-13.2]  
Notes: ● Asked of all high-risk respondents under 65.  
● “High-Risk” includes adults age 18 to 64 who have been diagnosed with heart disease, diabetes or respiratory disease.

# Tuberculosis

Viral hepatitis and tuberculosis (TB) can be prevented, yet healthcare systems often do not make the best use of their available resources to support prevention efforts. Because the US healthcare system focuses on treatment of illnesses, rather than health promotion, patients do not always receive information about prevention and healthy lifestyles. This includes advancing effective and evidence-based viral hepatitis and TB prevention priorities and interventions.

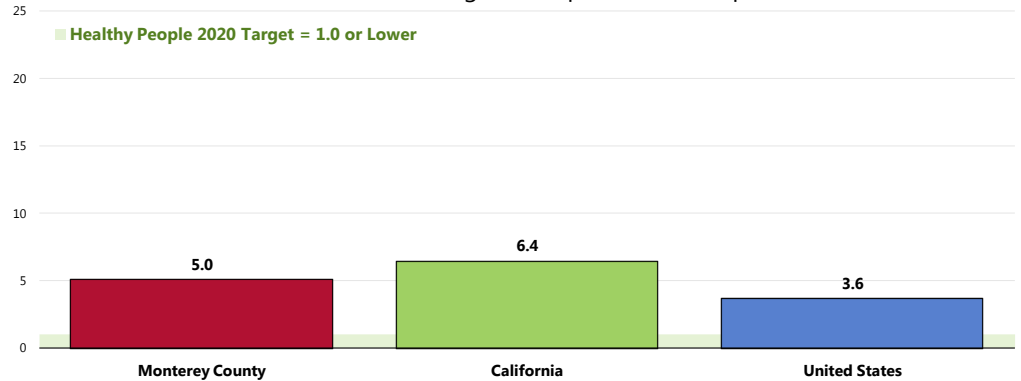
– Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

**Between 2009 and 2011, the annual average tuberculosis incidence rate (new cases per year) was 5.0 cases per 100,000 population in Monterey County.**

- Below the California incidence rate.
- Above the national incidence rate.
- Fails to satisfy the Healthy People 2020 target (1.0 or lower).

## Tuberculosis Incidence

(2009-2011 Annual Average Cases per 100,000 Population)



Sources:
 

- California Department of Public Health.
- US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective IID-29]
- Centers for Disease Control and Prevention, Division of Public Health Surveillance and Informatics. Epidemiology Program Office.

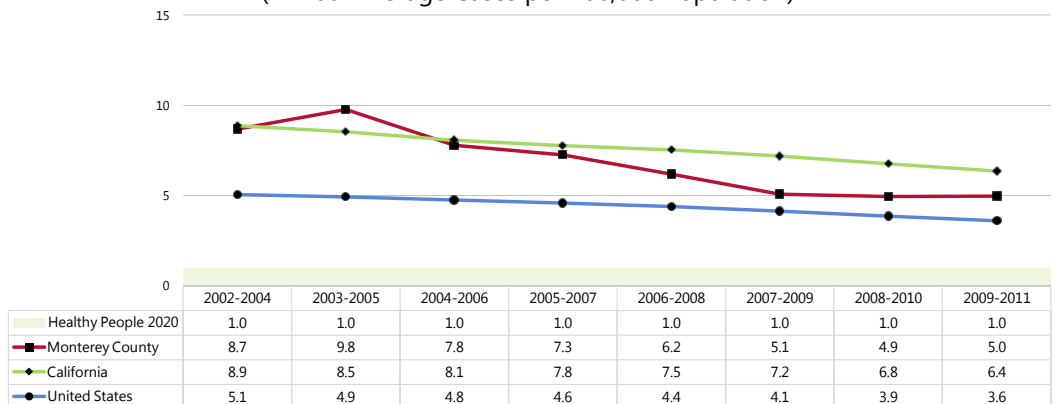
 Notes:
 

- Rates are annual average new cases per 100,000 population.

Tuberculosis incidence has decreased over the past decade.

## Tuberculosis Incidence

(Annual Average Cases per 100,000 Population)



Sources:
 

- California Department of Public Health.
- US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective IID-29]
- Centers for Disease Control and Prevention, Division of Public Health Surveillance and Informatics. Epidemiology Program Office.

 Notes:
 

- Rates are annual average new cases per 100,000 population.



# HIV

The HIV epidemic in the United States continues to be a major public health crisis. An estimated 1.1 million Americans are living with HIV, and 1 in 5 people with HIV do not know they have it. HIV continues to spread, leading to about 56,000 new HIV infections each year.

HIV is a preventable disease, and effective HIV prevention interventions have been proven to reduce HIV transmission. People who get tested for HIV and learn that they are infected can make significant behavior changes to improve their health and reduce the risk of transmitting HIV to their sex or drug-using partners. More than 50% of new HIV infections occur as a result of the 21% of people who have HIV but do not know it.

In the era of increasingly effective treatments for HIV, people with HIV are living longer, healthier, and more productive lives. Deaths from HIV infection have greatly declined in the United States since the 1990s. As the number of people living with HIV grows, it will be more important than ever to increase national HIV prevention and healthcare programs.

There are gender, race, and ethnicity disparities in new HIV infections:

- Nearly 75% of new HIV infections occur in men.
- More than half occur in gay and bisexual men, regardless of race or ethnicity.
- 45% of new HIV infections occur in African Americans, 35% in whites, and 17% in Hispanics.

Improving access to quality healthcare for populations disproportionately affected by HIV, such as persons of color and gay and bisexual men, is a fundamental public health strategy for HIV prevention. People getting care for HIV can receive:

- Antiretroviral therapy
- Screening and treatment for other diseases (such as sexually transmitted infections)
- HIV prevention interventions
- Mental health services
- Other health services

As the number of people living with HIV increases and more people become aware of their HIV status, prevention strategies that are targeted specifically for HIV-infected people are becoming more important. Prevention work with people living with HIV focuses on:

- Linking to and staying in treatment.
- Increasing the availability of ongoing HIV prevention interventions.
- Providing prevention services for their partners.

Public perception in the US about the seriousness of the HIV epidemic has declined in recent years. There is evidence that risky behaviors may be increasing among uninfected people, especially gay and bisexual men. Ongoing media and social campaigns for the general public and HIV prevention interventions for uninfected persons who engage in risky behaviors are critical.

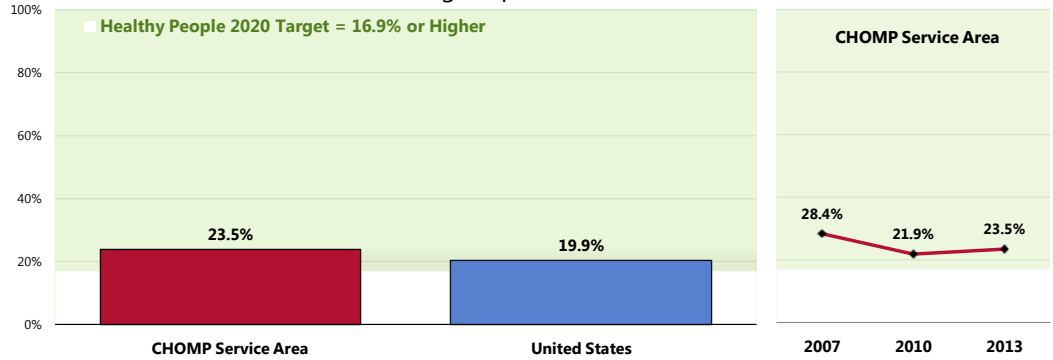
– Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

## HIV Testing

**Among CHOMP Service Area adults age 18-44, 23.5% report that they have been tested for human immunodeficiency virus (HIV) in the past year.**

- Similar to the proportion found nationwide.
- Satisfies the Healthy People 2020 target of 16.9% or higher.
- ☒ Testing has remained stable since 2007.

## Tested for HIV in the Past Year (Among Respondents 18-44)



Sources: 

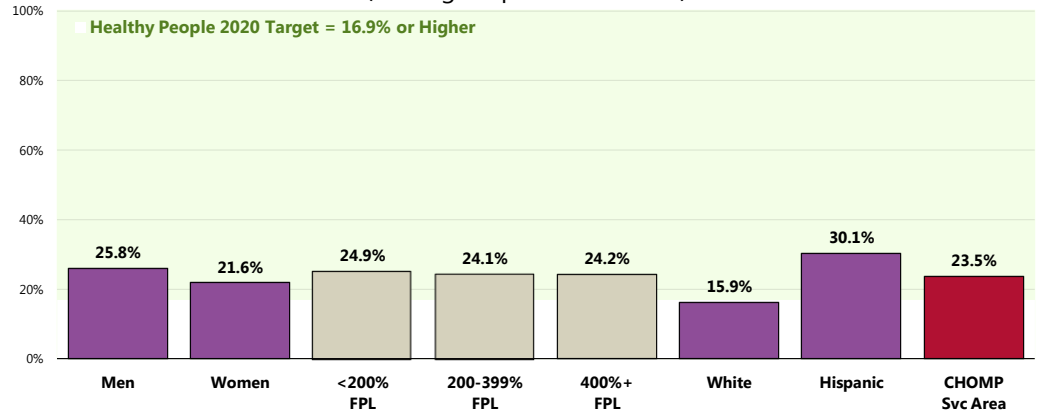
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 165]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective HIV-14.1]

Notes: 

- Reflects respondents age 18 to 44.
- Note that the Healthy People 2020 objective is for ages 15-44.

👤 Hispanics (age 18-44) more often report having been tested for HIV.

## Tested for HIV in the Past Year (Among Respondents 18-44)



Sources: 

- 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 165]
- US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective HIV-14.1]

Notes: 

- Reflects respondents age 18 to 44.
- Note that the Healthy People 2020 objective is for ages 15-44.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "<200% FPL" includes households with incomes up to 199% of the federal poverty level, "200-399% FPL" includes households with incomes between 200% and 399% of the federal poverty level, and "400%+ FPL" includes those households with incomes at 400% or more the federal poverty level.

# Sexually Transmitted Diseases

STDs refer to more than 25 infectious organisms that are transmitted primarily through sexual activity. Despite their burdens, costs, and complications, and the fact that they are largely preventable, STDs remain a significant public health problem in the United States. This problem is largely unrecognized by the public, policymakers, and health care professionals. STDs cause many harmful, often irreversible, and costly clinical complications, such as: reproductive health problems; fetal and perinatal health problems; cancer; and facilitation of the sexual transmission of HIV infection.

The Centers for Disease Control and Prevention (CDC) estimates that there are approximately 19 million new STD infections each year—almost half of them among young people ages 15 to 24. Because many cases of STDs go undiagnosed—and some common viral infections, such as human papillomavirus (HPV) and genital herpes, are not reported to CDC at all—the reported cases of chlamydia, gonorrhea, and syphilis represent only a fraction of the true burden of STDs in the US. Untreated STDs can lead to serious long-term health consequences, especially for adolescent girls and young women. CDC estimates that undiagnosed and untreated STDs cause at least 24,000 women in the United States each year to become infertile. Several factors contribute to the spread of STDs.

**Biological Factors.** STDs are acquired during unprotected sex with an infected partner. Biological factors that affect the spread of STDs include:

- **Asymptomatic nature of STDs.** The majority of STDs either do not produce any symptoms or signs, or they produce symptoms so mild that they are unnoticed; consequently, many infected persons do not know that they need medical care.
- **Gender disparities.** Women suffer more frequent and more serious STD complications than men do. Among the most serious STD complications are pelvic inflammatory disease, ectopic pregnancy (pregnancy outside of the uterus), infertility, and chronic pelvic pain.
- **Age disparities.** Compared to older adults, sexually active adolescents ages 15 to 19 and young adults ages 20 to 24 are at higher risk for getting STDs.
- **Lag time between infection and complications.** Often, a long interval, sometimes years, occurs between acquiring an STD and recognizing a clinically significant health problem.

**Social, Economic and Behavioral Factors.** The spread of STDs is directly affected by social, economic, and behavioral factors. Such factors may cause serious obstacles to STD prevention due to their influence on social and sexual networks, access to and provision of care, willingness to seek care, and social norms regarding sex and sexuality. Among certain vulnerable populations, historical experience with segregation and discrimination exacerbates these factors. Social, economic, and behavioral factors that affect the spread of STDs include:

- **Racial and ethnic disparities.** Certain racial and ethnic groups (mainly African American, Hispanic, and American Indian/Alaska Native populations) have high rates of STDs, compared with rates for whites.
- **Poverty and marginalization.** STDs disproportionately affect disenfranchised people and people in social networks where high-risk sexual behavior is common, and access to care or health-seeking behavior is compromised.
- **Access to health care.** Access to high-quality health care is essential for early detection, treatment, and behavior-change counseling for STDs. Groups with the highest rates of STDs are often the same groups for whom access to or use of health services is most limited.
- **Substance abuse.** Many studies document the association of substance abuse with STDs. The introduction of new illicit substances into communities often can alter sexual behavior drastically in high-risk sexual networks, leading to the epidemic spread of STDs.
- **Sexuality and secrecy.** Perhaps the most important social factors contributing to the spread of STDs in the United States are the stigma associated with STDs and the general discomfort of discussing intimate aspects of life, especially those related to sex. These social factors separate the United States from industrialized countries with low rates of STDs.
- **Sexual networks.** Sexual networks refer to groups of people who can be considered “linked” by sequential or concurrent sexual partners. A person may have only 1 sex partner, but if that partner is a member of a risky sexual network, that person is at higher risk for STDs than an individual from a nonrisky network.

– Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

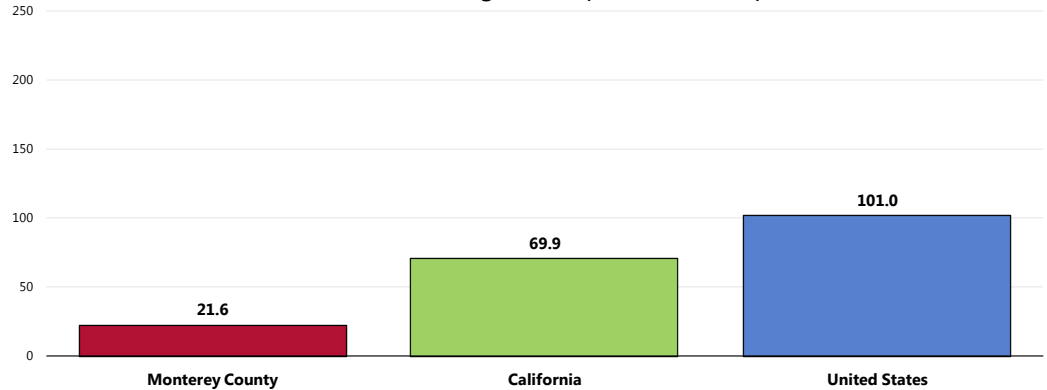
## Gonorrhea

Between 2009 and 2011, the annual average gonorrhea incidence rate was 21.6 cases per 100,000 population in Monterey County.

- Much lower than the California incidence rate.
- Notably lower than the national incidence rate.


### Gonorrhea Incidence

(2009-2011 Annual Average Cases per 100,000 Population)



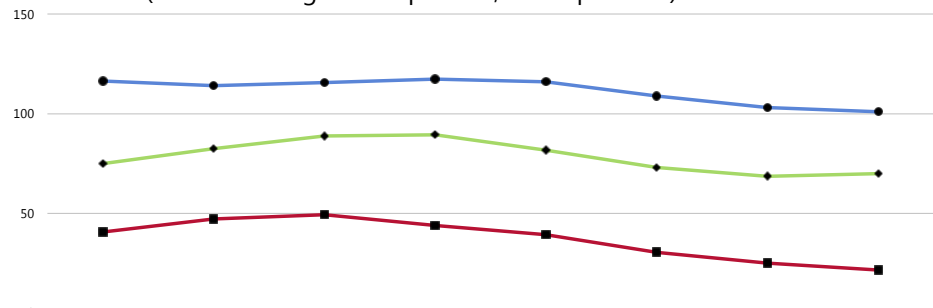
Sources: • California Department of Public Health.  
• Centers for Disease Control and Prevention, National Center for Health Statistics.

Notes: • Rates are annual average new cases per 100,000 population.

 The gonorrhea incidence rate decreased over the past decade in Monterey County, similar to the statewide and national trends.

### Gonorrhea Incidence

(Annual Average Cases per 100,000 Population)



Sources: • California Department of Public Health.  
• Centers for Disease Control and Prevention, National Center for Health Statistics.

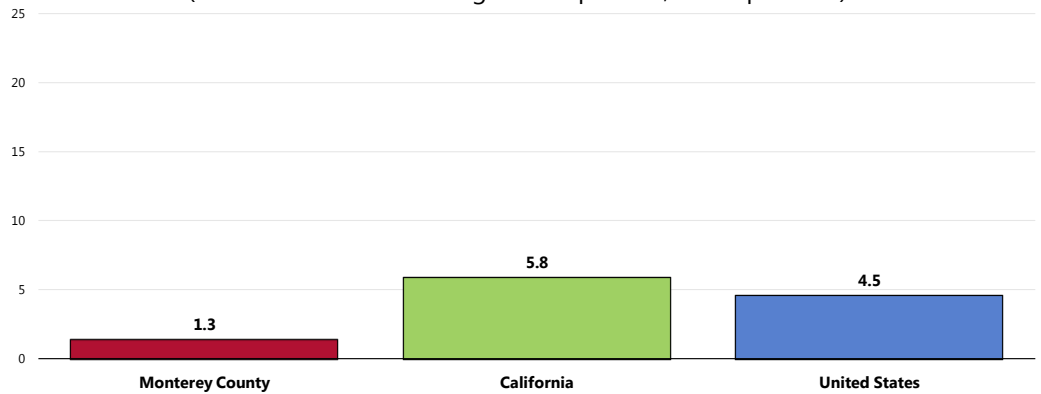
Notes: • Rates are annual average new cases per 100,000 population.

# Syphilis

Between 2009 and 2011, the annual average primary/secondary syphilis incidence rate was 1.3 cases per 100,000 population in Monterey County.

- Much lower than the California incidence rate.
- Much lower than the national incidence rate.

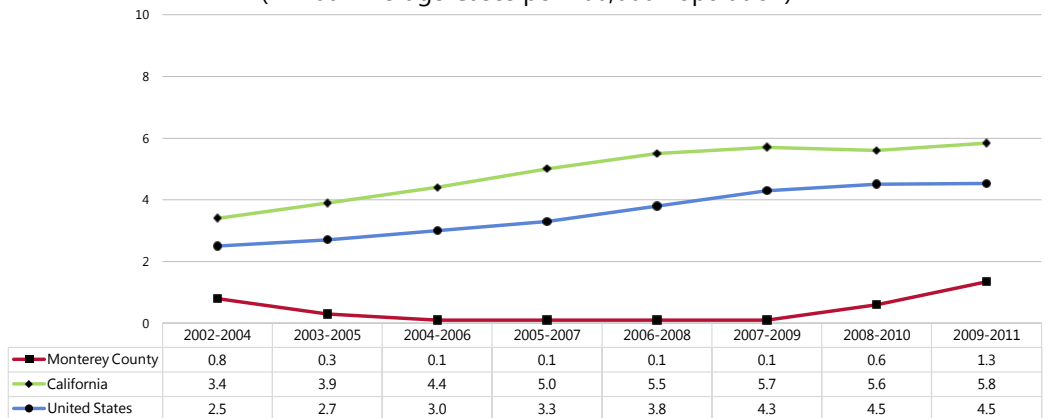
**Primary/Secondary Syphilis Incidence**  
(2009-2011 Annual Average Cases per 100,000 Population)



Sources: • California Department of Public Health.  
• Centers for Disease Control and Prevention, National Center for Health Statistics.  
Notes: • Rates are annual average new cases per 100,000 population.

⊠ Although remaining well below rising state and national trends, syphilis incidence has increased overall in Monterey County over the past decade.

**Primary/Secondary Syphilis Incidence**  
(Annual Average Cases per 100,000 Population)

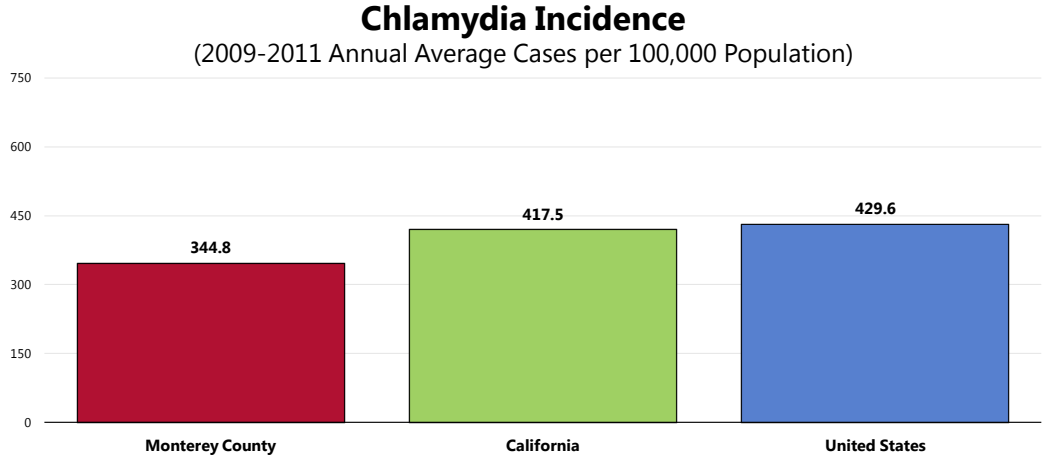


Sources: • California Department of Public Health.  
• Centers for Disease Control and Prevention, National Center for Health Statistics.  
Notes: • Rates are annual average new cases per 100,000 population.

# Chlamydia

Between 2009 and 2011, the annual average chlamydia incidence rate was 344.8 cases per 100,000 population in Monterey County.

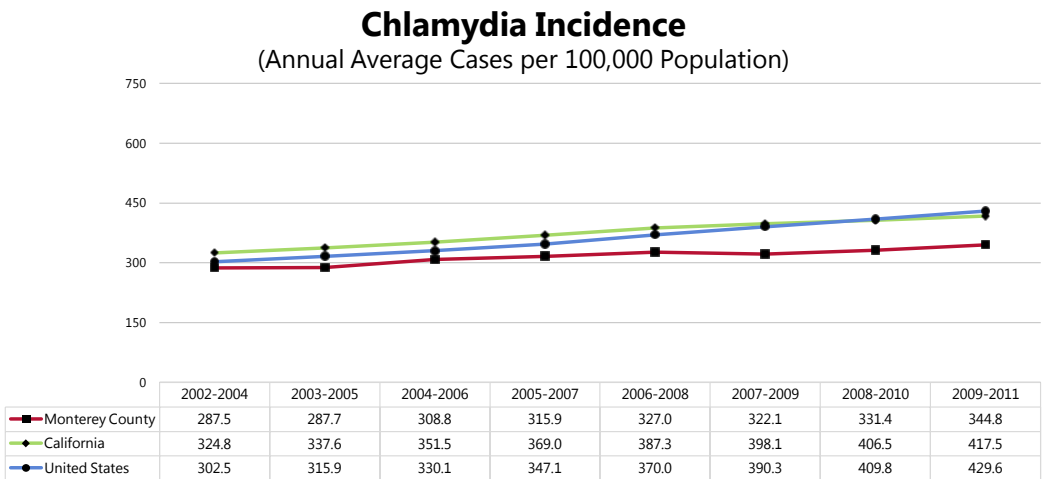
- Below the California incidence rate.
- Below the national incidence rate.



Sources: • California Department of Public Health.  
• Centers for Disease Control and Prevention, National Center for Health Statistics.

Notes: • Rates are annual average new cases per 100,000 population.

☒ Chlamydia incidence increased over the past decade in the county, as did the state and national incidence rates (albeit more steadily).



Sources: • California Department of Public Health.  
• Centers for Disease Control and Prevention, National Center for Health Statistics.

Notes: • Rates are annual average new cases per 100,000 population.

# Acute Hepatitis B

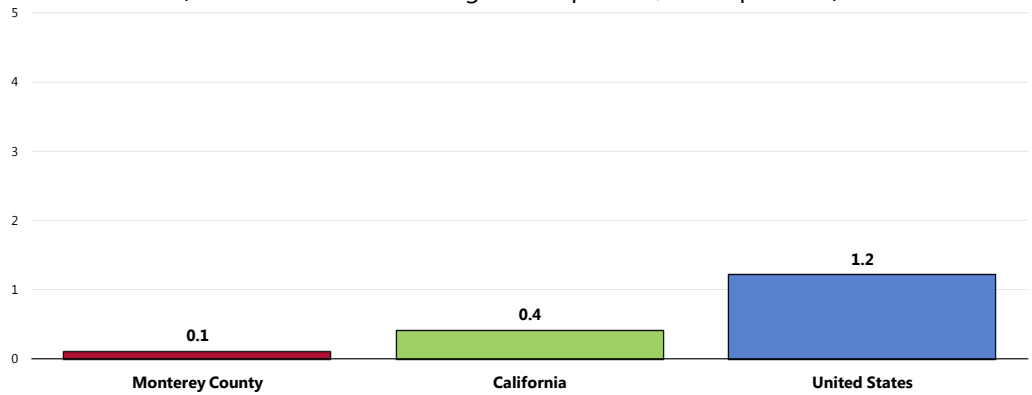
## Hepatitis B Incidence

Between 2010 and 2012, the hepatitis B incidence rate in Monterey County was just 0.1 cases per 100,000 population.

- More favorable than the statewide rate.
- Much more favorable than the national rate.

### Hepatitis B (Acute) Incidence

(2010-2012 Annual Average Cases per 100,000 Population)

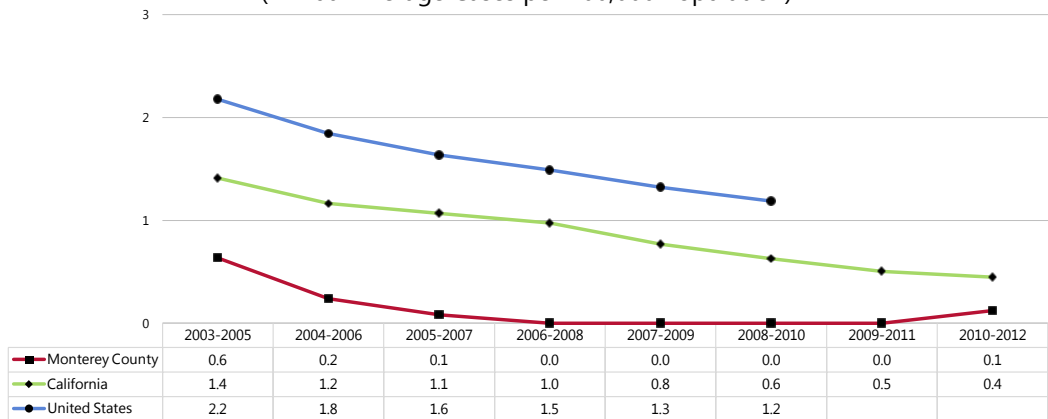


Sources: • California Department of Public Health.  
 • Centers for Disease Control and Prevention, National Center for Health Statistics.  
 Notes: • Rates are annual average new cases per 100,000 population.  
 • US rate represents 2008-2010 data.

Local incidence decreased overall in the past decade, echoing the downward trend reported both statewide and nationwide.

### Hepatitis B (Acute) Incidence

(Annual Average Cases per 100,000 Population)



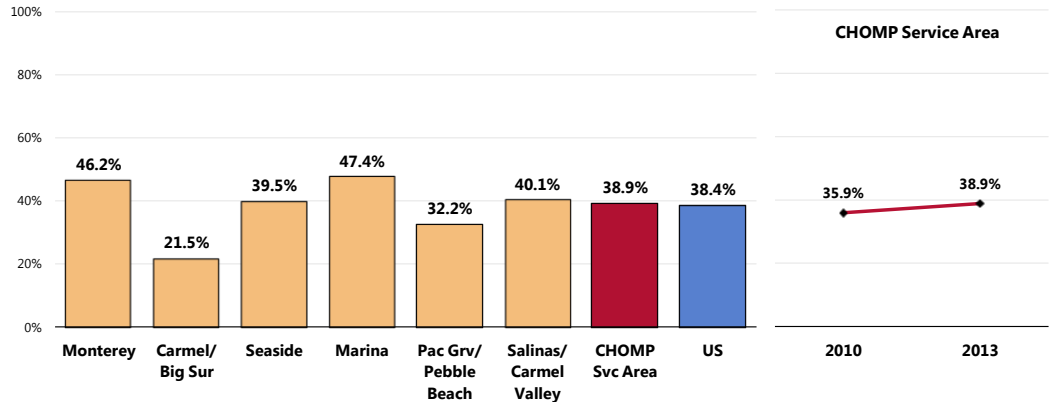
Sources: • California Department of Public Health.  
 • Centers for Disease Control and Prevention, National Center for Health Statistics.  
 Notes: • Rates are annual average new cases per 100,000 population.

## Hepatitis B Vaccination

Based on survey data, nearly 4 in 10 residents (38.9%) report having received the hepatitis B vaccine.

- Similar to what is reported nationwide.
- Lowest in Carmel/Big Sur; highest in Monterey and Marina.
- ☒ Statistically unchanged from 2010 survey results.

### Have Ever Received the Hepatitis B Vaccination

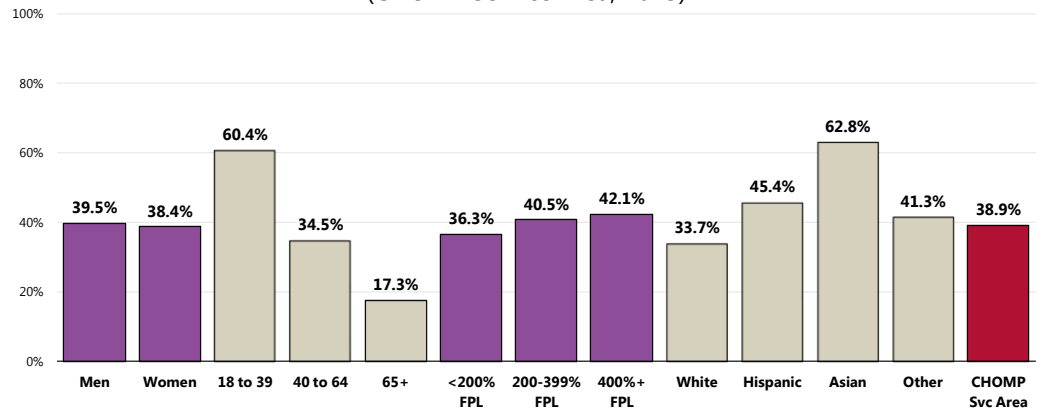


Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 79]  
 • 2011 PRC National Health Survey, Professional Research Consultants, Inc.  
 Notes: • Asked of all respondents.

- 👥 Note the negative correlation between age and hepatitis B vaccination.
- 👥 In addition, Whites and "Other" race adults are less likely to have received the hepatitis B vaccination.

### Have Ever Received the Hepatitis B Vaccination

(CHOMP Service Area, 2013)



Sources: • 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 79]  
 Notes: • Asked of all respondents.  
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "<200% FPL" includes households with incomes up to 199% of the federal poverty level; "200-399% FPL" includes households with incomes between 200% and 399% of the federal poverty level; and "400%+ FPL" includes those households with incomes at 400% or more the federal poverty level.



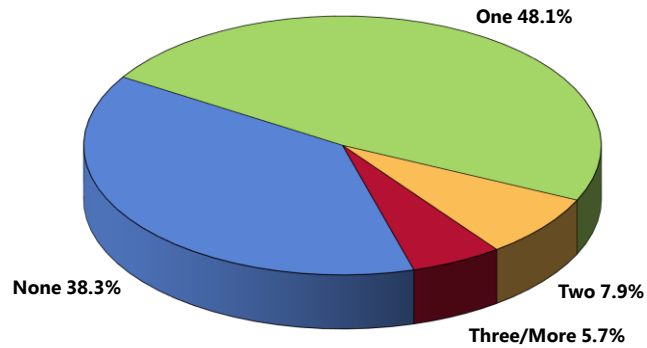
## Safe Sexual Practices

### Sexual Partners

Among unmarried CHOMP Service Area adults under age 65, the vast majority cites having one (48.1%) or no (38.3%) sexual partners in the past 12 months.

### Number of Sexual Partners in Past 12 Months

(Among Unmarried Adults 18-64; CHOMP Service Area, 2013)



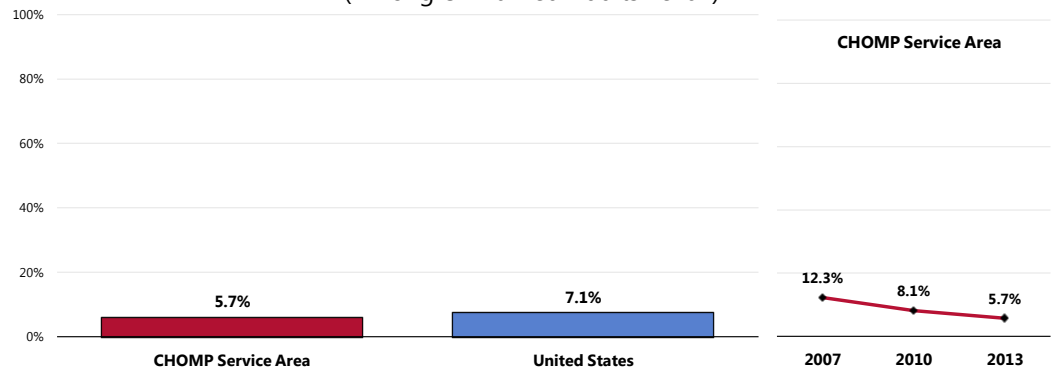
Sources: • 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 99]  
Notes: • Asked of all unmarried respondents under the age of 65.

However, 5.7% report three or more sexual partners in the past year.

- Comparable to that reported nationally.
- ▣ Marks a statistically significant decrease over time.

### Had Three or More Sexual Partners in the Past Year

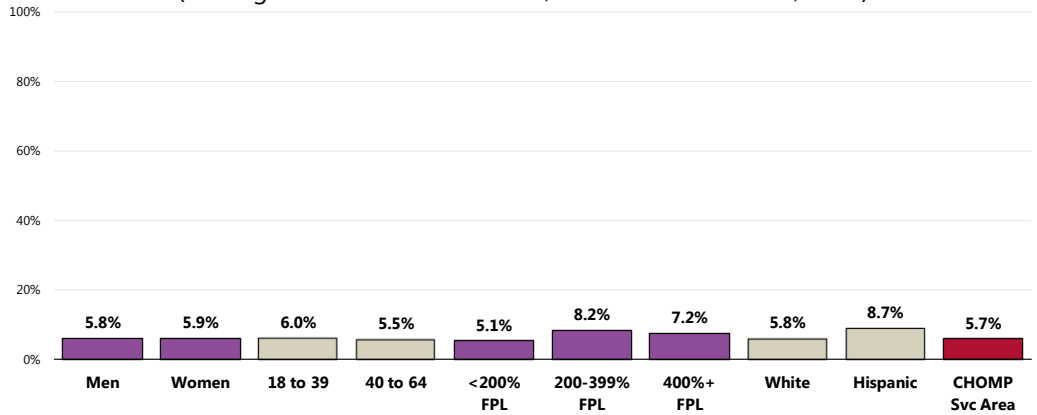
(Among Unmarried Adults 18-64)



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 99]  
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.  
Notes: • Asked of all unmarried respondents under the age of 65.

👤 No significant difference by key demographic characteristics.

### Had Three or More Sexual Partners in the Past Year (Among Unmarried Adults 18-64; CHOMP Service Area, 2013)



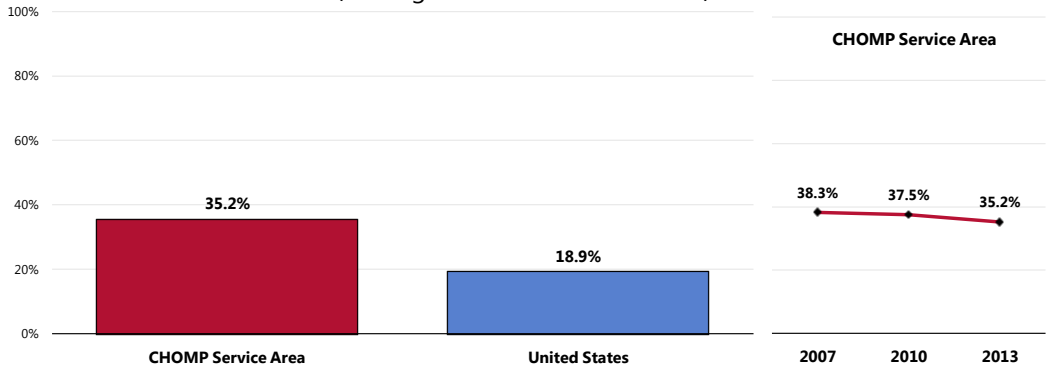
Sources: • 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 99]  
 Notes: • Asked of all unmarried respondents under the age of 65.  
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "<200% FPL" includes households with incomes up to 199% of the federal poverty level; "200-399% FPL" includes households with incomes between 200% and 399% of the federal poverty level; and "400%+ FPL" includes those households with incomes at 400% or more the federal poverty level.

### Condom Use

Among CHOMP Service Area adults who are under age 65 and unmarried, 35.2% report that a condom was used during their last sexual intercourse.

- Much higher than national findings.
- 📊 Statistically unchanged since 2007.

### Condom Was Used During Last Sexual Intercourse (Among Unmarried Adults 18-64)

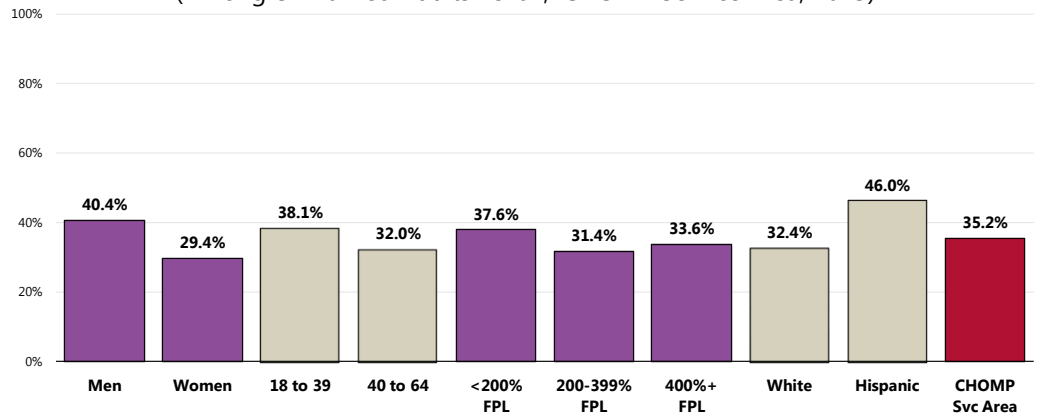


Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 100]  
 • 2011 PRC National Health Survey, Professional Research Consultants, Inc.  
 Notes: • Asked of all unmarried respondents under the age of 65.

Those more likely to report that a condom was used during their last sexual intercourse include:

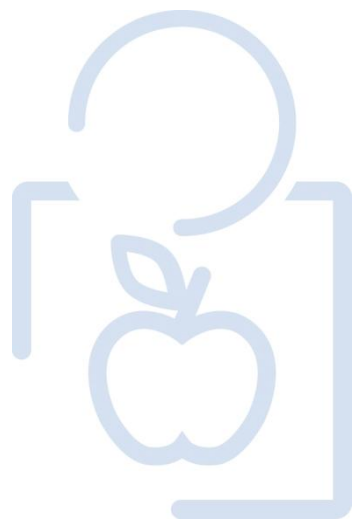
- Men.
- Young adults.
- Hispanic adults.

### Condom Was Used During Last Sexual Intercourse (Among Unmarried Adults 18-64; CHOMP Service Area, 2013)



Sources: • 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 100]  
Notes: • Asked of all unmarried respondents under the age of 65.  
• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "<200% FPL" includes households with incomes up to 199% of the federal poverty level; "200-399% FPL" includes households with incomes between 200% and 399% of the federal poverty level; and "400%+ FPL" includes those households with incomes at 400% or more the federal poverty level.

# BIRTHS



# Prenatal Care

Improving the well-being of mothers, infants, and children is an important public health goal for the US. Their well-being determines the health of the next generation and can help predict future public health challenges for families, communities, and the healthcare system. The risk of maternal and infant mortality and pregnancy-related complications can be reduced by increasing access to quality preconception (before pregnancy) and inter-conception (between pregnancies) care. Moreover, healthy birth outcomes and early identification and treatment of health conditions among infants can prevent death or disability and enable children to reach their full potential. Many factors can affect pregnancy and childbirth, including pre-conception health status, age, access to appropriate healthcare, and poverty.

Infant and child health are similarly influenced by socio-demographic factors, such as family income, but are also linked to the physical and mental health of parents and caregivers. There are racial and ethnic disparities in mortality and morbidity for mothers and children, particularly for African Americans. These differences are likely the result of many factors, including social determinants (such as racial and ethnic disparities in infant mortality; family income; educational attainment among household members; and health insurance coverage) and physical determinants (i.e., the health, nutrition, and behaviors of the mother during pregnancy and early childhood).

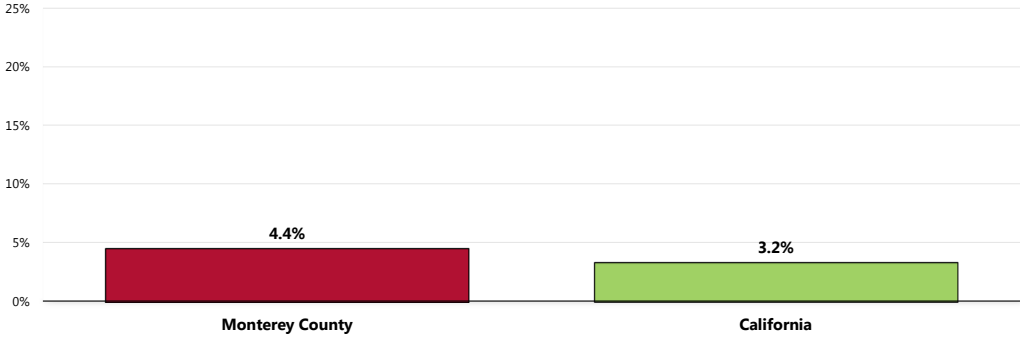
– Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

**Between 2008 and 2010, 4.4% of all Monterey County births received late or no prenatal care** (i.e., received prenatal care during the third trimester of pregnancy or not at all).

- Less favorable than the California proportion.

Early and continuous prenatal care is the best assurance of infant health.

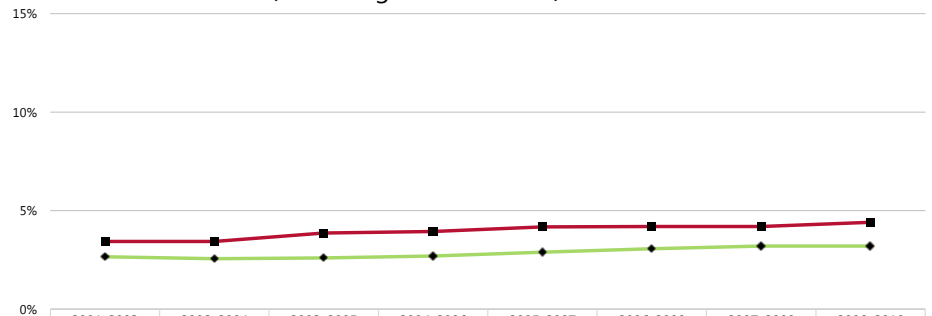
**Late or No Prenatal Care**  
(Percentage of Live Births, 2008-2010)



Sources: • California Department of Public Health.  
Note: • Numbers are a percentage of all live births within each population.  
• Defined as prenatal care received during the third trimester of pregnancy or not at all.

☒ The prevalence of late or no prenatal care has increased somewhat in the past decade, both in Monterey County and throughout California.

### Late or No Prenatal Care (Percentage of Live Births)



	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008	2007-2009	2008-2010
■ Monterey County	3.4%	3.4%	3.9%	3.9%	4.2%	4.2%	4.2%	4.4%
◆ California	2.7%	2.6%	2.6%	2.7%	2.9%	3.1%	3.2%	3.2%

Sources: ● California Department of Public Health.  
 Note: ● Numbers are a percentage of all live births within each population.  
 ● Defined as prenatal care received during the third trimester of pregnancy or not at all.

# Birth Outcomes & Risks

## Low-Weight Births

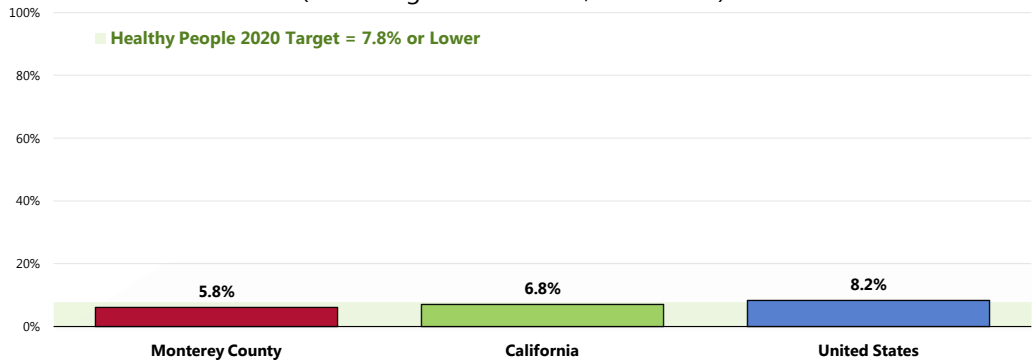
Low birthweight babies, those who weigh less than 2,500 grams (5 pounds, 8 ounces) at birth, are much more prone to illness and neonatal death than are babies of normal birthweight.

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

**A total of 5.8% of 2008-2010 Monterey County births were low-weight.**

- Better than the California proportion.
- Better than the national proportion.
- Satisfies the Healthy People 2020 target (7.8% or lower).

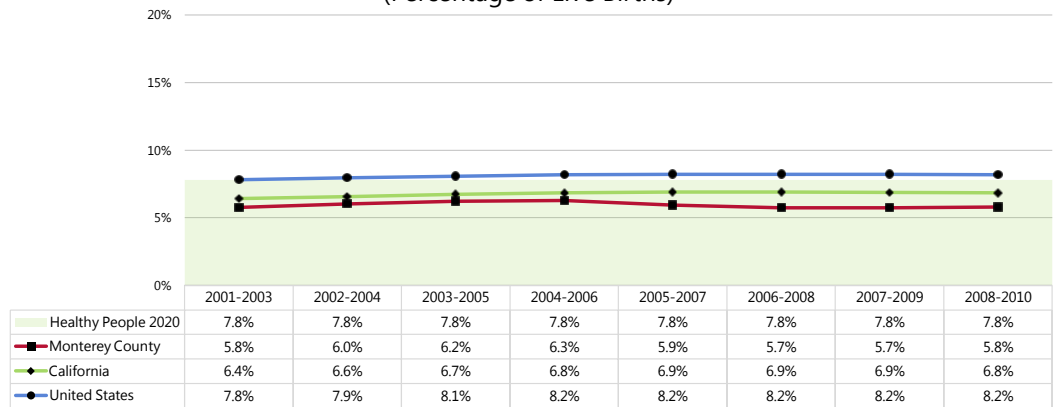
**Low-Weight Births**  
(Percentage of Live Births, 2008-2010)



Sources: • California Department of Public Health.  
• Centers for Disease Control and Prevention, National Vital Statistics System.  
• US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective MICH-8.1]  
Note: • Numbers are a percentage of all live births within each population.  
• Defined as an infant born weighing less than 5.5 pounds (2,500 grams) regardless of gestational age.

☒ The proportion of low-weight births has been relatively stable in Monterey County over the past decade; the proportion increased slightly both statewide and nationwide during this time.

**Low-Weight Births**  
(Percentage of Live Births)



Sources: • California Department of Public Health.  
• Centers for Disease Control and Prevention, National Vital Statistics System.  
• US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective MICH-8.1]  
Note: • Numbers are a percentage of all live births within each population.  
• Defined as an infant born weighing less than 5.5 pounds (2,500 grams) regardless of gestational age.

## Infant Mortality

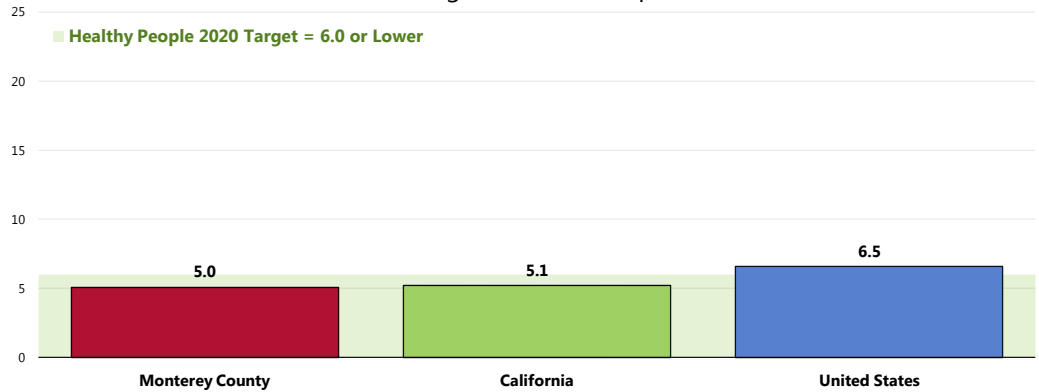
Infant mortality rates reflect deaths of children less than one year old per 1,000 live births.

**Between 2008 and 2010, there was an annual average of 5.0 infant deaths per 1,000 live births.**

- Comparable to the California rate.
- More favorable than the national rate.
- Satisfies the Healthy People 2020 target of 6.0 per 1,000 live births.

### Infant Mortality Rate

(2008-2010 Annual Average Infant Deaths per 1,000 Live Births)

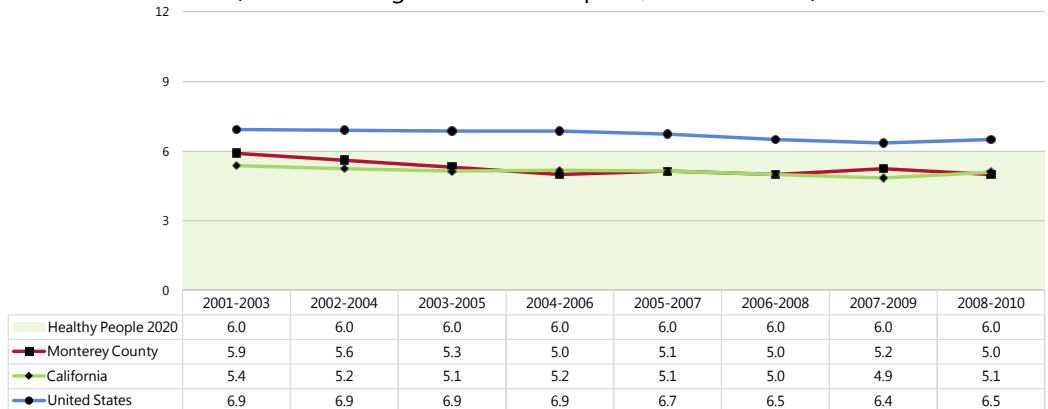


Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2013.  
 • Centers for Disease Control and Prevention, National Center for Health Statistics.  
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective MICH-1.3]  
 Notes: • Rates are three-year averages of deaths of children under 1 year old per 1,000 live births.

☒ Infant mortality has decreased slightly over the past decade.

### Infant Mortality Rate

(Annual Average Infant Deaths per 1,000 Live Births)



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2013.  
 • Centers for Disease Control and Prevention, National Center for Health Statistics.  
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective MICH-1.3]  
 Notes: • Rates are three-year averages of deaths of children under 1 year old per 1,000 live births.



# Family Planning

Family planning is one of the 10 great public health achievements of the 20<sup>th</sup> century. The availability of family planning services allows individuals to achieve desired birth spacing and family size and contributes to improved health outcomes for infants, children, and women. Family planning services include contraceptive and broader reproductive health services (patient education and counseling), breast and pelvic examinations, breast and cervical cancer screening, sexually transmitted infection (STI) and HIV prevention education/counseling/testing/referral, and pregnancy diagnosis and counseling. For many women, a family planning clinic is their entry point into the healthcare system and is considered to be their usual source of care. This is especially true for women with incomes below the poverty level, women who are uninsured, Hispanic women, and Black women.

Unintended pregnancies (those reported by women as being mistimed or unwanted) are associated with many negative health and economic outcomes. In 2001, almost one-half of all pregnancies in the US were unintended. For women, negative outcomes associated with unintended pregnancy include:

- Delays in initiating prenatal care
- Reduced likelihood of breastfeeding
- Poor maternal mental health
- Lower mother-child relationship quality
- Increased risk of physical violence during pregnancy

Children born as a result of an unintended pregnancy are more likely to experience poor mental and physical health during childhood and poor educational and behavioral outcomes.

– Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

## Births to Teen Mothers

The negative outcomes associated with unintended pregnancies are compounded for adolescents. Teen mothers:

- Are less likely to graduate from high school or attain a GED by the time they reach age 30.
- Earn an average of approximately \$3,500 less per year, when compared with those who delay childbearing.
- Receive nearly twice as much Federal aid for nearly twice as long.

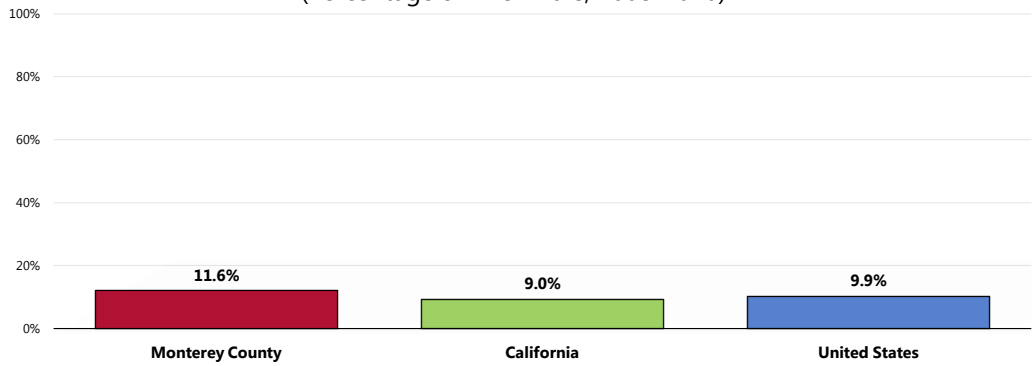
Similarly, early fatherhood is associated with lower educational attainment and lower income. Children of teen parents are more likely to have lower cognitive attainment and exhibit more behavior problems. Sons of teen mothers are more likely to be incarcerated, and daughters are more likely to become adolescent mothers.

– Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

**A total of 11.6% of 2008-2010 Monterey County births were to teenage mothers.**

- Higher than the California proportion.
- Higher than the national proportion.

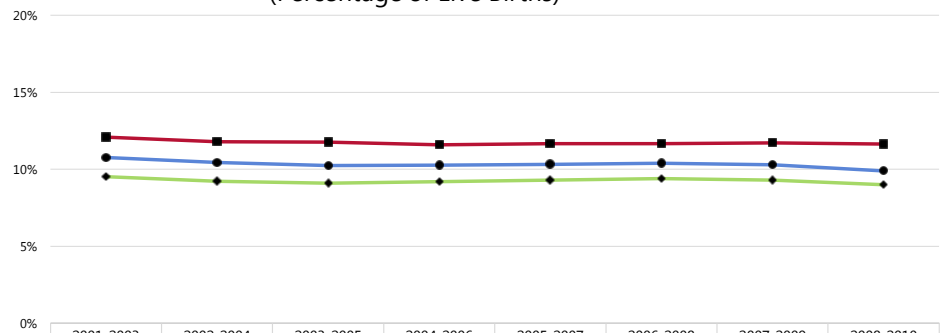
## Births to Teen Mothers (Percentage of Live Births, 2008-2010)



Sources: ● California Department of Public Health.  
● Centers for Disease Control and Prevention, National Vital Statistics System.  
Note: ● Numbers are a percentage of all live births within each population.

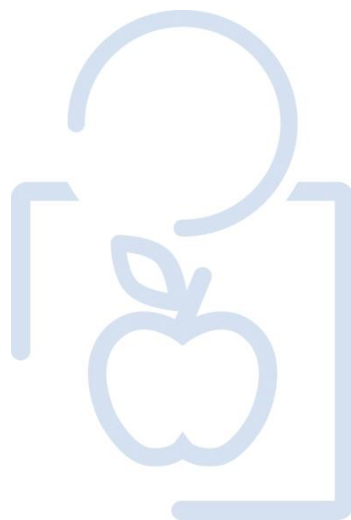
☒ The proportion of births to teen mothers has remained fairly stable in Monterey County over the past decade.

## Births to Teen Mothers (Percentage of Live Births)



Sources: ● California Department of Public Health.  
● Centers for Disease Control and Prevention, National Vital Statistics System.  
Note: ● Numbers are a percentage of all live births within each population.

# MODIFIABLE HEALTH RISKS



# Actual Causes Of Death

A 1999 study (an update to a landmark 1993 study), estimated that as many as 40% of premature deaths in the United States are attributed to behavioral factors. This study found that behavior patterns represent the single-most prominent domain of influence over health prospects in the United States. The daily choices we make with respect to diet, physical activity, and sex; the substance abuse and addictions to which we fall prey; our approach to safety; and our coping strategies in confronting stress are all important determinants of health.

The most prominent contributors to mortality in the United States in 2000 were tobacco (an estimated 435,000 deaths), diet and activity patterns (400,000), alcohol (85,000), microbial agents (75,000), toxic agents (55,000), motor vehicles (43,000), firearms (29,000), sexual behavior (20,000), and illicit use of drugs (17,000). Socioeconomic status and access to medical care are also important contributors, but difficult to quantify independent of the other factors cited. Because the studies reviewed used different approaches to derive estimates, the stated numbers should be viewed as first approximations.

These analyses show that smoking remains the leading cause of mortality. However, poor diet and physical inactivity may soon overtake tobacco as the leading cause of death. These findings, along with escalating healthcare costs and aging population, argue persuasively that the need to establish a more preventive orientation in the US healthcare and public health systems has become more urgent.

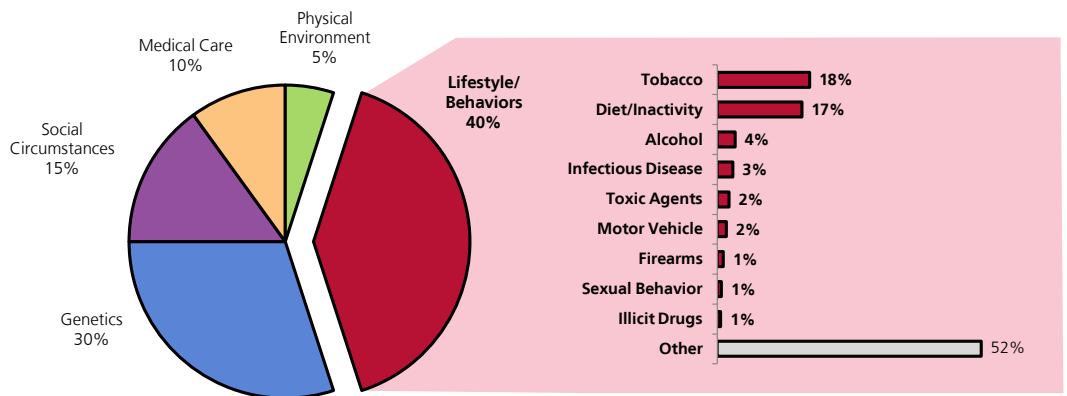
– Ali H. Mokdad, PhD; James S. Marks, MD, MPH; Donna F. Stroup, PhD, MSc; Julie L. Gerberding, MD, MPH. "Actual Causes of Death in the United States." JAMA, 291(2004):1238-1245.

Leading Causes of Death	Underlying Risk Factors (Actual Causes of Death)	
Cardiovascular disease	Tobacco use Elevated serum cholesterol High blood pressure	Obesity Diabetes Sedentary lifestyle
Cancer	Tobacco use Improper diet	Alcohol Occupational/environmental exposures
Cerebrovascular disease	High blood pressure Tobacco use	Elevated serum cholesterol
Accidental injuries	Safety belt noncompliance Alcohol/substance abuse Reckless driving	Occupational hazards Stress/fatigue
Chronic lung disease	Tobacco use	Occupational/environmental exposures

Source: National Center for Health Statistics/US Department of Health and Human Services, Health United States: 1987. DHHS Pub. No. (PHS) 88-1232.

## Factors Contributing to Premature Deaths in the United States

While causes of death are typically described as the diseases or injuries immediately precipitating the end of life, a few important studies have shown that the actual causes of premature death (reflecting underlying risk factors) are often preventable.



Sources: "The Case For More Active Policy Attention to Health Promotion"; (McGinnis, Williams-Russo, Knickman) Health Affairs, Vol. 21, No. 2, March/April 2002. "Actual Causes of Death in the United States"; (Ali H. Mokdad, PhD; James S. Marks, MD, MPH; Donna F. Stroup, PhD, MSc; Julie L. Gerberding, MD, MPH) JAMA, 291(2000):1238-1245.

# Nutrition

Strong science exists supporting the health benefits of eating a healthful diet and maintaining a healthy body weight. Efforts to change diet and weight should address individual behaviors, as well as the policies and environments that support these behaviors in settings such as schools, worksites, healthcare organizations, and communities.

The goal of promoting healthful diets and healthy weight encompasses increasing household food security and eliminating hunger.

Americans with a healthful diet:

- Consume a variety of nutrient-dense foods within and across the food groups, especially whole grains, fruits, vegetables, low-fat or fat-free milk or milk products, and lean meats and other protein sources.
- Limit the intake of saturated and trans fats, cholesterol, added sugars, sodium (salt), and alcohol.
- Limit caloric intake to meet caloric needs.

Diet and body weight are related to health status. Good nutrition is important to the growth and development of children. A healthful diet also helps Americans reduce their risks for many health conditions, including: overweight and obesity; malnutrition; iron-deficiency anemia; heart disease; high blood pressure; dyslipidemia (poor lipid profiles); type 2 diabetes; osteoporosis; oral disease; constipation; diverticular disease; and some cancers.

Diet reflects the variety of foods and beverages consumed over time and in settings such as worksites, schools, restaurants, and the home. Interventions to support a healthier diet can help ensure that:

- Individuals have the knowledge and skills to make healthier choices.
- Healthier options are available and affordable.

**Social Determinants of Diet.** Demographic characteristics of those with a more healthful diet vary with the nutrient or food studied. However, most Americans need to improve some aspect of their diet.

Social factors thought to influence diet include:

- Knowledge and attitudes
- Skills
- Social support
- Societal and cultural norms
- Food and agricultural policies
- Food assistance programs
- Economic price systems

**Physical Determinants of Diet.** Access to and availability of healthier foods can help people follow healthful diets. For example, better access to retail venues that sell healthier options may have a positive impact on a person's diet; these venues may be less available in low-income or rural neighborhoods.

The places where people eat appear to influence their diet. For example, foods eaten away from home often have more calories and are of lower nutritional quality than foods prepared at home.

Marketing also influences people's—particularly children's—food choices.

- Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

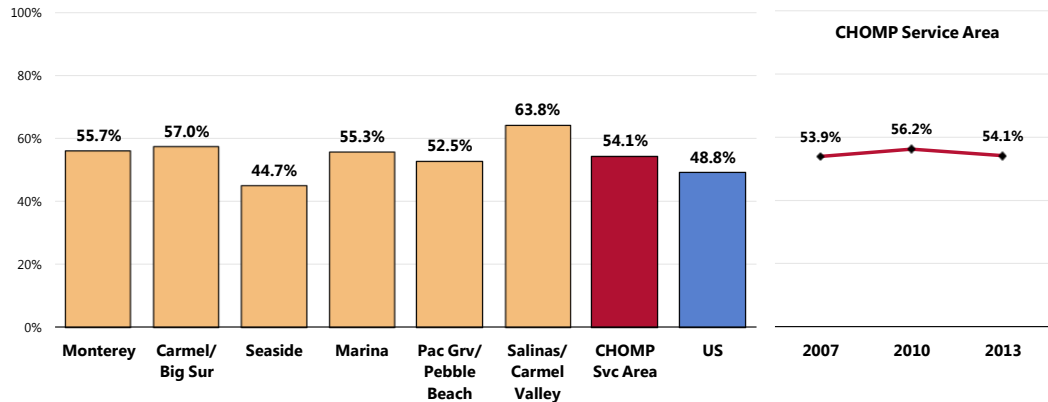
## Daily Recommendation of Fruits/Vegetables

**A total of 54.1% of CHOMP Service Area adults report eating five or more servings of fruits and/or vegetables per day.**

- More favorable than national findings.
- Lowest in Seaside; highest in Salinas/Carmel Valley.
- ▣ Fruit/vegetable consumption has not changed significantly since 2007.

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

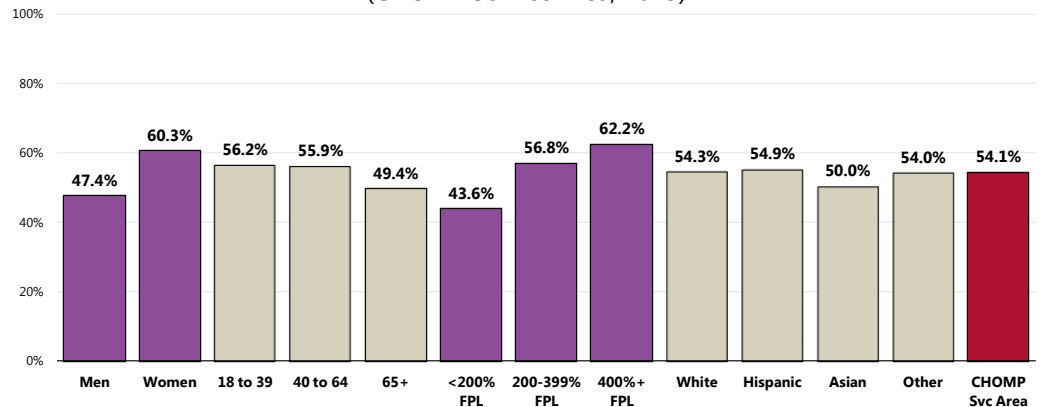
### Consume Five or More Servings of Fruits/Vegetables Per Day



- Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 167]  
 • 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- Notes: • Asked of all respondents.  
 • For this issue, respondents were asked to recall their food intake on the previous day.

👤 Area men are less likely to get the recommended servings of daily fruits/vegetables, as are low-income adults (note the positive correlation with income).

### Consume Five or More Servings of Fruits/Vegetables Per Day (CHOMP Service Area, 2013)



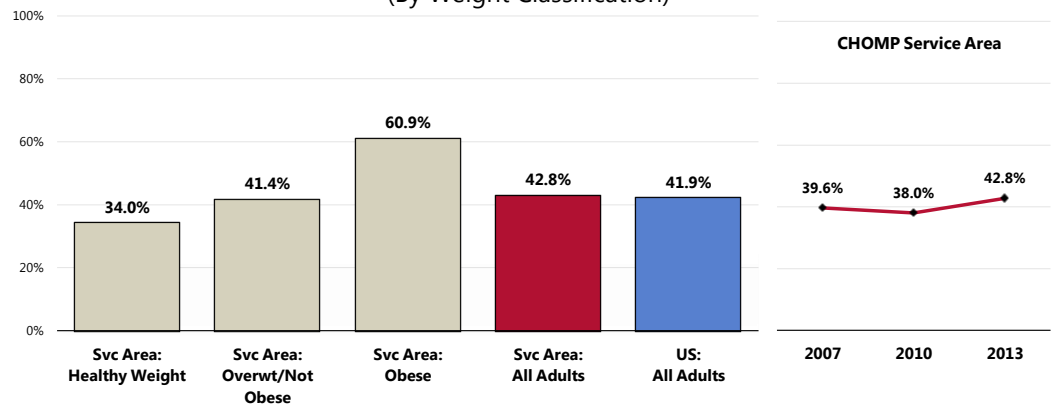
- Sources: • 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 167]
- Notes: • Asked of all respondents.  
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "<200% FPL" includes households with incomes up to 199% of the federal poverty level; "200-399% FPL" includes households with incomes between 200% and 399% of the federal poverty level; and "400%+ FPL" includes those households with incomes at 400% or more the federal poverty level.  
 • For this issue, respondents were asked to recall their food intake on the previous day.

## Health Advice About Diet & Nutrition

**A total of 42.8% of survey respondents acknowledge that a physician counseled them about diet and nutrition in the past year.**

- Comparable to national findings.
- ☒ Statistically unchanged since 2007.
- 👥 Note: Among obese respondents, 60.9% report receiving diet/nutrition advice (meaning that roughly 40% did not).

### Have Received Advice About Diet and Nutrition in the Past Year From a Physician, Nurse, or Other Health Professional (By Weight Classification)



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 18]  
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes: • Asked of all respondents.

## Related Focus Group Findings: Nutrition and Obesity

Many focus group participants discussed nutrition and obesity, emphasizing these issues:

- Poor nutrition
- Fast food establishments
- Generational trends
- Food deserts
- Nutrition education
- Hunger concerns

Participants believe that residents have **poor nutrition** which contributes to the high prevalence of obesity in the community. This frustrates key informants because the area has many farmers' markets and fresh produce is readily available. Many community members rely on **fast food establishments** because fast food represents the quick, cheap and easy option. Many times the lack of proper nutrition stems from **generational trends**. Residents eat what is familiar, or what they ate growing up; therefore, the families perpetuate the unhealthy cycle.

Residents may also lack access to fresh fruits and vegetables, which contributes to the high obesity levels. Some residents live in neighborhoods classified as **food deserts**, wherein community members do not have easy access to grocery stores. The limited availability and accessibility to fresh foods eliminate even the choice to eat better foods. Overcrowding and not possessing cooking tools or appliances also complicates preparation and the ability to eat healthy. A community leader explains:

*"I live in East Salinas – I have my own little tiny kitchen. A lot of the places to live over there, there's way too many people in each apartment and very small kitchens, so it's difficult to cook."  
— Community Leader*

Currently, CHOMP and the Community Partnership for Youth provide **nutrition education**; however, attendees think that this type of schooling needs to occur more frequently in the community. Nutrition education needs to begin as early as elementary school before unhealthy habits are established.

*"They need to learn what are good foods and what are bad foods, and then the choice is theirs or their families. But they can say to their mom or dad, oh we shouldn't be eating this because it's high in saturated fats, or we should eat more of this...If we don't teach the kids how are they going to learn? I mean they're already established in their habits by the time they get into college and early adulthood. And then they're going to have children and it goes on and on and on." — Healthcare Provider*

On the other side of the obesity epidemic are **hunger concerns**. Monterey County has several food banks, but participants believe that these organizations could better coordinate the services. However, the Monterey County Food Bank in Salinas is working hard to provide more fresh food choices for recipients, as a key informant describes:

*"I think that the food bank, the Monterey County Food Bank in Salinas is an amazing resource. We work with them really closely. A lot of other organizations work with them. They have a lot more vegetables. They're actively working on getting donations of vegetables for farmers and coming up with strategies for keeping those goods fresh." — Community Leader*



# Physical Activity

Regular physical activity can improve the health and quality of life of Americans of all ages, regardless of the presence of a chronic disease or disability. Among adults and older adults, physical activity can lower the risk of: early death; coronary heart disease; stroke; high blood pressure; type 2 diabetes; breast and colon cancer; falls; and depression. Among children and adolescents, physical activity can: improve bone health; improve cardiorespiratory and muscular fitness; decrease levels of body fat; and reduce symptoms of depression. For people who are inactive, even small increases in physical activity are associated with health benefits.

Personal, social, economic, and environmental factors all play a role in physical activity levels among youth, adults, and older adults. Understanding the barriers to and facilitators of physical activity is important to ensure the effectiveness of interventions and other actions to improve levels of physical activity.

Factors **positively** associated with adult physical activity include: postsecondary education; higher income; enjoyment of exercise; expectation of benefits; belief in ability to exercise (self-efficacy); history of activity in adulthood; social support from peers, family, or spouse; access to and satisfaction with facilities; enjoyable scenery; and safe neighborhoods.

Factors **negatively** associated with adult physical activity include: advancing age; low income; lack of time; low motivation; rural residency; perception of great effort needed for exercise; overweight or obesity; perception of poor health; and being disabled. Older adults may have additional factors that keep them from being physically active, including lack of social support, lack of transportation to facilities, fear of injury, and cost of programs.

Among children ages 4 to 12, the following factors have a positive association with physical activity:

- Gender (boys)
- Belief in ability to be active (self-efficacy)
- Parental support

Among adolescents ages 13 to 18, the following factors have a positive association with physical activity:

- Parental education
- Gender (boys)
- Personal goals
- Physical education/school sports
- Belief in ability to be active (self-efficacy)
- Support of friends and family

Environmental influences positively associated with physical activity among children and adolescents include:

- Presence of sidewalks
- Having a destination/walking to a particular place
- Access to public transportation
- Low traffic density
- Access to neighborhood or school play area and/or recreational equipment

People with disabilities may be less likely to participate in physical activity due to physical, emotional, and psychological barriers. Barriers may include the inaccessibility of facilities and the lack of staff trained in working with people with disabilities.

– Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

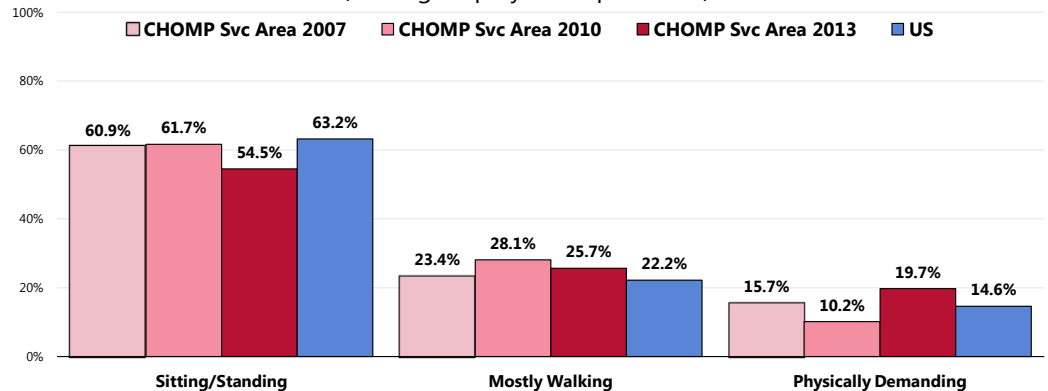
## Level of Activity at Work

### A majority of employed respondents reports low levels of physical activity at work.

- Just over one-half of employed respondents (54.5%) reports that their job entails mostly sitting or standing, lower than the US figure.
  - 25.7% report that their job entails mostly walking (similar to that reported nationally).
  - 19.7% report that their work is physically demanding (higher than reported nationally).
- ☒ Over time, note the decrease in sedentary work among employed respondents.

### Primary Level of Physical Activity At Work

(Among Employed Respondents)



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 105]  
 • 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes: • Asked of those respondents who are employed for wages.

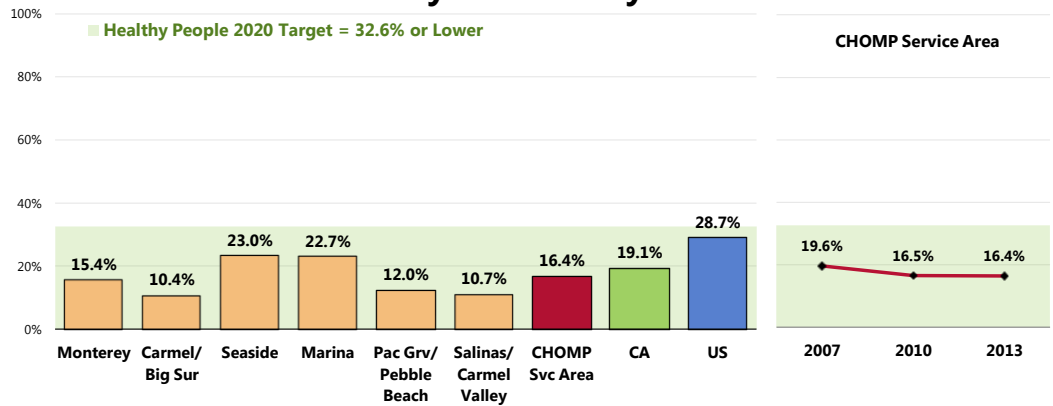
## Leisure-Time Physical Activity

### A total of 16.4% of CHOMP Service Area adults report no leisure-time physical activity in the past month.

- More favorable than statewide findings.
  - More favorable than national findings.
  - Satisfies the Healthy People 2020 target (32.6% or lower).
  - Less favorable in Seaside and Marina; more favorable in Carmel/Big Sur and Salinas/Carmel Valley.
- ☒ Statistically unchanged since 2007.

Leisure-time physical activity includes any physical activities or exercises (such as running, calisthenics, golf, gardening, walking, etc.) which take place outside of one's line of work.

## No Leisure-Time Physical Activity in the Past Month



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 106]  
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC). 2011 California data.  
 • 2011 PRC National Health Survey, Professional Research Consultants, Inc.  
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective PA-1]

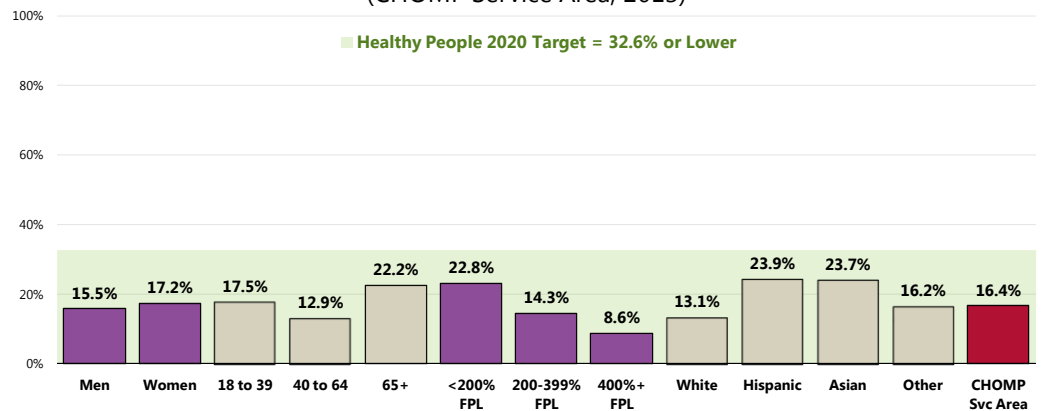
Notes: • Asked of all respondents.

Lack of leisure-time physical activity in the area is higher among:

- 👥 Seniors (age 65+).
- 👥 Lower-income residents (note the negative correlation with income).
- 👥 Hispanic adults and Asian adults.

## No Leisure-Time Physical Activity in the Past Month

(CHOMP Service Area, 2013)



Sources: • 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 106]  
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective PA-1]

Notes: • Asked of all respondents.  
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "<200% FPL" includes households with incomes up to 199% of the federal poverty level; "200-399% FPL" includes households with incomes between 200% and 399% of the federal poverty level; and "400%+ FPL" includes those households with incomes at 400% or more the federal poverty level.

## Activity Levels

Adults (age 18–64) should do 2 hours and 30 minutes a week of moderate-intensity, or 1 hour and 15 minutes (75 minutes) a week of vigorous-intensity aerobic physical activity, or an equivalent combination of moderate- and vigorous-intensity aerobic physical activity. Aerobic activity should be performed in episodes of at least 10 minutes, preferably spread throughout the week.

Additional health benefits are provided by increasing to 5 hours (300 minutes) a week of moderate-intensity aerobic physical activity, or 2 hours and 30 minutes a week of vigorous-intensity physical activity, or an equivalent combination of both.

Older adults (age 65 and older) should follow the adult guidelines. If this is not possible due to limiting chronic conditions, older adults should be as physically active as their abilities allow. They should avoid inactivity. Older adults should do exercises that maintain or improve balance if they are at risk of falling.

For all individuals, some activity is better than none. Physical activity is safe for almost everyone, and the health benefits of physical activity far outweigh the risks.

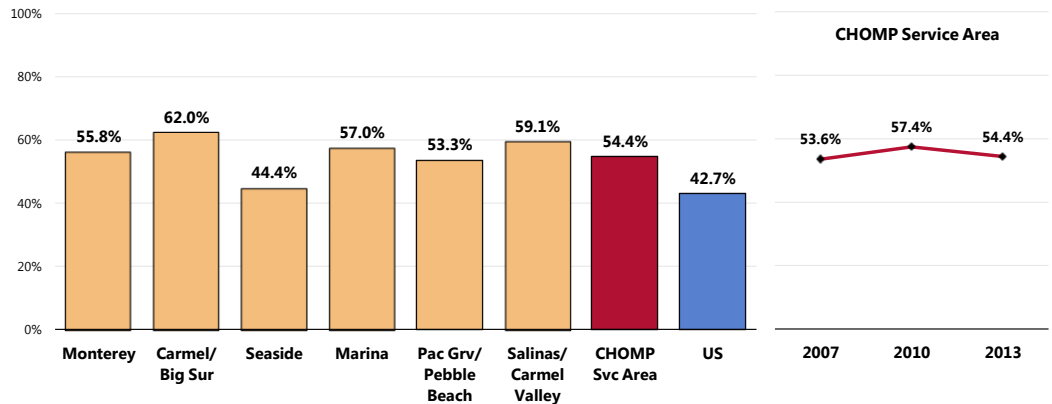
– 2008 Physical Activity Guidelines for Americans, U.S. Department of Health and Human Services. [www.health.gov/PAGuidelines](http://www.health.gov/PAGuidelines)

### Recommended Levels of Physical Activity

**A total of 54.4% of CHOMP Service Area adults participate in regular, sustained moderate or vigorous physical activity (meeting physical activity recommendations).**

- More favorable than national findings.
- Unfavorably low in Seaside.
- ☒ Statistically unchanged since 2007.

### Meets Physical Activity Recommendations



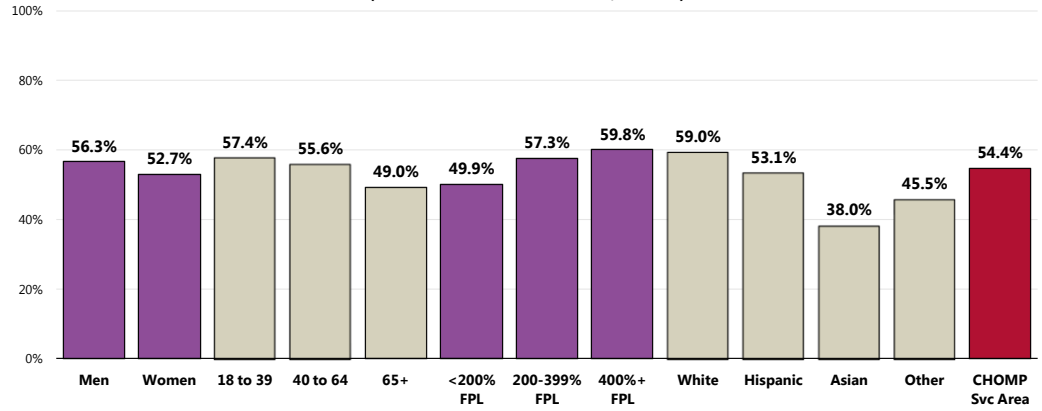
Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 170]  
● 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes: ● Asked of all respondents.  
● In this case the term "meets physical activity recommendations" refers to participation in moderate physical activity (exercise that produces only light sweating or a slight to moderate increase in breathing or heart rate) at least 5 times a week for 30 minutes at a time, and/or vigorous physical activity (activities that cause heavy sweating or large increases in breathing or heart rate) at least 3 times a week for 20 minutes at a time.

Those less likely to meet physical activity requirements include:

- 👤 Residents in lower-income households.
- 👤 Asian adults and "Other" race adults.

## Meets Physical Activity Recommendations (CHOMP Service Area, 2013)



Sources: • 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 170]

- Notes:
- Asked of all respondents.
  - Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
  - Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "<200% FPL" includes households with incomes up to 199% of the federal poverty level; "200-399% FPL" includes households with incomes between 200% and 399% of the federal poverty level; and "400%+ FPL" includes those households with incomes at 400% or more the federal poverty level.
  - In this case the term "meets physical activity recommendations" refers to participation in moderate physical activity (exercise that produces only light sweating or a slight to moderate increase in breathing or heart rate) at least 5 times a week for 30 minutes at a time, and/or vigorous physical activity (activities that cause heavy sweating or large increases in breathing or heart rate) at least 3 times a week for 20 minutes at a time.

### Moderate & Vigorous Physical Activity

In the past month:

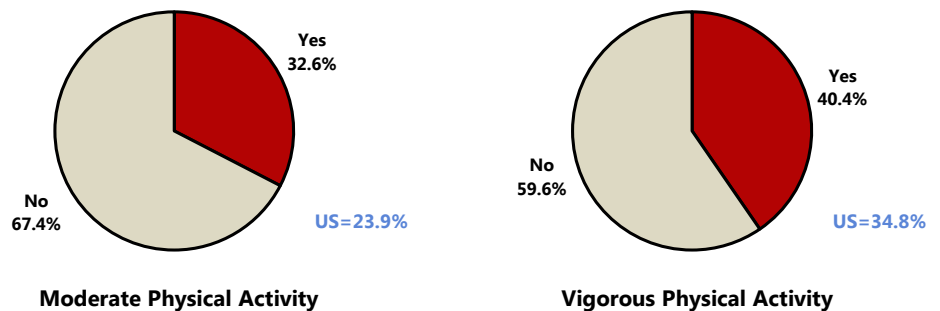
**A total of 32.6% of adults participated in moderate physical activity (5 times a week, 30 minutes at a time).**

- More favorable than the nationwide figure.
- ☒ Statistically unchanged since 2007.

**A total of 40.4% participated in vigorous physical activity (3 times a week, 20 minutes at a time).**

- More favorable than the nationwide figure.
- ☒ Statistically unchanged since 2007.

### Moderate & Vigorous Physical Activity (CHOMP Service Area, 2013)



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Items 172-173]  
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.

- Notes:
- Asked of all respondents.
  - Moderate Physical Activity: Takes part in exercise that produces only light sweating or a slight to moderate increase in breathing or heart rate at least 5 times per week for at least 30 minutes per time.
  - Vigorous Physical Activity: Takes part in activities that cause heavy sweating or large increases in breathing or heart rate at least 3 times per week for at least 20 minutes per time.

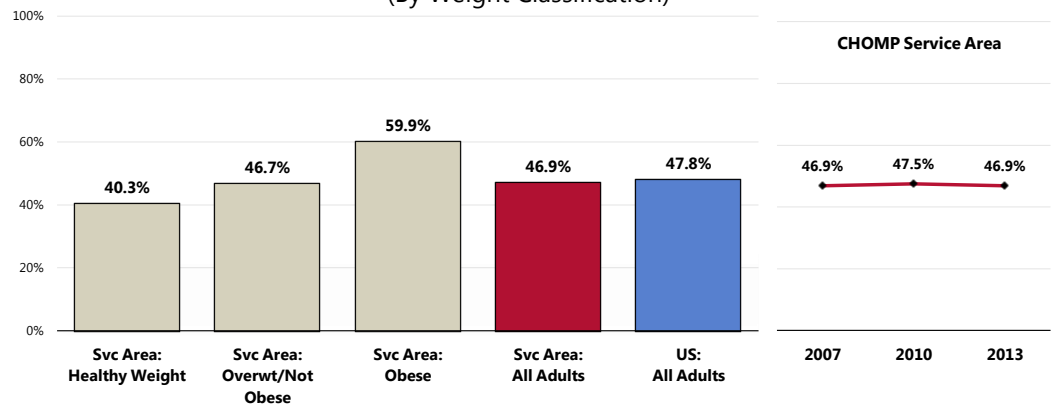
The individual indicators of moderate and vigorous physical activity are shown here.

## Health Advice About Physical Activity & Exercise

**A total of 46.9% of CHOMP Service Area adults report that their physician has asked about or given advice to them about physical activity in the past year.**

- Similar to the national average.
- ☒ Unchanged from the 2007 survey findings.
- 👥 Note: 59.9% of obese CHOMP Service Area respondents say that they have talked with their doctor about physical activity/exercise in the past year.

### Have Received Advice About Exercise in the Past Year From a Physician, Nurse, or Other Health Professional (By Weight Classification)



Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 19]  
● 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes: ● Asked of all respondents.

## Children's Screen Time

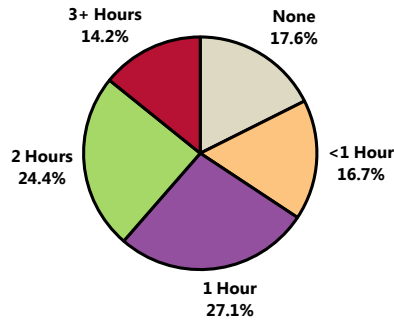
### Television Watching & Other Screen Time

**Among children age 5 through 17, 14.2% are reported to watch three or more hours of television per day; 14.3% are reported to spend three or more hours on other types of screen time for entertainment (video games, Internet, etc.).**

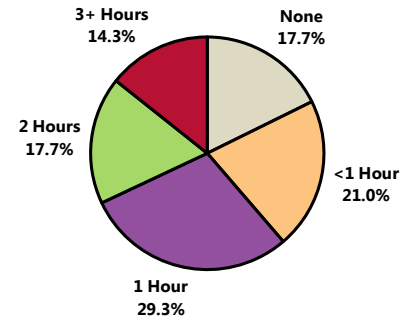
- Both percentages are comparable to the respective US figures.

## Children's Screen Time

(Among Parents of Children Ages 5-17; CHOMP Service Area, 2013)



Hours per Day of Television



Hours per Day of Other Screen Time  
(i.e., video games, computer/Internet entertainment)

Sources: • 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 137-138, 174-175]  
Notes: • Asked of respondents with a child aged 5 to 17 in the household

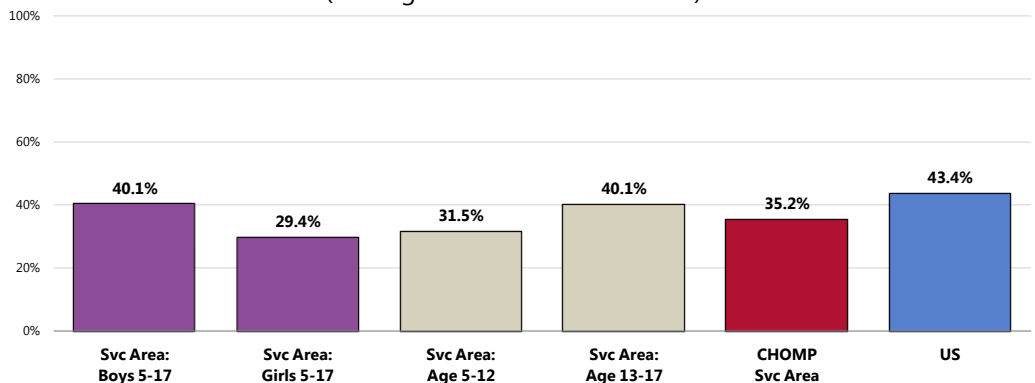
## Total Screen Time

When combined, 35.2% of CHOMP Service Area children aged 5 to 17 spend three or more hours on screen time (whether television or computer, Internet, video games, etc.) per day.

- Comparable to that found nationally.
- 👤 Higher in boys (age 5-17) and teens.

## Children With Three or More Hours per School Day of Total Screen Time [TV, Computer, Video Games, Etc. for Entertainment]

(Among Parents of Children 5-17)



Sources: • 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 176]  
• PRC National Health Survey, Professional Research Consultants, Inc.  
Notes: • Asked of all respondents with children 5-17 at home.  
• For this issue, respondents with children who are not in school were asked about "weekdays," while parents of children in school were asked about typical "school days."  
• "Three or more hours" includes reported screen time of 180 minutes or more per day.

## Related Focus Group Findings: Physical Activity

Many focus group participants discussed the lack of physical activity in the community. The main discussion centered on:

- Sedentary lifestyle
  - *Technology*
  - *Safety*

Focus group attendees agree that many community members live **sedentary lifestyles**. This lack of activity stems from a reliance on **technology** and **potential safety concerns** in areas of Monterey County. Children and adolescents spend more time in front of the television, video games, and computers than ever before. Monterey County also has limited green space for recreation. In general, the participants believe that the community lacks awareness about the free activities available to them, and that busy, structured lives do not encourage physical activity. A respondent explains

*“So we have all these parks and beaches free, people come to use them, but in our minds I think when we go home we don’t think, ‘Oh, its light for another three hours. What a great opportunity. I’ll go walk at Manzanita Park.’ I don’t think that’s part of our education anymore or it’s just not in our minds. I think we get home and we sit, and so I think there’s a disconnect between free walks on the beach and what do you do after you get home.” — Community Leader*

Other families may not feel safe allowing their child to play outside after dark or unsupervised. A focus group member describes how a city park is taken over by gangs after dark:

*“I think it’s worth mentioning that the sense of communities being unsafe also feeds into the Nintendo being a solution because parents don’t want their kids out on the street. When we were doing our community forums for our planning there’s this beautiful city park that the city had just built and somebody asked and the park literally got taken over by a certain gang at 5:30, and so all the kids they had to bring them in and basically keep them in the house because it was gang turf at 5:30 to dark, and so violence plays a part in that lifestyle as well.” — Community Leader*



# Weight Status

Because weight is influenced by energy (calories) consumed and expended, interventions to improve weight can support changes in diet or physical activity. They can help change individuals' knowledge and skills, reduce exposure to foods low in nutritional value and high in calories, or increase opportunities for physical activity. Interventions can help prevent unhealthy weight gain or facilitate weight loss among obese people. They can be delivered in multiple settings, including healthcare settings, worksites, or schools.

The social and physical factors affecting diet and physical activity (see Physical Activity topic area) may also have an impact on weight. Obesity is a problem throughout the population. However, among adults, the prevalence is highest for middle-aged people and for non-Hispanic black and Mexican American women. Among children and adolescents, the prevalence of obesity is highest among older and Mexican American children and non-Hispanic black girls. The association of income with obesity varies by age, gender, and race/ethnicity.

– Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

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

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

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

Classification of Overweight and Obesity by BMI	BMI ( $kg/m^2$ )
Underweight	<18.5
Normal	18.5 – 24.9
Overweight	25.0 – 29.9
Obese	$\geq 30.0$

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

## Adult Weight Status

### Healthy Weight

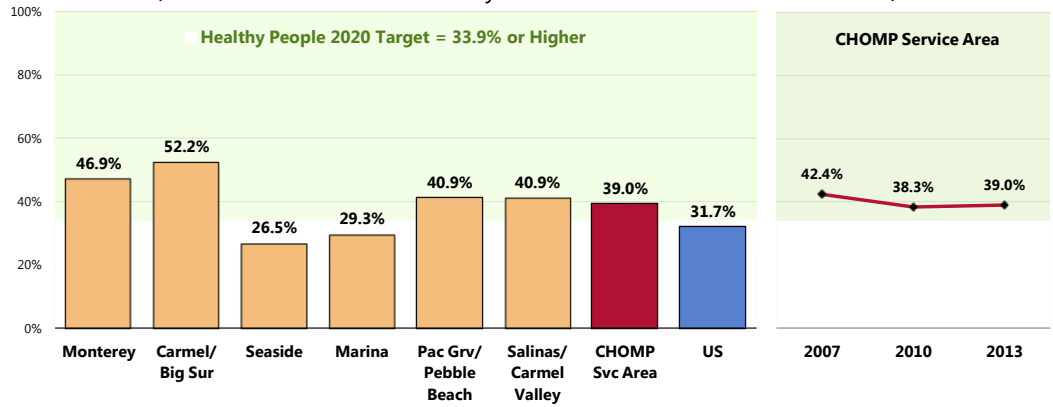
“Healthy weight” means neither underweight, nor overweight (BMI = 18.5-24.9).

**Based on self-reported heights and weights, 39.0% of CHOMP Service Area adults are at a healthy weight.**

- More favorable than national findings.
- Satisfies the Healthy People 2020 target (33.9% or higher).
- Least favorable in Seaside and Marina; most favorable in Monterey and Carmel/Big Sur.
- ☒ Statistically unchanged since 2007.

## Healthy Weight

(Percent of Adults With a Body Mass Index Between 18.5 and 24.9)



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 178]  
 • 2011 PRC National Health Survey, Professional Research Consultants, Inc.  
 Notes: • Based on reported heights and weights, asked of all respondents.  
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective NWS-8]  
 • The definition of healthy weight is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), between 18.5 and 24.9.

## Overweight Status

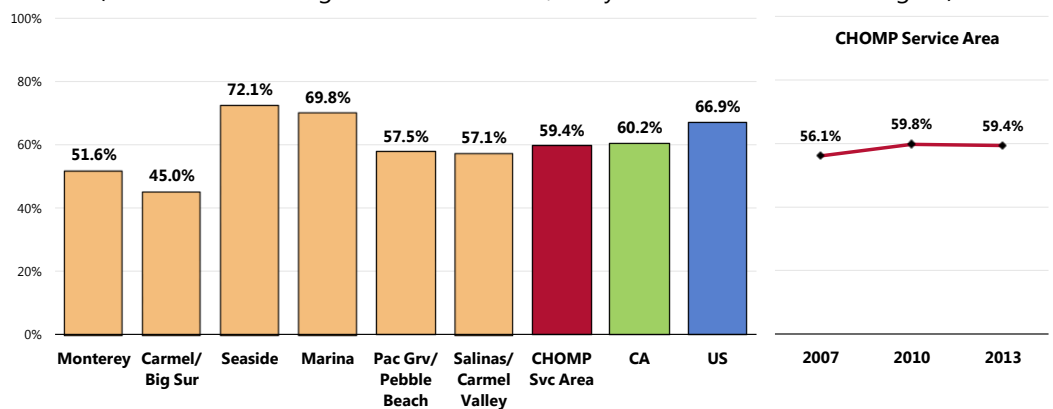
Here, "overweight" includes those respondents with a BMI value  $\geq 25$ .

**A total of 6 in 10 CHOMP Service Area adults (59.4%) are overweight.**

- Comparable to the California prevalence.
- More favorable than the US overweight prevalence.
- Least favorable in Seaside and Marina; most favorable in Monterey and Carmel/Big Sur.
- ☒ Statistically unchanged since 2007.

## Prevalence of Total Overweight

(Percent of Overweight or/Obese Adults; Body Mass Index of 25.0 or Higher)



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 178]  
 • 2011 PRC National Health Survey, Professional Research Consultants, Inc.  
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2011 California data.  
 Notes: • Based on reported heights and weights, asked of all respondents.  
 • The definition of overweight is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 25.0, regardless of gender. The definition for obesity is a BMI greater than or equal to 30.0.

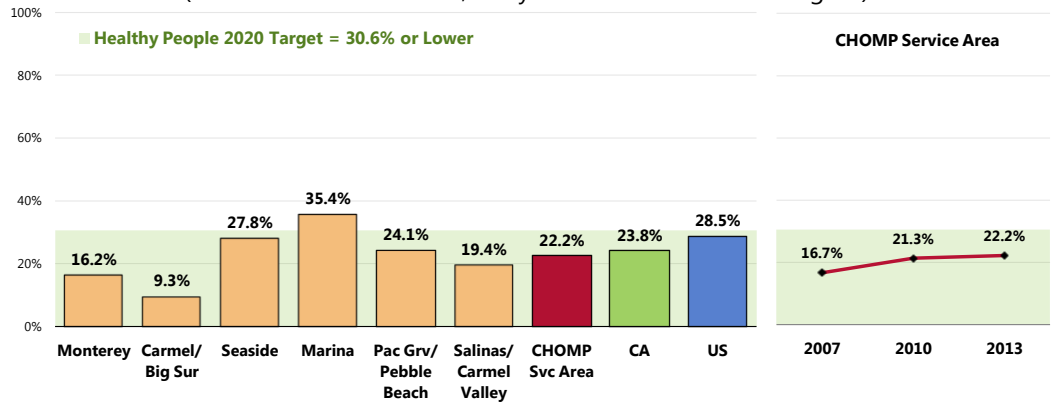
“Obese” (also included in overweight prevalence discussed previously) includes respondents with a BMI value  $\geq 30$ .

### Further, 22.2% of CHOMP Service Area adults are obese.

- Similar to California findings.
  - More favorable than US findings.
  - Satisfies the Healthy People 2020 target (30.6% or lower).
  - Highest in Seaside and Marina; lowest in Monterey and Carmel/Big Sur.
- ☒ Denotes a statistically significant increase in obesity since 2007.

## Prevalence of Obesity

(Percent of Obese Adults; Body Mass Index of 30.0 or Higher)

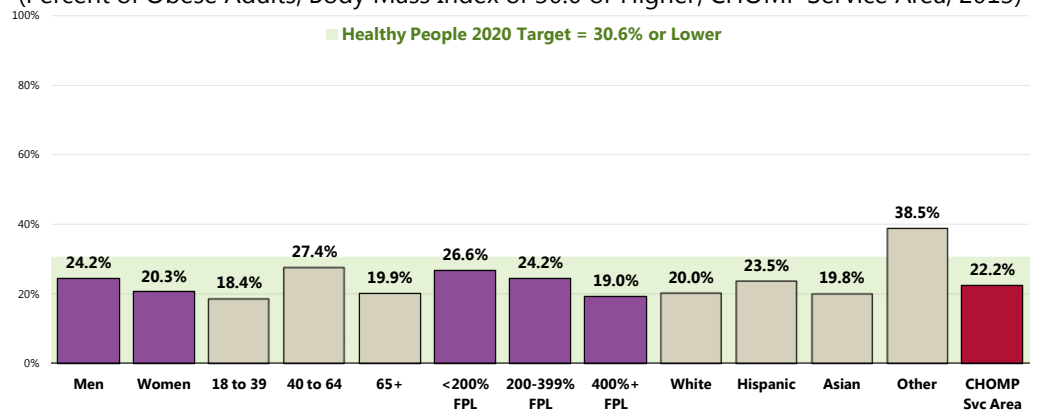


- Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 178]
  - 2011 PRC National Health Survey, Professional Research Consultants, Inc.
  - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective NWS-9]
  - Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2011 California data.
- Notes:
- Based on reported heights and weights, asked of all respondents.
  - The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0, regardless of gender.

☺ Obesity is notably more prevalence among respondents between the ages of 40 and 64, lower-income residents, and adults of “Other” races.

## Prevalence of Obesity

(Percent of Obese Adults; Body Mass Index of 30.0 or Higher; CHOMP Service Area, 2013)



- Sources:
- 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 178]
  - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective NWS-9]
- Notes:
- Based on reported heights and weights, asked of all respondents.
  - Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., “White” reflects non-Hispanic White respondents).
  - Income categories reflect respondent’s household income as a ratio to the federal poverty level (FPL) for their household size. “<200% FPL” includes households with incomes up to 199% of the federal poverty level; “200-399% FPL” includes households with incomes between 200% and 399% of the federal poverty level; and “400%+ FPL” includes those households with incomes at 400% or more the federal poverty level.
  - The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0, regardless of gender.

## Relationship of Overweight With Other Health Issues

The correlation between overweight and various health issues cannot be disputed.

### Overweight and obese adults are more likely to report a number of adverse health conditions.

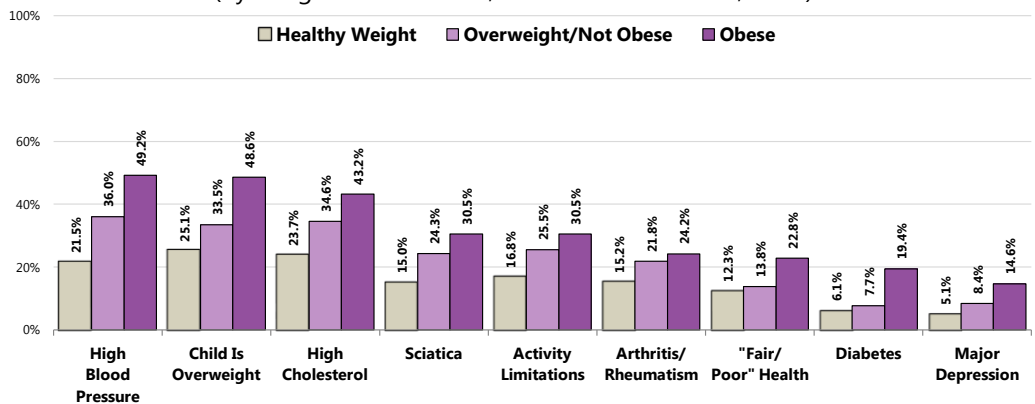
Among these are:

- Hypertension (high blood pressure).
- High cholesterol.
- Sciatica/chronic back pain.
- Activity limitations.
- Arthritis/rheumatism.
- "Fair" or "poor" physical health.
- Diabetes.
- Major depression.

Overweight/obese residents are also more likely to have overweight children.

### Relationship of Overweight With Other Health Issues

(By Weight Classification; CHOMP Service Area, 2013)



Sources: • 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 5, 28, 29, 43, 117, 141, 142, 182]  
Notes: • Based on reported heights and weights, asked of all respondents.

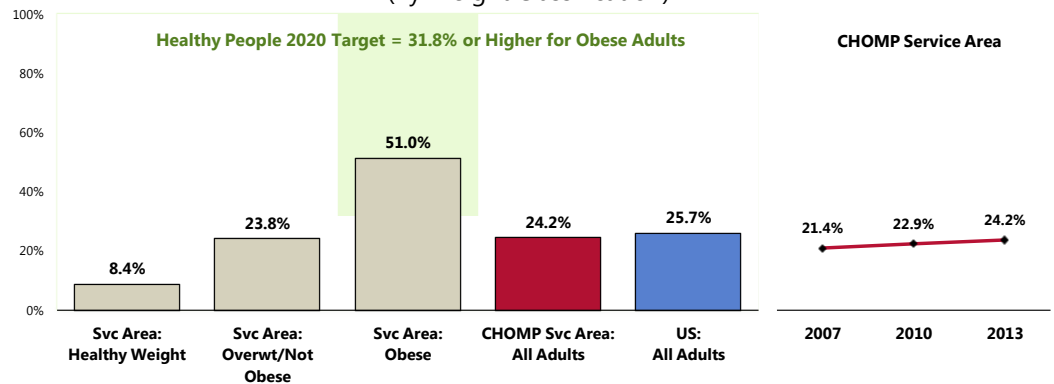
# Weight Management

## Health Advice

**A total of 24.2% of adults have been given advice about their weight by a doctor, nurse or other health professional in the past year.**

- Statistically similar to the national findings.
- 📊 Statistically unchanged from that reported in 2007.
- 👥 Note that 51.0% of obese adults have been given advice about their weight by a health professional in the past year (while nearly one-half have not).
  - This satisfies the Healthy People 2020 target of 31.8% or higher.

### Have Received Advice About Weight in the Past Year From a Physician, Nurse, or Other Health Professional (By Weight Classification)



Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Items 112, 181]  
● 2011 PRC National Health Survey, Professional Research Consultants, Inc.  
● US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective NWS-6.2]  
Notes: ● Asked of all respondents.

## Weight Control

Individuals who are at a healthy weight are less likely to:

- Develop chronic disease risk factors, such as high blood pressure and dyslipidemia.
- Develop chronic diseases, such as type 2 diabetes, heart disease, osteoarthritis, and some cancers.
- Experience complications during pregnancy.
- Die at an earlier age.

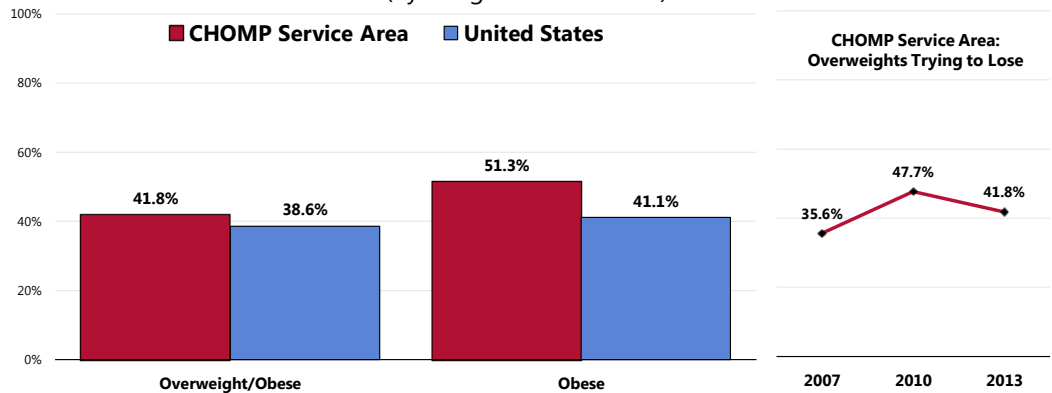
All Americans should avoid unhealthy weight gain, and those whose weight is too high may also need to lose weight.

– Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

**A total of 41.8% of CHOMP Service Area adults who are overweight say that they are both modifying their diet and increasing their physical activity to try to lose weight.**

- Similar to national findings.
- ▣ Marks a significant increase over time.
- 👥 Note: 51.3% of obese CHOMP Service Area adults report that they are trying to lose weight through a combination of diet and exercise, higher than that found nationally.

### Trying to Lose Weight by Both Modifying Diet and Increasing Physical Activity (By Weight Classification)



Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 179]  
● 2011 PRC National Health Survey, Professional Research Consultants, Inc.  
Notes: ● Based on reported heights and weights, asked of all respondents.

## Childhood Overweight & Obesity

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

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

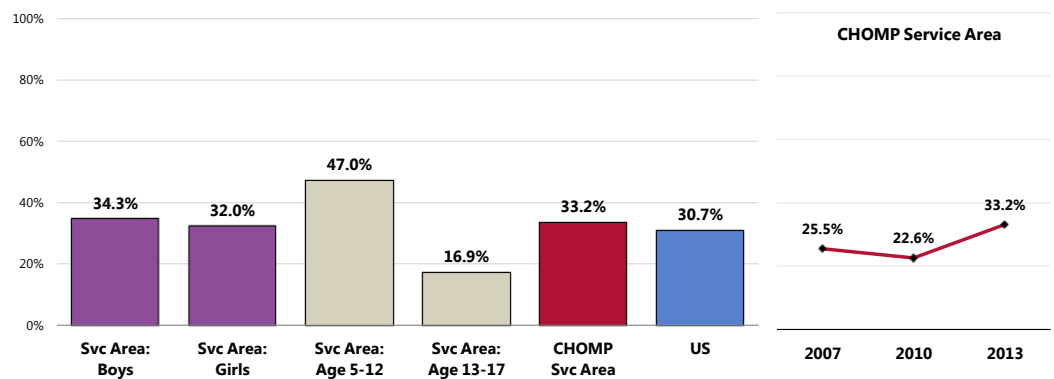
- Underweight <5th percentile
- Healthy Weight ≥5th and <85th percentile
- Overweight ≥85th and <95th percentile
- Obese ≥95th percentile

– Centers for Disease Control and Prevention.

**Based on the heights/weights reported by surveyed parents, 33.2% of CHOMP Service Area children age 5 to 17 are overweight or obese (≥85th percentile).**

- Similar to the national prevalence.
- Note that sample sizes are too small to allow for community-level data.
- ☒ Statistically unchanged since 2007.
- 👤 Similar by gender; significantly high in younger children (age 5-12).

### Child Total Overweight Prevalence (Percent of Children 5-17 Who Are Overweight/Obese; Body Mass Index in the 85th Percentile or Higher)



Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 182]  
● 2011 PRC National Health Survey, Professional Research Consultants, Inc.

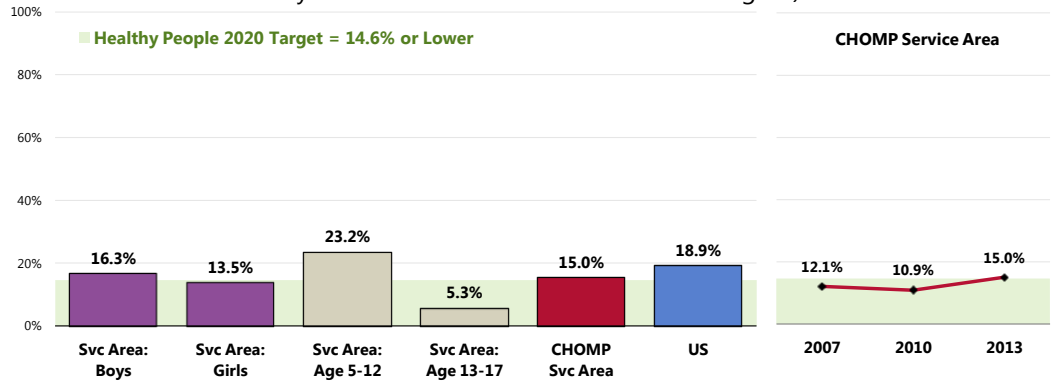
Notes: ● Asked of all respondents with children age 5-17 at home.  
● Overweight among children is determined by children's Body Mass Index status at or above the 85<sup>th</sup> percentile of US growth charts by gender and age.

**Further, 15.0% of CHOMP Service Area children age 5 to 17 are obese (≥95th percentile).**

- Comparable to the national percentage.
- Similar to the Healthy People 2020 target (14.6% or lower for children age 2-19).
- Note that sample sizes are too small to allow for community-level data.
- ☒ Statistically unchanged since 2007.
- 👤 Similar by gender; statistically high in children age 5 to 12.

### Child Obesity Prevalence

(Percent of Children 5-17 Who Are Obese; Body Mass Index in the 95<sup>th</sup> Percentile or Higher)



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 182]  
 • 2011 PRC National Health Survey, Professional Research Consultants, Inc.  
 • US Department of Health and Human Services, Healthy People 2020, December 2010. <http://www.healthypeople.gov> [Objective NWS-10.4]  
 Notes: • Asked of all respondents with children age 5-17 at home.  
 • Obesity among children is determined by children's Body Mass Index status equal to or above the 95<sup>th</sup> percentile of US growth charts by gender and age.



# Substance Abuse

In 2005, an estimated 22 million Americans struggled with a drug or alcohol problem. Almost 95% of people with substance use problems are considered unaware of their problem. Of those who recognize their problem, 273,000 have made an unsuccessful effort to obtain treatment. These estimates highlight the importance of increasing prevention efforts and improving access to treatment for substance abuse and co-occurring disorders.

Substance abuse has a major impact on individuals, families, and communities. The effects of substance abuse are cumulative, significantly contributing to costly social, physical, mental, and public health problems. These problems include:

- Teenage pregnancy
- Human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS)
- Other sexually transmitted diseases (STDs)
- Domestic violence
- Child abuse
- Motor vehicle crashes
- Physical fights
- Crime
- Homicide
- Suicide

The field has made progress in addressing substance abuse, particularly among youth. According to data from the national Institute of Drug Abuse (NIDA) Monitoring the Future (MTF) survey, which is an ongoing study of the behaviors and values of America's youth between 2004 and 2009, a drop in drug use (including amphetamines, methamphetamine, cocaine, hallucinogens, and LSD) was reported among students in 8th, 10th, and 12th grades. Note that, despite a decreasing trend in marijuana use which began in the mid-1990s, the trend has stalled in recent years among these youth. Use of alcohol among students in these three grades also decreased during this time.

Substance abuse refers to a set of related conditions associated with the consumption of mind- and behavior-altering substances that have negative behavioral and health outcomes. Social attitudes and political and legal responses to the consumption of alcohol and illicit drugs make substance abuse one of the most complex public health issues. In addition to the considerable health implications, substance abuse has been a flash-point in the criminal justice system and a major focal point in discussions about social values: people argue over whether substance abuse is a disease with genetic and biological foundations or a matter of personal choice.

Advances in research have led to the development of evidence-based strategies to effectively address substance abuse. Improvements in brain-imaging technologies and the development of medications that assist in treatment have gradually shifted the research community's perspective on substance abuse. There is now a deeper understanding of substance abuse as a disorder that develops in adolescence and, for some individuals, will develop into a chronic illness that will require lifelong monitoring and care.

Improved evaluation of community-level prevention has enhanced researchers' understanding of environmental and social factors that contribute to the initiation and abuse of alcohol and illicit drugs, leading to a more sophisticated understanding of how to implement evidence-based strategies in specific social and cultural settings.

A stronger emphasis on evaluation has expanded evidence-based practices for drug and alcohol treatment. Improvements have focused on the development of better clinical interventions through research and increasing the skills and qualifications of treatment providers.

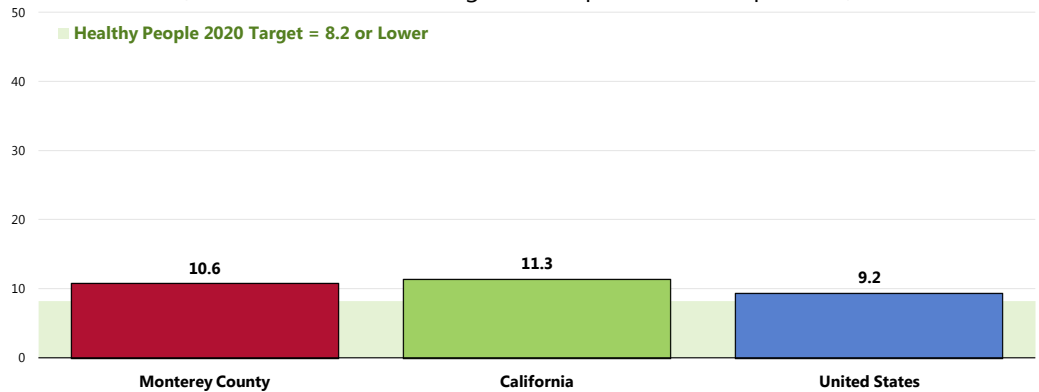
– Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

## Age-Adjusted Cirrhosis/Liver Disease Deaths

Between 2008 and 2010, there was an annual average age-adjusted cirrhosis/liver disease mortality rate of 10.6 deaths per 100,000 population in Monterey County.

- Better than the statewide rate.
- Worse than the national rate.
- Fails to satisfy the Healthy People 2020 target (8.2 or lower).

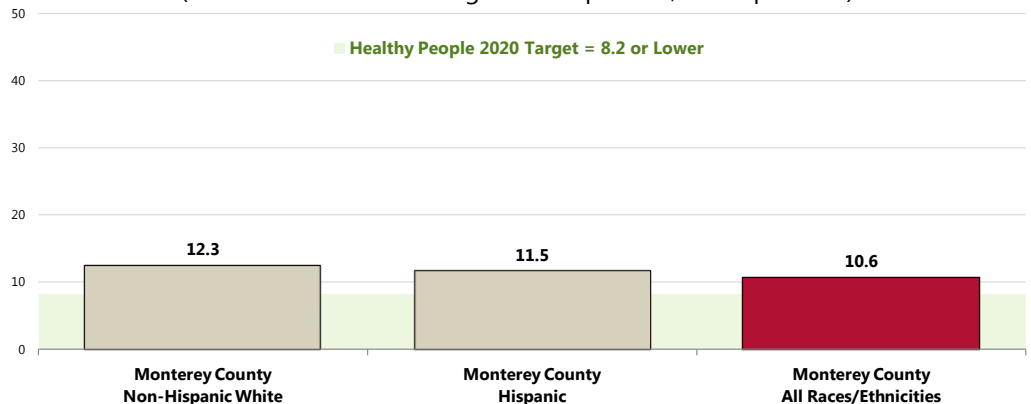
### Cirrhosis/Liver Disease: Age-Adjusted Mortality (2008-2010 Annual Average Deaths per 100,000 Population)



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2013.  
• US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective SA-11]  
Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).  
• Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.  
• Local, state and national data are simple three-year averages.

👤 The cirrhosis mortality rate is somewhat higher among Whites than Hispanics (and lower in "Other" races, with counts too small to be reliable).

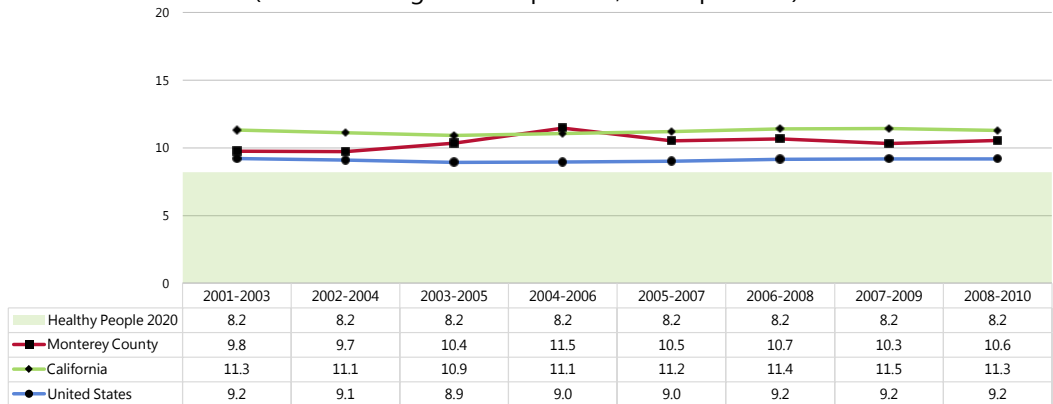
### Cirrhosis/Liver Disease: Age-Adjusted Mortality by Race (2008-2010 Annual Average Deaths per 100,000 Population)



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2013.  
• US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective SA-11]  
Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).  
• Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.

☒ The net result of cirrhosis/liver disease mortality trends in Monterey County over the past decade has been an overall slight increase.

### Cirrhosis/Liver Disease: Age-Adjusted Mortality Trends (Annual Average Deaths per 100,000 Population)



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2013.  
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective SA-11]  
 Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).  
 • Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.  
 • State and national data are simple three-year averages.

## High-Risk Alcohol Use

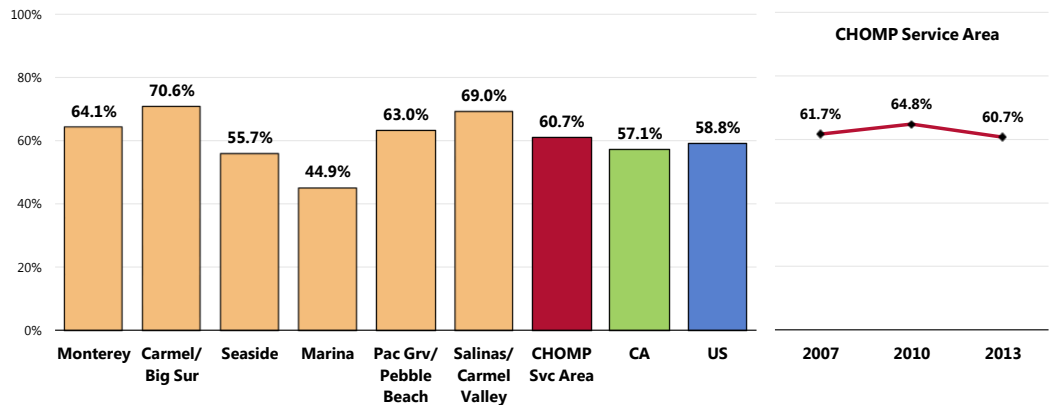
### Current Drinking

**A total of 60.7% of area adults had at least one drink of alcohol in the past month (current drinkers).**

- Higher than the statewide proportion.
- Similar to the national proportion.
- Highest in Carmel/Big Sur and Salinas/Carmel Valley; lowest in Marina.
- ☒ Statistically unchanged since 2007.

“Current drinkers” include survey respondents who had at least one drink of alcohol in the month preceding the interview. For the purposes of this study, a “drink” is considered one can or bottle of beer, one glass of wine, one can or bottle of wine cooler, one cocktail, or one shot of liquor.

### Current Drinkers

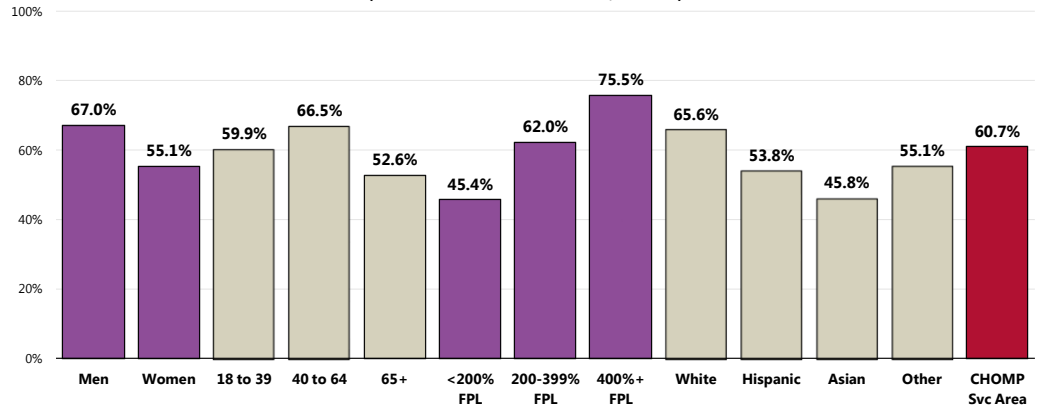


Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 187]  
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2011 California data.  
 • 2011 PRC National Health Survey, Professional Research Consultants, Inc.  
 Notes: • Asked of all respondents.  
 • Current drinkers had at least one alcoholic drink in the past month.

👤 Current drinking is more prevalent among men, adults age 40 to 64, and Whites.

👤 Note also the positive correlation between income and current drinkers.

### Current Drinkers (CHOMP Service Area, 2013)



Sources: • 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 187]  
 • Asked of all respondents.  
 Notes: • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "<200% FPL" includes households with incomes up to 199% of the federal poverty level; "200-399% FPL" includes households with incomes between 200% and 399% of the federal poverty level; and "400+% FPL" includes those households with incomes at 400% or more the federal poverty level.  
 • Current drinkers had at least one alcoholic drink in the past month.

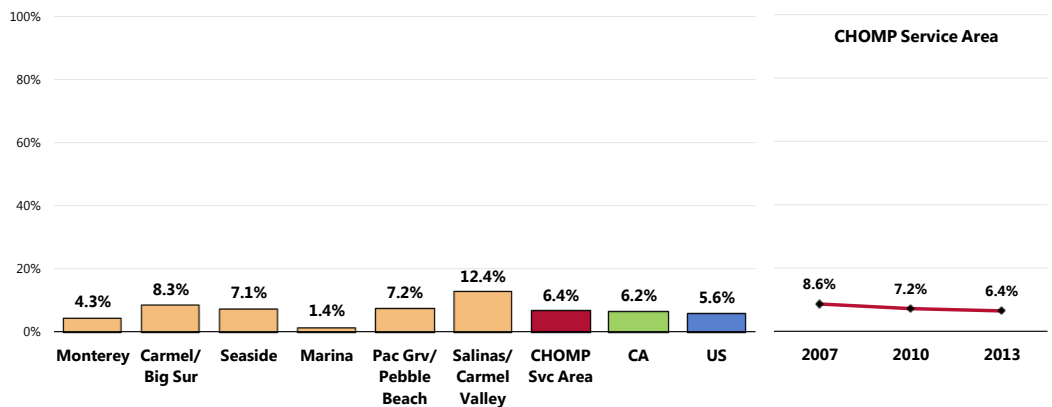
### Chronic Drinking

"Chronic drinkers" include survey respondents reporting 60 or more drinks of alcohol in the month preceding the interview.

**A total of 6.4% of area adults averaged two or more drinks of alcohol per day in the past month (chronic drinkers).**

- Similar to the statewide proportion.
- Similar to the national proportion.
- Highest in Salinas/Carmel Valley; lowest in Marina.
- 📊 Statistically unchanged since 2007.

### Chronic Drinkers

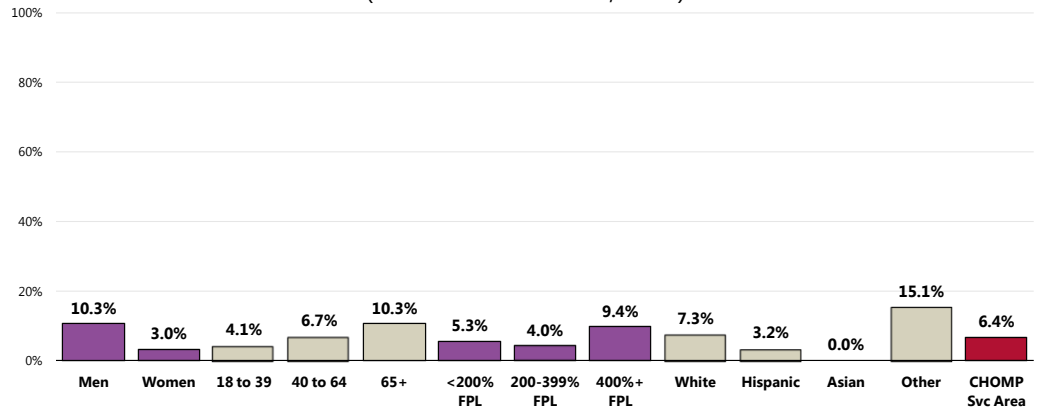


Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 188]  
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2011 California data.  
 • 2011 PRC National Health Survey, Professional Research Consultants, Inc.  
 Notes: • Asked of all respondents.  
 • Chronic drinkers are defined as having 60+ alcoholic drinks in the past month.  
 • \*The state definition for chronic drinkers is males consuming 2+ drinks per day and females consuming 1+ drink per day.

RELATED ISSUE:  
See also *Stress* in the **Mental Health & Mental Disorders** section of this report.

👤 Chronic drinking is more prevalent among men, seniors, upper-income residents, Whites, and “Other” adults.

### Chronic Drinkers (CHOMP Service Area, 2013)



Sources: • 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 188]  
Notes: • Asked of all respondents.  
• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., “White” reflects non-Hispanic White respondents).  
• Income categories reflect respondent’s household income as a ratio to the federal poverty level (FPL) for their household size. “<200% FPL” includes households with incomes up to 199% of the federal poverty level; “200-399% FPL” includes households with incomes between 200% and 399% of the federal poverty level; and “400%+ FPL” includes those households with incomes at 400% or more the federal poverty level.  
• Chronic drinkers are defined as those having 60+ alcoholic drinks in the past month.

### Binge Drinking

“Binge drinkers” include:

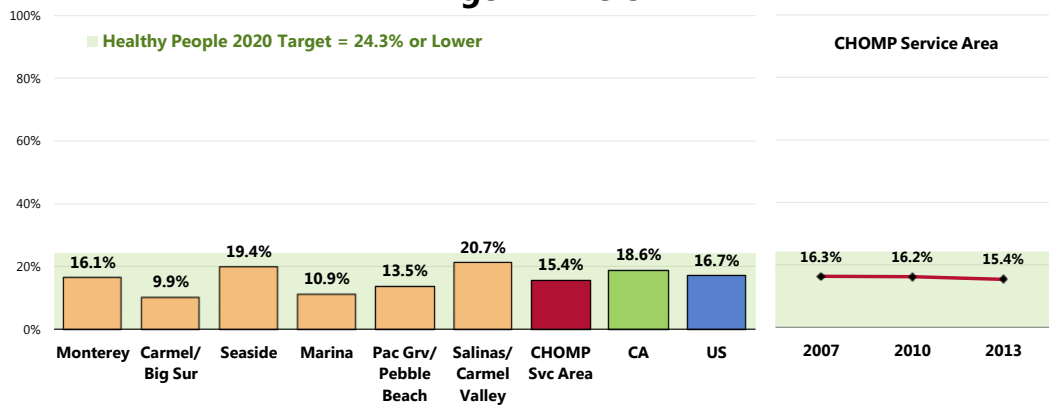
1) MEN who report drinking 5 or more alcoholic drinks on any single occasion during the past month; and

2) WOMEN who report drinking 4 or more alcoholic drinks on any single occasion during the past month.

**A total of 15.4% of CHOMP Service Area adults are binge drinkers.**




- Lower than California findings.
- Similar to national findings.
- Satisfies the Healthy People 2020 target (24.3% or lower).
- Favorably low in Carmel/Big Sur.
- ☒ Similar to the 2007 percentage (note, however, that the previous definition for binge drinking was five or more drinks, regardless of gender).

### Binge Drinkers

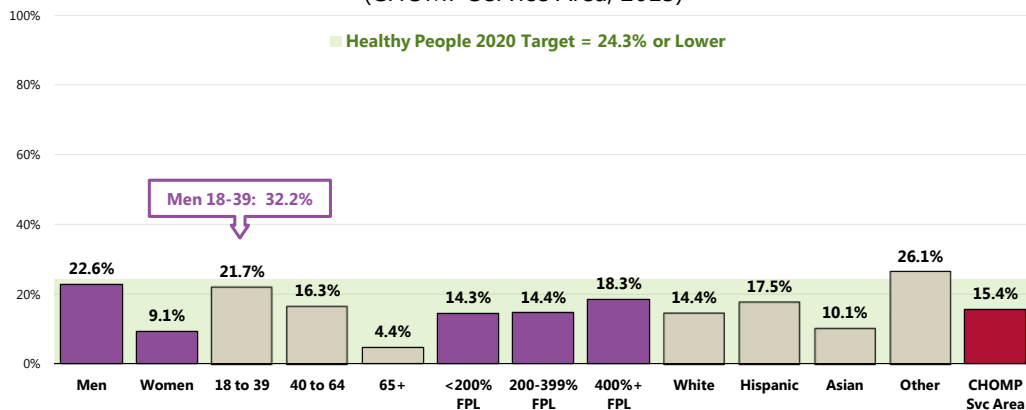


Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 189]  
• Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC). 2011 California data.  
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.  
• US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective SA-14.3]  
Notes: • Asked of all respondents.  
• Binge drinkers are defined as men having 5+ alcoholic drinks on any one occasion or women consuming 4+ drinks on any one occasion.

Binge drinking is more prevalent among:

-  Men (especially those under age 40).
-  Adults under age 65, and especially those under 40.
-  Adults of "Other" races.

### Binge Drinkers (CHOMP Service Area, 2013)




Sources: • 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 189]  
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective SA-14.3]  
 Notes: • Asked of all respondents.  
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "<200% FPL" includes households with incomes up to 199% of the federal poverty level, "200-399% FPL" includes households with incomes between 200% and 399% of the federal poverty level, and "400+ FPL" includes those households with incomes at 400% or more the federal poverty level.  
 • Binge drinkers are defined as men having 5+ alcoholic drinks on any one occasion or women consuming 4+ drinks on any one occasion

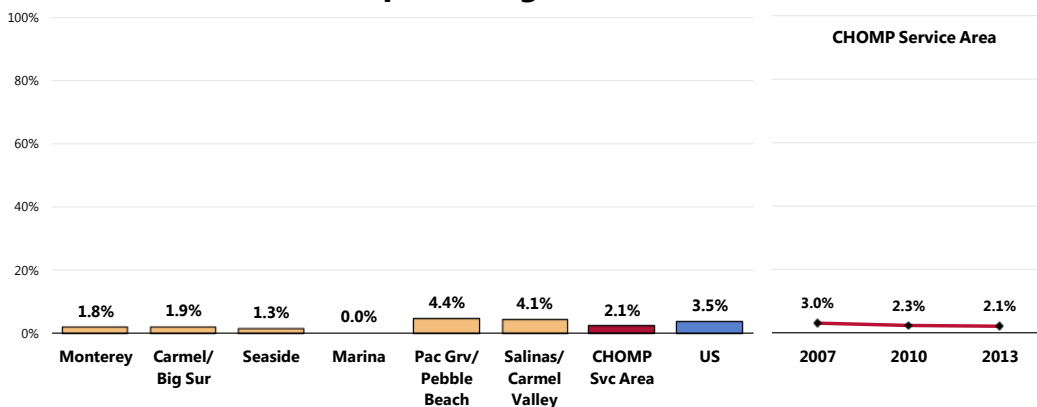
### Drinking & Driving

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

**A total of 2.1% of CHOMP Service Area adults acknowledge having driven a vehicle in the past month after they had perhaps too much to drink.**

- Similar to the national findings.
- Lowest in Marina.
-  The drinking and driving prevalence has not changed significantly over time.

### Have Driven in the Past Month After Perhaps Having Too Much to Drink

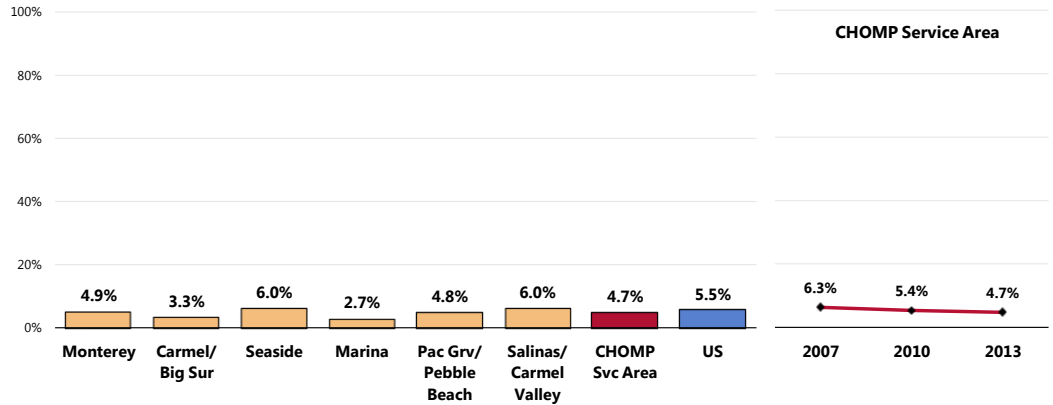


Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 72]  
 • 2011 PRC National Health Survey, Professional Research Consultants, Inc.  
 Notes: • Asked of all respondents.

A total of 4.7% of CHOMP Service Area adults acknowledge either drinking and driving or riding with a drunk driver in the past month.

- Similar to the national findings.
- Similar findings by community.
- ☒ Statistically unchanged over time in the CHOMP Service Area.

### Have Driven Drunk OR Ridden With a Driver in the Past Month Who Had Too Much to Drink



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 190]  
 • 2011 PRC National Health Survey, Professional Research Consultants, Inc.

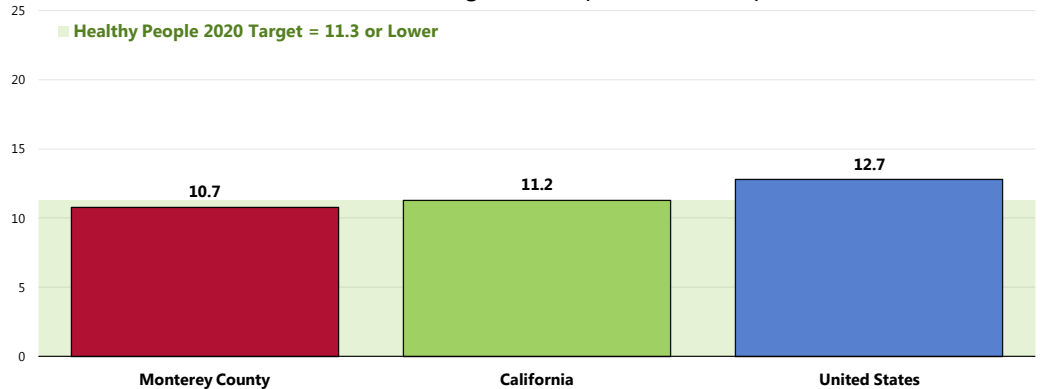
Notes: • Asked of all respondents.

### Age-Adjusted Drug-Induced Deaths

Between 2008 and 2010, there was an annual average age-adjusted drug-induced mortality rate of 10.7 deaths per 100,000 population in Monterey County.

- Similar to the statewide rate.
- Lower than the national rate.
- Satisfies the Healthy People 2020 target (11.3 or lower).

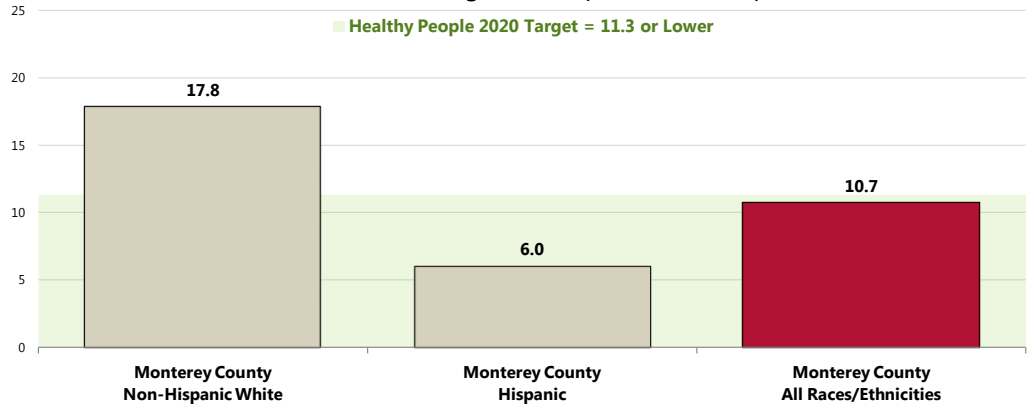
### Drug-Induced Deaths: Age-Adjusted Mortality (2008-2010 Annual Average Deaths per 100,000 Population)



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2013.  
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective SA-12]  
 Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).  
 • Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.  
 • Local, state and national data are simple three-year averages.

👤 The drug-induced mortality rate is notably higher among Whites than Hispanics in Monterey County.

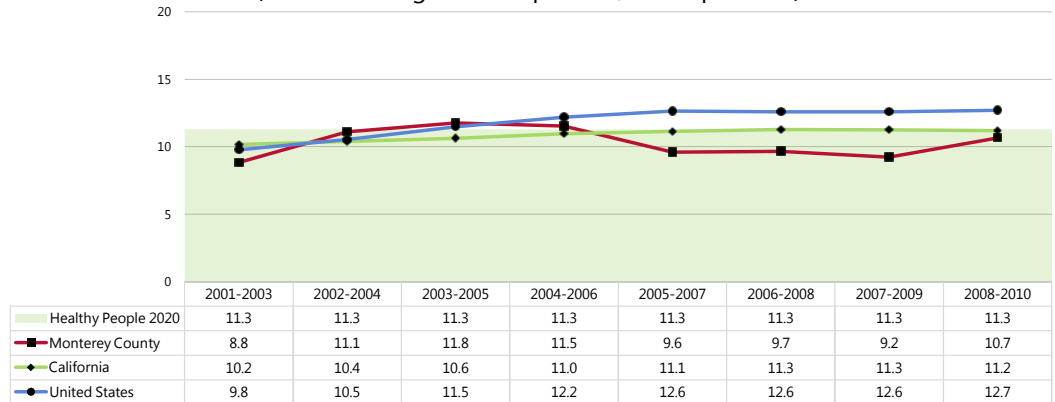
### Drug-Induced Deaths: Age-Adjusted Mortality by Race (2008-2010 Annual Average Deaths per 100,000 Population)



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2013.  
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> (Objective SA-12)  
 Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).  
 • Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.  
 • County, state and national data are simple three-year averages.

📈 The drug-induced mortality rate has fluctuated in the county over the past decade, with an uptick in the most recent reporting period. Statewide and nationwide, rates have clearly increased.

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



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2013.  
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> (Objective SA-12)  
 Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).  
 • Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.  
 • County, state and national data are simple three-year averages.



## Illicit Drug Use

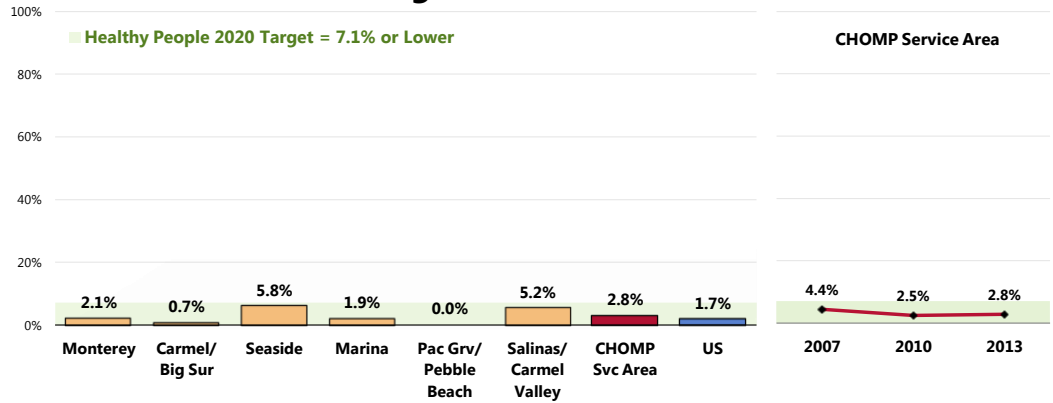
For the purposes of this survey, "illicit drug use" includes use of illegal substances or of prescription drugs taken without a physician's order.

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

**A total of 2.8% of CHOMP Service Area adults acknowledge using an illicit drug in the past month.**

- Similar to the proportion found nationally.
- Similar to the Healthy People 2020 target of 7.1% or lower.
- Lowest in Carmel/Big Sur and Pacific Grove/Pebble Beach; highest in Seaside.
- ☒ Unchanged over time.

### Illicit Drug Use in the Past Month



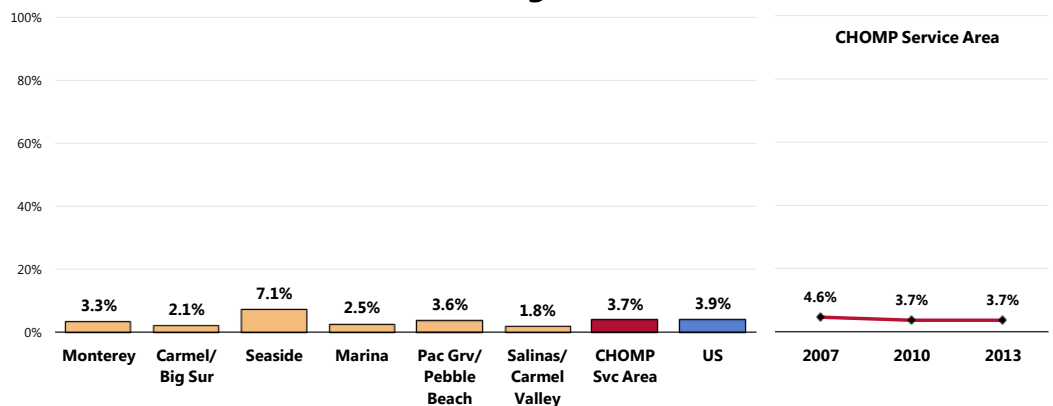
Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 74]  
 • 2011 PRC National Health Survey, Professional Research Consultants, Inc.  
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective SA-13.3]  
 Notes: • Asked of all respondents.

## Alcohol & Drug Treatment

**A total of 3.7% of CHOMP Service Area adults report that they have sought professional help for an alcohol or drug problem at some point in their lives.**

- Similar to national findings.
- Highest among Seaside residents.
- ☒ Statistically unchanged over time.

### Have Ever Sought Professional Help for an Alcohol/Drug-Related Problem



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 75]  
 • 2011 PRC National Health Survey, Professional Research Consultants, Inc.  
 Notes: • Asked of all respondents.

## Related Focus Group Findings: Substance Abuse

Substance abuse in the community is of concern to many focus group attendees. The main issues discussed surrounding substance abuse included:

- Prevalence of drug use
- Prescription medication
- Need additional substance abuse treatment facilities

A number of focus group participants worry about the **prevalence of drug use** in the community and its negative impact on residents' lives. Participants agree that the high substance use rates in the community are one contributor to the high rates of violence, sexually transmitted diseases and other poor behavioral choices. Drugs are readily available in the community and use begins as early as middle school. Many parents are in denial about their children's drug or alcohol use.

Attendees agree that substance use occurs across all demographics and worry specifically about alcohol, methamphetamine, cocaine, heroin, marijuana, and prescription drugs. Participants think that many residents have easy access to **prescription medication** and that the current healthcare system supports prescription drug abuse. Key informants feel that medical providers do not pay enough attention to past prescriptions, nor do they check records closely. If physicians did these things it might eliminate some of the "doctor-shopping" behaviors.

*"We recently treated a kid; this kid was getting all of his drugs legally. Again, in today's day and age of electronics we have the abilities to find out whether people are doctor shopping to get prescription meds and abusing prescription meds. And we really, when you hear a physician say I'm not going to take the time to look and see that my colleague just prescribed 60 Vicodin yesterday even though it's right there in front of you in the computer and so forth, we've got to continue to address the fact that again our system is supporting substance abuse, especially prescription substance abuse in this community horrendously. This kid was taking 30 milligrams of Xanax a day, plus opiates, plus Adderall, and he was getting it all via his insurance." — Healthcare Provider*

Participants believe that the community **needs additional substance abuse treatment facilities**. Key informants describe the Sun Street Centers in Salinas as an agency that provides some education, prevention and recovery services for residents of any income. Beacon and Genesis House offer residential substance abuse treatment programs. However, participants think that very few have programs available locally for adolescents (the inpatient adolescent treatment center closed because of low census numbers).

# Tobacco Use

Tobacco use is the single most preventable cause of death and disease in the United States. Each year, approximately 443,000 Americans die from tobacco-related illnesses. For every person who dies from tobacco use, 20 more people suffer with at least one serious tobacco-related illness. In addition, tobacco use costs the US \$193 billion annually in direct medical expenses and lost productivity.

Scientific knowledge about the health effects of tobacco use has increased greatly since the first Surgeon General's report on tobacco was released in 1964.

Tobacco use causes:

- Cancer
- Heart disease
- Lung diseases (including emphysema, bronchitis, and chronic airway obstruction)
- Premature birth, low birth weight, stillbirth, and infant death

There is no risk-free level of exposure to secondhand smoke. Secondhand smoke causes heart disease and lung cancer in adults and a number of health problems in infants and children, including: severe asthma attacks; respiratory infections; ear infections; and sudden infant death syndrome (SIDS).

Smokeless tobacco causes a number of serious oral health problems, including cancer of the mouth and gums, periodontitis, and tooth loss. Cigar use causes cancer of the larynx, mouth, esophagus, and lung.

– Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

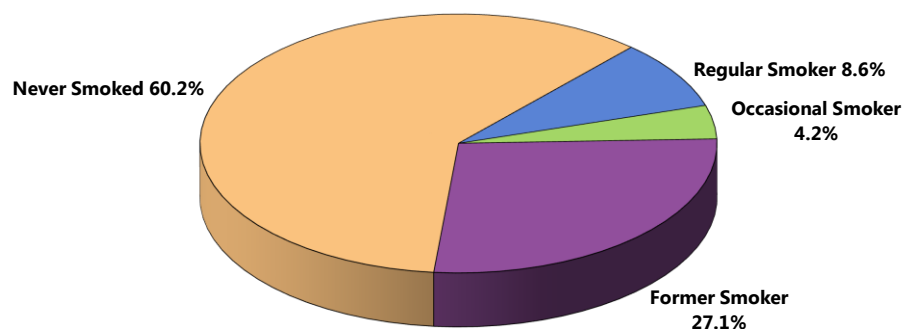
## Cigarette Smoking

### Cigarette Smoking Prevalence

**A total of 12.8% of CHOMP Service Area adults currently smoke cigarettes, either regularly (8.6% every day) or occasionally (4.2% on some days).**

### Cigarette Smoking Prevalence

(CHOMP Service Area, 2013)

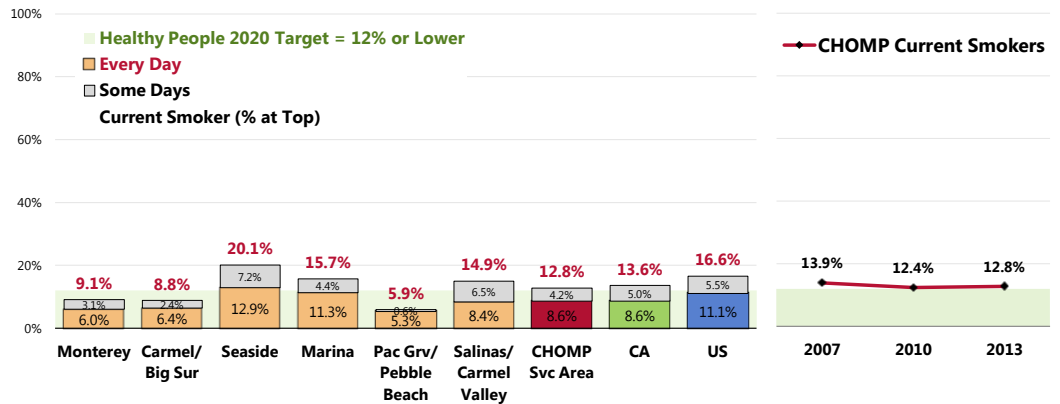


Sources: • 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 183]  
Notes: • Asked of all respondents.

- Similar to statewide findings.
- More favorable than national findings.
- Similar to the Healthy People 2020 target (12% or lower).

- Least favorable in Seaside; most favorable in Monterey and Pacific Grove/Pebble Beach.
- ☒ The current smoking percentage is statistically unchanged since 2007.

## Current Smokers



Sources:
 

- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 183]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC). 2011 California data.
- US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective TU-1.1]

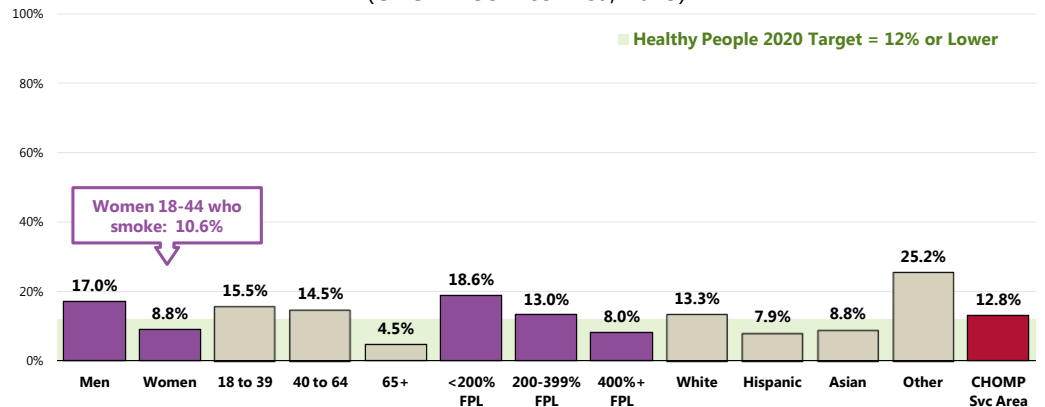
 Notes:
 

- Asked of all respondents.
- Includes regular and occasional smokers (everyday and some days).

Cigarette smoking is more prevalent among:

- ☺ Men.
- ☺ Adults under 65.
- ☺ Lower-income residents.
- ☺ Whites and "Other" adults.
- ☺ Note also that 10.6% of women of child-bearing age (ages 18 to 44) currently smoke. This is notable given that tobacco use increases the risk of infertility, as well as the risks for miscarriage, stillbirth and low birthweight for women who smoke during pregnancy.

## Current Smokers (CHOMP Service Area, 2013)



Sources:
 

- 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 183-184]
- US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective TU-1.1]

 Notes:
 

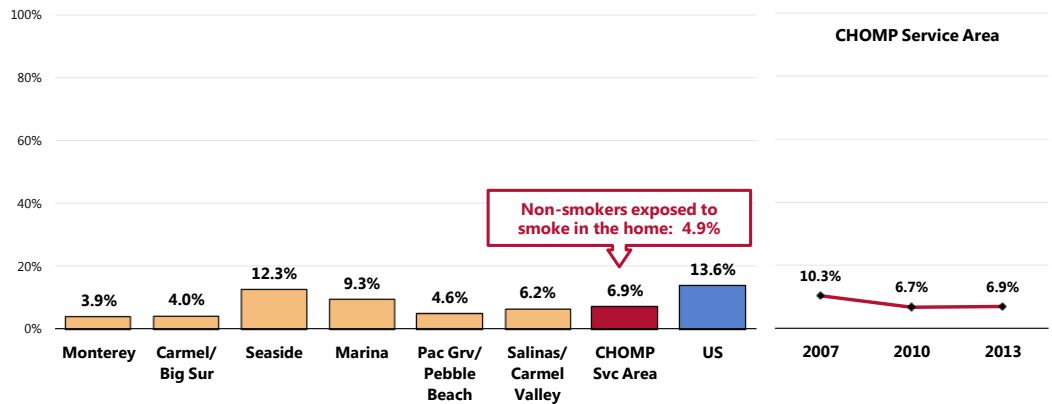
- Asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "<200% FPL" includes households with incomes up to 199% of the federal poverty level; "200-399% FPL" includes households with incomes between 200% and 399% of the federal poverty level; and "400%+ FPL" includes those households with incomes at 400% or more the federal poverty level.
- Includes regular and occasion smokers (everyday and some days).

## Environmental Tobacco Smoke

**A total of 6.9% of CHOMP Service Area adults (including smokers and non-smokers) report that a member of their household has smoked cigarettes in the home an average of 4+ times per week over the past month.**

- More favorable than national findings.
- Highest in Seaside; lowest in Monterey.
- ▣ Marks a statistically significant decrease over time.
- 👤 Note that 4.9% of CHOMP Service Area non-smokers are exposed to cigarette smoke at home.

### Member of Household Smokes at Home

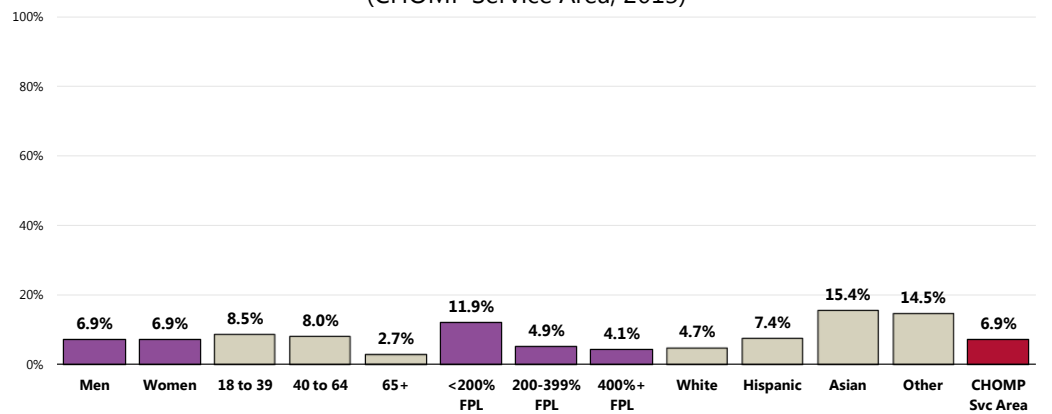


Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Items 66, 185]  
 • 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes: • Asked of all respondents.  
 • "Smokes at home" refers to someone smoking cigarettes, cigars, or a pipe in the home an average of four or more times per week in the past month.

- 👤 Notably higher among residents under 65, those with lower incomes, Asian residents, and residents of "Other" races.

### Member of Household Smokes At Home (CHOMP Service Area, 2013)



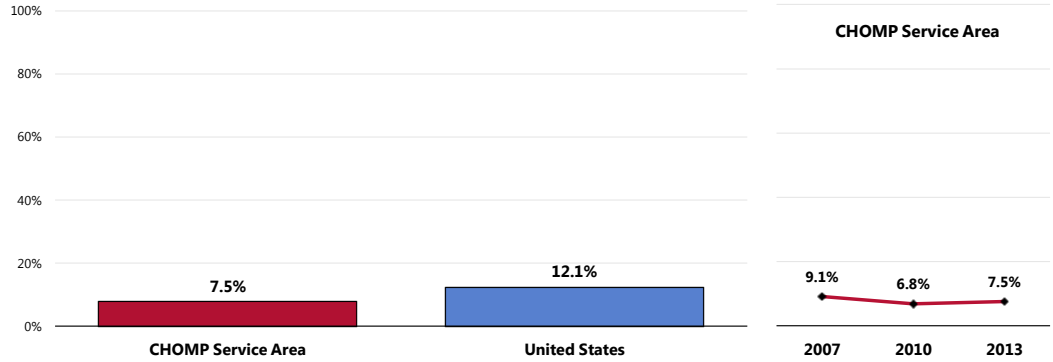
Sources: • 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 66]

Notes: • Asked of all respondents.  
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "<200% FPL" includes households with incomes up to 199% of the federal poverty level; "200-399% FPL" includes households with incomes between 200% and 399% of the federal poverty level; and "400%+ FPL" includes those households with incomes at 400% or more the federal poverty level.  
 • "Smokes at home" refers to someone smoking cigarettes, cigars, or a pipe in the home an average of four or more times per week in the past month.

**Among households with children, 7.5% have someone who smokes cigarettes in the home.**

- More favorable than national findings.
- ☒ Statistically unchanged over time.

**Percentage of Households With Children In Which Someone Smokes in the Home**



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 186]  
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.  
Notes: • Asked of all respondents.  
• "Smokes at home" refers to someone smoking cigarettes, cigars, or a pipe in the home an average of four or more times per week in the past month.

**Smoking Cessation**

Preventing tobacco use and helping tobacco users quit can improve the health and quality of life for Americans of all ages. People who stop smoking greatly reduce their risk of disease and premature death. Benefits are greater for people who stop at earlier ages, but quitting tobacco use is beneficial at any age.

Many factors influence tobacco use, disease, and mortality. Risk factors include race/ethnicity, age, education, and socioeconomic status. Significant disparities in tobacco use exist geographically; such disparities typically result from differences among states in smoke-free protections, tobacco prices, and program funding for tobacco prevention.

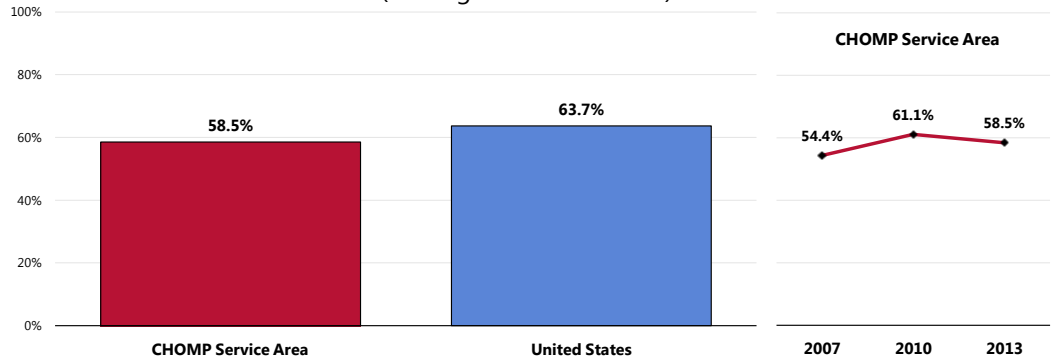
– Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

**Health Advice About Smoking Cessation**

**A total of 58.5% of smokers say that a doctor, nurse or other health professional has recommended in the past year that they quit smoking.**

- Comparable to the national percentage.
- ☒ No statistically significant change since 2007.

## Advised by a Healthcare Professional in the Past Year to Quit Smoking (Among Current Smokers)



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 65]  
 • 2011 PRC National Health Survey, Professional Research Consultants, Inc.  
 Notes: • Asked of all current smokers.

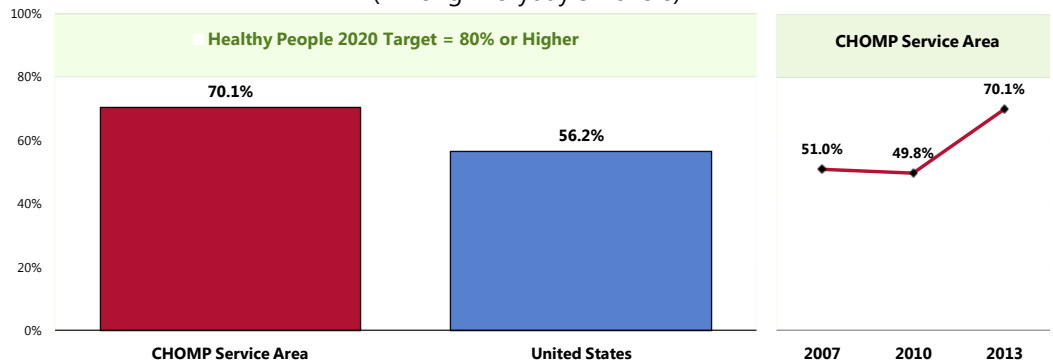
### Smoking Cessation Attempts

**A total of 7 in 10 (70.1%) regular smokers went without smoking for one day or longer in the past year because they were trying to quit smoking.**

- Higher than the national percentage.
- Fails to satisfy the Healthy People 2020 target (80% or higher).

Denotes a significant increase over time.

## Have Stopped Smoking for One Day or Longer in the Past Year in an Attempt to Quit Smoking (Among Everyday Smokers)



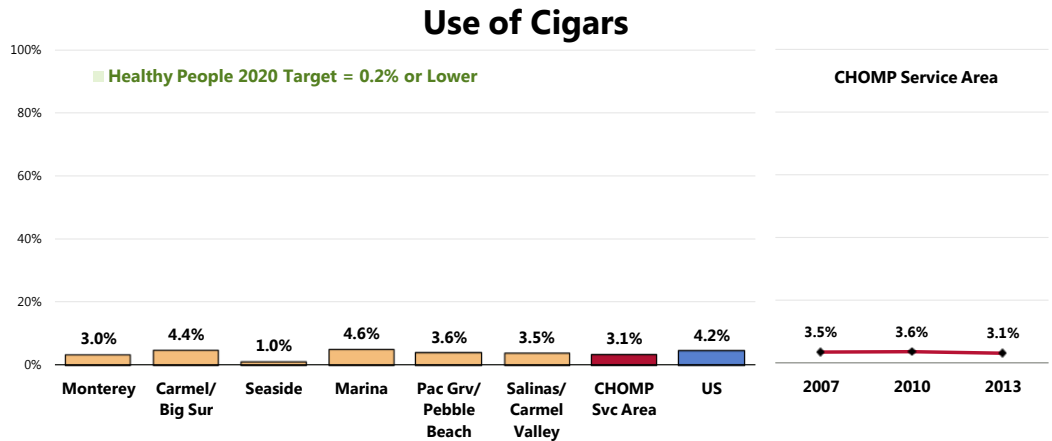
Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 64]  
 • 2011 PRC National Health Survey, Professional Research Consultants, Inc.  
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective TU-4.1]  
 Notes: • Asked of respondents who smoke cigarettes every day.

## Other Tobacco Use

### Cigars

**A total of 3.1% of CHOMP Service Area adults use cigars every day or on some days.**

- Similar to the national percentage.
- Fails to satisfy the Healthy People 2020 target (0.2% or lower).
- Favorably low in Seaside.
- 📊 Statistically unchanged since 2007.

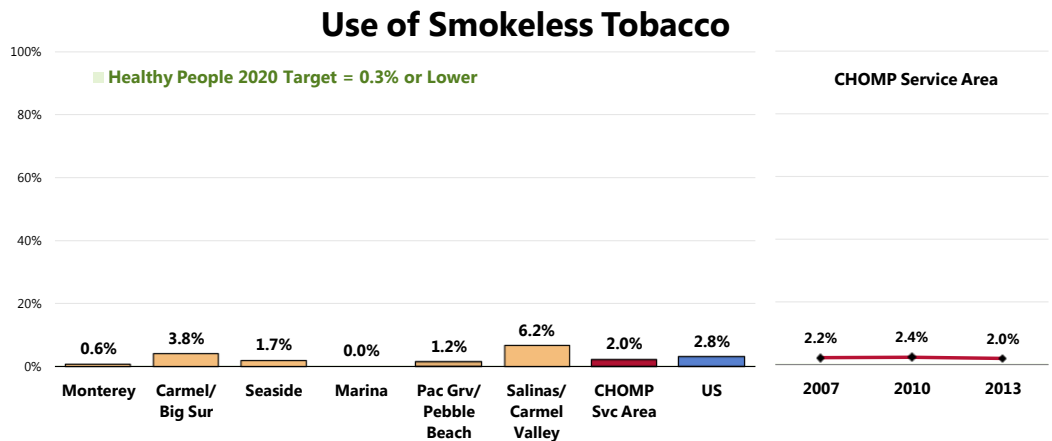


Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 68]  
 • 2011 PRC National Health Survey, Professional Research Consultants, Inc.  
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective TU-1.3]  
 Notes: • Asked of all respondents.

### Smokeless Tobacco

**2.0% of CHOMP Service Area adults use smokeless tobacco every day or on some days.**

- Comparable to the national percentage.
- Fails to satisfy the Healthy People 2020 target (0.3% or lower).
- Unfavorably high in Salinas/Carmel Valley; lowest in Monterey and Marina.
- 📊 Similar to 2007 findings.

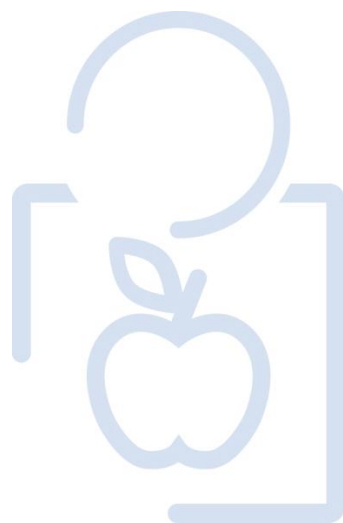


Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 67]  
 • 2011 PRC National Health Survey, Professional Research Consultants, Inc.  
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective TU-1.2]  
 Notes: • Asked of all respondents.  
 • Smokeless tobacco includes chewing tobacco or snuff.

Examples of smokeless tobacco include chewing tobacco, snuff, or "snus."



# ACCESS TO HEALTH SERVICES



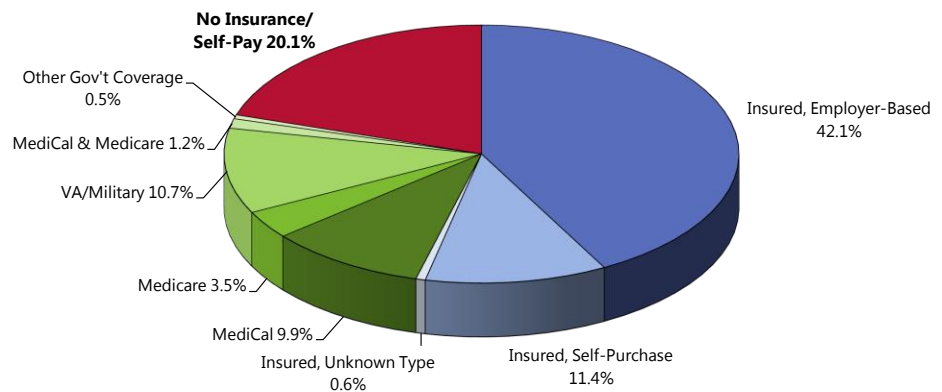
# Health Insurance Coverage

Survey respondents were asked a series of questions to determine their healthcare insurance coverage, if any, from either private or government-sponsored sources.

## Type of Healthcare Coverage

**A total of 54.1% of CHOMP Service Area adults age 18 to 64 report having healthcare coverage through private insurance. Another 25.8% report coverage through a government-sponsored program (e.g., MediCal, Medicare, military benefits).**

**Healthcare Insurance Coverage**  
(Among Adults 18-64; CHOMP Service Area, 2013)



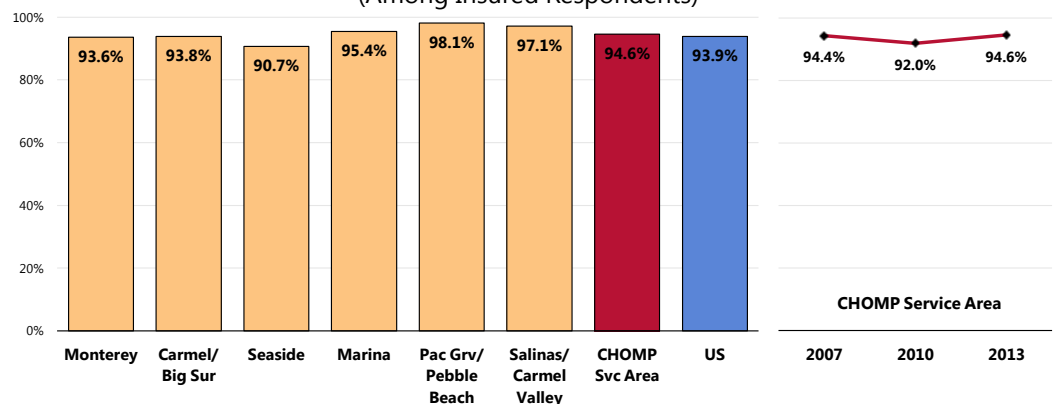
Sources: • 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 191]  
Notes: • Reflects respondents age 18 to 64

## Prescription Drug Coverage

**Among insured adults, 94.6% report having prescription coverage as part of their insurance plan.**

- Comparable to the national prevalence.
- Lowest in Seaside; highest in Pacific Grove/Pebble Beach.
- ☒ Unchanged over time.

**Health Insurance Covers Prescriptions at Least in Part**  
(Among Insured Respondents)



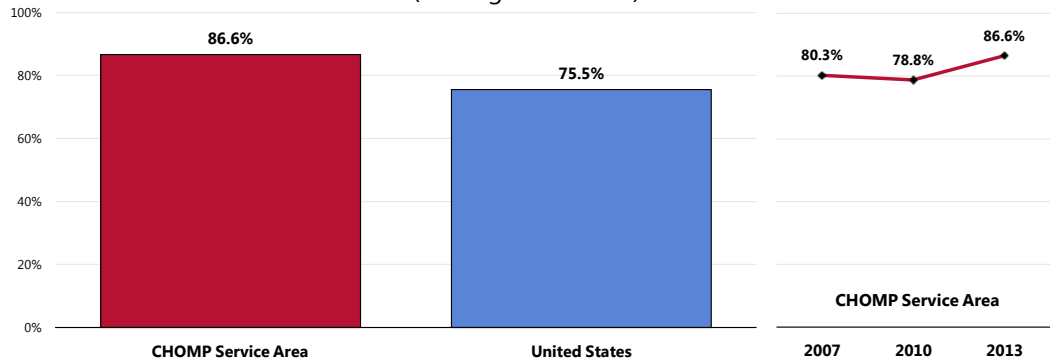
Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 89]  
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.  
Notes: • Asked of all respondents with healthcare insurance coverage.

## Supplemental Coverage

Among Medicare recipients, the majority (86.6%) has additional, supplemental healthcare coverage.

- Higher than that reported among Medicare recipients nationwide.
- ☒ Denotes a significant increase over time.

### Have Supplemental Coverage in Addition to Medicare (Among Adults 65+)



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 88]  
 • 2011 PRC National Health Survey, Professional Research Consultants, Inc.  
 Notes: • Asked of respondents age 65+.

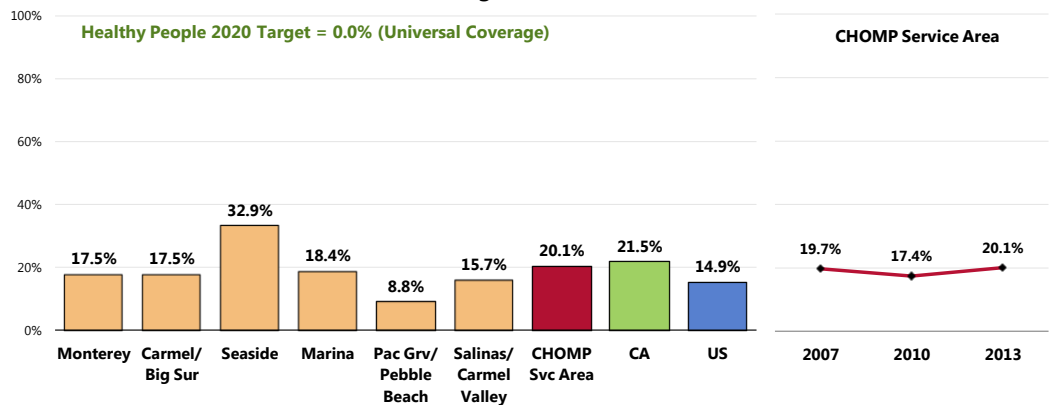
## Lack of Health Insurance Coverage

Here, lack of health insurance coverage reflects respondents age 18 to 64 (thus, excluding the Medicare population) who have no type of insurance coverage for healthcare services – neither private insurance nor government-sponsored plans (e.g., Medicaid).

Among adults age 18 to 64, 20.1% report having no insurance coverage for healthcare expenses.




- Similar to the state finding.
- Worse than the national finding.
- The Healthy People 2020 target is universal coverage (0% uninsured).
- Highest in Seaside; lowest in Pacific Grove/Pebble Beach.
- ☒ Statistically similar to 2007 findings.

### Lack of Healthcare Insurance Coverage (Among Adults 18-64)



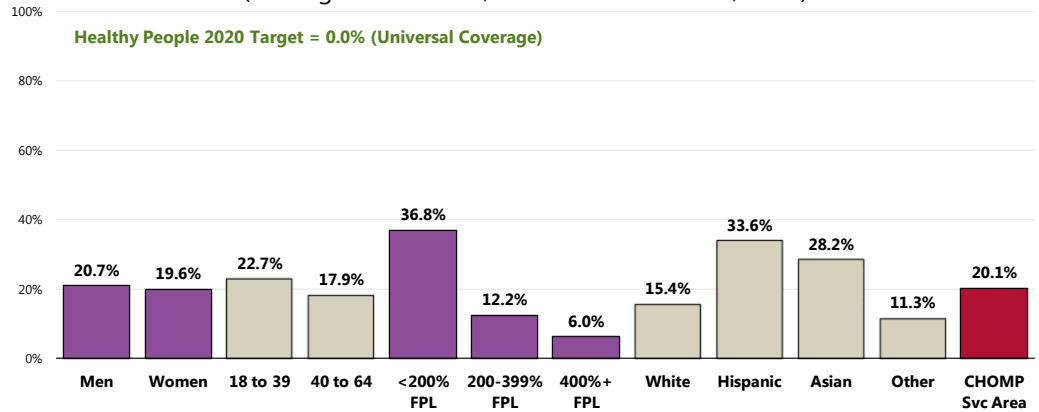
Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 191]  
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2011 California data.  
 • 2011 PRC National Health Survey, Professional Research Consultants, Inc.  
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective AHS-1]  
 Notes: • Asked of all respondents under the age of 65.

The following population segments are more likely to be without healthcare insurance coverage:


-  Young adults (under 40).
-  Residents living at lower incomes (note the 36.8% uninsured prevalence among low-income adults).
-  Hispanics and Asians.

## Lack of Healthcare Insurance Coverage

(Among Adults 18-64; CHOMP Service Area, 2013)

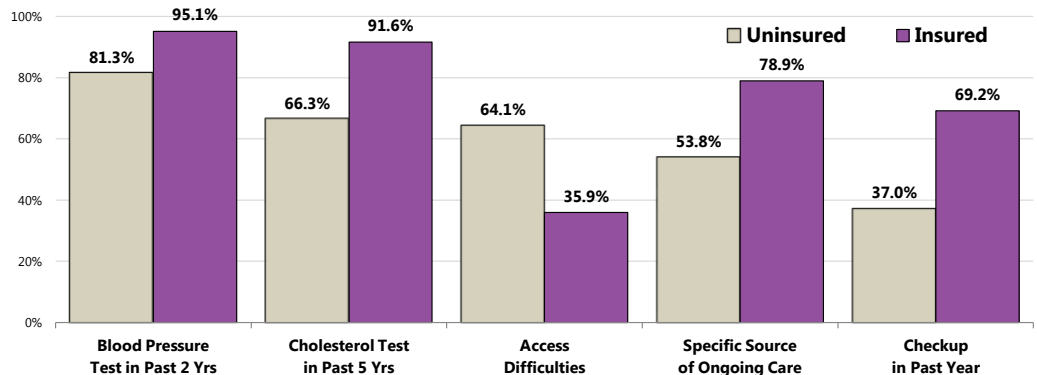


- Sources:
- 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 191]
  - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective AHS-1]
- Notes:
- Asked of all respondents under the age of 65.
  - Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
  - Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "<200% FPL" includes households with incomes up to 199% of the federal poverty level; "200-399% FPL" includes households with incomes between 200% and 399% of the federal poverty level; and "400%+ FPL" includes those households with incomes at 400% or more the federal poverty level.

-  As might be expected, uninsured adults in CHOMP Service Area are less likely to receive routine care and preventive health screenings, and are more likely to have experienced difficulties accessing healthcare.

## Preventive Healthcare

(By Insured Status; CHOMP Service Area, 2013)



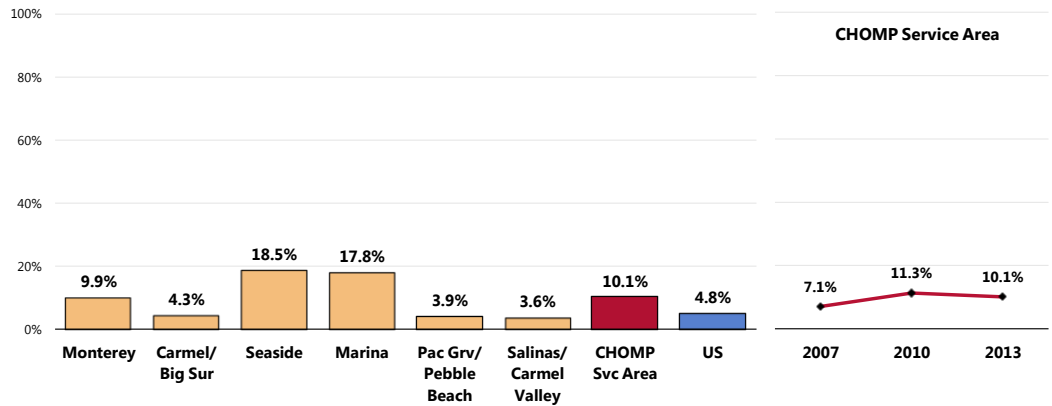
- Sources:
- 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 17, 48, 51, 192, 195]
- Notes:
- Asked of all respondents.

## Recent Lack of Coverage (Insurance Instability)

Among currently insured adults in CHOMP Service Area, 10.1% report that they were without healthcare coverage at some point in the past year.

- Twice the US prevalence.
- Higher in Seaside and Marina; lower in Carmel/Big Sur, Pacific Grove/Pebble Beach, and Salinas/Carmel Valley.
- ☒ Marks a statistically significant increase in insurance instability.

### Went Without Healthcare Insurance Coverage At Some Point in the Past Year (Among Insured Adults)



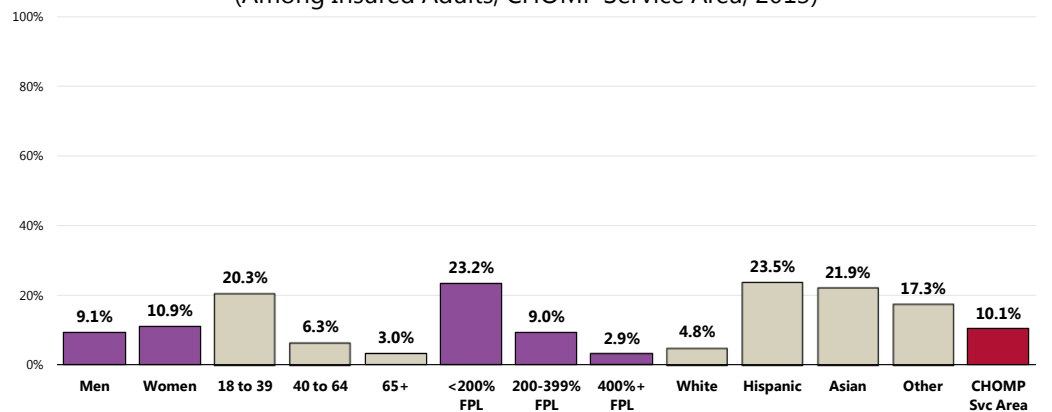
Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 90]  
● 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes: ● Asked of all insured respondents.

Among insured adults, the following segments are more likely to have gone without healthcare insurance coverage at some point in the past year:

- ☒ Adults under age 40, lower-income residents, and Non-White adults.

### Went Without Healthcare Insurance Coverage At Some Point in the Past Year (Among Insured Adults; CHOMP Service Area, 2013)



Sources: ● 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 90]

Notes: ● Asked of all insured respondents.

● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).

● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "<200% FPL" includes households with incomes up to 199% of the federal poverty level; "200-399% FPL" includes households with incomes between 200% and 399% of the federal poverty level; and "400%+ FPL" includes those households with incomes at 400% or more the federal poverty level.

# Difficulties Accessing Healthcare

Access to comprehensive, quality health care services is important for the achievement of health equity and for increasing the quality of a healthy life for everyone. It impacts: overall physical, social, and mental health status; prevention of disease and disability; detection and treatment of health conditions; quality of life; preventable death; and life expectancy.

Access to health services means the timely use of personal health services to achieve the best health outcomes. It requires three distinct steps: 1) Gaining entry into the health care system; 2) Accessing a health care location where needed services are provided; and 3) Finding a health care provider with whom the patient can communicate and trust.

- Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

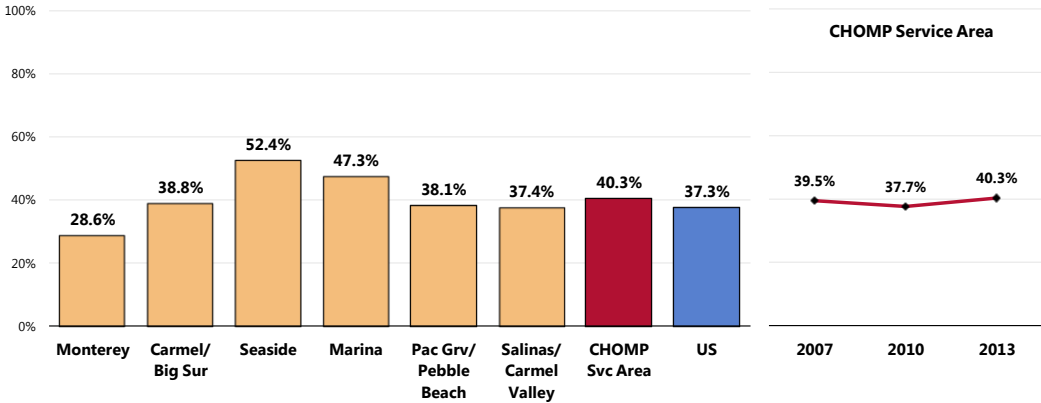
## Difficulties Accessing Services

**A total of 40.3% of CHOMP Service Area adults report some type of difficulty or delay in obtaining healthcare services in the past year.**

- Similar to national findings.
- Highest in Seaside, lowest in Monterey.
- ☒ Similar to the percentage reported in 2007.




This indicator reflects the percentage of the total population experiencing problems accessing healthcare in the past year, regardless of whether they needed or sought care.

### Experienced Difficulties or Delays of Some Kind in Receiving Needed Healthcare in the Past Year

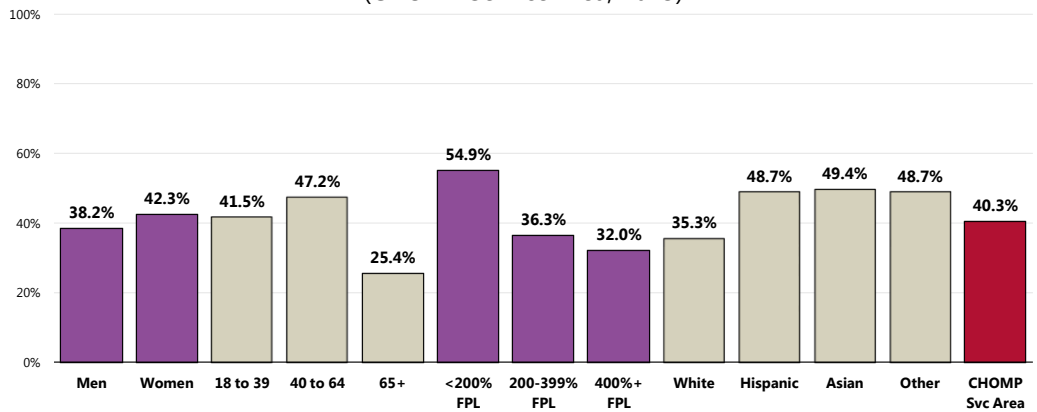


Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 195]  
 ● 2011 PRC National Health Survey, Professional Research Consultants, Inc.  
 Notes: ● Asked of all respondents.  
 ● Represents the percentage of respondents experiencing one or more barriers to accessing healthcare in the past 12 months.

Note that the following demographic groups more often report difficulties accessing healthcare services:

-  Adults under the age of 65.
-  Lower-income residents.
-  Non-Whites.

### Experienced Difficulties or Delays of Some Kind in Receiving Needed Healthcare in the Past Year (CHOMP Service Area, 2013)



Sources: • 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 195]  
 Notes: • Asked of all respondents.  
 • Represents the percentage of respondents experiencing one or more barriers to accessing healthcare in the past 12 months.  
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "<200% FPL" includes households with incomes up to 199% of the federal poverty level; "200-399% FPL" includes households with incomes between 200% and 399% of the federal poverty level; and "400%+ FPL" includes those households with incomes at 400% or more the federal poverty level.

### Barriers to Healthcare Access

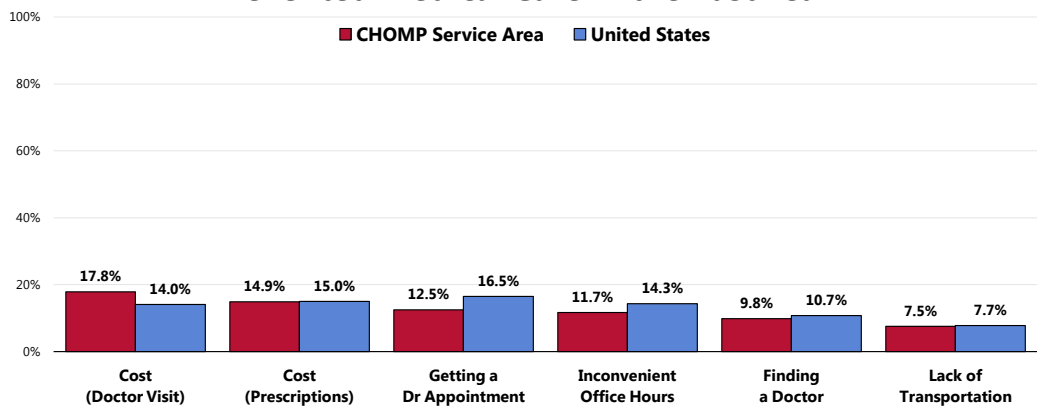
To better understand healthcare access barriers, survey participants were asked whether any of six types of barriers to access prevented them from seeing a physician or obtaining a needed prescription in the past year.

Again, these percentages reflect the total population, regardless of whether medical care was needed or sought.

**Of the tested barriers, cost of a physician visit impacted the greatest share of CHOMP Service Area adults (17.8% say that cost prevented them from obtaining a visit to a physician in the past year).**

- The proportion of CHOMP Service Area adults impacted was statistically comparable to that found nationwide for **each** of the tested barriers, with the exception of cost for a doctor visit (for which the service area fared worse).

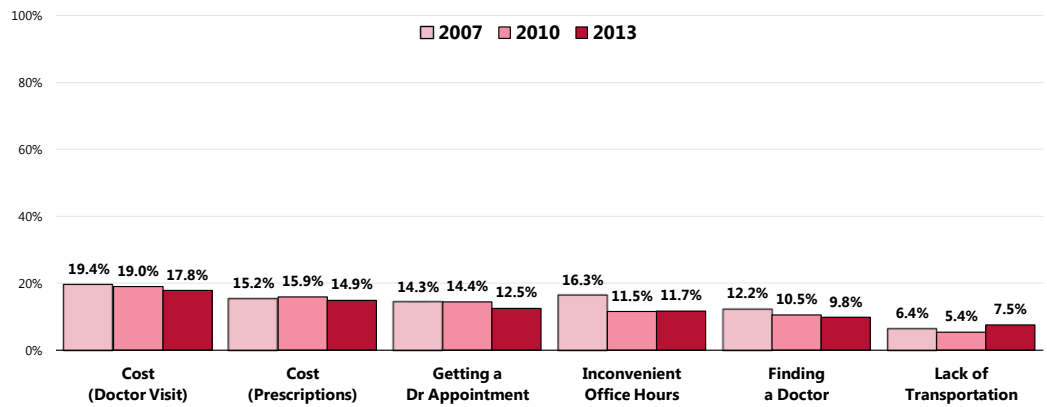
### Barriers to Access Have Prevented Medical Care in the Past Year



Sources: • 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 7-12]  
 • 2011 PRC National Health Survey, Professional Research Consultants, Inc.  
 Notes: • Asked of all respondents.

☒ Compared to baseline 2007 data, the CHOMP Service Area has seen a significant decrease with regard to the barrier of **inconvenient office hours** (all other barriers remained stable over time).

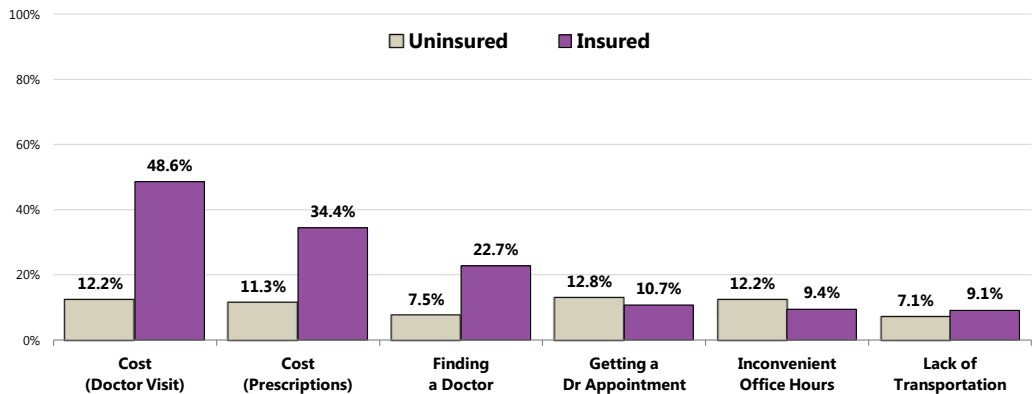
### CHOMP Service Area Trend: Barriers to Access Prevented Medical Care in the Past Year



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Items 7-12]  
Notes: • Asked of all respondents.

👥 As might be expected, CHOMP Service Area adults without health insurance are much more likely to report access barriers when compared to the insured population, particularly those related to cost.

### Barriers to Healthcare Access (By Insured Status, Adults 18+; CHOMP Service Area, 2013)



Sources: • 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 7-12]  
Notes: • Asked of all respondents.

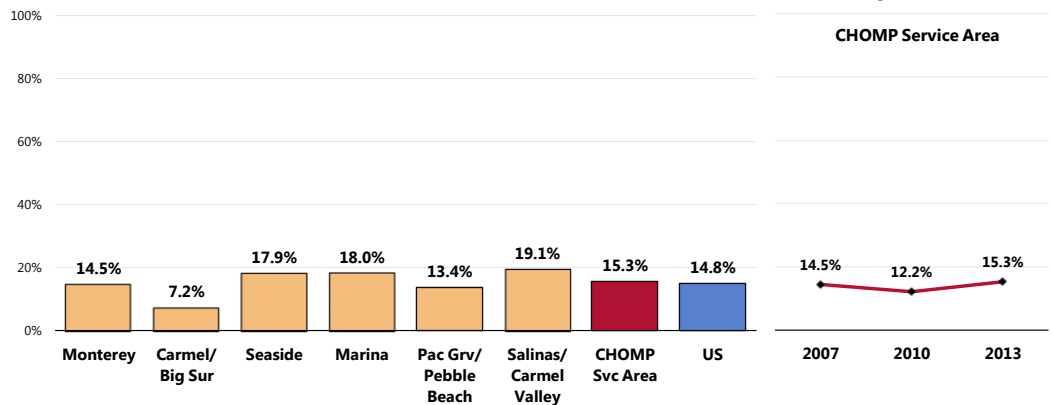


## Prescriptions

Among all CHOMP Service Area adults, 15.3% skipped or reduced medication doses in the past year in order to stretch a prescription and save money.

- Comparable to national findings.
- Favorably low in Carmel/Big Sur.
- ▨ Statistically similar to 2007 findings.

### Skipped or Reduced Prescription Doses in Order to Stretch Prescriptions and Save Money



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 13]  
 • 2011 PRC National Health Survey, Professional Research Consultants, Inc.

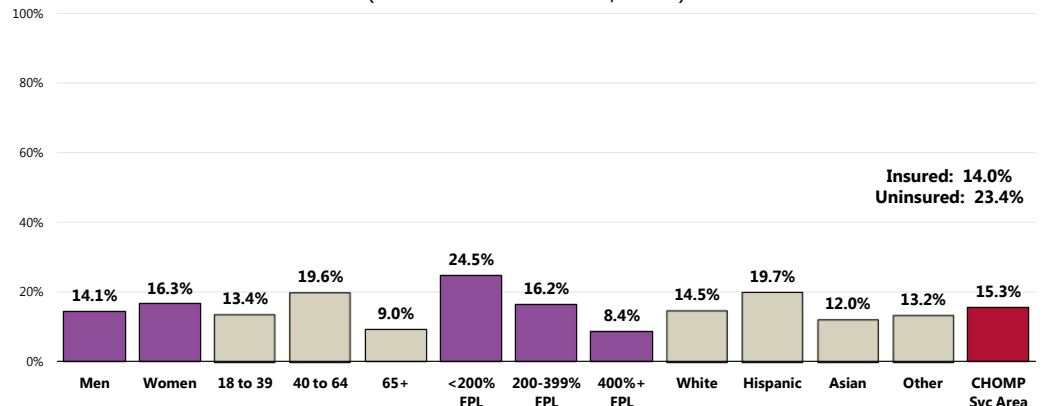
Notes: • Asked of all respondents.

Adults more likely to have skipped or reduced their prescription doses include:

- 👤 Adults age 40 to 64.
- 👤 Respondents with lower incomes (note the negative correlation with income).
- 👤 Uninsured adults.

### Skipped or Reduced Prescription Doses in Order to Stretch Prescriptions and Save Money

(CHOMP Service Area, 2013)



Sources: • 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 13]

Notes: • Asked of all respondents.

• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).

• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "<200% FPL" includes households with incomes up to 199% of the federal poverty level; "200-399% FPL" includes households with incomes between 200% and 399% of the federal poverty level; and "400%+ FPL" includes those households with incomes at 400% or more the federal poverty level.

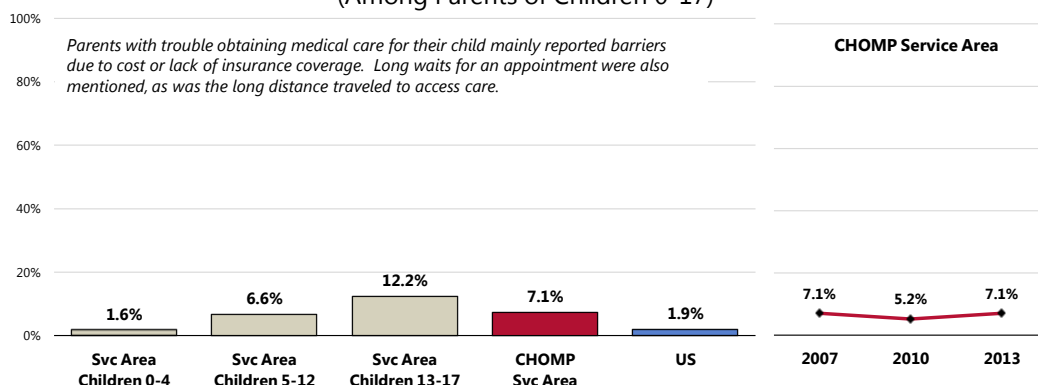
## Accessing Healthcare for Children

Surveyed parents were also asked if, within the past year, they experienced any trouble receiving medical care for a randomly-selected child in their household.

**A total of 7.1% of parents say there was a time in the past year when they needed medical care for their child, but were unable to get it.**

- Well above that reported nationwide.
- ☒ No significant change from 2007 survey findings.
- 👪 Note the positive correlation with child's age.

### Had Trouble Obtaining Medical Care for Child in the Past Year (Among Parents of Children 0-17)



Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Items 126-127]  
● 2011 PRC National Health Survey, Professional Research Consultants, Inc.  
Notes: ● Asked of all respondents with children 0 to 17 in the household.

Among the parents experiencing difficulties, the majority cited **cost or a lack of insurance** as the primary reason; others cited long waits for appointments and distance traveled to access care.

### Related Focus Group Findings: Access to Healthcare Services

Many of the key informants participating in the focus groups are concerned with access to healthcare, discussing such issues as:

- Barriers to accessing healthcare (including transportation and language)
- Poverty
- Health literacy
- Insurance status
- Limited number of physicians

Focus group participants agree that residents encounter several **barriers** when trying to **access healthcare services** in the community. Attendees report that Monterey County is economically diverse, with more residents living in poverty in the southern part of the county, many of whom may struggle to access healthcare services. Many residents work low-paying jobs in either the tourism or farming industries, both of which do not normally offer health insurance or paid time off. These factors make getting to a doctor's appointment during normal office hours difficult; residents do not want to miss work

because of the dock in pay.

*“One issue of access is time. Some of our farm workers will lose a whole day of pay for a one- or two-hour appointment because they’re not allowed to take that break and when it comes to a kid that’s a real hardship... When we were trying to get six years’ worth of teenagers vaccinated for pertussis, there were some free clinics that the Health Department put up. The main clinics that people access our services for were open for vaccinations between 9:00 and 12:00 and 1:00 and 3:00. Those were school hours...actually banks are doing better than medical care offices are now ‘cause they’re open on Saturdays, but the whole issue of having care provided at the same time everybody else is having to do their business limits the ability of people to get timely treatment because they might wait for the one available Saturday for the month to be able to get into care.”*  
— Community Leader

Many residents have low **health literacy** and do not realize the importance of preventative healthcare. Physicians are not reimbursed for providing health education and see many patients in a short period, so they do not have time to coach their patients. A healthcare provider stresses the importance of health education:

*“Physicians are by and large kind of providing band aid medicine. Hypertension, here a band aid for that. Diabetes, here a band aid for that. Dyslipidemia, there’s a band aid for that. But what’s really addressing the bigger issue? And that’s where we, are we really looking at lifestyle? Are we really looking at our diet the proper way... And that’s where if we can educate more efficiently, whether it’s to hit larger organizations on the Peninsula that have maybe larger employee populations or we get access through other community providers, organizations that people access around here, maybe that’s where we can get the word out a little bit.”*  
Healthcare Provider

Other key informants think that although the county has an extensive array of services, many people do not know about them or how to access the services.

*“Knowledge of those services is another area and then those that are able to access the services one of the other barriers, a language barrier, and when I say language barrier I don’t just mean the native language, I mean that they’re not receiving the information in a format that they can understand it. So they will leave the physician’s office not really understanding their diagnosis, not really understanding what their course of treatment should be, and as a result many people go without treatment.”*  
— Community Leader

Focus group members agree that **insurance status** impacts residents’ ability to obtain healthcare. Many community members are also under-insured or uninsured. The underinsured population includes the working poor, those individuals who may qualify for employer insurance but the deductibles are too high or the monthly employee cost is too much, so they elect to go without. Several options exist to serve this population: Natividad Medical Center serves the uninsured population; Seaside Family is a Federally Qualified Health Center (FQHC), but patients may have to wait hours to see a provider; RotoCare is a rotary-club-funded clinic that is open one night per week and operates solely through volunteers and donations. The clinic provides free medication, but no mental health services and the majority of their patients are undocumented. A healthcare provider explains the reality that these individuals face with accessing healthcare:

*“80 percent of my population anyway won’t be able to get insurance because most of them are undocumented. They’re barely hanging on. They could go back to their home country maybe and get some maybe better care. I doubt it. But they’re all trying to just hang on.”*  
— Healthcare

Another concern for focus group members is the **limited number of physicians** that work in Monterey County due to the high cost of living. A participant explains the difficulties recruiting physicians:

*“And you’re wondering why it’s so difficult to recruit a physician here, try buying a home here. Try going to medical school, having bills to pay, wanting to have a life, and a family, and a car, and a home, and send your children to school, and living in Monterey. Good luck.” — Healthcare Provider*

In addition, the number of schools with on-site nurses has decreased because of funding changes. This worries attendees because in the past school nurses would catch an illness in the early stages, but without nurses the child’s illness may not be identified.

*“Most schools do not have school nurses, we are lucky if we have a nurse per district full time. There are some very small school districts share nurses and so the nurses may be there only when called or emergencies, and that’s one of the really primary access points for the identification of a healthcare problem for a young child is the school nurse system. So when that’s not possible it’s delayed and maybe becomes a problem that’s more problematic and needs more expensive service.” — Community Leader*

**Transportation** can also act as a barrier, with many families depending on one car for the entire family, and others without any personal vehicles. Within the city of Monterey, public transportation is sufficient, but outside of the city residents have limited options. Many residents must make several transfers, or bus changes, to get to Natividad Medical Center or Big Sur. A healthcare provider describes the transportation crisis:

*“It’s hard just getting around in Salinas. Sometimes you have to go to the central, take one bus to one place, change to go back somewhere else.” — Healthcare Provider*

Key informants describe Monterey and the surrounding communities as having a fair number of undocumented immigrants. These residents may struggle accessing care due to the **language barrier** (and uninsured status.) Additional interpretive services are needed to better serve these populations.

# Primary Care Services

Improving health care services depends in part on ensuring that people have a usual and ongoing source of care. People with a usual source of care have better health outcomes and fewer disparities and costs. Having a primary care provider (PCP) as the usual source of care is especially important. PCPs can develop meaningful and sustained relationships with patients and provide integrated services while practicing in the context of family and community. Having a usual PCP is associated with:

- Greater patient trust in the provider
- Good patient-provider communication
- Increased likelihood that patients will receive appropriate care

Improving health care services includes increasing access to and use of evidence-based preventive services. Clinical preventive services are services that: **prevent** illness by detecting early warning signs or symptoms before they develop into a disease (primary prevention); or **detect** a disease at an earlier, and often more treatable, stage (secondary prevention).

– Healthy People 2020 (www.healthypeople.gov)

## Specific Source of Ongoing Care

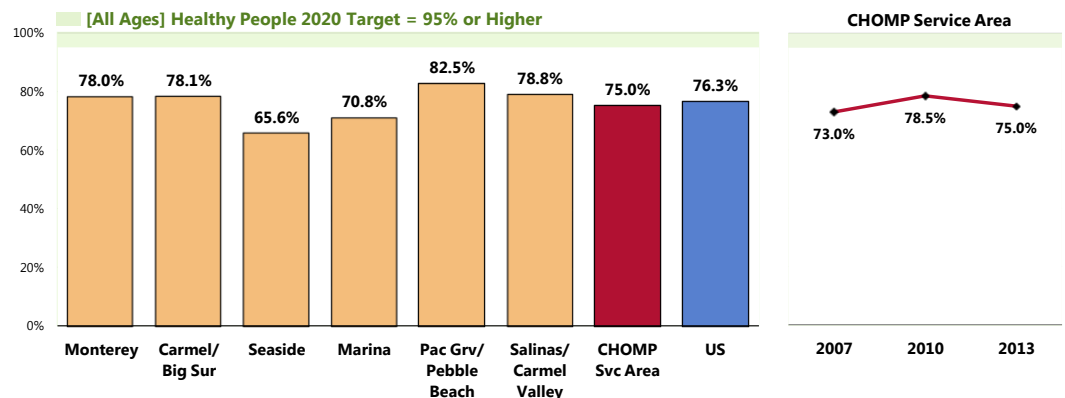
**A total of 75.0% of CHOMP Service Area adults were determined to have a specific source of ongoing medical care (a “medical home”).**

- Similar to national findings.
- Fails to satisfy the Healthy People 2010 objective (95% or higher).
- Lowest in Seaside; highest in Pacific Grove/Pebble Beach.
- 📊 Statistically unchanged over time.

Having a specific source of ongoing care includes having a doctor’s office, clinic, urgent care center, walk-in clinic, health center facility, hospital outpatient clinic, HMO or prepaid group, military/VA clinic, or some other kind of place to go if one is sick or needs advice about his or her health. This resource is also known as a “medical home.”

A hospital emergency room is not considered a source of ongoing care in this instance.

### Have a Specific Source of Ongoing Medical Care



Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 192]  
 ● 2011 PRC National Health Survey, Professional Research Consultants, Inc.  
 ● US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective AHS-5.1]  
 Notes: ● Asked of all respondents.

When viewed by demographic characteristics, the following population segments are less likely to have a specific source of care:

- 👥 Adults under age 65.
- 👥 Lower-income adults.

- 👥 Hispanic adults and Asian adults.
- 👥 Among adults age 18-64, 73.4% have a specific source for ongoing medical care, comparable to national findings.
  - Fails to satisfy the Healthy People 2020 target for this age group (89.4% or higher).
- 👥 Among adults 65+, 81.3% have a specific source for care, similar to the percentage reported among seniors nationally.
  - Fails to satisfy the Healthy People 2020 target of 100% for seniors.

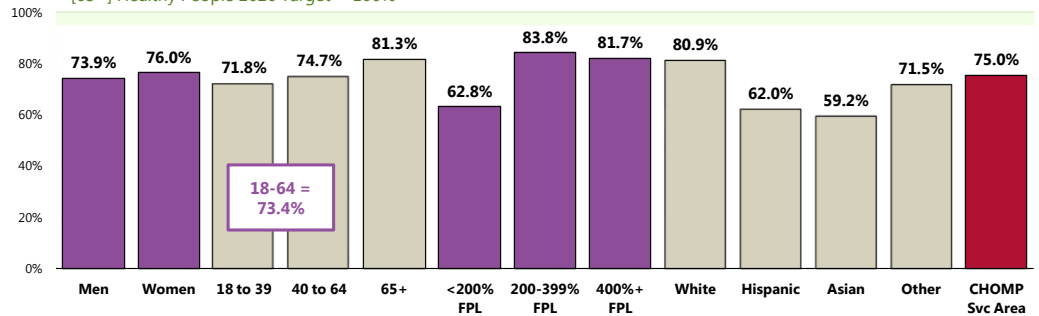
## Have a Specific Source of Ongoing Medical Care

(CHOMP Service Area, 2013)

[All Ages] Healthy People 2020 Target = 95.0% or Higher

[18-64] Healthy People 2020 Target = 89.4% or Higher

[65+] Healthy People 2020 Target = 100%



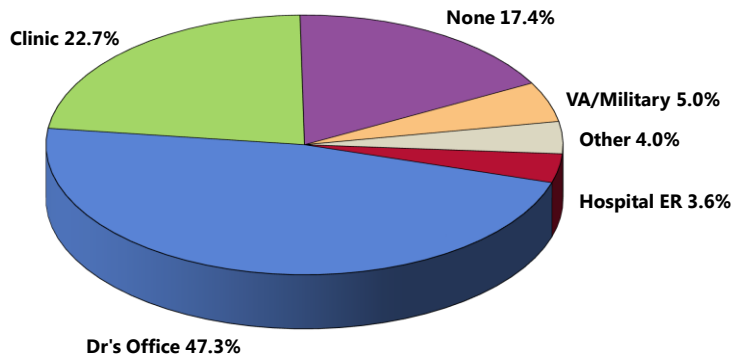
- Sources:
- 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 192-194]
  - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objectives AHS-5.1, 5.3, 5.4]
- Notes:
- Asked of all respondents.
  - Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
  - Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "<200% FPL" includes households with incomes up to 199% of the federal poverty level; "200-399% FPL" includes households with incomes between 200% and 399% of the federal poverty level; and "400%+ FPL" includes those households with incomes at 400% or more the federal poverty level.

## Type of Place Used for Medical Care

When asked where they usually go if they are sick or need advice about their health, the greatest share of respondents (47.3%) identified a particular doctor's office. A total of 22.7% say they usually go to some type of clinic, while 5.0% use a VA/military source for care and 3.6% rely on a hospital emergency room.

## Particular Place Utilized for Medical Care

(CHOMP Service Area, 2013)



- Sources:
- 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 15-16]
- Notes:
- Asked of all respondents.

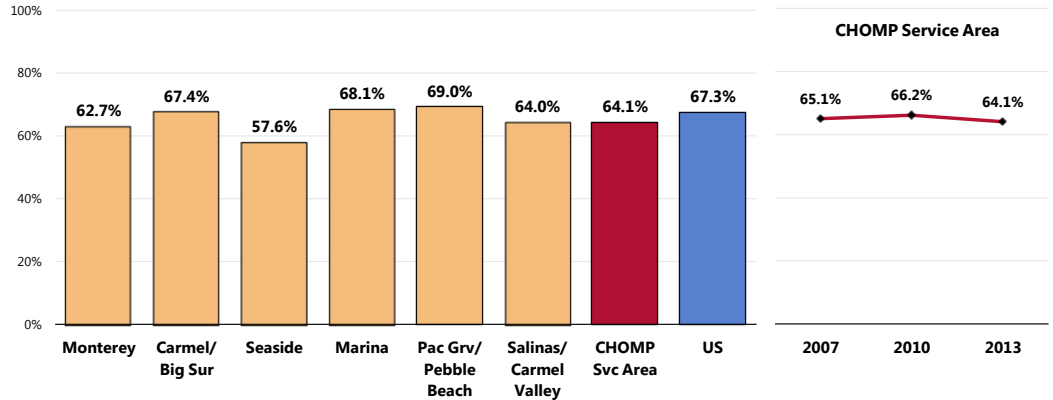
# Utilization of Primary Care Services

## Adults

Nearly two-thirds (64.1%) of adults visited a physician for a routine checkup in the past year.

- Comparable to national findings.
- Lowest in Seaside.
- 📊 Statistically similar to 2007 findings.

### Have Visited a Physician for a Checkup in the Past Year

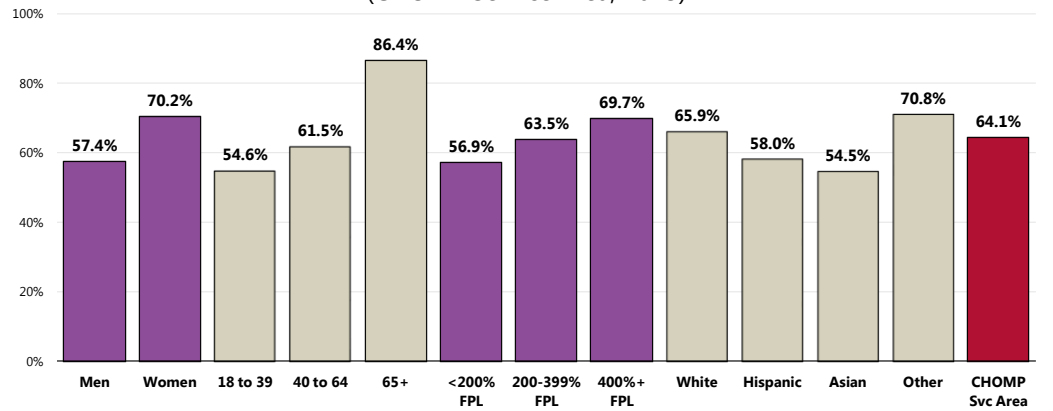


Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 17]  
 • 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes: • Asked of all respondents.

👥 Adults under age 65 are less likely to have received routine care in the past year (note the positive correlation with age), as are men and lower-income residents.

### Have Visited a Physician for a Checkup in the Past Year (CHOMP Service Area, 2013)



Sources: • 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 17]

Notes: • Asked of all respondents.

• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).

• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "<200% FPL" includes households with incomes up to 199% of the federal poverty level; "200-399% FPL" includes households with incomes between 200% and 399% of the federal poverty level; and "400%+ FPL" includes those households with incomes at 400% or more the federal poverty level.

## Children

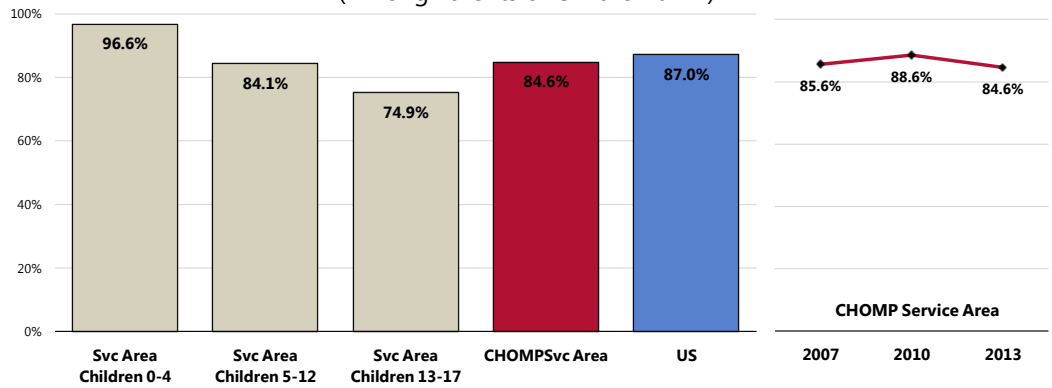
Among surveyed parents, 84.6% report that their child has had a routine checkup in the past year.

- Comparable to national findings.

👤 Note that routine checkups are highest in CHOMP Service Area among children under age 5.

📊 Statistically similar to 2007 findings.

### Child Has Visited a Physician for a Routine Checkup in the Past Year (Among Parents of Children 0-17)



Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 128]  
● 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes: ● Asked of all respondents with children 0 to 17 in the household.

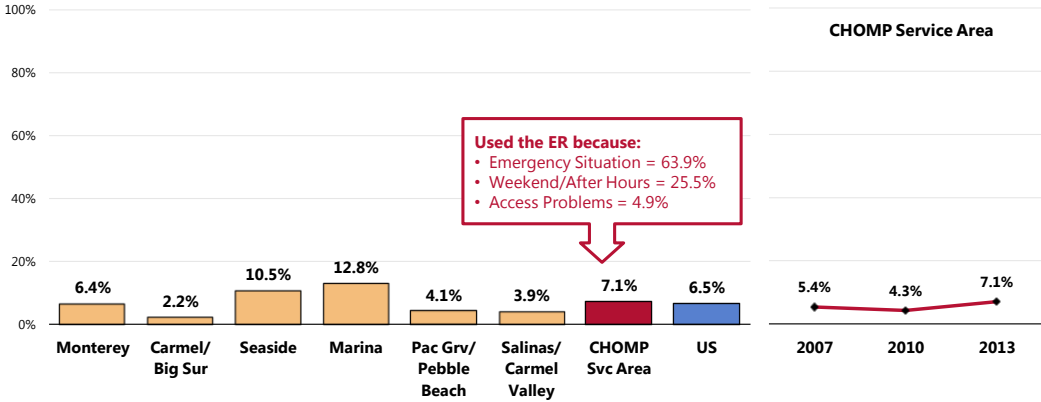


# Emergency Room Utilization

A total of 7.1% of CHOMP Service Area adults have gone to a hospital emergency room more than once in the past year about their own health.

- Comparable to national findings.
- Highest in Marina; lowest in Carmel/Big Sur.
- Statistically unchanged over time.

## Have Used a Hospital Emergency Room More Than Once in the Past Year



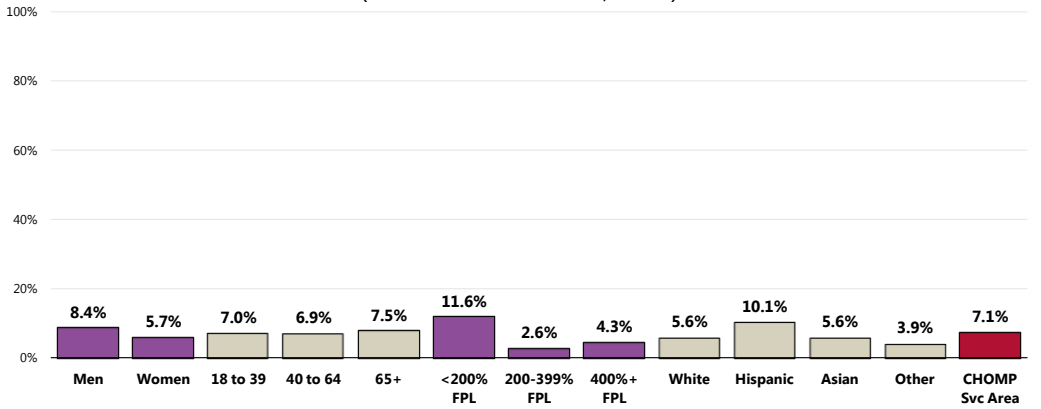
Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Items 23-24]  
 • 2011 PRC National Health Survey, Professional Research Consultants, Inc.  
 Notes: • Asked of all respondents.

Of those using a hospital ER, 63.9% say this was due to an **emergency or life-threatening situation**, while 25.5% indicated that the visit was during **after-hours or on the weekend**. A total of 4.9% cited **difficulties accessing care** for various reasons.

ER use is unfavorably high among residents living in lower-income households.

## Have Used a Hospital Emergency Room More Than Once in the Past Year

(CHOMP Service Area, 2013)



Sources: • 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 23]  
 Notes: • Asked of all respondents.  
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "<200% FPL" includes households with incomes up to 199% of the federal poverty level; "200-399% FPL" includes households with incomes between 200% and 399% of the federal poverty level; and "400%+ FPL" includes those households with incomes at 400% or more the federal poverty level.

# Oral Health

The health of the mouth and surrounding craniofacial (skull and face) structures is central to a person's overall health and well-being. Oral and craniofacial diseases and conditions include: dental caries (tooth decay); periodontal (gum) diseases; cleft lip and palate; oral and facial pain; and oral and pharyngeal (mouth and throat) cancers.

The significant improvement in the oral health of Americans over the past 50 years is a public health success story. Most of the gains are a result of effective prevention and treatment efforts. One major success is community water fluoridation, which now benefits about 7 out of 10 Americans who get water through public water systems. However, some Americans do not have access to preventive programs. People who have the least access to preventive services and dental treatment have greater rates of oral diseases. A person's ability to access oral healthcare is associated with factors such as education level, income, race, and ethnicity.

Oral health is essential to overall health. Good oral health improves a person's ability to speak, smile, smell, taste, touch, chew, swallow, and make facial expressions to show feelings and emotions. However, oral diseases, from cavities to oral cancer, cause pain and disability for many Americans. Good self-care, such as brushing with fluoride toothpaste, daily flossing, and professional treatment, is key to good oral health. Health behaviors that can lead to poor oral health include:

- Tobacco use
- Excessive alcohol use
- Poor dietary choices

Barriers that can limit a person's use of preventive interventions and treatments include:

- Limited access to and availability of dental services
- Lack of awareness of the need for care
- Cost
- Fear of dental procedures

There are also social determinants that affect oral health. In general, people with lower levels of education and income, and people from specific racial/ethnic groups, have higher rates of disease. People with disabilities and other health conditions, like diabetes, are more likely to have poor oral health.

Community water fluoridation and school-based dental sealant programs are 2 leading evidence-based interventions to prevent tooth decay.

Major improvements have occurred in the nation's oral health, but some challenges remain and new concerns have emerged. One important emerging oral health issue is the increase of tooth decay in preschool children. A recent CDC publication reported that, over the past decade, dental caries (tooth decay) in children ages 2 to 5 have increased.

Lack of access to dental care for all ages remains a public health challenge. This issue was highlighted in a 2008 Government Accountability Office (GAO) report that described difficulties in accessing dental care for low-income children. In addition, the Institute of Medicine (IOM) has convened an expert panel to evaluate factors that influence access to dental care.

Potential strategies to address these issues include:

- Implementing and evaluating activities that have an impact on health behavior.
- Promoting interventions to reduce tooth decay, such as dental sealants and fluoride use.
- Evaluating and improving methods of monitoring oral diseases and conditions.
- Increasing the capacity of State dental health programs to provide preventive oral health services.
- Increasing the number of community health centers with an oral health component.

– Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

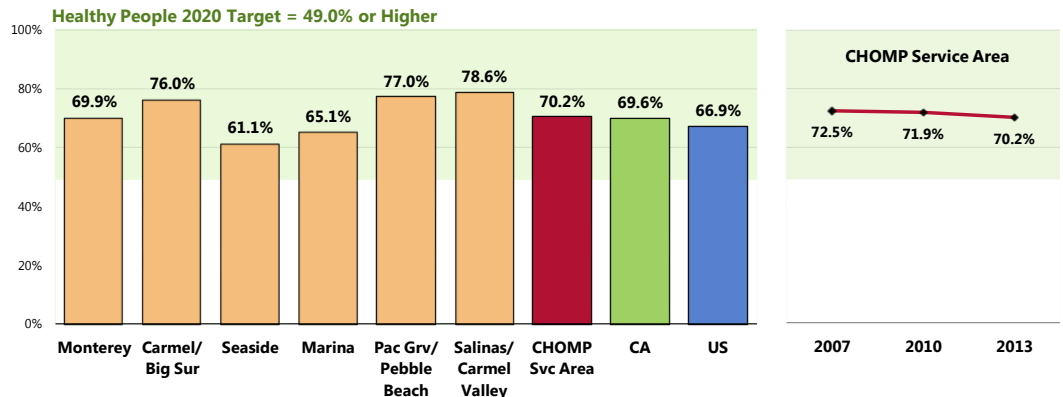
## Dental Care

### Adults

**A total of 7 in 10 CHOMP Service Area adults (70.2%) have visited a dentist or dental clinic (for any reason) in the past year.**

- Similar to statewide findings.
- Similar to national findings.
- Satisfies the Healthy People 2020 target (49% or higher).
- Highest in Pacific Grove/Pebble Beach and Salinas/Carmel Valley; lowest in Seaside.
- ☒ Statistically unchanged since 2007.

### Have Visited a Dentist or Dental Clinic Within the Past Year



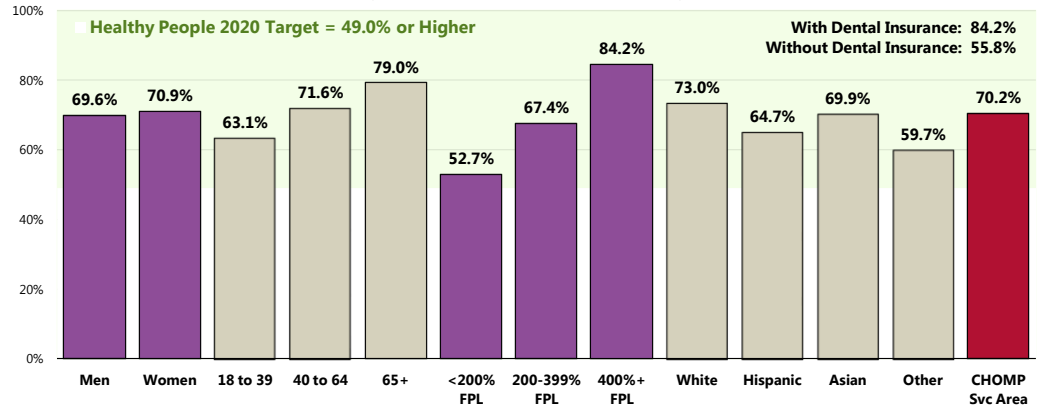
Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 21]  
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.  
• US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective OH-7]  
• Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2011 California data.

Notes: • Asked of all respondents.

Note the following:

- 👤 There is a positive correlation between age and recent dental visits.
- 👤 Persons living in the higher income categories report much higher utilization of oral health services.
- 👤 Whites and Asians are more likely than Hispanics or "Other" races to report recent dental care.
- 👤 As might be expected, persons without dental insurance report much lower utilization of oral health services than those with dental coverage.

## Have Visited a Dentist or Dental Clinic Within the Past Year (CHOMP Service Area, 2013)



Sources: • 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 21]  
• US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective OH-7]

Notes: • Asked of all respondents.  
• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "<200% FPL" includes households with incomes up to 199% of the federal poverty level; "200-399% FPL" includes households with incomes between 200% and 399% of the federal poverty level; and "400%+ FPL" includes those households with incomes at 400% or more the federal poverty level.

### Children

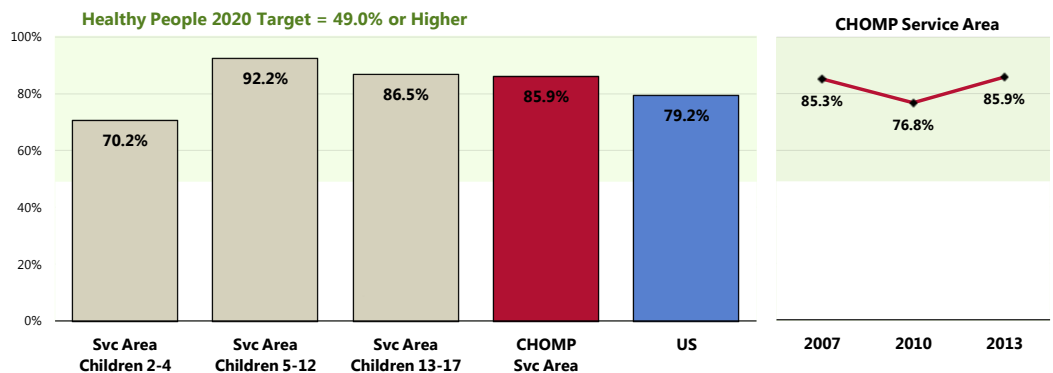
**A total of 85.9% of parents report that their child (age 2 to 17) has been to a dentist or dental clinic within the past year.**

- More favorable than national findings.
- Satisfies the Healthy People 2020 target (49% or higher).

👨👩👧 As may be expected, regular dental care is notably lower among children age 2 to 4.

📊 No significant change from 2007 survey findings (but an increase from 2010 results).

## Child Has Visited a Dentist or Dental Clinic Within the Past Year (Among Parents of Children 2-17)



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 129]  
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.  
• US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective OH-7]

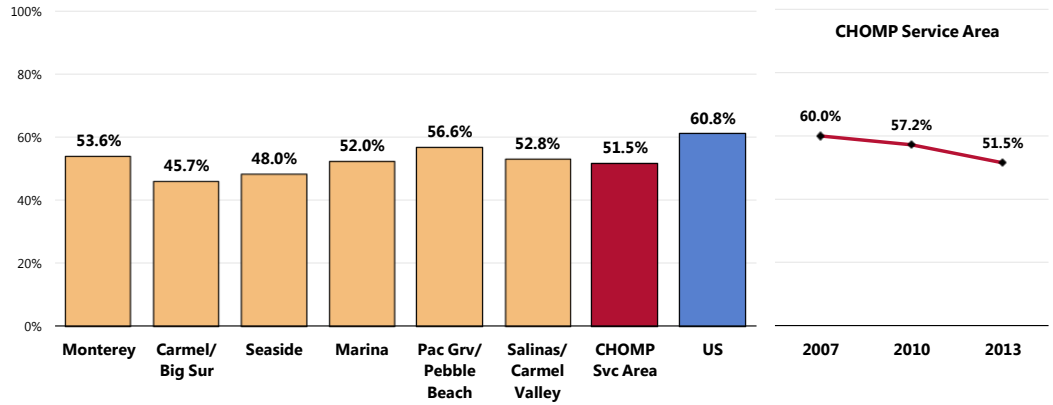
Notes: • Asked of all respondents with children age 2 through 17.

## Dental Insurance

**Over one-half of CHOMP Service Area adults (51.5%) have dental insurance that covers all or part of their dental care costs.**

- Lower than the national finding.
- No significant difference in results by community.
- ▣ Marks a significant decrease over time.

### Have Insurance Coverage That Pays All or Part of Dental Care Costs



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 22]  
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes: • Asked of all respondents.

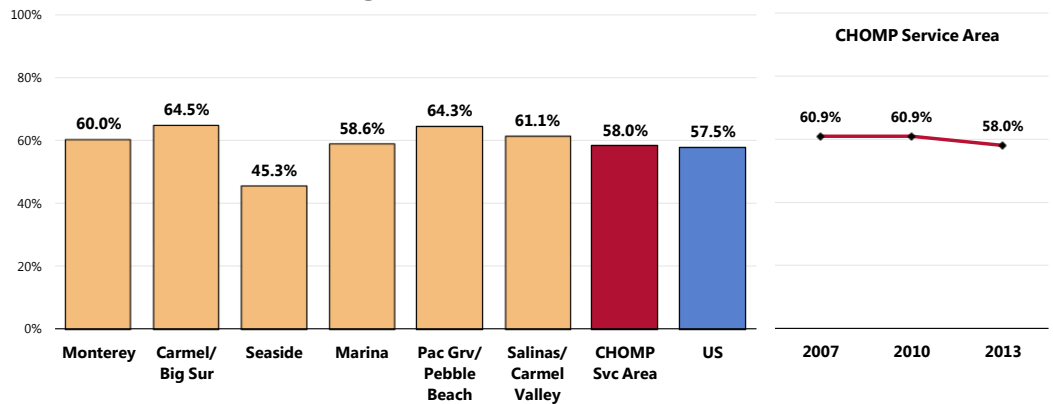
# Vision Care

RELATED ISSUE:  
See also *Vision & Hearing* in the **Deaths & Disease** section of this report.

**A total of 58.0% of residents had an eye exam in the past two years during which their pupils were dilated.**

- Statistically comparable to national findings.
- Unfavorably low in the Seaside community.
- ☒ Statistically unchanged over time.

## Had an Eye Exam in the Past Two Years During Which the Pupils Were Dilated

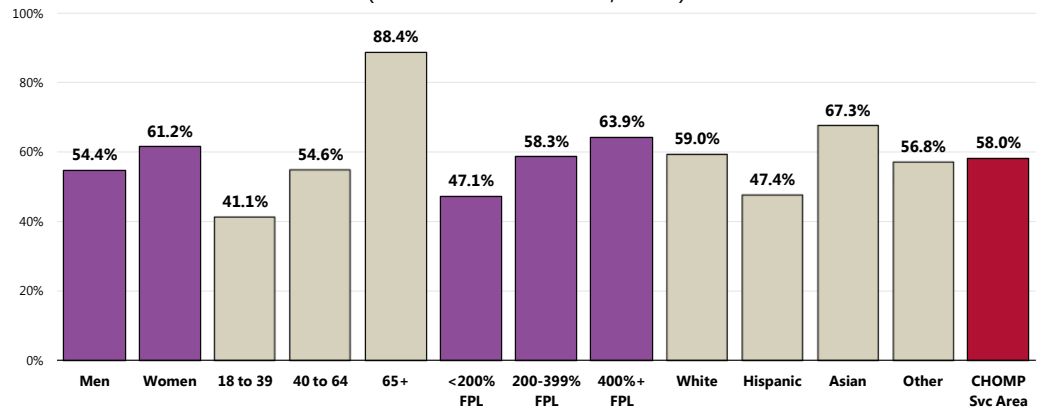


Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 20]  
● 2011 PRC National Health Survey, Professional Research Consultants, Inc.  
Notes: ● Asked of all respondents.

Recent vision care in CHOMP Service Area is less often reported among:

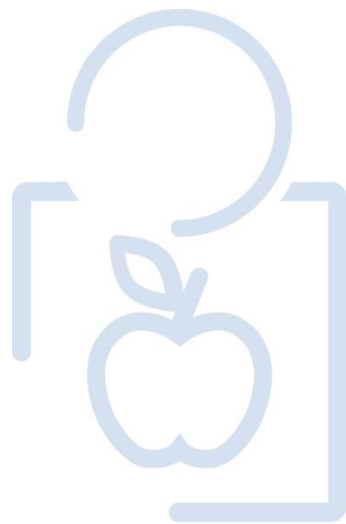
- 👤 Men, lower-income residents, and Hispanic adults.
- 👤 Note also the positive correlation between age and recent eye exams.

## Had an Eye Exam in the Past Two Years During Which the Pupils Were Dilated (CHOMP Service Area, 2013)



Sources: ● 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 20]  
Notes: ● Asked of all respondents.  
● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "<200% FPL" includes households with incomes up to 199% of the federal poverty level; "200-399% FPL" includes households with incomes between 200% and 399% of the federal poverty level; and "400%+ FPL" includes those households with incomes at 400% or more the federal poverty level.

# HEALTH EDUCATION & OUTREACH

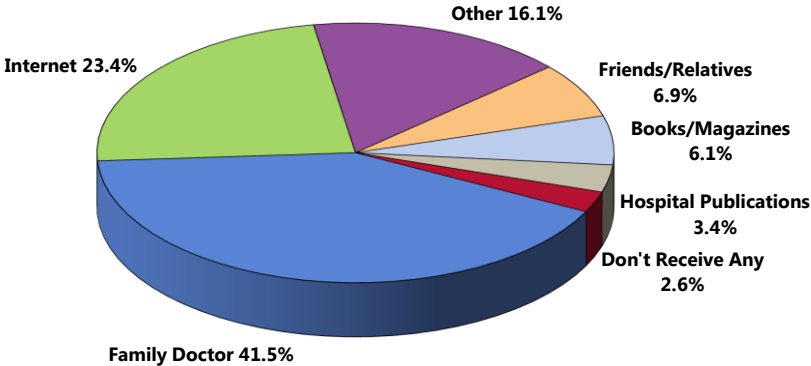


# Healthcare Information Sources

**Family physicians and the Internet are residents' primary sources of healthcare information.**

- 41.5% of CHOMP Service Area adults cited their **family physician** as their primary source of healthcare information.
- The **Internet** received the second-highest response, with 23.4%.
  - Other sources mentioned include friends and relatives (6.9%), books and magazines (6.1%) and hospital publications (3.4%).
- Just 2.6% of survey respondents say that they do not receive any healthcare information.

**Primary Source of Healthcare Information**  
(CHOMP Service Area, 2013)



Sources: ● 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 119]  
Notes: ● Asked of all respondents.



# Participation in Health Promotion Events

Educational and community-based programs play a key role in preventing disease and injury, improving health, and enhancing quality of life.

Health status and related-health behaviors are determined by influences at multiple levels: personal, organizational/institutional, environmental, and policy. Because significant and dynamic interrelationships exist among these different levels of health determinants, educational and community-based programs are most likely to succeed in improving health and wellness when they address influences at all levels and in a variety of environments/settings.

Education and community-based programs and strategies are designed to reach people outside of traditional healthcare settings. These settings may include schools, worksites, healthcare facilities, and/or communities.

Using nontraditional settings can help encourage informal information sharing within communities through peer social interaction. Reaching out to people in different settings also allows for greater tailoring of health information and education.

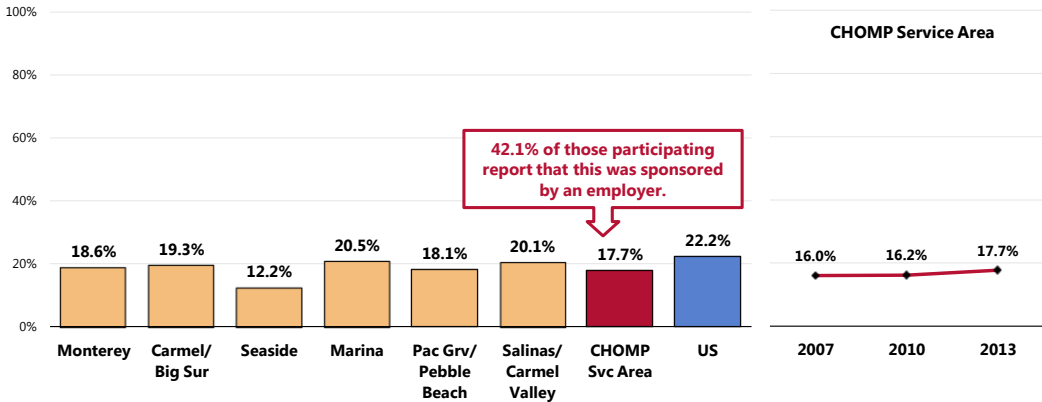
Educational and community-based programs encourage and enhance health and wellness by educating communities on topics such as: chronic diseases; injury and violence prevention; mental illness/behavioral health; unintended pregnancy; oral health; tobacco use; substance abuse; nutrition; and obesity prevention.

- Healthy People 2020 (www.healthypeople.gov)

**A total of 17.7% of CHOMP Service Area adults participated in some type of organized health promotion activity in the past year, such as health fairs, health screenings, or seminars.**


- Lower than the national prevalence.
- Lowest among residents of Seaside.
- ▣ Unchanged since the 2007 survey was conducted.
- 👥 Note that 42.1% of adults who participated in a health promotion activity in the past year indicate that it was sponsored by their employer.

### Participated in a Health Promotion Activity in the Past Year

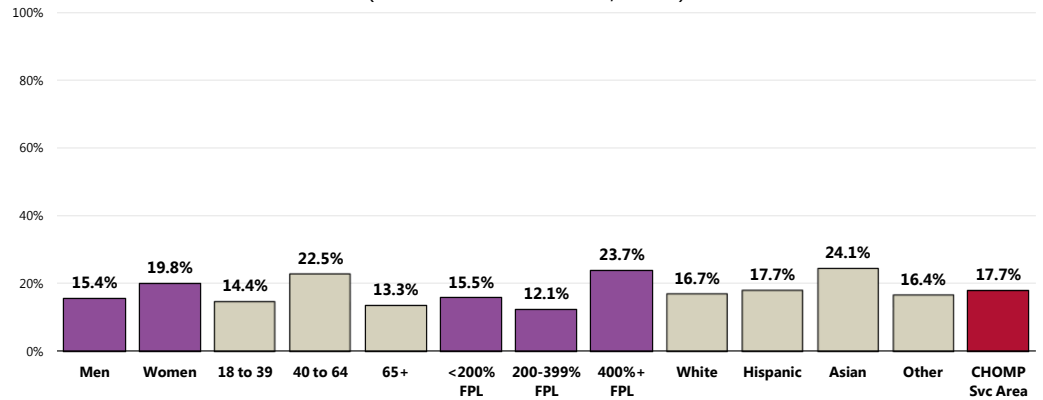


Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Items 120-121]  
 ● 2011 PRC National Health Survey, Professional Research Consultants, Inc.  
 Notes: ● Asked of all respondents.

The following chart outlines participation by various demographic characteristics.

 Note that young adults, seniors, and residents with lower incomes less often report participation in health promotion activities.

### Participated in a Health Promotion Activity in the Past Year (CHOMP Service Area, 2013)



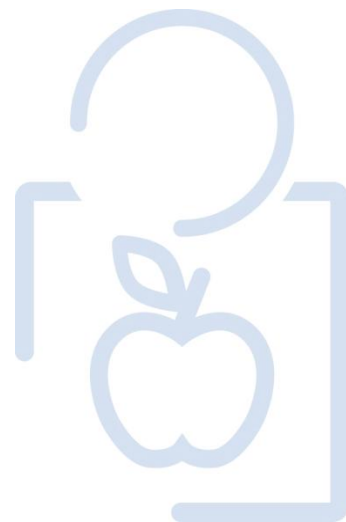
Sources: 

- 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 120]

Notes: 

- Asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "<200% FPL" includes households with incomes up to 199% of the federal poverty level; "200-399% FPL" includes households with incomes between 200% and 399% of the federal poverty level; and "400%+ FPL" includes those households with incomes at 400% or more the federal poverty level.

# LOCAL HEALTHCARE SERVICES & RESOURCES

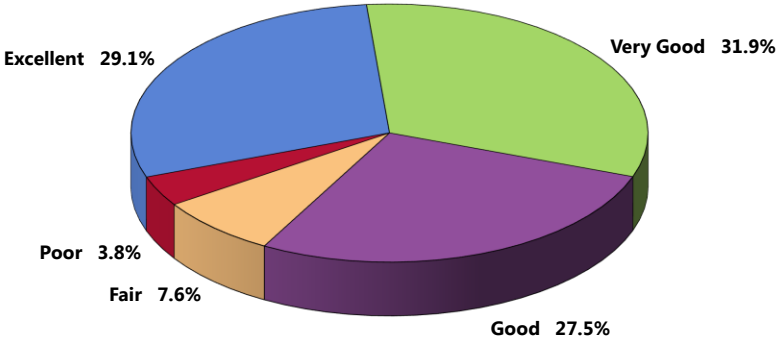


# Perceptions of Local Healthcare Services

Just over 6 in 10 CHOMP Service Area adults (61.0%) rate the overall healthcare services available in their community as “excellent” or “very good.”

- Another 27.5% gave “good” ratings.

**Rating of Overall Healthcare Services Available in the Community**  
(CHOMP Service Area, 2013)

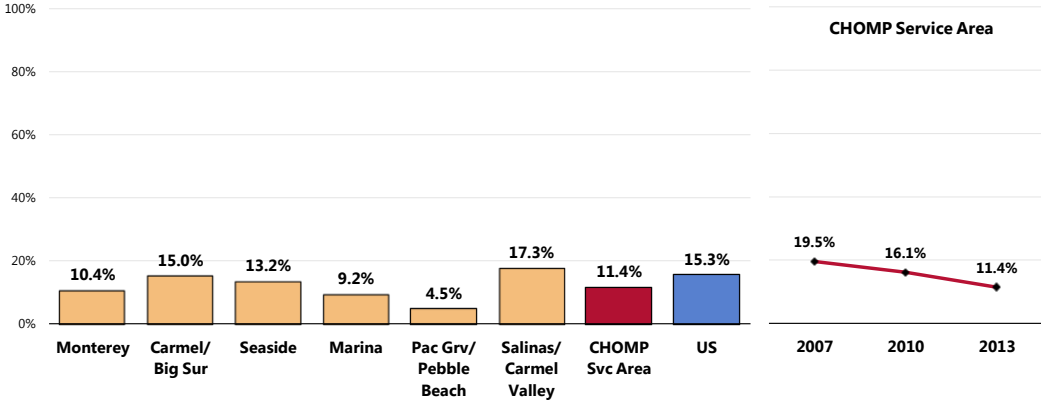


Sources: • 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 6]  
Notes: • Asked of all respondents.

However, 11.4% of residents characterize local healthcare services as “fair” or “poor.”





- More favorable than reported nationally.
- Most favorable in the Pacific Grove/Pebble Beach community.
- ▣ Marks a statistically significant improvement in ratings.

**Perceive Local Healthcare Services as “Fair/Poor”**

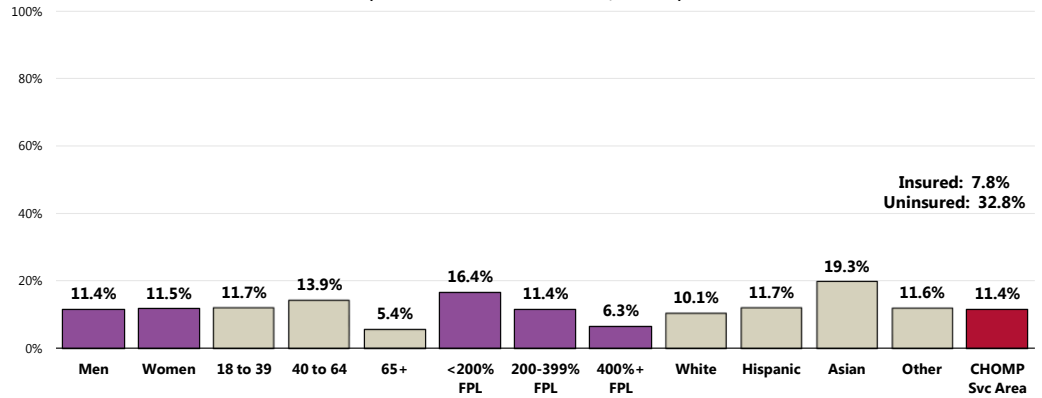


Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 6]  
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.  
Notes: • Asked of all respondents.

The following residents are more critical of local healthcare services:

-  Adults under age 65.
-  Residents with lower incomes.
-  Asians.
-  Uninsured adults.

### Perceive Local Healthcare Services as “Fair/Poor” (CHOMP Service Area, 2013)



Sources: • 2013 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 6]

Notes: • Asked of all respondents.

• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).

• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "<200% FPL" includes households with incomes up to 199% of the federal poverty level; "200-399% FPL" includes households with incomes between 200% and 399% of the federal poverty level; and "400%+ FPL" includes those households with incomes at 400% or more the federal poverty level.

# Resources Available to Address the Significant Health Needs

The following represent potential measures and resources (such as programs, organizations, and facilities in the community) available to address the significant health needs identified in this report. This list is not exhaustive, but rather outlines those resources identified by focus group participants in the course of conducting this Community Health Needs Assessment.

- Alliance on Aging
- Alzheimer's Association
- Beacon House
- Central California Alliance for Health
- Central Coast Citizenship Project
- Chamber of Commerce
- Clinica de Salud
- Community Hospital of the Monterey Peninsula (CHOMP)
- Community Partnership for Youth
- Compassionate Alliance
- Dorothy's House
- Employers
- Family Resource Center
- Federally Qualified Health Centers
- Food Bank
- Harmony at House
- Home Health Agencies
- Homelessness Prevention
- Hospice
- Insurance Agencies
- Interim, Inc.
- Law Enforcement
- Libraries
- Media
- Monterey County Behavioral Health
- Monterey County Clinic Services & Public Health
- Natividad Medical Center
- Paradigm Day Program

- 
- Primary Care Providers
  - Private Psychiatrists
  - Public Transportation
  - Read 4 Life
  - RotoCare Clinic
  - Rural Health Clinics
  - Salinas Valley Memorial Healthcare System
  - School Districts
  - Smoking Cessation Programs
  - Social Service Providers
  - Sun Street Centers
  - United Way Monterey County
  - Visiting Nurses Association (VNA)
  - Wellness Programs
  - YMCA

# Collaboration

## Related Focus Group Findings

Participants spent time discussing the varying levels of collaboration occurring in the community between non-profit organizations, schools, healthcare providers and hospitals. Topics of conversation included:

- Varying opinions on the level of collaboration
- Financial pressures
- Communication needs to improve
- Hospitals operate in a competitive landscape

Attendees had **varying opinions on the level of collaboration** occurring in the community. Some participants spoke about the excellent coordination occurring between the RotoCare Clinic and Monterey County Public Health.

Other participants feel that organizations collaborate to some degree, but that this remains an area in need of improvement. Historically, organizations in Monterey County have not been collaborative. Respondents agree that **communication needs to improve** among agencies, and that organizations operate in silos, or “cylinders of excellence.” Many local non-profits operate under enormous **financial pressures**, limiting their capacity for collaboration. Respondents report that many organizations have great ideas for coordination, but actually moving forward with a plan is difficult.

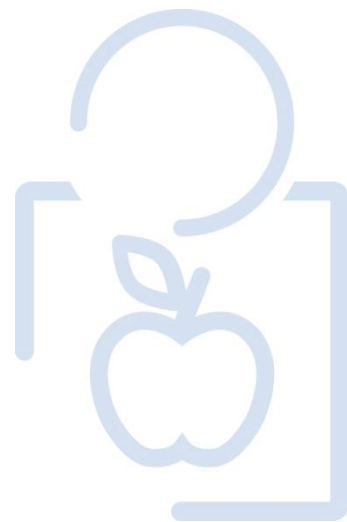
*“I sat on this group. And again, a lot of discussion, a lot of good ideas, but for people’s availabilities to really all partner together and say yeah we’re really committed to making a difference and putting something together, and everybody both putting the manpower and money, etcetera into it. It hasn’t transpired yet.” — Healthcare Provider*

Key informants believe that the healthcare system is fragmented and **hospitals are seen as competitive**, far from collaborative entities. The competition remains a double-edged sword with duplication of services inevitably occurring, and gaps in service still existing. An attendee explains the current competitive mentality:

*“Historically, medically our community has not been, at least in acute care level, very collaborative. Community Hospital has done its thing, Salinas Valley has done its thing, La Natividad Medical Center has done its thing and the other hospital has done theirs, and in a county of 400,000 thousand we’ve got four acute care hospitals.” — Community Leader*



# SPECIAL POPULATIONS



# Seniors

## Related Focus Group Findings

Many focus group participants discussed the limited number of services available to senior citizens, with emphasis on the following:

- Aging community
- Medicare reimbursement rates
- Dementia or Alzheimer's disease resources
- Palliative care

Participants believe that Monterey County represents an **aging community** and voiced concern about the health of senior citizens living in the area. Seniors may not know how to access care, or who to contact to learn more about how to receive services. This uncertainty may be amplified if the resident has lost a spouse, or is moving out of their home.

*"I think just coordination of care; transitions of care seem to be very important for people that are living alone. A spouse dies they have a hard time. What do I do now? I can't take care of my house anymore. What do I do? How do I transition into a different living arrangement? I've found that to be quite challenging because it's not usually covered under insurance to make that transition. Patients don't really know who to reach out to. A lot of times children are out of town so they're not able to help." — Healthcare Provider*

In general, the community possesses limited resources for seniors. Many Medicare recipients struggle to access a primary care physician because medical providers do not want to accept many **Medicare recipients due to the low reimbursement rates**.

Key informants also worry for those residents suffering from **dementia or Alzheimer's disease**. Attendees agree that the area does not have an adequate number of assisted living or memory care facilities. Additionally, behavioral health resources can be difficult to obtain for older residents.

*"There isn't any real robust system out there for behavioral health services towards the older adults, and because of the way it's designed in California people with dementia do not qualify for mental health services. So you'll have a person who will be admitted through the ED because of a behavioral issue related to their dementia, get tuned up, get their IV, get their UTI resolved and be sent back home to the same environment, and they're going to come back because of their dementia. So it's a cycling door." — Community Leader*

Focus group member also spent time discussing the importance of **palliative care**. Key informants view palliative care as a need in the community and believe that it would be a very positive addition to healthcare. Currently, the community avoids talking about end-of-life options or plans. Many residents have limited knowledge about palliative care options for the non-terminally ill and the time-length of hospice. Physicians also may need further education about these topics because attendees report that the utilization of palliative care is slim.

# Homeless

## Related Focus Group Findings

Focus group participants are concerned with the lack of affordable housing available in the community. The main issue discussed surrounding housing included:

- Homeless residents and families
- Multiple health needs
- Additional non-medical resources needed for the homeless population

Focus group participants worry about the high cost of living and houses in Monterey County. Attendees feel that the number of **homeless residents and families** in the area is increasing. (*For purposes of discussion, key informants were told to include multiple families that live together in one home or apartment in their definition of "homelessness."*)

In general, homeless residents are more likely to have **multiple health needs**, which include oral healthcare, wound care, mental health and access to prescription medications. Currently, a mobile health unit operates to service these community members, but more is needed.

*"Cities like San Francisco, Berkeley, have specific clinics for homeless folks. We have the van, the mobile van at Clinica de Salud, and that could be expanded, especially in the Chinatown area. We could really use more clinics that are actually going to the homeless population because it's hard to get those folks to go to the hospital to leave really where they live. So if we want them to have healthcare we have to bring it to them and a lot of other communities have done that because they understand that." — Community Leader*

Focus group attendees believe that **additional non-medical resources are also needed** to aid the homeless population. Homeless shelters service men and women with children, but childless females do not have any overnight facilities at this time.