2016 Community Health Needs Assessment Report

CHOMP Service Area
Monterey, Peninsula – Monterey County, CA

Prepared for:

Community Hospital of the Monterey Peninsula

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Introduction

Professional Research Consultants, Inc.

Project Overview

Project Goals

This Community Health Needs Assessment, a follow-up to similar studies conducted in 2007, 2010, and 2013, 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 an Online Key Informant Survey.

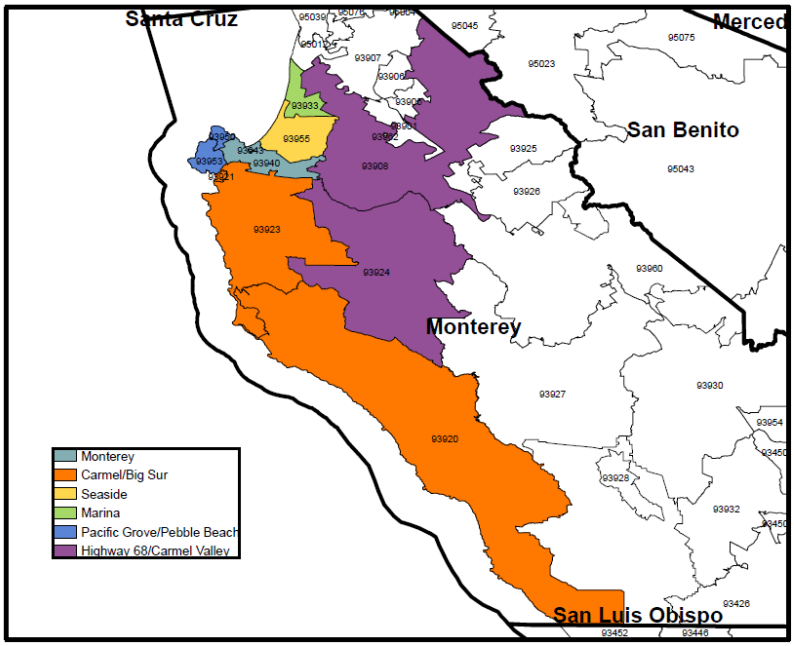
PRC Community Health Survey

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) is defined as each of the communities comprising the hospital's primary service area, the Monterey Peninsula, Health Facility Planning Area (HFPA) #707. The Monterey Peninsula includes the Zip Codes outlined below, encompassing the communities of Monterey, Carmel/Big Sur, Seaside, Marina, Pacific Grove/Pebble Beach, and Highway 68/Carmel Valley, as well as some unincorporated areas of Monterey County. This community definition, represented approximately 81% of the hospital's patients in 2015.



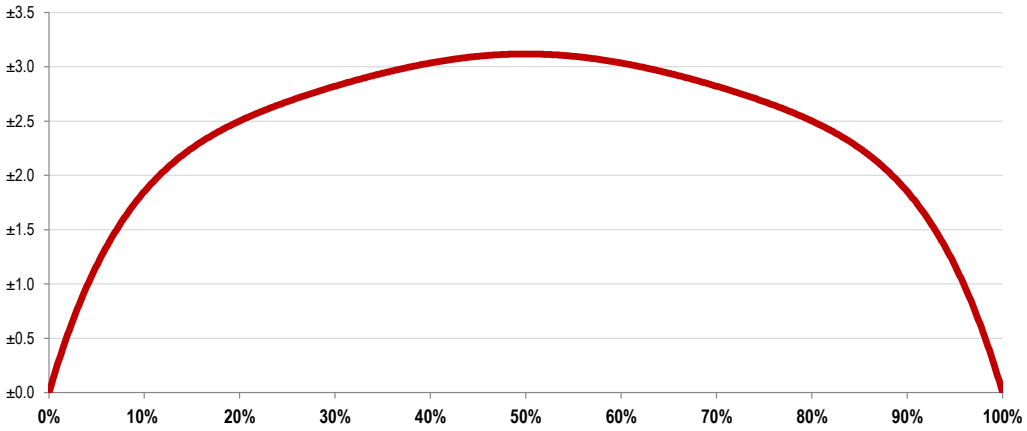
Sample Approach & Design

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 170 surveys in Monterey, 116 in Carmel/Big Sur, 220 in Seaside, 188 in Marina, 145 in Pacific Grove/Pebble Beach, and 161 in Highway 68/Carmel Valley. All administration of the surveys, data collection and data analysis was conducted by Professional Research Consultants, Inc. (PRC).

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

Expected Error Ranges for a Sample of 1,000 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 1,000 respondents answered a certain question with a "yes," it can be asserted that between 8.1% and 11.9% (10% ± 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% ± 3.1%) of the total population would respond "yes" if asked this question.

Sample Characteristics

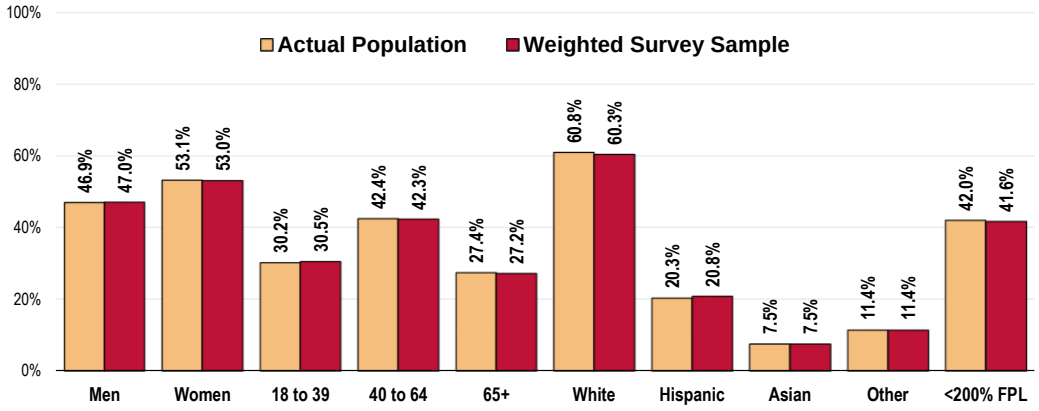
To accurately represent the population studied, PRC strives to minimize bias through application of a proven telephone methodology and random-selection techniques. And, while this random sampling of the population produces a highly representative sample, it is a common and preferred practice to “weight” 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 & Survey Sample Characteristics

(CHOMP Service Area, 2016)



Sources:
- Census 2010, Summary File 3 (SF 3). US Census Bureau.
- 2016 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 2015 guidelines place the poverty threshold for a family of four at $24,250 annual household income or lower)*. In sample segmentation: "**low income**" refers to community members living in a household with defined poverty status or living just above the poverty level, earning up to twice the poverty threshold; "**mid/high income**" refers to those households living on incomes which are twice 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.

Online Key Informant Survey

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

Key informants were contacted by email, introducing the purpose of the survey and providing a link to take the survey online; reminder emails were sent as needed to increase participation. In all, 133 community stakeholders took part in the Online Key Informant Survey, as outlined below:

Online Key Informant Survey Participation

Key Informant Type	Number Invited	Number Participating
Physician	76	35
Other Health Provider	16	5
Public Health Representative	27	12
Social Services Provider	80	37
Community/Business Leader	106	44

Final participation included representatives of the organizations outlined below.

- Alliance on Aging
- American Cancer Society
- American Heart Association
- Beacon House
- Big Sur Health Center
- Big Sur Intl. Marathon JUST RUN Program
- Boys & Girls Clubs of Monterey County
- Breakthrough for Men
- Breathe California Central Coast
- CAL-FIRE City of Soledad Fire Department
- Carmel Hills Care Center
- Carmel Internal Medicine
- Carmel Valley Chamber of Commerce
- Catholic Charities of the Diocese of Monterey
- Central California Alliance for Health
- Central Coast High School
- Choice Home Health Care
- City of Marina
- City of Monterey
- City of Monterey Recreation
- City of Salinas
- City of Sand City

- City of Seaside
- Clinica de Salud del Valle de Salinas
- Community Health Innovations
- Community Hospital of the Monterey Peninsula
- Community Partnership for Youth
- Doctors on Duty
- Family inHome Caregiving, Inc.
- Fire Department
- Forest Hill
- Gathering for Women – Monterey
- Geriatric Medical Center
- Harmony At Home
- Health Projects Center
- Housing Resource Center of Monterey County
- Independent Transportation Network Monterey County
- Kernes Adaptive Aquatics
- McSig (Municipalities Colleges Schools Insurance Group)
- Monterey Bay Aquarium
- Monterey Bay Dental Society
- Monterey Bay Independent Physician Association
- Monterey County
- Monterey County Free Libraries
- Monterey County Health Department
- Monterey County Rape Crisis Center
- Monterey Peninsula College
- Monterey Peninsula Foundation
- Monterey Peninsula Unified School District
- Monterey Police Department
- Multiple Sclerosis Quality of Life Project
- NAMI Monterey County
- Organicgirl, LLC
- Pediatric Group of Monterey
- Peninsula After School Programs and Early Learning
- Peninsula Primary Care
- Peninsula Primary Care – Cardiology
- Salinas Fire Department
- Sand City Police Department
- Seaside Family Health Center
- Seniors Helping Seniors of the Central Coast
- Sun Street Centers
- Sunrise House
- The Carmel Foundation
- The Fertility and Gynecology Center
- United Way Monterey County
- Voices for Children CASA

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

Minority/medically underserved populations represented:

> *adults who need special accommodations, African-Americans, Asians, children, the chronically ill, the disabled, Eastern Indians, the elderly, farm/field workers, Filipinos, Hispanics, homeless individuals, hospitality workers, those with a language barrier, LGBT individuals, low income residents, Medicare/Medicaid/Medi-Cal recipients, the mentally ill, Native Americans, Pacific Islanders, substance abusers, Tricare recipients, undocumented residents, unemployed residents, uninsured/underinsured persons, veterans*

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

NOTE: These findings represent qualitative rather than quantitative data. The Online Key Informant Survey was designed to gather input 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):

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

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

Benchmark Data

Trending

A similar survey was administered in the service area in 2007, 2010, and 2013 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 represent the most recent *BRFSS (Behavioral Risk Factor Surveillance System) Prevalence and Trends Data* published online by the Centers for Disease Control and Prevention. State-level vital statistics are also provided for comparison of secondary data indicators.

Nationwide Risk Factor Data

Nationwide risk factor data, which are also provided in comparison charts, are taken from either the *PRC National Health Survey* or the *PRC National Child & Adolescent Health Survey*. the methodological approach for these national studies 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. For three decades, Healthy People has established benchmarks and monitored progress over time in order to:

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

Healthy People strives to:

- Identify nationwide health improvement priorities.
- Increase public awareness and understanding of the determinants of health, disease, and disability and the opportunities for progress.
- Provide measurable objectives and goals that are applicable at the national, State, and local levels.
- Engage multiple sectors to take actions to strengthen policies and improve practices that are driven by the best available evidence and knowledge.
- Identify critical research, evaluation, and data collection needs.

Determining Significance

Differences noted in this report represent those determined to be significant. For survey-derived indicators (which are subject to sampling error), statistical significance is determined based on confidence intervals (at the 95 percent confidence level) using question-specific samples and response rates. For secondary data indicators (which do not carry sampling error, but might be subject to reporting error), "significance," for the purpose of this report, is determined by a 5% variation from the comparative measure.

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 medical conditions that are not specifically addressed.

IRS Form 990, Schedule H Compliance

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

IRS Form 990, Schedule H (2015)	See Report Page(s)
Part V Section B Line 3a *A definition of the community served by the hospital facility*	9
Part V Section B Line 3b *Demographics of the community*	44
Part V Section B Line 3c *Existing health care facilities and resources within the community that are available to respond to the health needs of the community*	272
Part V Section B Line 3d *How data was obtained*	9
Part V Section B Line 3e *The significant health needs of the community*	18
Part V Section B Line 3f *Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups*	Addressed Throughout
Part V Section B Line 3g *The process for identifying and prioritizing community health needs and services to meet the community health needs*	19
Part V Section B Line 3h *The process for consulting with persons representing the community's interests*	12
Part V Section B Line 3i *Information gaps that limit the hospital facility's ability to assess the community's health needs*	16

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).

The Areas of Opportunity were determined after consideration of various criteria, including: standing in comparison with benchmark data (particularly national data); identified trends; the preponderance of significant findings within topic areas; the magnitude of the issue in terms of the number of persons affected; and the potential health impact of a given issue.

Areas of Opportunity Identified Through This Assessment	

Access to Healthcare Services	• Barriers to Access
	  ○ Cost of Prescriptions
	  ○ Cost of Physician Visits
	  ○ Appointment Availability
	  ○ Finding a Physician
	  ○ Lack of Transportation
	• Primary Care Physician Ratio
	• Emergency Room Utilization
	• Participation in Health Events
	• Dental Insurance Coverage
	• Linguistically Isolated Population
	• *Access to Healthcare ranked as a top concern in the Online Key Informant Survey.*

Cancer	• *Cancer is a leading cause of death.* • Prostate Cancer Incidence • Skin Cancer Prevalence • Cervical Cancer Screening
Dementia, Including Alzheimer's Disease	• Alzheimer's Disease Deaths
Diabetes	• Diabetes Deaths • Prevalence of Borderline/Pre-Diabetes • *Diabetes ranked as a top concern in the Online Key Informant Survey.*
Family Planning	• Teen Births
Heart Disease & Stroke	• *Cardiovascular disease is a leading cause of death.* • High Blood Pressure Prevalence • Overall Cardiovascular Risk
Injury & Violence	• Firearm-Related Deaths • Homicide Deaths • Violent Crime Rate • Violent Crime Experience

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Areas of Opportunity (continued)	
Mental Health	• "Fair/Poor" Mental Health • Symptoms of Chronic Depression • Suicide Deaths • *Mental Health ranked as a top concern in the Online Key Informant Survey.*
Nutrition, Physical Activity & Weight	• Fruit/Vegetable Consumption • Overweight & Obesity [Adults] • Overweight & Obesity [Children] • Children's Total Screen Time • Access to Recreation/Fitness Facilities • *Nutrition, Physical Activity & Weight ranked as a top concern in the Online Key Informant Survey.*
Potentially Disabling Conditions	• Activity Limitations • Osteoporosis Prevalence (50+) • Sciatica/Back Pain Prevalence • Blindness/Vision Trouble
Respiratory Diseases	• Asthma Prevalence [Adults] • Asthma Prevalence [Children] • Chronic Obstructive Pulmonary Disease (COPD) Prevalence • Flu Vaccination [65+]
Substance Abuse	• Drug-Induced Deaths • Negatively Affected by Substance Abuse (Self or Other's) • *Substance Abuse ranked as a top concern in the Online Key Informant Survey.*

Prioritization of Health Needs

On August 10, 2016, Community Hospital of the Monterey Peninsula convened two groups of community stakeholders (representing a cross-section of community-based agencies and organizations) and internal team members to evaluate, discuss and prioritize health issues for community, based on findings of this Community Health Needs Assessment (CHNA). Professional Research Consultants, Inc. (PRC) began the meeting with a presentation of key findings from the CHNA, highlighting the significant health issues identified from the research (see Areas of Opportunity above).

Following the data review, PRC answered any questions and facilitated a group dialogue, allowing participants to advocate for any of the health issues discussed. Finally, participants were provided an overview of the prioritization exercise that followed.

In order to assign priority to the identified health needs (i.e., Areas of Opportunity), a wireless audience response system was used in which each participant was able to register his/her ratings using a small remote keypad. The participants were asked to evaluate each health issue along two criteria:

- **Scope & Severity —** The first rating was to gauge the magnitude of the problem in consideration of the following:
    - How many people are affected?
    - How does the local community data compare to state or national levels, or Healthy People 2020 targets?
    - To what degree does each health issue lead to death or disability, impair quality of life, or impact other health issues?

  Ratings were entered on a scale of 1 (not very prevalent at all, with only minimal health consequences) to 10 (extremely prevalent, with very serious health consequences).
- **Ability to Impact —** A second rating was designed to measure the perceived likelihood of the hospital having a positive impact on each health issue, given available resources, competencies, spheres of influence, etc. Ratings were entered on a scale of 1 (no ability to impact) to 10 (great ability to impact).

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

1. **Diabetes**
2. **Nutrition, Physical Activity & Weight**
3. **Access to Healthcare Services**
4. **Mental Health**
5. **Heart Disease & Stroke**
6. **Substance Abuse**
7. **Cancer**
8. **Dementias, Including Alzheimer's Disease**
9. **Respiratory Diseases**
10. **Injury & Violence**
11. **Potentially Disabling Conditions**
12. **Family Planning**

While the hospital will likely not implement strategies for all of these health issues, the results of this prioritization exercise will be used to inform the development of Community Hospital of the Monterey Peninsula's Implementation Strategy to address the top health needs of the community in the coming years.

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

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 for all of Monterey County.**

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 local data 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.

Social Determinants	Each Sub-Area vs. Others Combined: Monterey	Carmel/ Big Sur	Seaside	Marina	Pac Grv/ Pebble Beach	Hwy 68/ Carmel Valley	CHOMP Service Area	CHOMP vs. Benchmarks: vs. CA	vs. US	vs. HP2020	TREND
Linguistically Isolated Population (Percent)*							16.0	9.5	4.7		
Population in Poverty (Percent)*							17.2	16.4	15.6		
Population Below 200% FPL (Percent)*							42.0	36.4	34.5		
Children Below 200% FPL (Percent)*							55.4	46.4	44.2		
No High School Diploma (Age 25+, Percent)*							28.8	18.5	13.7		
Unemployment Rate (Age 16+, Percent)*							5.9	4.7	4.5		7.3
% Worry/Stress Over Rent/Mortgage in Past Year	31.0	16.3	42.2	38.4	29.7	21.6	31.7		31.6		
% Worried About Food in the Past Year	19.8	2.8	35.5	27.9	10.9	15.3	21.0		21.0		
% Ran Out of Food in the Past Year	12.3	5.5	31.5	18.6	5.2	13.8	16.1		19.9		
% Food Insecure	23.4	5.8	40.7	28.7	12.6	18.1	24.0		25.9		

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.

better similar worse

Overall Health	Each Sub-Area vs. Others Combined: Monterey	Carmel/ Big Sur	Seaside	Marina	Pac Grv/ Pebble Beach	Hwy 68/ Carmel Valley	CHOMP Service Area	CHOMP vs. Benchmarks: vs. CA	vs. US	vs. HP2020	TREND
% "Fair/Poor" Physical Health	16.3	8.8	26.5	21.1	15.8	17.3	18.6	18.1	18.3		14.5
% Activity Limitations	26.8	28.4	24.5	29.2	26.8	24.6	26.6	19.9	20.0		18.6

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.

better similar worse

Access to Health Services	Each Sub-Area vs. Others Combined: Monterey	Carmel/ Big Sur	Seaside	Marina	Pac Grv/ Pebble Beach	Hwy 68/ Carmel Valley	CHOMP Service Area	CHOMP vs. Benchmarks: vs. CA	vs. US	vs. HP2020	TREND
% [Age 18-64] Lack Health Insurance	6.6	12.1	10.3	11.0	8.3	7.1	9.1	17.8	10.1	0.0	19.7
% [Insured] Went Without Coverage in Past Year	5.4	1.2	12.9	1.9	5.5	4.7	5.9		8.1		7.1
% [Insured 18-64] Have Coverage Through ACA	14.1	10.1	18.2	7.9	10.1	10.6	12.5		10.8		
% Difficulty Accessing Healthcare in Past Year (Composite)	47.2	45.0	56.0	46.3	44.5	43.6	48.0		35.0		39.5
% Inconvenient Hrs Prevented Dr Visit in Past Year	10.6	10.3	21.6	12.1	12.2	14.4	14.0		14.4		16.3

Access to Health Services (continued)	Each Sub-Area vs. Others Combined: Monterey	Carmel/ Big Sur	Seaside	Marina	Pac Grv/ Pebble Beach	Hwy 68/ Carmel Valley	CHOMP Service Area	CHOMP vs. Benchmarks: vs. CA	vs. US	vs. HP2020	TREND
% Cost Prevented Getting Prescription in Past Year	14.9	6.2	23.4	9.2	15.3	14.3	14.8		9.5		15.2
% Cost Prevented Physician Visit in Past Year	19.8	6.7	26.8	8.9	12.8	11.6	16.0		11.5		19.4
% Difficulty Getting Appointment in Past Year	29.4	24.0	22.5	21.6	24.8	27.5	25.0		15.4		14.3
% Difficulty Finding Physician in Past Year	19.8	23.3	16.4	23.6	20.6	14.0	19.4		8.7		12.2
% Transportation Hindered Dr Visit in Past Year	11.4	6.3	11.9	7.4	6.7	5.9	8.9		5.0		6.4
% Language/Culture Prevented Care in Past Year	0.0	0.0	6.2	0.0	0.3	7.7	2.4		1.7		
% Skipped Prescription Doses to Save Costs	14.4	9.4	14.1	9.8	15.6	13.4	13.0		10.2		14.5
% Difficulty Getting Child's Healthcare in Past Year							2.2		3.9		7.1
% Have Completed Advance Directive Documents	52.8	60.8	25.3	29.6	46.2	47.1	42.0		33.7		
% Low Health Literacy	20.4	18.0	31.1	15.2	12.1	17.6	20.2		23.3		

Access to Health Services (continued)	Each Sub-Area vs. Others Combined: Monterey	Carmel/ Big Sur	Seaside	Marina	Pac Grv/ Pebble Beach	Hwy 68/ Carmel Valley	CHOMP Service Area	CHOMP vs. Benchmarks: vs. CA	vs. US	vs. HP2020	TREND
Primary Care Doctors per 100,000*							62.3	77.2	74.5		
% [Age 18+] Have a Specific Source of Ongoing Care	78.8	79.0	60.3	72.1	81.1	71.8	72.9		74.0	95.0	73.0
% [Age 18-64] Have a Specific Source of Ongoing Care	80.9	81.8	56.5	69.7	80.5	67.8	70.8		73.1	89.4	70.6
% [Age 65+] Have a Specific Source of Ongoing Care	71.2	77.3	78.3	82.0	81.5	79.2	77.8		76.8	100.0	82.8
% Have Had Routine Checkup in Past Year	80.2	76.5	66.1	66.0	75.0	70.6	72.3	66.6	70.5		65.1
% Child Has Had Checkup in Past Year							89.6		89.3		85.6
% Two or More ER Visits in Past Year	12.2	6.1	11.4	3.2	5.3	9.4	8.4		8.5		5.4
% Rate Local Healthcare "Fair/Poor"	14.8	14.9	26.0	15.0	9.3	13.6	16.4		14.2		19.5

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.

better | similar | worse

Arthritis, Osteoporosis & Chronic Back Conditions	Each Sub-Area vs. Others Combined: Monterey	Carmel/ Big Sur	Seaside	Marina	Pac Grv/ Pebble Beach	Hwy 68/ Carmel Valley	CHOMP Service Area	CHOMP vs. Benchmarks: vs. CA	vs. US	vs. HP2020	TREND
% [50+] Arthritis/Rheumatism	30.8	26.3	30.3	36.7	34.2	31.0	31.4		32.0		29.4
% [50+] Osteoporosis	9.8	14.6	12.7	9.8	13.0	12.0	11.8		8.7	5.3	8.2
% Sciatica/Chronic Back Pain	23.2	24.4	26.5	20.1	31.6	20.9	24.5		19.4		21.7
% Caregiver to a Friend/Family Member	19.6	31.8	26.5	15.7	29.4	28.2	24.4		20.9		

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.

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Cancer	Each Sub-Area vs. Others Combined: Monterey	Carmel/ Big Sur	Seaside	Marina	Pac Grv/ Pebble Beach	Hwy 68/ Carmel Valley	CHOMP Service Area	CHOMP vs. Benchmarks: vs. CA	vs. US	vs. HP2020	TREND
Cancer (Age-Adjusted Death Rate)*							136.0	147.3	163.6	161.4	146.2
Lung Cancer (Age-Adjusted Death Rate)*							27.5	31.9	43.4	45.5	
Prostate Cancer (Age-Adjusted Death Rate)*							19.8	19.4	19.2	21.8	

Cancer (continued)	Each Sub-Area vs. Others Combined: Monterey	Carmel/ Big Sur	Seaside	Marina	Pac Grv/ Pebble Beach	Hwy 68/ Carmel Valley	CHOMP Service Area	CHOMP vs. Benchmarks: vs. CA	vs. US	vs. HP2020	TREND
Female Breast Cancer (Age-Adjusted Death Rate)*							19.0	20.4	20.9	20.7	
Colorectal Cancer (Age-Adjusted Death Rate)*							9.8	13.2	14.6	14.5	
Prostate Cancer Incidence per 100,000*							156.2	126.9	131.7		
Female Breast Cancer Incidence per 100,000*							113.2	122.1	123.0		
Lung Cancer Incidence per 100,000*							43.2	48.0	63.7		
Colorectal Cancer Incidence per 100,000*							29.3	40.0	41.9		
Cervical Cancer Incidence per 100,000*							7.2	7.7	7.7		
% Skin Cancer	10.5	16.9	6.3	4.5	10.0	10.7	9.3	4.8	7.7		6.8
% Cancer (Other Than Skin)	6.6	10.1	7.0	7.3	9.6	8.9	7.9	6.0	7.7		5.8
% [Women 50-74] Mammogram in Past 2 Years							75.3	82.9	80.3	81.1	81.3

Cancer (continued)	Each Sub-Area vs. Others Combined: Monterey	Carmel/ Big Sur	Seaside	Marina	Pac Grv/ Pebble Beach	Hwy 68/ Carmel Valley	CHOMP Service Area	CHOMP vs. Benchmarks: vs. CA	vs. US	vs. HP2020	TREND
% [Women 21-65] Pap Smear in Past 3 Years							80.6	83.1	84.8	93.0	88.4
% [Age 50+] Sigmoid/Colonoscopy Ever	75.8	79.1	74.7	76.0	80.1	79.0	77.2	66.6	75.6		69.4
% [Age 50+] Blood Stool Test in Past 2 Years	35.5	32.9	19.2	30.7	31.2	28.9	30.1	20.5	31.8		34.1
% [Age 50-75] Colorectal Cancer Screening	75.1	71.4	59.3	73.1	71.7	75.7	70.8	66.0	74.5	70.5	66.7

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.

better similar worse

Chronic Kidney Disease	Each Sub-Area vs. Others Combined: Monterey	Carmel/ Big Sur	Seaside	Marina	Pac Grv/ Pebble Beach	Hwy 68/ Carmel Valley	CHOMP Service Area	CHOMP vs. Benchmarks: vs. CA	vs. US	vs. HP2020	TREND
Kidney Disease (Age-Adjusted Death Rate)*							8.3	7.4	13.2		10.6
% Kidney Disease	1.4	3.3	1.8	4.3	4.0	6.0	3.1	2.4	3.6		

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.

better similar worse

Dementias, Including Alzheimer's Disease	Each Sub-Area vs. Others Combined: Monterey	Carmel/ Big Sur	Seaside	Marina	Pac Grv/ Pebble Beach	Hwy 68/ Carmel Valley	CHOMP Service Area	CHOMP vs. Benchmarks: vs. CA	vs. US	vs. HP2020	TREND
Alzheimer's Disease (Age-Adjusted Death Rate)*							20.0	30.3	24.2		14.7
% [Age 45+] Increasing Confusion/Memory Loss in Past Yr	13.6	16.0	19.0	10.8	16.9	20.6	15.9		12.8		

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.

better similar worse

Diabetes	Each Sub-Area vs. Others Combined: Monterey	Carmel/ Big Sur	Seaside	Marina	Pac Grv/ Pebble Beach	Hwy 68/ Carmel Valley	CHOMP Service Area	CHOMP vs. Benchmarks: vs. CA	vs. US	vs. HP2020	TREND
Diabetes Mellitus (Age-Adjusted Death Rate)*							20.0	20.6	21.1	20.5	18.7
% Diabetes/High Blood Sugar	7.3	6.7	13.5	18.7	10.3	8.2	11.1	10.3	14.5		8.5
% Borderline/Pre-Diabetes	12.4	9.7	12.5	17.1	10.4	5.7	11.8		5.7		
% [Non-Diabetes] Blood Sugar Tested in Past 3 Years	58.3	63.9	53.7	55.0	49.9	53.0	55.6		55.1		

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.

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Educational & Community-Based Programs	Each Sub-Area vs. Others Combined: Monterey	Carmel/ Big Sur	Seaside	Marina	Pac Grv/ Pebble Beach	Hwy 68/ Carmel Valley	CHOMP Service Area	CHOMP vs. Benchmarks: vs. CA	vs. US	vs. HP2020	TREND
% Attended Health Event in Past Year	14.8	13.2	12.0	9.6	9.3	6.9	11.3		23.8		16.0

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.

better similar worse

Environmental Health	Each Sub-Area vs. Others Combined: Monterey	Carmel/ Big Sur	Seaside	Marina	Pac Grv/ Pebble Beach	Hwy 68/ Carmel Valley	CHOMP Service Area	CHOMP vs. Benchmarks: vs. CA	vs. US	vs. HP2020	TREND
% Illness/Symptom in Past Yr from Indoor Air	20.8	8.9	21.9	20.8	16.2	8.1	17.4				17.0
% Illness/Symptom in Past Yr from Outdoor Air	6.9	5.1	12.1	15.0	4.2	9.7	9.2				7.9
% Mold in the Home	11.2	4.9	14.6	7.4	8.6	5.8	9.5				10.7

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.

better similar worse

Family Planning	Each Sub-Area vs. Others Combined: Monterey	Carmel/ Big Sur	Seaside	Marina	Pac Grv/ Pebble Beach	Hwy 68/ Carmel Valley	CHOMP Service Area	CHOMP vs. Benchmarks: vs. CA	vs. US	vs. HP2020	TREND
Births to Teenagers Under Age 20 (Percent)*							8.2	6.2	7.1		11.9
	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.							better	similar	worse	

Hearing & Other Sensory or Communication Disorders	Each Sub-Area vs. Others Combined: Monterey	Carmel/ Big Sur	Seaside	Marina	Pac Grv/ Pebble Beach	Hwy 68/ Carmel Valley	CHOMP Service Area	CHOMP vs. Benchmarks: vs. CA	vs. US	vs. HP2020	TREND
% Deafness/Trouble Hearing	7.7	23.8	4.5	5.9	15.2	11.5	10.0		8.6		9.9
	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.							better	similar	worse	

Heart Disease & Stroke	Each Sub-Area vs. Others Combined: Monterey	Carmel/ Big Sur	Seaside	Marina	Pac Grv/ Pebble Beach	Hwy 68/ Carmel Valley	CHOMP Service Area	CHOMP vs. Benchmarks: vs. CA	vs. US	vs. HP2020	TREND
Diseases of the Heart (Age-Adjusted Death Rate)*							119.3	149.1	169.1	156.9	164.3
Stroke (Age-Adjusted Death Rate)*							37.4	34.7	36.5	34.8	43.3
% Heart Disease (Heart Attack, Angina, Coronary Disease)	8.5	4.9	5.0	10.5	9.4	3.3	7.1		6.9		5.3

Heart Disease & Stroke (continued)	Each Sub-Area vs. Others Combined: Monterey	Carmel/ Big Sur	Seaside	Marina	Pac Grv/ Pebble Beach	Hwy 68/ Carmel Valley	CHOMP Service Area	CHOMP vs. Benchmarks: vs. CA	vs. US	vs. HP2020	TREND
% Stroke	1.0	1.6	4.4	3.6	2.5	2.9	2.7	2.7	2.6		1.9
% Blood Pressure Checked in Past 2 Years	97.5	94.6	85.6	96.4	96.8	94.6	93.8		93.6	92.6	94.1
% Told Have High Blood Pressure (Ever)	33.1	29.6	33.5	42.3	37.1	37.4	35.5	28.7	36.5	26.9	27.1
% [HBP] Taking Action to Control High Blood Pressure							92.2		92.5		91.2
% Cholesterol Checked in Past 5 Years	96.2	94.6	84.3	88.5	94.8	91.6	91.2	75.2	87.4	82.1	83.6
% Told Have High Cholesterol (Ever)	39.4	37.0	31.5	39.4	37.6	32.3	36.2		33.5	13.5	33.2
% [HBC] Taking Action to Control High Blood Cholesterol							88.1		84.2		88.5
% 1+ Cardiovascular Risk Factor	85.7	67.2	84.5	93.5	75.6	82.9	82.9		83.0		77.5

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.

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HIV	Each Sub-Area vs. Others Combined: Monterey	Carmel/ Big Sur	Seaside	Marina	Pac Grv/ Pebble Beach	Hwy 68/ Carmel Valley	CHOMP Service Area	CHOMP vs. Benchmarks: vs. CA	vs. US	vs. HP2020	TREND
HIV/AIDS (Age-Adjusted Death Rate)*							1.2	2.4	3.0	3.3	
HIV Prevalence per 100,000*							187.4	376.2	353.2		

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.

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Immunization & Infectious Diseases	Each Sub-Area vs. Others Combined: Monterey	Carmel/ Big Sur	Seaside	Marina	Pac Grv/ Pebble Beach	Hwy 68/ Carmel Valley	CHOMP Service Area	CHOMP vs. Benchmarks: vs. CA	vs. US	vs. HP2020	TREND
% [Age 65+] Flu Vaccine in Past Year	56.2	n/a	38.1	52.0	58.6	64.0	54.2	58.2	58.9	70.0	66.7
% [High-Risk 18-64] Flu Vaccine in Past Year							40.8		48.0	70.0	28.1
% [Age 65+] Pneumonia Vaccine Ever	72.0	n/a	67.7	84.3	74.6	74.8	74.6	70.0	76.3	90.0	67.7
% [High-Risk 18-64] Pneumonia Vaccine Ever							43.3		38.7	60.0	27.9

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.

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Injury & Violence Prevention	Each Sub-Area vs. Others Combined: Monterey	Carmel/ Big Sur	Seaside	Marina	Pac Grv/ Pebble Beach	Hwy 68/ Carmel Valley	CHOMP Service Area	CHOMP vs. Benchmarks: vs. CA	vs. US	vs. HP2020	TREND
Unintentional Injury (Age-Adjusted Death Rate)*							29.9	28.8	39.7	36.4	32.6
Motor Vehicle Crashes (Age-Adjusted Death Rate)*							7.5	8.1	10.6	12.4	12.8
[65+] Falls (Age-Adjusted Death Rate)*							30.4	37.4	57.2	47.0	
% [Age 45+] Fell in the Past Year	23.9	29.6	36.9	23.6	34.6	28.6	29.3		28.2		
Firearm-Related Deaths (Age-Adjusted Death Rate)*							11.6	7.7	10.4	9.3	
Homicide (Age-Adjusted Death Rate)*							9.5	4.9	5.2	5.5	5.1
Violent Crime per 100,000*							464.3	425.0	395.5		
% Perceive Neighborhood as “Slightly/Not At All Safe”	8.6	1.8	33.0	11.5	3.3	5.6	12.7		15.3		
% Victim of Violent Crime in Past 5 Years	3.8	0.8	9.4	4.5	0.3	2.3	4.2		2.3		3.5
% Victim of Domestic Violence (Ever)	15.7	11.1	10.6	15.8	12.8	9.4	12.8		15.1		11.0

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.

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Maternal, Infant & Child Health	Each Sub-Area vs. Others Combined: Monterey	Carmel/ Big Sur	Seaside	Marina	Pac Grv/ Pebble Beach	Hwy 68/ Carmel Valley	CHOMP Service Area	CHOMP vs. Benchmarks: vs. CA	vs. US	vs. HP2020	TREND
No Prenatal Care in First Trimester (Percent)*							26.7	16.7		22.1	28.1
Low Birthweight Births (Percent)*							5.9	6.7	8.0	7.8	5.7
Infant Death Rate*							4.5	4.5	5.9	6.0	5.1

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.

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Mental Health & Mental Disorders	Each Sub-Area vs. Others Combined: Monterey	Carmel/ Big Sur	Seaside	Marina	Pac Grv/ Pebble Beach	Hwy 68/ Carmel Valley	CHOMP Service Area	CHOMP vs. Benchmarks: vs. CA	vs. US	vs. HP2020	TREND
% "Fair/Poor" Mental Health	9.5	3.9	25.8	17.6	9.2	8.7	13.8		15.5		9.6
% Diagnosed Depression	18.8	10.0	26.1	19.4	22.6	17.9	20.0	13.3	17.9		
% Symptoms of Chronic Depression (2+ Years)	30.1	26.1	49.1	42.7	21.8	28.5	34.6		29.9		25.0
Suicide (Age-Adjusted Death Rate)*							9.1	10.2	12.7	10.2	8.6
% Have Ever Sought Help for Mental Health	31.0	27.2	35.5	30.4	41.7	30.8	32.9		27.4		28.6

Mental Health & Mental Disorders (continued)	Each Sub-Area vs. Others Combined: Monterey	Carmel/ Big Sur	Seaside	Marina	Pac Grv/ Pebble Beach	Hwy 68/ Carmel Valley	CHOMP Service Area	CHOMP vs. Benchmarks: vs. CA	vs. US	vs. HP2020	TREND
% Taking Rx/Receiving Mental Health Trtmt	12.9	11.8	21.1	18.2	17.8	10.2	15.8		13.6		
% Unable to Get Mental Health Svcs in Past Yr	1.6	2.2	9.6	3.4	5.2	5.2	4.7		4.4		
% Typical Day Is "Extremely/Very" Stressful	13.6	1.7	13.4	10.1	6.0	18.7	11.3		11.7		9.9
% Average <7 Hours of Sleep per Night	31.3	19.1	39.6	32.2	34.8	15.4	30.4		39.5		

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.

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Nutrition, Physical Activity & Weight	Each Sub-Area vs. Others Combined: Monterey	Carmel/ Big Sur	Seaside	Marina	Pac Grv/ Pebble Beach	Hwy 68/ Carmel Valley	CHOMP Service Area	CHOMP vs. Benchmarks: vs. CA	vs. US	vs. HP2020	TREND
% Eat 5+ Servings of Fruit or Vegetables per Day	41.6	55.6	31.5	35.7	38.8	38.8	39.2		27.4		53.9
% "Very/Somewhat" Difficult to Buy Fresh Produce	11.6	5.0	33.4	12.2	12.7	12.2	16.1		21.9		
Population With Low Food Access (Percent)*							15.9	14.3	23.6		
% 7+ Sugar-Sweetened Drinks in Past Week	17.5	11.5	27.4	31.0	12.6	13.7	20.0		30.2		

Nutrition, Physical Activity & Weight (continued)	Each Sub-Area vs. Others Combined: Monterey	Carmel/ Big Sur	Seaside	Marina	Pac Grv/ Pebble Beach	Hwy 68/ Carmel Valley	CHOMP Service Area	CHOMP vs. Benchmarks: vs. CA	vs. US	vs. HP2020	TREND
% Medical Advice on Nutrition in Past Year	47.1	36.3	44.4	45.6	42.8	38.2	43.2		39.2		39.6
% Healthy Weight (BMI 18.5-24.9)	38.0	57.3	33.0	22.3	41.6	36.8	36.9	37.7	32.9	33.9	42.4
% Overweight (BMI 25+)	61.4	41.8	66.4	77.7	57.8	59.9	62.2	59.7	65.2		56.1
% Obese (BMI 30+)	25.5	8.1	25.7	37.8	22.5	21.2	24.6	24.7	33.4	30.5	16.7
% Medical Advice on Weight in Past Year	22.3	15.8	27.2	34.4	22.8	21.9	24.7		20.4		21.4
% [Overweights] Counseled About Weight in Past Year	29.6	31.4	38.2	44.6	24.3	30.0	34.2		27.1		28.5
% [Obese Adults] Counseled About Weight in Past Year							46.9		40.8		46.2
% [Overweights] Trying to Lose Weight Both Diet/Exercise	52.3	58.2	68.7	57.3	62.5	61.5	60.0		57.0		35.6
% Child [Age 5-17] Healthy Weight							56.1		67.2		
% Children [Age 5-17] Overweight (85th Percentile)							35.8		24.2		25.5
% Children [Age 5-17] Obese (95th Percentile)							18.3		9.5	14.5	12.1

Nutrition, Physical Activity & Weight (continued)	Each Sub-Area vs. Others Combined: Monterey	Carmel/ Big Sur	Seaside	Marina	Pac Grv/ Pebble Beach	Hwy 68/ Carmel Valley	CHOMP Service Area	CHOMP vs. Benchmarks: vs. CA	vs. US	vs. HP2020	TREND
% No Leisure-Time Physical Activity	14.7	13.3	24.5	17.2	11.7	9.6	16.1	21.7	27.9	32.6	19.6
% Meeting Physical Activity Guidelines	31.8	36.9	23.1	29.0	29.4	33.3	29.8	24.1	23.6	20.1	
Recreation/Fitness Facilities per 100,000*							5.3	8.9	9.7		
% Child [Age 2-17] Physically Active 1+ Hours per Day							47.5		47.9		
% Child [Age 5-17] Watches TV 3+ Hours per Day							17.1		30.1		14.2
% Child [Age 5-17] Uses Computer 3+ Hours per Day							19.7		27.4		14.3
% Child [Age 5-17] 3+ Hours per Day of Total Screen Time							46.4		63.8		35.2

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.

better similar worse

Oral Health	Each Sub-Area vs. Others Combined: Monterey	Carmel/ Big Sur	Seaside	Marina	Pac Grv/ Pebble Beach	Hwy 68/ Carmel Valley	CHOMP Service Area	CHOMP vs. Benchmarks: vs. CA	vs. US	vs. HP2020	TREND
% [Age 18+] Dental Visit in Past Year	80.7	86.8	49.9	70.0	77.4	82.6	72.6	65.1	67.2	49.0	72.5

Oral Health (continued)	Each Sub-Area vs. Others Combined: Monterey	Carmel/ Big Sur	Seaside	Marina	Pac Grv/ Pebble Beach	Hwy 68/ Carmel Valley	CHOMP Service Area	CHOMP vs. Benchmarks: vs. CA	vs. US	vs. HP2020	TREND
% Child [Age 2-17] Dental Visit in Past Year							90.5		90.7	49.0	85.3
% Have Dental Insurance	56.1	53.5	62.4	64.4	60.8	64.3	60.3		66.5		60.0

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.

better similar worse

Respiratory Diseases	Each Sub-Area vs. Others Combined: Monterey	Carmel/ Big Sur	Seaside	Marina	Pac Grv/ Pebble Beach	Hwy 68/ Carmel Valley	CHOMP Service Area	CHOMP vs. Benchmarks: vs. CA	vs. US	vs. HP2020	TREND
CLRD (Age-Adjusted Death Rate)*							27.7	33.9	41.4		34.7
Pneumonia/Influenza (Age-Adjusted Death Rate)*							12.4	15.5	15.1		15.4
% COPD (Lung Disease)	13.5	14.2	7.9	10.7	11.2	13.1	11.5	4.9	9.5		7.6
% [Adult] Currently Has Asthma	11.9	6.2	4.6	21.3	7.9	9.8	10.3	7.8	9.5		6.9
% [Child 0-17] Currently Has Asthma							7.7		6.5		2.9

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.

better similar worse

Sexually Transmitted Diseases	Each Sub-Area vs. Others Combined: Monterey	Carmel/ Big Sur	Seaside	Marina	Pac Grv/ Pebble Beach	Hwy 68/ Carmel Valley	CHOMP Service Area	CHOMP vs. Benchmarks: vs. CA	vs. US	vs. HP2020	TREND
Gonorrhea Incidence per 100,000*							69.0	118.5	110.7		
Chlamydia Incidence per 100,000*							397.1	459.2	456.1		

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.

better similar worse

Substance Abuse	Each Sub-Area vs. Others Combined: Monterey	Carmel/ Big Sur	Seaside	Marina	Pac Grv/ Pebble Beach	Hwy 68/ Carmel Valley	CHOMP Service Area	CHOMP vs. Benchmarks: vs. CA	vs. US	vs. HP2020	TREND
Cirrhosis/Liver Disease (Age-Adjusted Death Rate)*							9.4	11.8	10.2	8.2	10.5
% Current Drinker	63.0	68.4	43.4	46.2	50.8	65.2	55.0	53.6	59.7		61.7
% Excessive Drinker	24.5	34.1	22.1	12.9	13.8	22.4	21.4		22.2	25.4	22.2
% Drinking & Driving in Past Month	1.2	0.3	1.1	1.4	0.6	1.9	1.1		4.1		3.0
Drug-Induced Deaths (Age-Adjusted Death Rate)*							12.2	11.5	14.6	11.3	9.6
% Illicit Drug Use in Past Month	1.4	1.6	1.4	2.3	3.8	0.0	1.7		3.0	7.1	4.4

Substance Abuse (continued)	Each Sub-Area vs. Others Combined: Monterey	Carmel/ Big Sur	Seaside	Marina	Pac Grv/ Pebble Beach	Hwy 68/ Carmel Valley	CHOMP Service Area	CHOMP vs. Benchmarks: vs. CA	vs. US	vs. HP2020	TREND
% Ever Sought Help for Alcohol or Drug Problem	5.7	1.7	7.7	5.6	3.1	2.0	4.9		4.1		4.6
% Life Negatively Affected by Substance Abuse	36.7	39.7	34.5	33.7	44.0	49.0	38.7		32.2		

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.

better similar worse

Tobacco Use	Each Sub-Area vs. Others Combined: Monterey	Carmel/ Big Sur	Seaside	Marina	Pac Grv/ Pebble Beach	Hwy 68/ Carmel Valley	CHOMP Service Area	CHOMP vs. Benchmarks: vs. CA	vs. US	vs. HP2020	TREND
% Current Smoker	8.3	4.5	10.4	13.8	8.0	6.0	8.9	12.9	14.0	12.0	13.9
% Someone Smokes at Home	5.9	1.1	11.0	17.1	6.4	7.6	8.7		10.2		10.3
% [Nonsmokers] Someone Smokes in the Home	3.5	0.6	6.7	8.7	1.5	6.4	4.8		3.9		3.9
% [Household With Children] Someone Smokes in the Home							6.7		10.2		9.1
% [Smokers] Received Advice to Quit Smoking							69.3		76.0		54.4
% [Smokers] Have Quit Smoking 1+ Days in Past Year							41.1		43.7	80.0	51.0

Tobacco Use (continued)	Each Sub-Area vs. Others Combined: Monterey	Carmel/ Big Sur	Seaside	Marina	Pac Grv/ Pebble Beach	Hwy 68/ Carmel Valley	CHOMP Service Area	CHOMP vs. Benchmarks: vs. CA	vs. US	vs. HP2020	TREND
% Currently Use Electronic Cigarettes	0.9	0.0	2.0	2.6	3.8	0.0	1.6		3.8		
% Smoke Cigars	4.5	3.0	2.7	9.6	0.0	0.5	3.7		3.6	0.2	3.5
% Use Smokeless Tobacco	2.6	3.2	2.8	2.3	1.7	0.0	2.2	1.6	3.0	0.3	2.2

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.

better similar worse

Vision	Each Sub-Area vs. Others Combined: Monterey	Carmel/ Big Sur	Seaside	Marina	Pac Grv/ Pebble Beach	Hwy 68/ Carmel Valley	CHOMP Service Area	CHOMP vs. Benchmarks: vs. CA	vs. US	vs. HP2020	TREND
% Blindness/Trouble Seeing	9.3	6.6	16.6	12.8	7.4	9.4	11.0	5.0	7.3		10.0
% Eye Exam in Past 2 Years	65.7	76.2	45.2	57.8	64.0	56.7	59.6		59.3		60.9

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.

better similar worse

Community Description

Professional Research Consultants, Inc.

Population Characteristics: Monterey County

Total Population

Monterey County, California encompasses 129.5 square miles and houses a total population of 424,927 residents, according to latest census estimates.

Total Population
(Estimated Population, 2010-2014)

	Total Population	Total Land Area (Square Miles)	Population Density (Per Square Mile)
Monterey County	424,927	3,280.6	129.5
California	38,066,920	155,786.0	244.4
United States	314,107,083	3,531,932.3	88.9

Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Retrieved April 2016 from Community Commons at http://www.chna.org.

Population Change 2000-2010

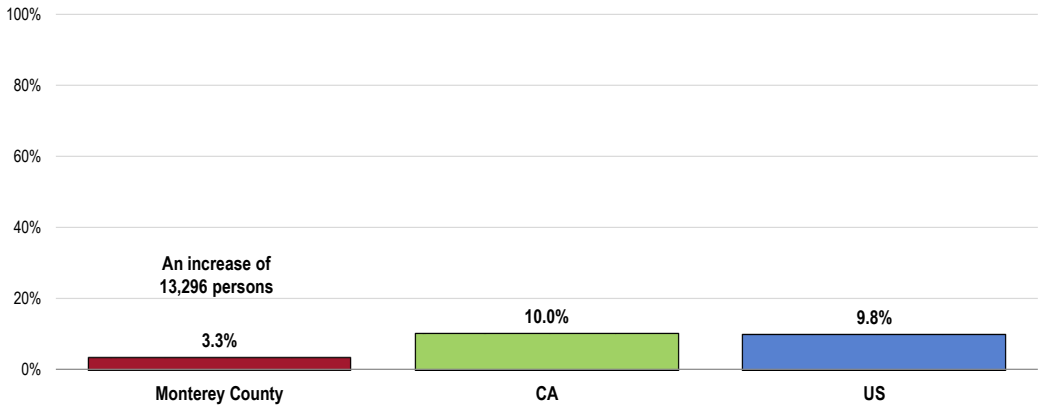
A significant positive or negative shift in total population over time impacts healthcare providers and the utilization of community resources.

Between the 2000 and 2010 US Censuses, the population of Monterey County increased by 13,296 persons, or 3.3%.

- A lower proportional increase than seen across both the state and the nation overall.

Change in Total Population

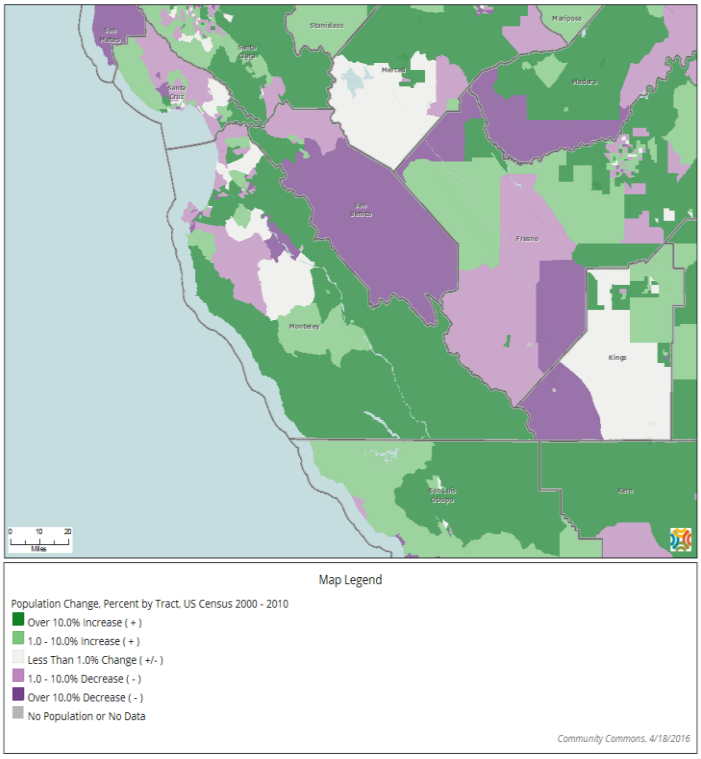
(Percentage Change Between 2000 and 2010)



Sources:
- Retrieved April 2016 from Community Commons at http://www.chna.org.
- US Census Bureau Decennial Census (2000-2010).

Notes:
- A significant positive or negative shift in total population over time impacts healthcare providers and the utilization of community resources.

Population Change, Percent by Tract, US Census 2000-2010



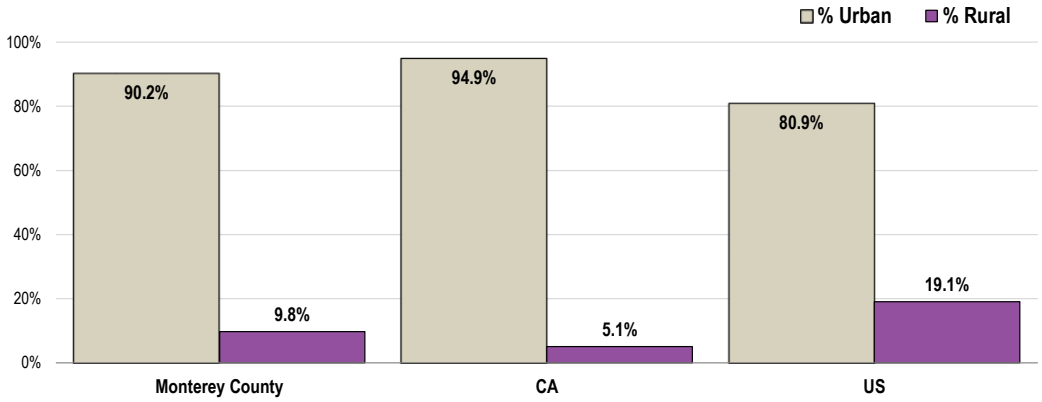
Urban/Rural Population

Urban areas are identified using population density, count, and size thresholds. Urban areas also include territory with a high degree of impervious surface (development). Rural areas are all areas that are not urban.

Monterey County is predominantly urban, with 90.2% of the population living in areas designated as urban.

- Note that at least 80% of the state and national populations live in urban areas.

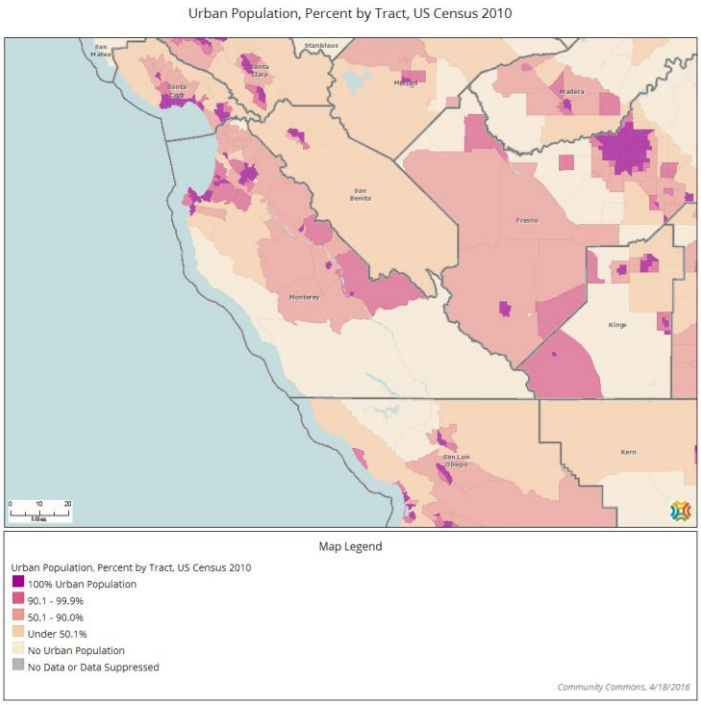
Urban and Rural Population
(2010)



Sources:
- US Census Bureau Decennial Census (2010).
- Retrieved April 2016 from Community Commons at http://www.chna.org.

Notes:
- This indicator reports the percentage of population living in urban and rural areas. Urban areas are identified using population density, count, and size thresholds. Urban areas also include territory with a high degree of impervious surface (development). Rural areas are all areas that are not urban.

- Note the following map outlining the urban population in Monterey County census tracts as of 2010.

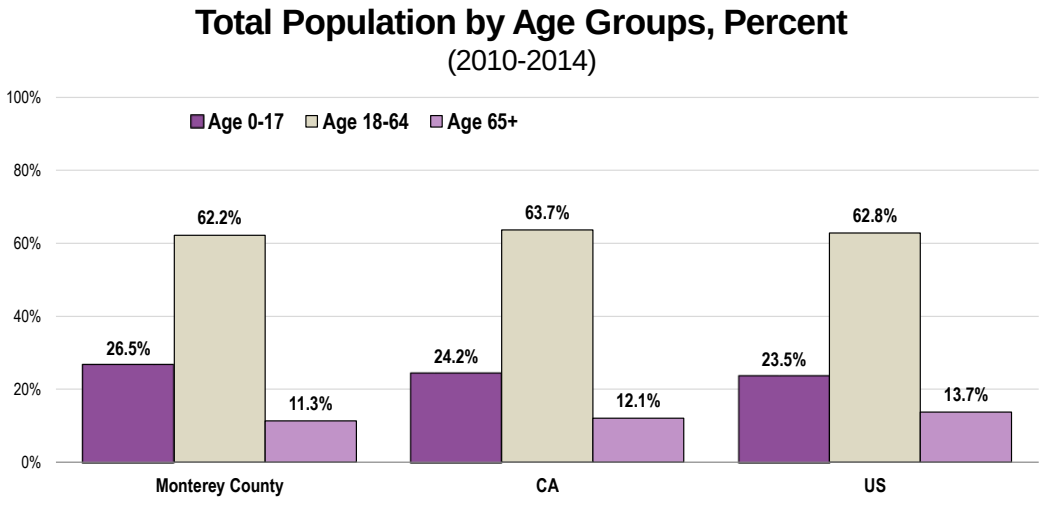


Age

It is important to understand the age distribution of the population as different age groups have unique health needs which should be considered separately from others along the age spectrum.

In Monterey County, 26.5% of the population are infants, children or adolescents (age 0-17); another 62.2% are age 18 to 64, while 11.3% are age 65 and older.

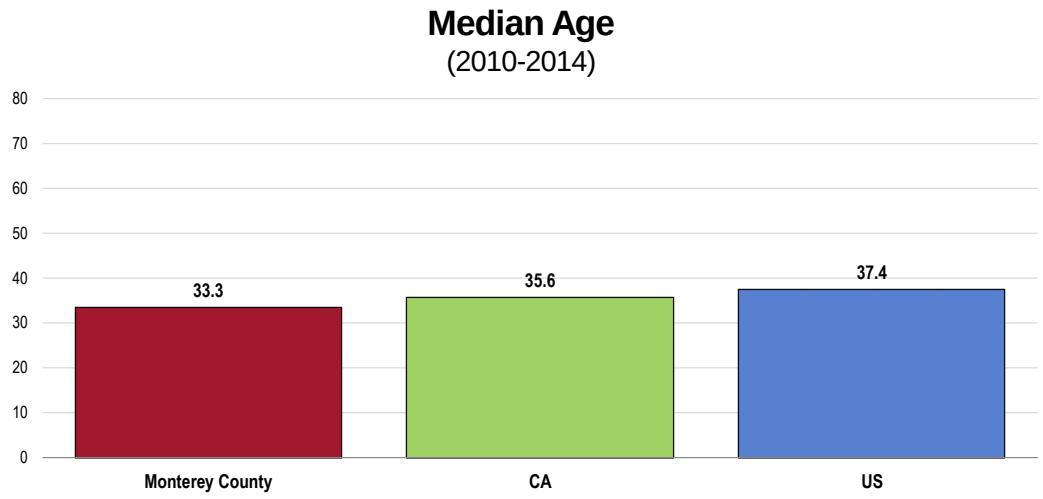
- Similar to the age distributions found statewide and nationally.



Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Retrieved April 2016 from Community Commons at http://www.chna.org.

Median Age

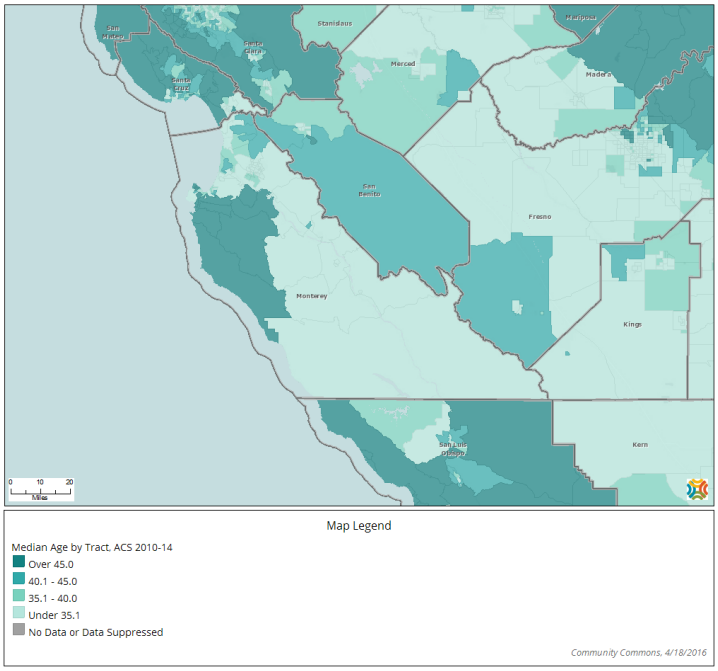
Monterey County is somewhat "younger" than the state and the nation in that the median age is lower.



Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Retrieved April 2016 from Community Commons at http://www.chna.org.

- The following map provides an illustration of the median age in Monterey County, segmented by census tract.

Median Age, by Tract, ACS 2010-2014



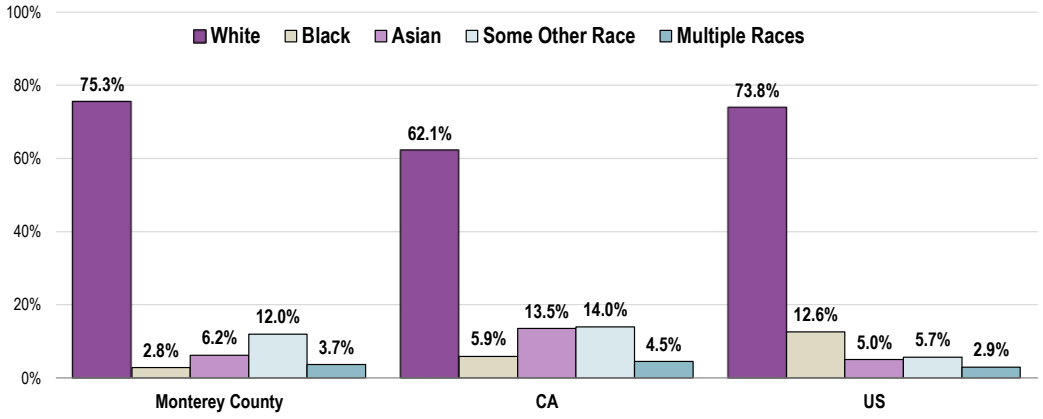
Race & Ethnicity

Race

In looking at race independent of ethnicity (Hispanic or Latino origin), 75.3% of residents of Monterey County are White, 6.2% are Asian, and 2.8% are Black.

- The state racial distribution is less White and more Asian.
- Nationally, the US population is more Black and less "Other" race.

Total Population by Race Alone, Percent
(2010-2014)



Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Retrieved April 2016 from Community Commons at http://www.chna.org.

Ethnicity

A total of 56.5% of Monterey County residents are Hispanic or Latino.

- Notably higher than the state and nationwide percentages.

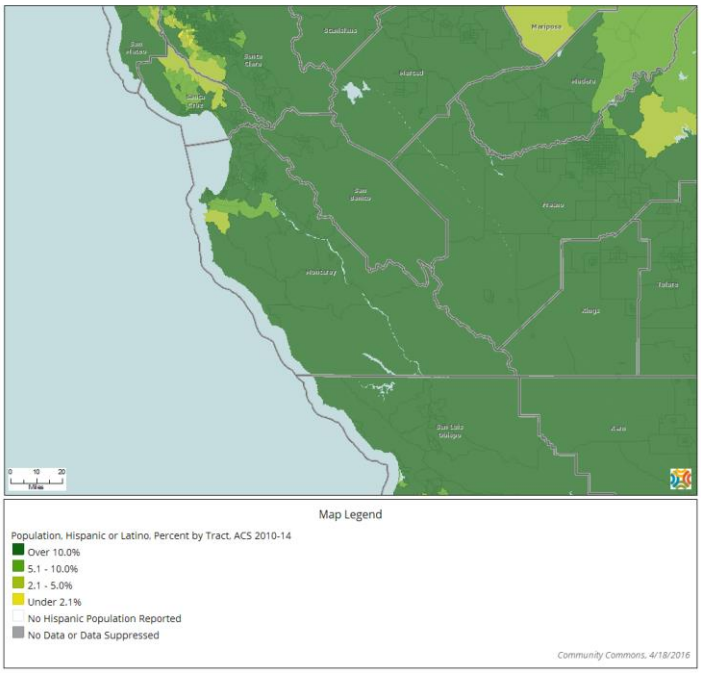
Hispanic Population
(2010-2014)

Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Retrieved April 2016 from Community Commons at http://www.chna.org.

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

- The Hispanic population appears to be less concentrated in northern portions of the county.

Population Hispanic or Latino, Percent by Tract, ACS 2010-2014

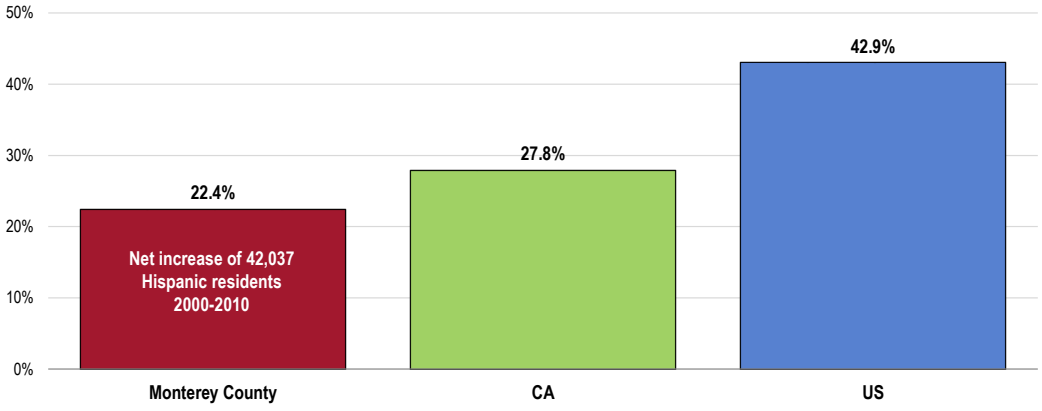


Between 2000 and 2010, the Hispanic population in Monterey County increased by 42,037 or 22.4%.

- Lower (in terms of percentage growth) than found statewide and nationally.

Hispanic Population Change

(Percentage Change in Hispanic Population Between 2000 and 2010)



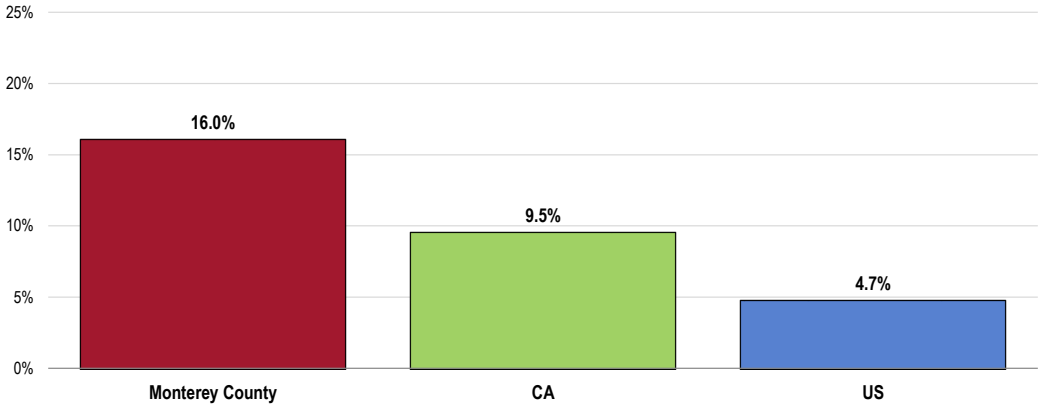
Sources:
- US Census Bureau Decennial Census (2000-2010).
- Retrieved April 2016 from Community Commons at http://www.chna.org.

Linguistic Isolation

A total of 16.0% of the Monterey County population age 5 and older live in a home in which no persons age 14 or older is proficient in English (speaking only English, or speaking English "very well").

- Considerably higher than found both statewide and nationally.

Linguistically Isolated Population
(2010-2014)

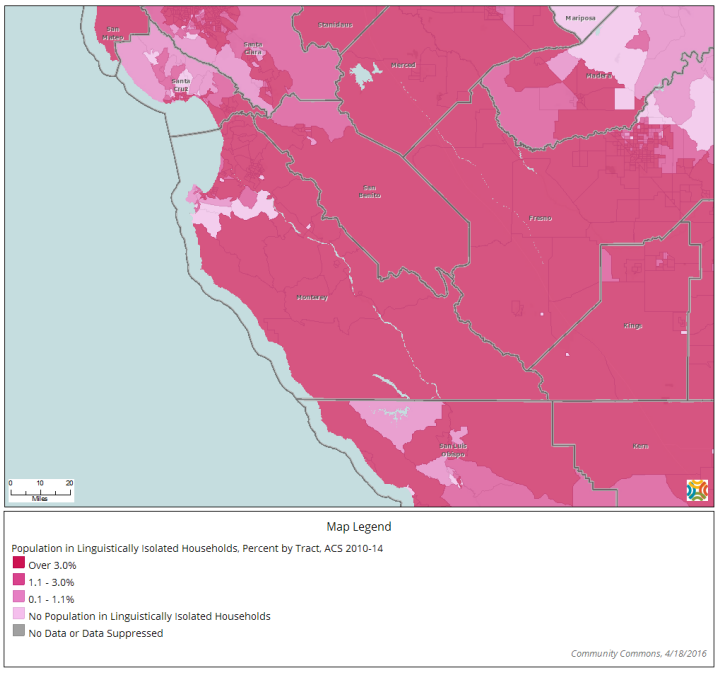


Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Retrieved April 2016 from Community Commons at http://www.chna.org.

Notes:
- This indicator reports the percentage of the population age 5+ who live in a home in which no person age 14+ speaks only English, or in which no person age 14+ speak a non-English language and speak English "very well."

- Note the following map illustrating linguistic isolation in Monterey County.

Population in Linguistically Isolated Households, Percent by Tract, ACS 2010-2014



Social Determinants of Health

About Social Determinants

Health starts in our homes, schools, workplaces, neighborhoods, and communities. We know that taking care of ourselves by eating well and staying active, not smoking, getting the recommended immunizations and screening tests, and seeing a doctor when we are sick all influence our health. Our health is also determined in part by access to social and economic opportunities; the resources and supports available in our homes, neighborhoods, and communities; the quality of our schooling; the safety of our workplaces; the cleanliness of our water, food, and air; and the nature of our social interactions and relationships. The conditions in which we live explain in part why some Americans are healthier than others and why Americans more generally are not as healthy as they could be.

- Healthy People 2020 (www.healthypeople.gov)

Poverty

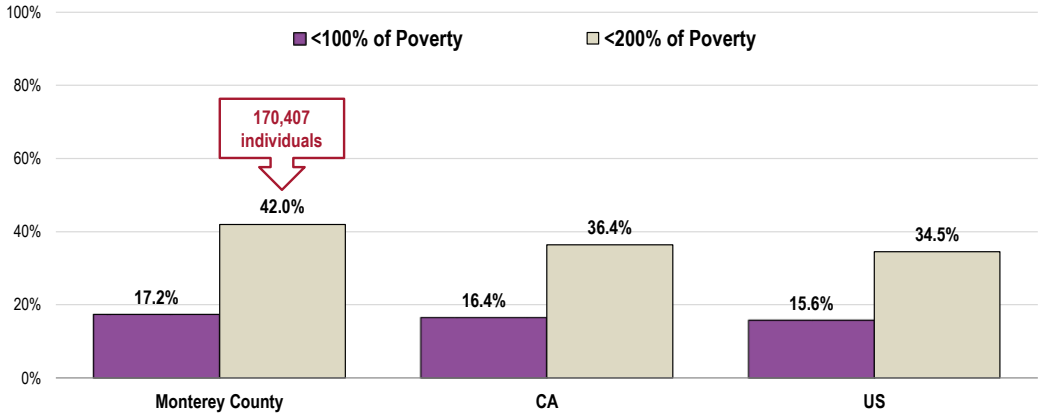
The latest census estimate shows 17.2% of the Monterey County population living below the federal poverty level.

In all, 42.0% of Monterey County residents (an estimated 170,407 individuals) live below 200% of the federal poverty level.

- Higher than the proportions reported statewide and nationally.

Population in Poverty

(Populations Living Below 100% and Below 200% of the Poverty Level; 2010-2014)

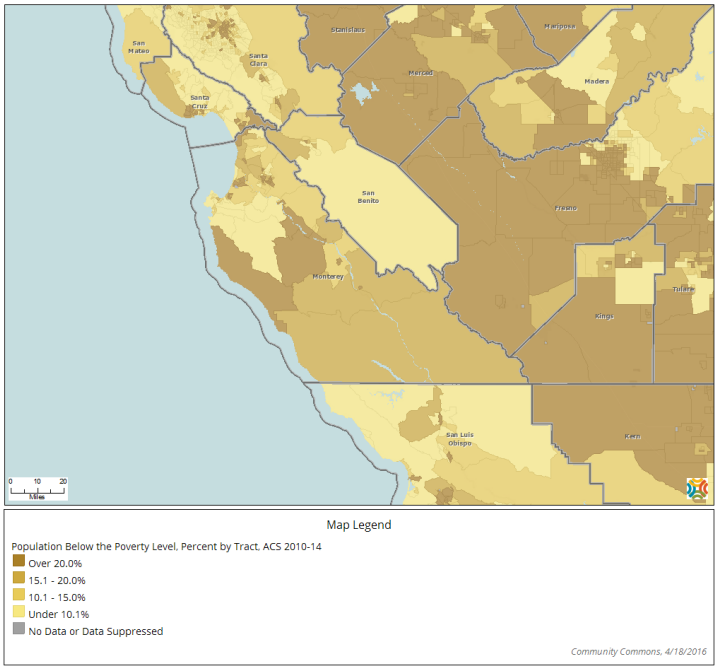


Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Retrieved April 2016 from Community Commons at http://www.chna.org.

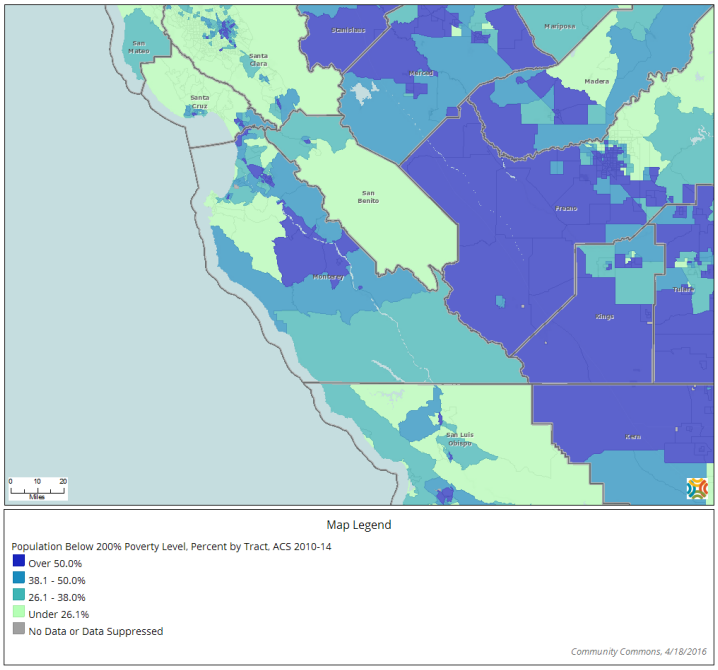
Notes:
- Poverty is considered a key driver of health status. This indicator is relevant because poverty creates barriers to access including health services, healthy food, and other necessities that contribute to poor health status.

- The following maps provide a visual illustration of the distribution of poverty in Monterey County.

Population Below the Poverty Level, Percent by Tract, ACS 2010-2014



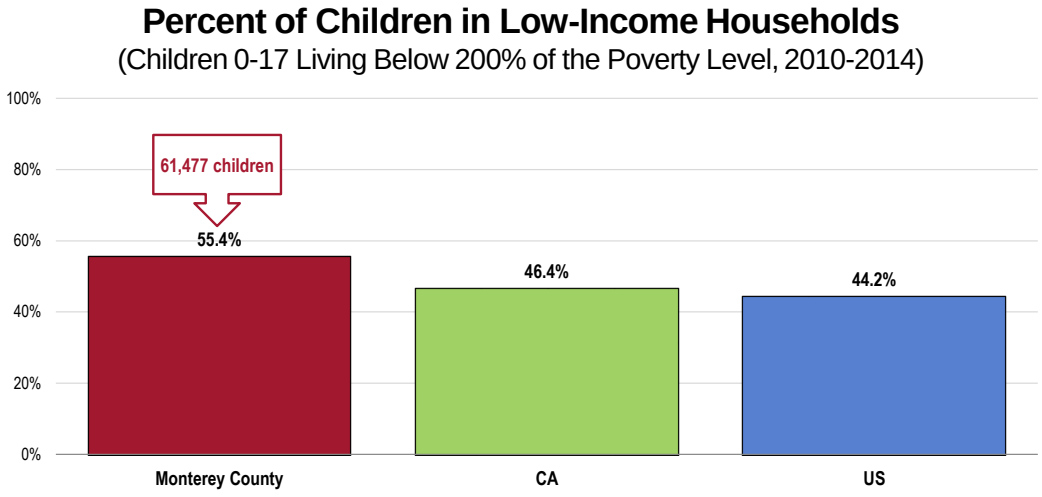
Population Below 200% of Poverty, Percent by Tract, ACS 2010-2014



Children in Low-Income Households

Additionally, 55.4% of Monterey County children age 0-17 (representing an estimated 61,477 children) live below the 200% poverty threshold.

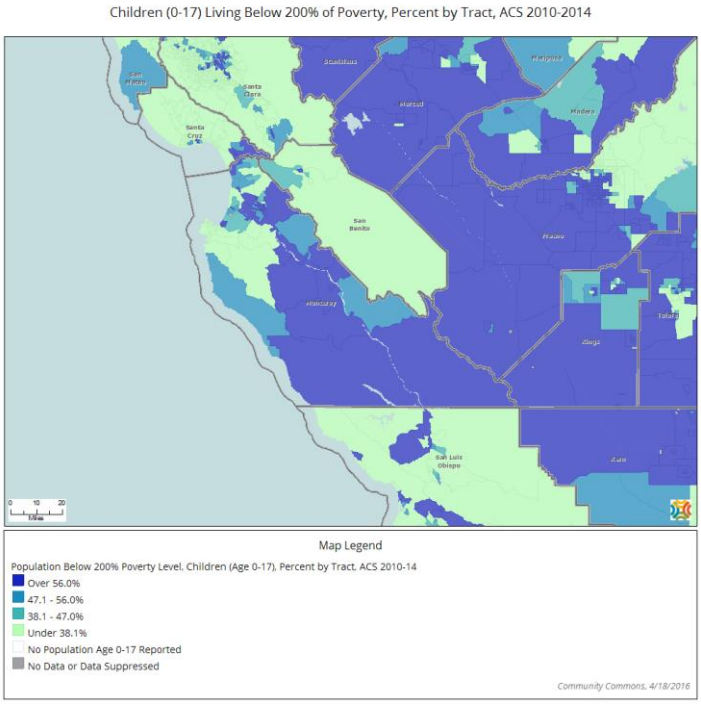
- Above the statewide and national proportions.



Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Retrieved April 2016 from Community Commons at http://www.chna.org.

Notes:
- This indicator reports the percentage of children aged 0-17 living in households with income below 200% of the Federal Poverty Level (FPL). This indicator is relevant because poverty creates barriers to access including health services, healthy food, and other necessities that contribute to poor health status.

- Geographically, a notably higher concentration of children in lower-income households is found in eastern and southern parts of Monterey County.



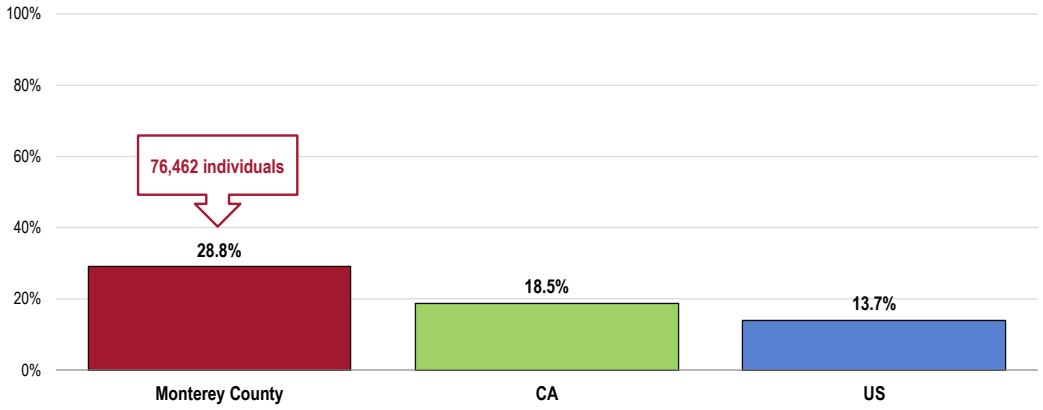
Education

Among the Monterey County population age 25 and older, an estimated 28.8% (nearly 76,500 people) do not have a high school education.

- Much less favorable than found statewide and nationally.

Population With No High School Diploma

(Population Age 25+ Without a High School Diploma or Equivalent, 2010-2014)

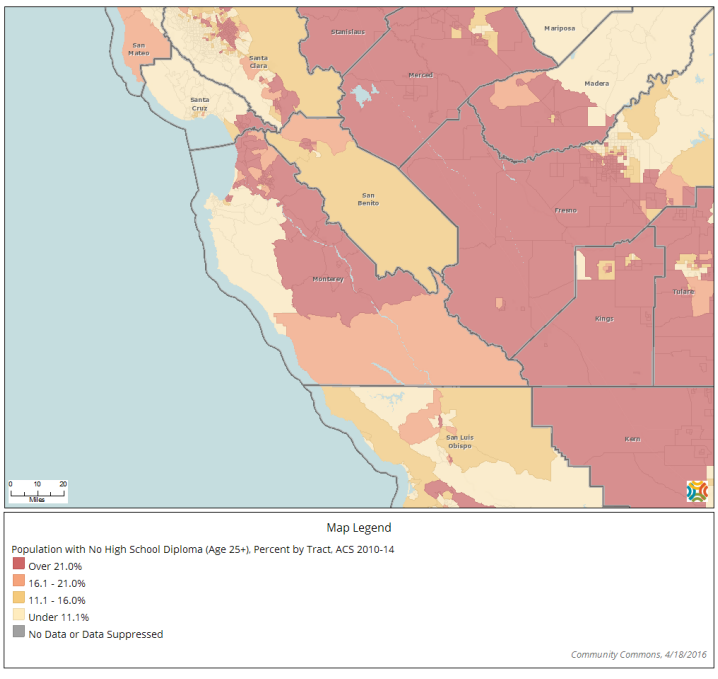


Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Retrieved April 2016 from Community Commons at http://www.chna.org.

Notes:
- This indicator is relevant because educational attainment is linked to positive health outcomes.

- Geographically, this indicator is more concentrated in the central portion of the county and the areas which border San Benito County.

Population With No High School Diploma, Percent by Tract, ACS 2010-2014



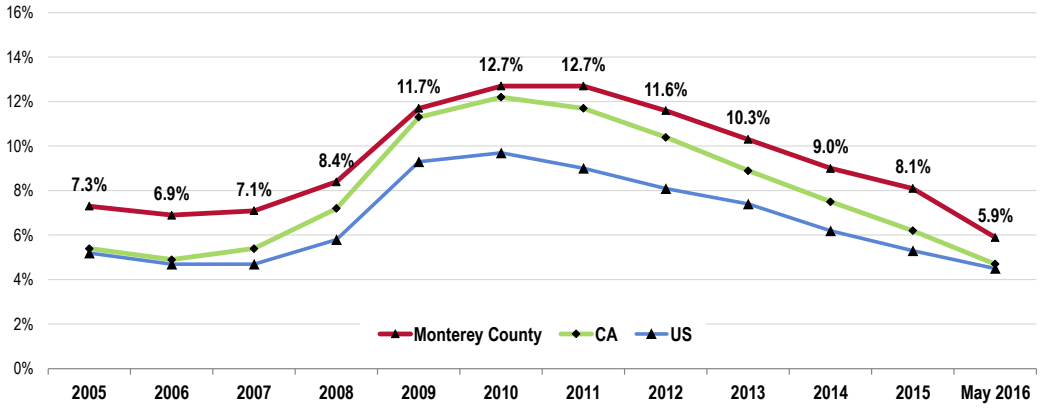
Employment

According to data derived from the US Department of Labor, the unemployment rate in Monterey County as of May 2016 was 5.9%.

- Above the statewide and national unemployment rates.
- TREND: Throughout the decade, unemployment in Monterey County has echoed the state and national trends while consistently remaining above them.

Unemployment Rate

(Percent of Non-Institutionalized Population Age 16+ Unemployed, Not Seasonally-Adjusted)



Sources:
- US Department of Labor, Bureau of Labor Statistics.
- Retrieved July 2016 from Community Commons at http://www.chna.org.

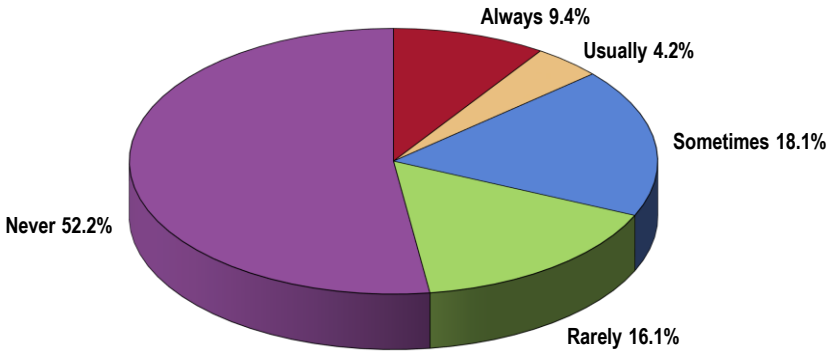
Notes:
- This indicator is relevant because unemployment creates financial instability and barriers to access including insurance coverage, health services, healthy food, and other necessities that contribute to poor health status.

Housing Insecurity

While most surveyed adults rarely, if ever, worry about the cost of housing, a considerable share (31.7%) do, reporting that they were "sometimes," "usually" or "always" worried or stressed about having enough money to pay their rent or mortgage in the past year.

Frequency of Worry or Stress Over Paying Rent/Mortgage in the Past Year

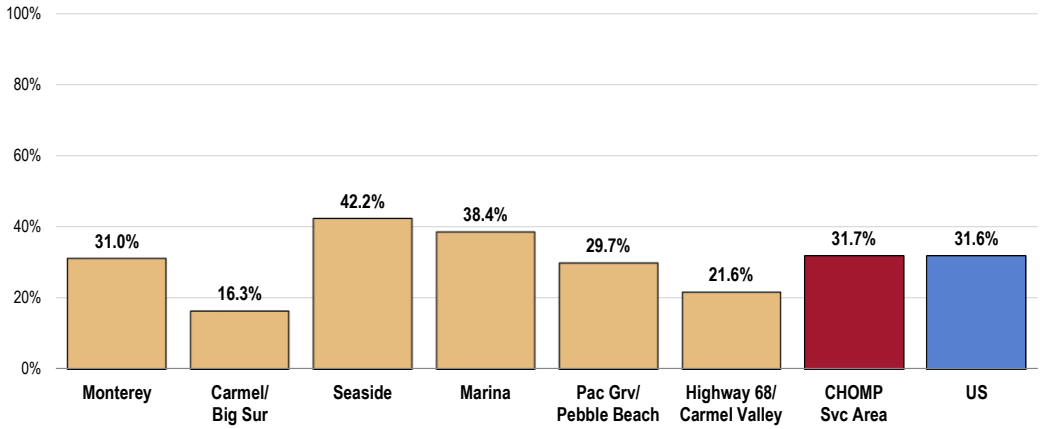
(CHOMP Service Area, 2016)



Sources: ● 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 81]
Notes: ● Asked of all respondents.

- Compared to the US prevalence, the CHOMP Service Area proportion of adults who worried about paying for rent or mortgage in the past year is nearly identical.
- Housing insecurity appears highest in Seaside and Marina.

"Always/Usually/Sometimes" Worried About Paying Rent/Mortgage in the Past Year



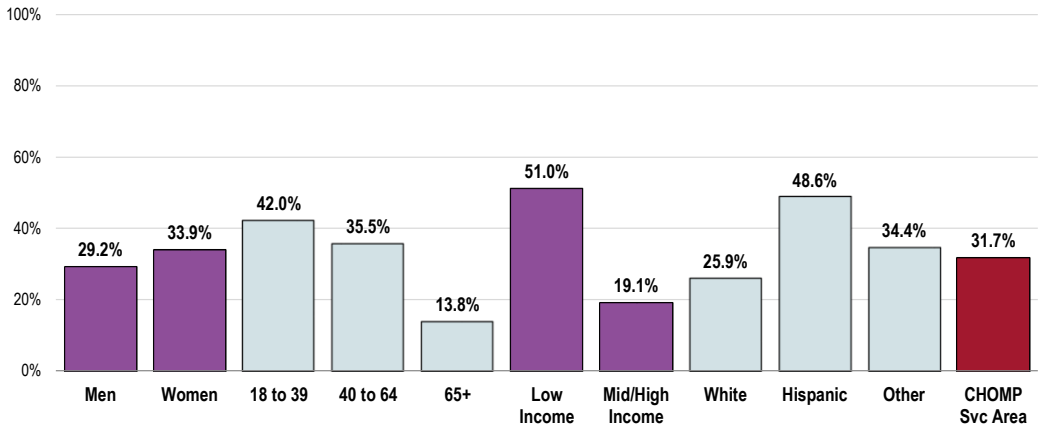
Sources: ● 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 81]
● 2015 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all respondents.

- Adults more likely to report housing insecurity include younger adults, residents living at lower incomes, and Hispanics.
- 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.

"Always/Usually/Sometimes" Worried About Paying Rent/Mortgage in the Past Year

(CHOMP Service Area, 2016)



Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 81]

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. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

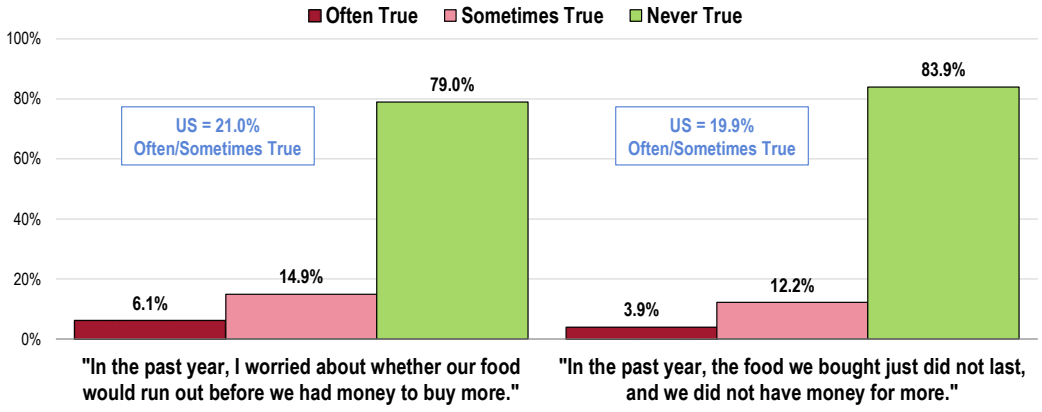
Food Insecurity

In the past year, 21.0% of CHOMP Service Area adults "often" or "sometimes" worried about whether their food would run out before they had money to buy more.

Another 16.1% report a time in the past year ("often" or "sometimes") when the food they bought just did not last, and they did not have money to get more.

Food Insecurity

(CHOMP Service Area, 2016)



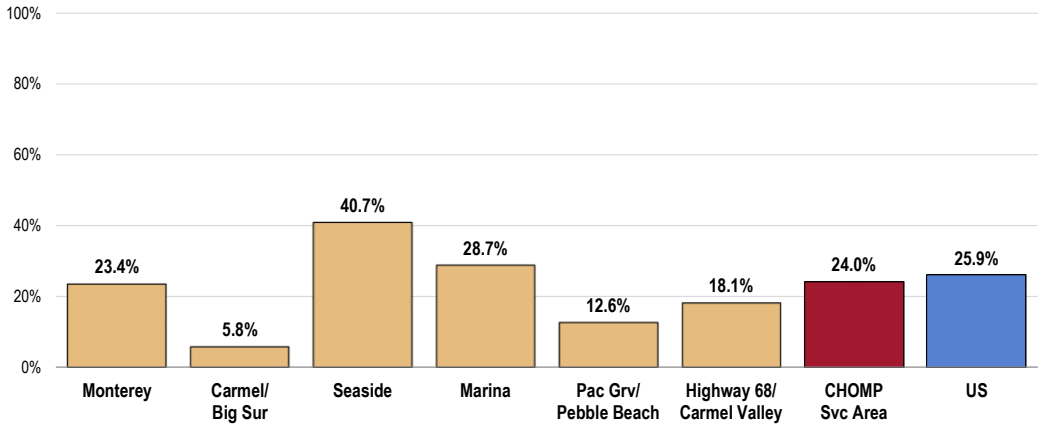
Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 104-105]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Reflects the total sample of respondents.

Overall, 24.0% of community residents are determined to be "food insecure," having run out of food in the past year and/or been worried about running out of food.

- Compared to US data the prevalence of adults who are food insecure is similar.
- The prevalence is unfavorably higher in Seaside.

Food Insecurity



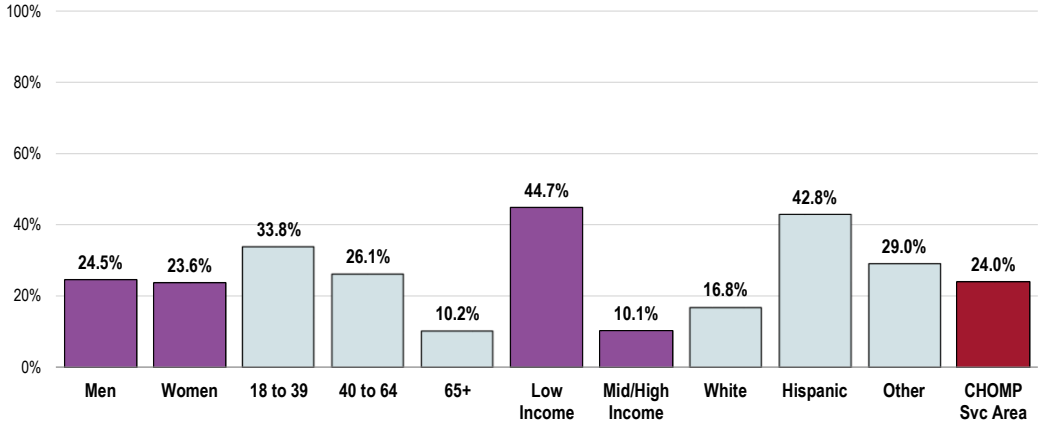
Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 169]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

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

Adults more likely affected by food insecurity include:

- Younger adults (negative correlation with age).
- Residents living at lower incomes.
- Hispanics followed by "Other" races.

Food Insecurity
(CHOMP Service Area, 2016)



Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 169]

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. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
- Includes adults who A) ran out of food at least once in the past year and/or B) worried about running out of food in the past year.

General Health Status

Professional Research Consultants, Inc.

Overall Health Status

Evaluation of Health Status

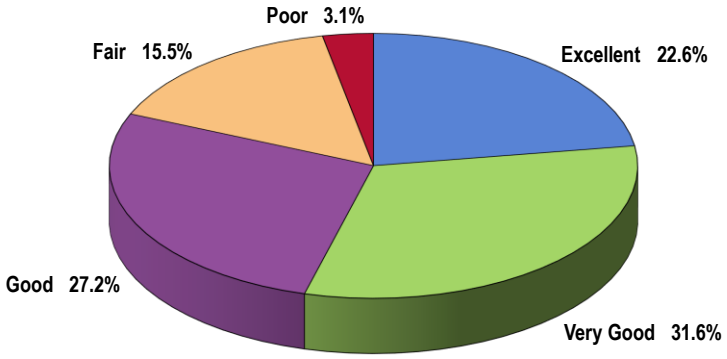
The initial inquiry of the PRC Community Health Survey asked respondents the following:

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

A total of 54.2% of CHOMP Service Area adults rate their overall health as "excellent" or "very good."

- Another 27.2% gave "good" ratings of their overall health.

Self-Reported Health Status
(CHOMP Service Area, 2016)



Sources: ● 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 5]
Notes: ● Asked of all respondents.

NOTE:

Differences noted in the text represent significant differences determined through statistical testing.

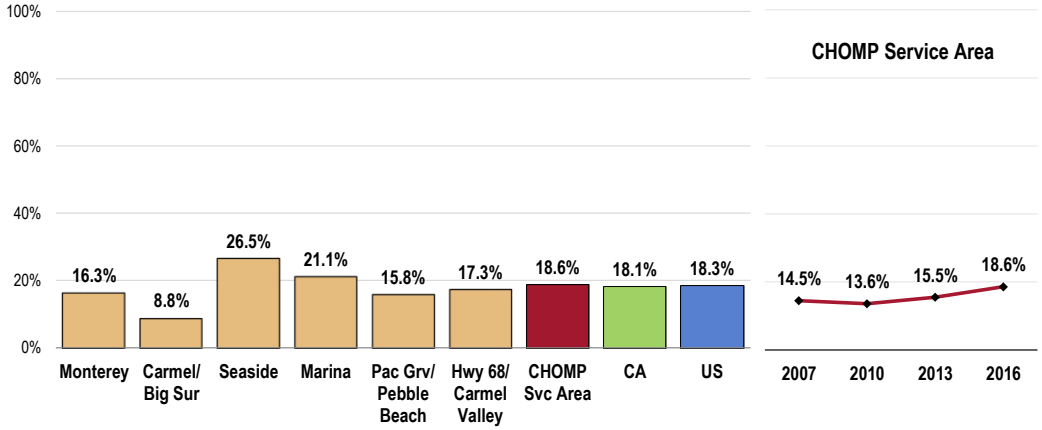
Where sample sizes permit, community-level data are provided.

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

However, 18.6% of CHOMP Service Area adults believe that their overall health is "fair" or "poor."

- Similar to statewide and national findings.
- Least favorable in Seaside.
- TREND: "Fair/poor" overall health reports have significantly increased from previous survey results.

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): 2014 California data.
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

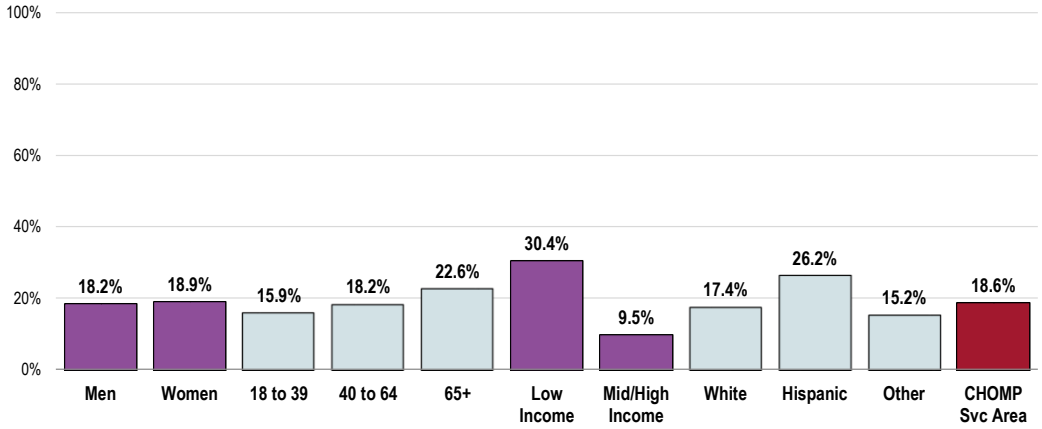
Notes:
- Asked of all respondents.

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

- Residents living at lower incomes.
- Hispanics.

Experience "Fair" or "Poor" Overall Health

(CHOMP Service Area, 2016)



Sources:
- 2016 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. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Activity Limitations

About Disability & Health

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.

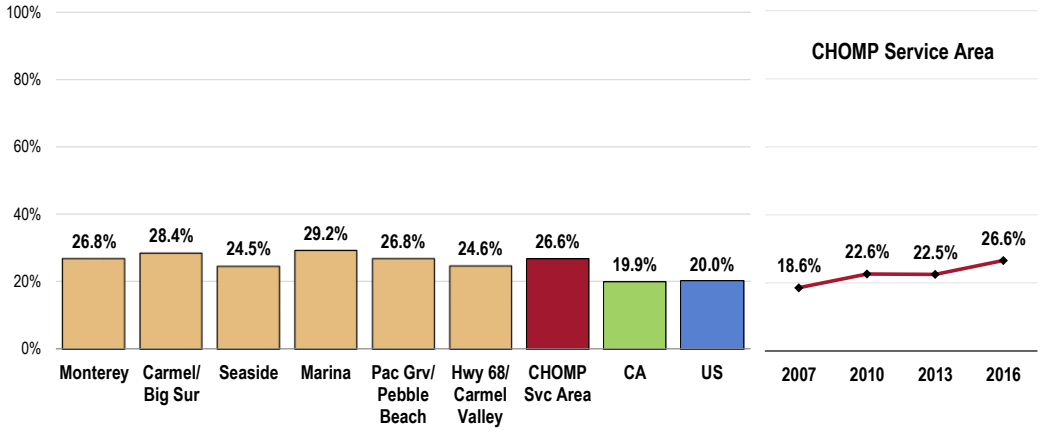
- Healthy People 2020 (www.healthypeople.gov)

A total of 26.6% of CHOMP Service Area adults are limited in some way in some activities due to a physical, mental or emotional problem.

- Less favorable than the prevalence noted statewide and nationally.
- Similar findings by community.
- TREND: Marks a statistically significant increase in activity limitations since 2007.

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

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



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 128]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2014 California data.
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

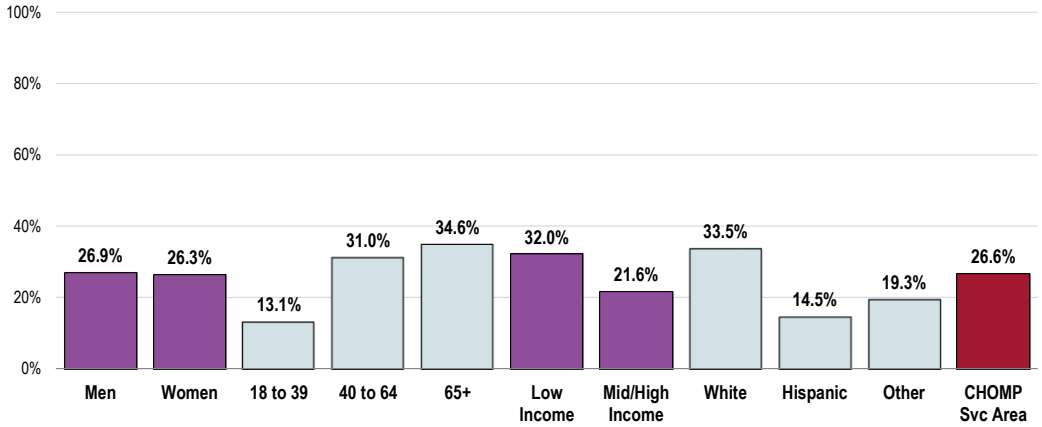
Notes:
- Asked of all respondents.

In looking at responses by key demographic characteristics, these adults are statistically more likely to report some type of activity limitation:

- Adults age 40 and older (note the positive correlation with age).
- Non-Hispanic Whites.

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

(CHOMP Service Area, 2016)



Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 128]

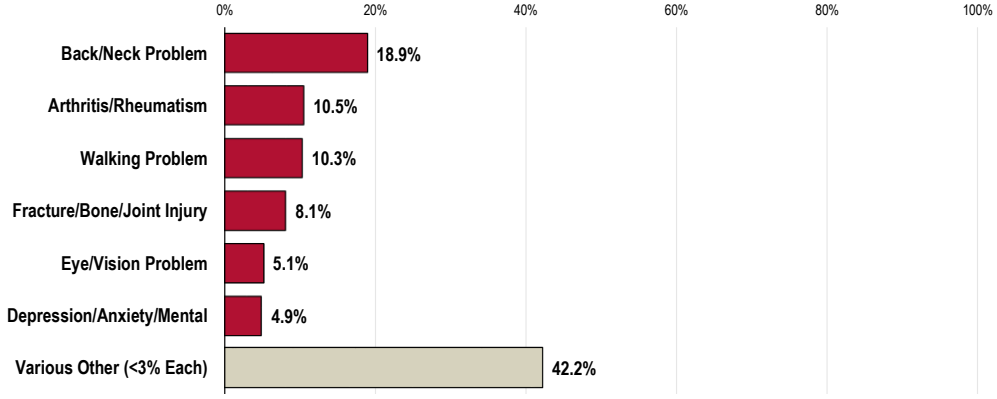
Notes:
- Asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

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

Other limitations noted with some frequency include those related to eye/vision difficulties and mental health conditions (depression, anxiety).

Type of Problem That Limits Activities

(Among Those Reporting Activity Limitations; CHOMP Service Area, 2016)



Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 129]
Notes: • Asked of those respondents reporting activity limitations.

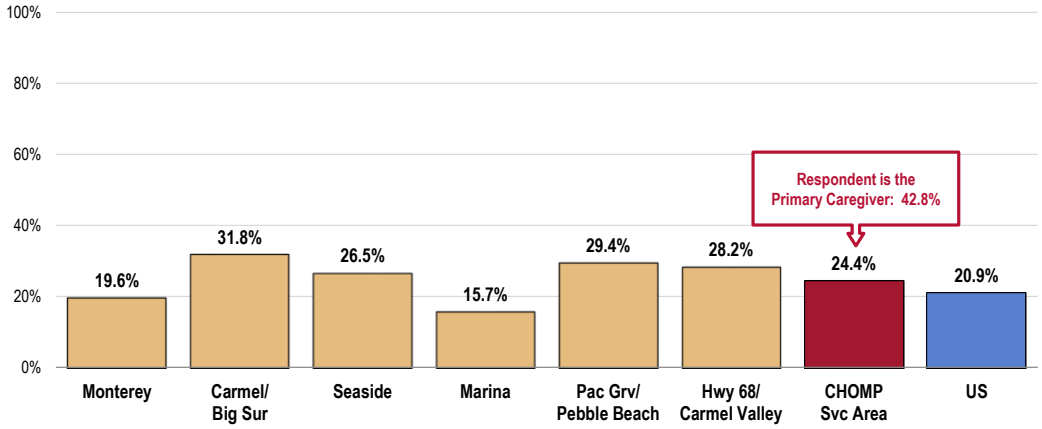
Caregiving

A total of 24.4% of CHOMP Service Area adults currently provide care or assistance to a friend or family member who has a health problem, long-term illness, or disability.

- Statistically similar to the national finding.
- There is a lower prevalence in Marina.

Of these adults, 42.8% are the ***primary*** caregiver for the individual receiving care.

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



Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 130-131]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

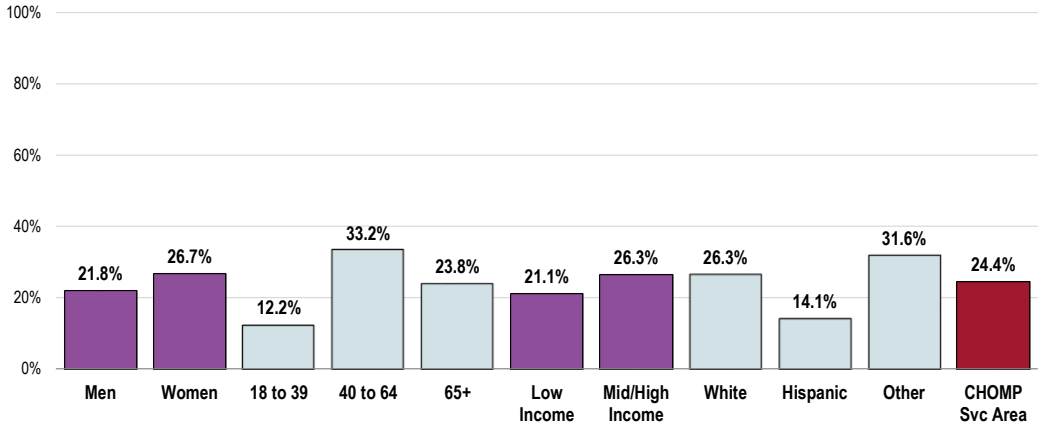
Notes:
- Asked of all respondents.

The prevalence of caregivers in the community is notably higher among:

- Adults between the ages of 40 and 64.
- Whites and "Other" races.

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

(CHOMP Service Area, 2016)



Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 130]

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. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Mental Health

About 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.

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 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 in 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, 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)

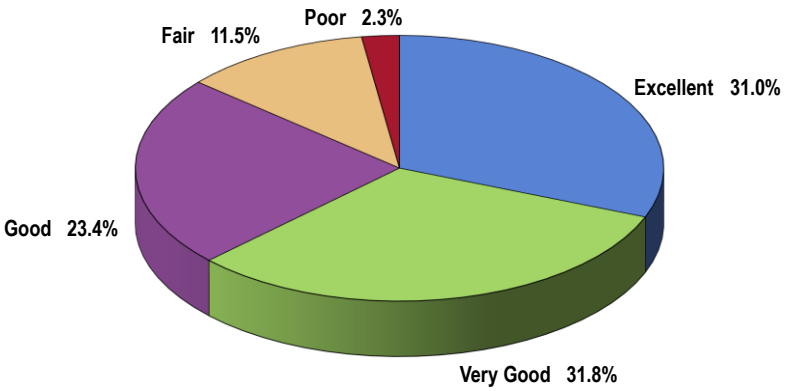
Evaluation of Mental Health Status

"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?"

A total of 62.8% of CHOMP Service Area adults rate their overall mental health as "excellent" or "very good."

- Another 23.4% gave "good" ratings of their own mental health status.

Self-Reported Mental Health Status
(CHOMP Service Area, 2016)

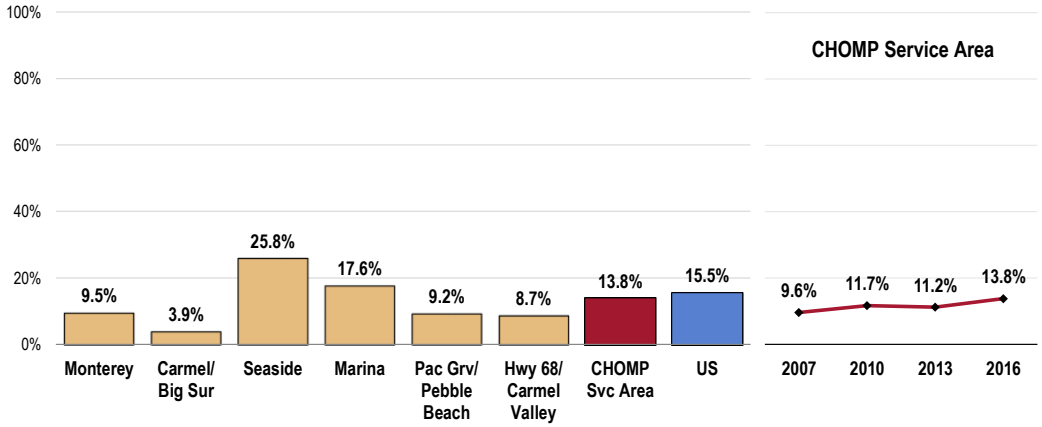


Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 116]
Notes: • Asked of all respondents.

A total of 13.8% of CHOMP Service Area adults, however, believe that their overall mental health is "fair" or "poor."

- Similar to the "fair/poor" response reported nationally.
- Least favorable in Seaside.
- TREND: Has shown a statistically significant increase over time.

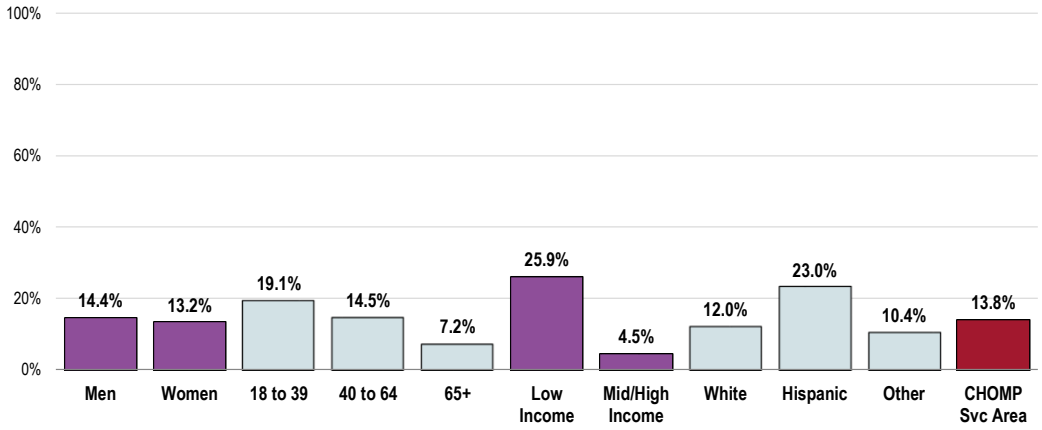
Experience "Fair" or "Poor" Mental Health



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 116]
• 2015 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

- Note the negative correlation between poor mental health and age.
- Low-income residents and Hispanics are much more likely to report experiencing "fair/poor" mental health than their demographic counterparts.

Experience "Fair" or "Poor" Mental Health
(CHOMP Service Area, 2016)



Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 116]

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. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

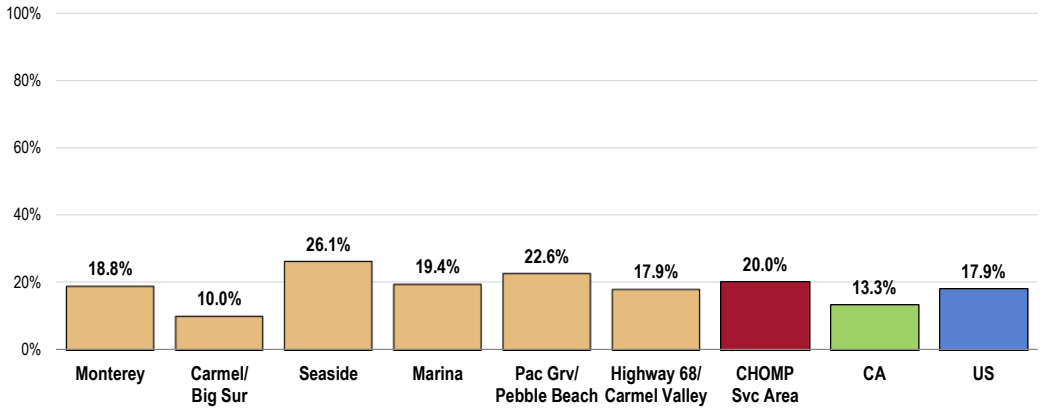
Depression

Diagnosed Depression

One-fifth (20.0%) of CHOMP Service Area adults have been diagnosed by a physician as having a depressive disorder (such as depression, major depression, dysthymia, or minor depression).

- Higher than the California finding.
- Comparable to the national finding.
- Highest in Seaside.

Have Been Diagnosed With a Depressive Disorder



Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 119]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2014 California data.
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

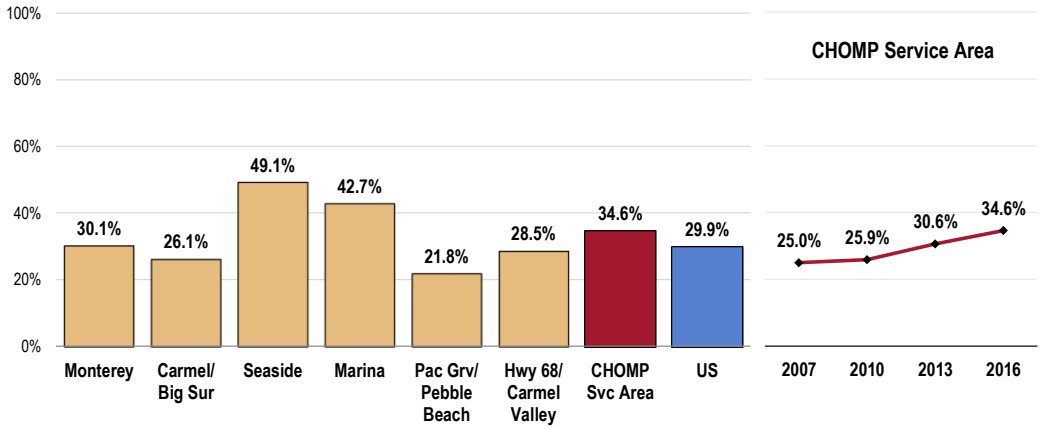
Notes:
- Asked of all respondents.
- Depressive disorders include depression, major depression, dysthymia, or minor depression.

Symptoms of Chronic Depression

A total of 34.6% 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 (symptoms of chronic depression).

- Less favorable than national findings.
- Highest in Seaside and Marina.
- TREND: Has significantly increased in prevalence since 2007.

Have Experienced Symptoms of Chronic Depression



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 117]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

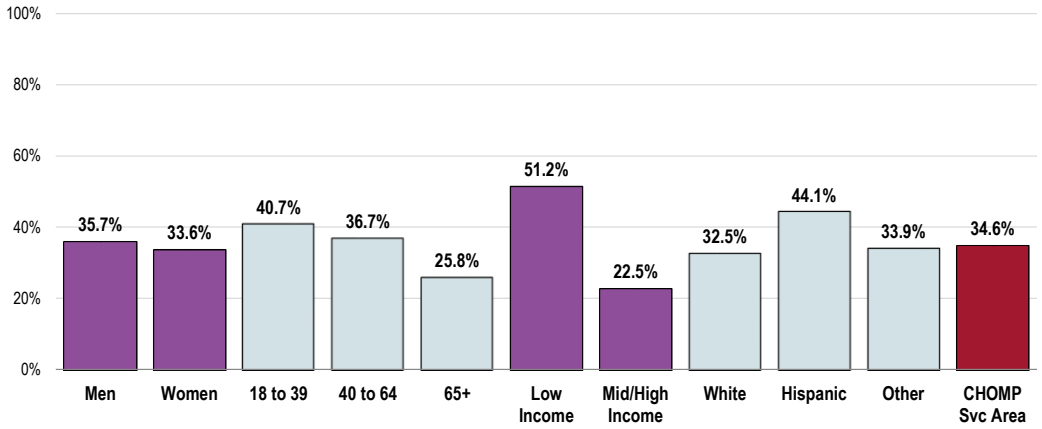
Notes:
- Asked of all respondents.
- Chronic depression includes periods of two or more years during which the respondent felt depressed or sad on most days, even if (s)he felt okay sometimes.

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

- Adults under age 65.
- Adults with lower incomes.
- Hispanics.

Have Experienced Symptoms of Chronic Depression

(CHOMP Service Area, 2016)



Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 117]
Notes: • Asked of all respondents.
• Chronic depression includes periods of two or more years during which the respondent felt depressed or sad on most days, even if (s)he felt okay sometimes.
• 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. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Stress

More than one-half of CHOMP Service Area adults consider their typical day to be "not very stressful" (34.0%) or "not at all stressful" (17.4%).

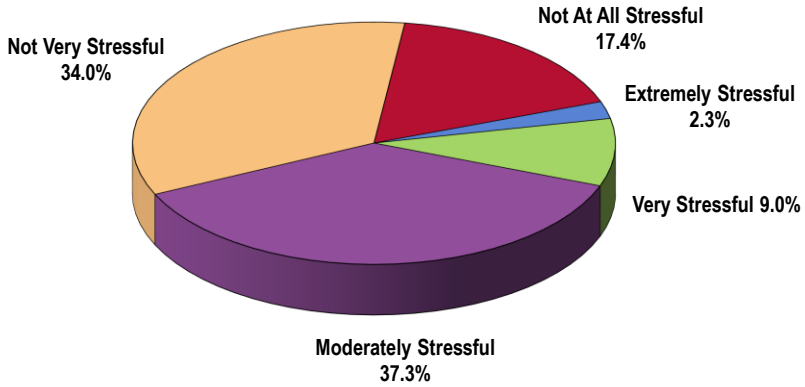
RELATED ISSUE:

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

- Another 37.3% of survey respondents characterize their typical day as "moderately stressful."

Perceived Level of Stress On a Typical Day

(CHOMP Service Area, 2016)

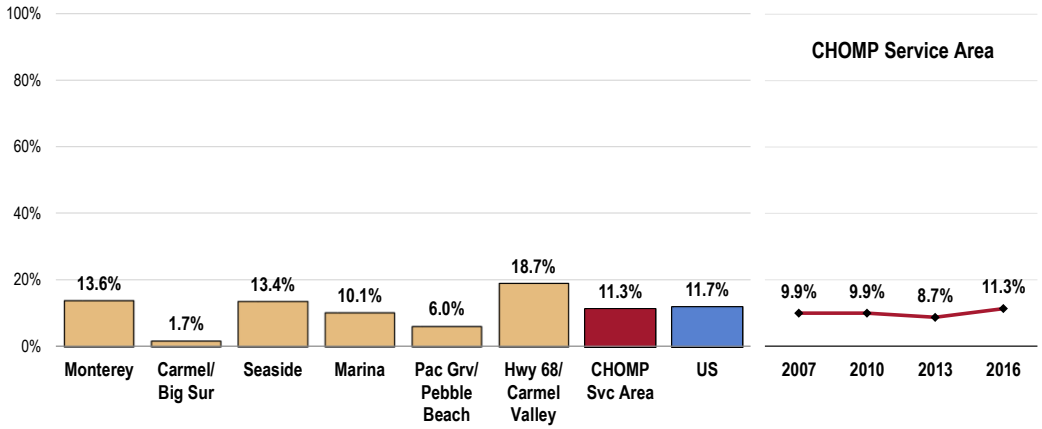


Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 118]
Notes: • Asked of all respondents.

In contrast, 11.3% of CHOMP Service Area adults experience "very" or "extremely" stressful days on a regular basis.

- Similar to national findings.
- Particularly high in Highway 68/Carmel Valley.
- TREND: Has not changed significantly since 2007.

Perceive Most Days As "Extremely" or "Very" Stressful



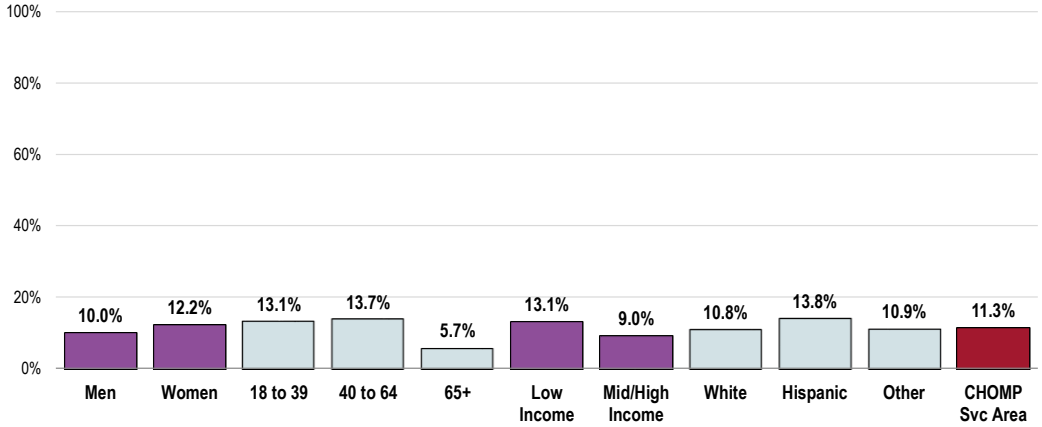
Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 118]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

- Note that high stress levels are more prevalent among adults under 65.

Perceive Most Days as "Extremely" or "Very" Stressful

(CHOMP Service Area, 2016)



Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 118]

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. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Suicide

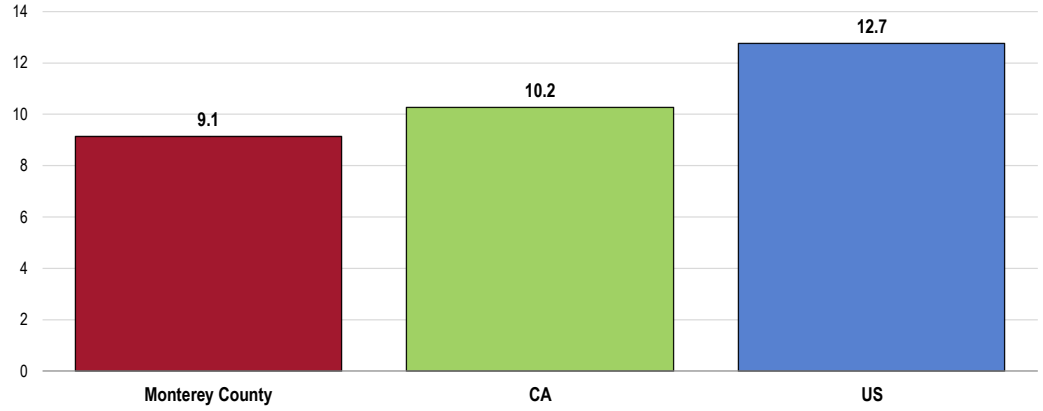
Between 2012 and 2014, there was an annual average age-adjusted suicide rate of 9.1 deaths per 100,000 population in Monterey County.

- Lower than the statewide and national rates.
- Satisfies the Healthy People 2020 target of 10.2 or lower.

Suicide: Age-Adjusted Mortality

(2012-2014 Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 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 April 2016.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective MHMD-1]

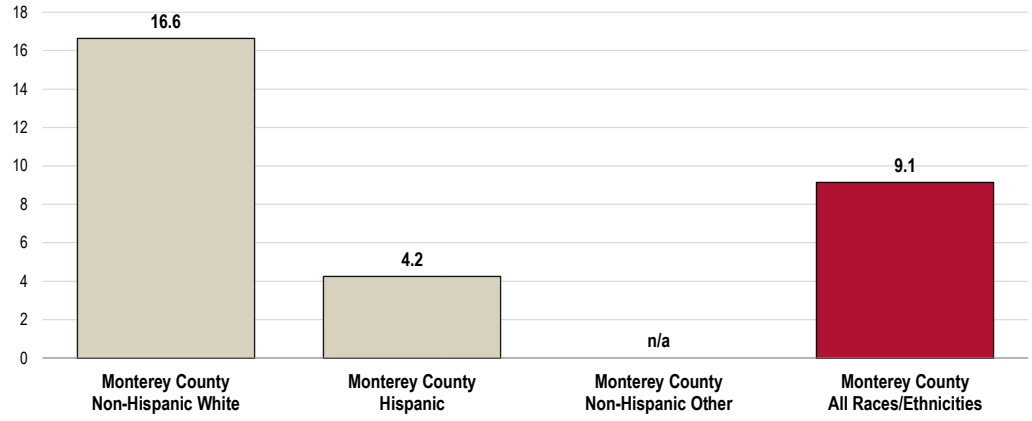
Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

- The suicide rate in Monterey County is dramatically higher among Non-Hispanic Whites than among Hispanics.

Suicide: Age-Adjusted Mortality by Race

(2012-2014 Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 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 April 2016.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective MHMD-1]

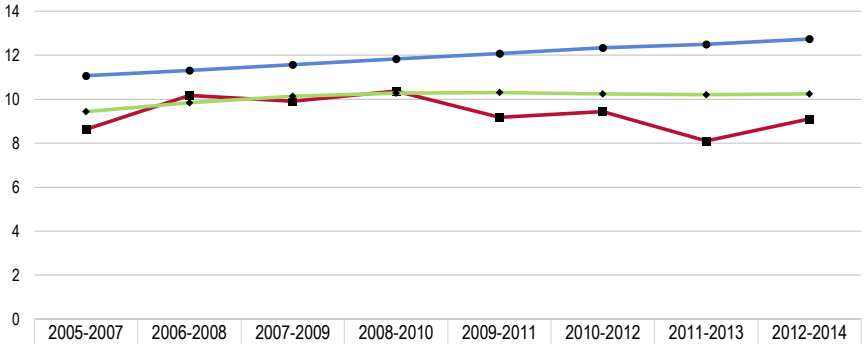
Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

- TREND: The area suicide rate has fluctuated over time.

Suicide: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 10.2 or Lower



	2005-2007	2006-2008	2007-2009	2008-2010	2009-2011	2010-2012	2011-2013	2012-2014
Monterey County	8.6	10.2	9.9	10.4	9.2	9.4	8.1	9.1
CA	9.4	9.8	10.1	10.3	10.3	10.2	10.2	10.2
US	11.1	11.3	11.6	11.8	12.1	12.3	12.5	12.7

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2016.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective MHMD-1]

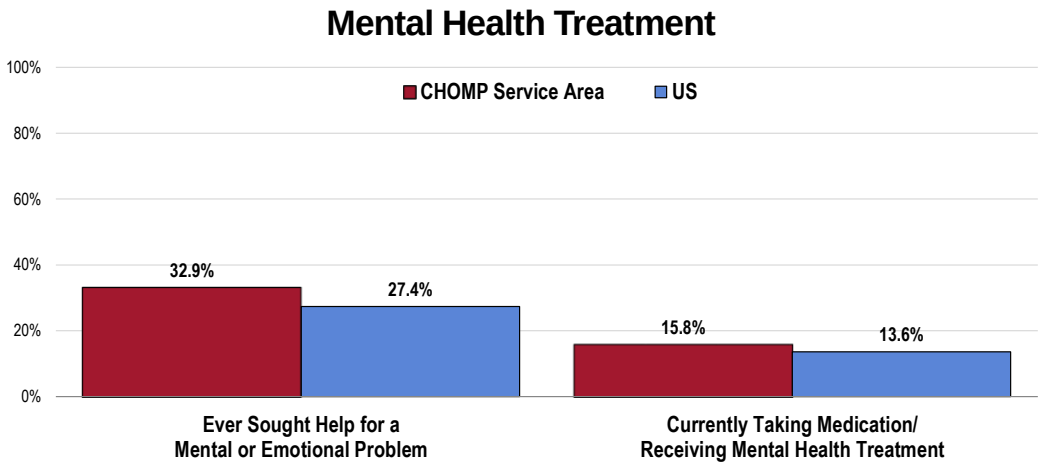
Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Mental Health Treatment

A total of 32.9% of CHOMP Service Area adults acknowledge having ever sought professional help for a mental or emotional problem.

A total of 15.8% are currently taking medication or receiving treatment from a doctor or other health professional for some type of mental health condition or emotional problem.

- Compared to national findings, adults seeking help for a mental or emotional problem is more prevalent in the service area, but the proportion receiving medication or treatment is similar.



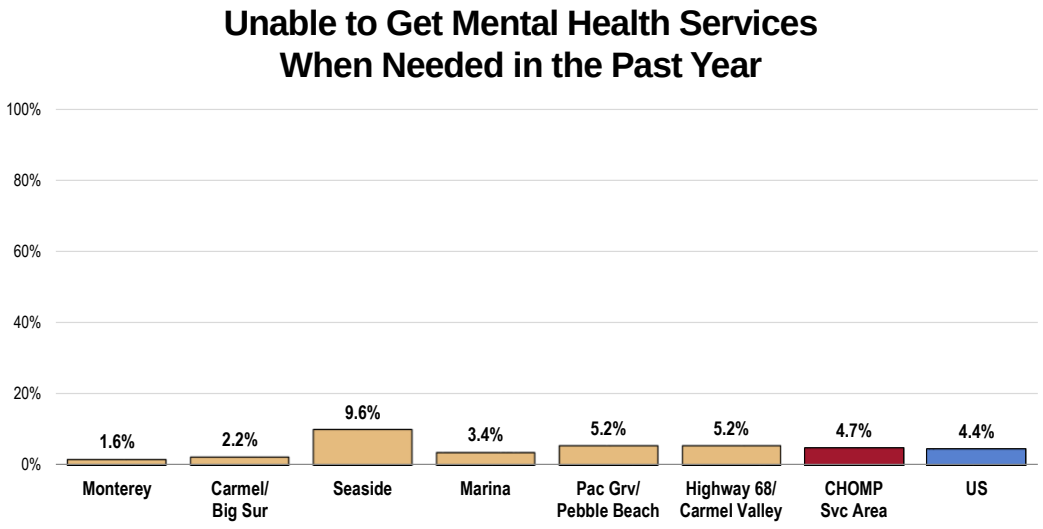
Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 120-121]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Reflects the total sample of respondents.

Difficulty Accessing Mental Health Services

A total of 4.7% of CHOMP Service Area adults report a time in the past year when they needed mental health services, but were not able to get them.

- Similar to the national finding.
- Highest in Seaside.



Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 122]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

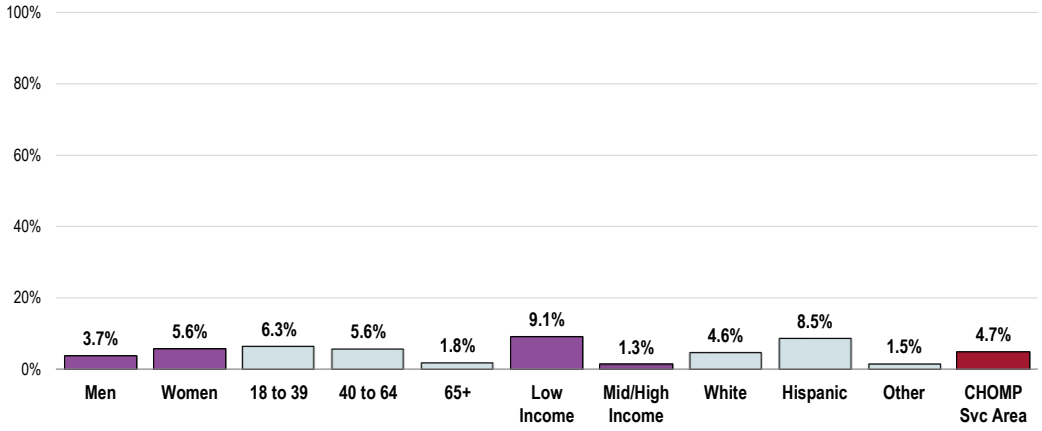
Notes:
- Asked of all respondents.

Note that access difficulty is notably more prevalent among:

- Adults under age 65.
- Adults with lower incomes.
- Whites and Hispanics.

Unable to Get Mental Health Services When Needed in the Past Year

(CHOMP Service Area, 2016)

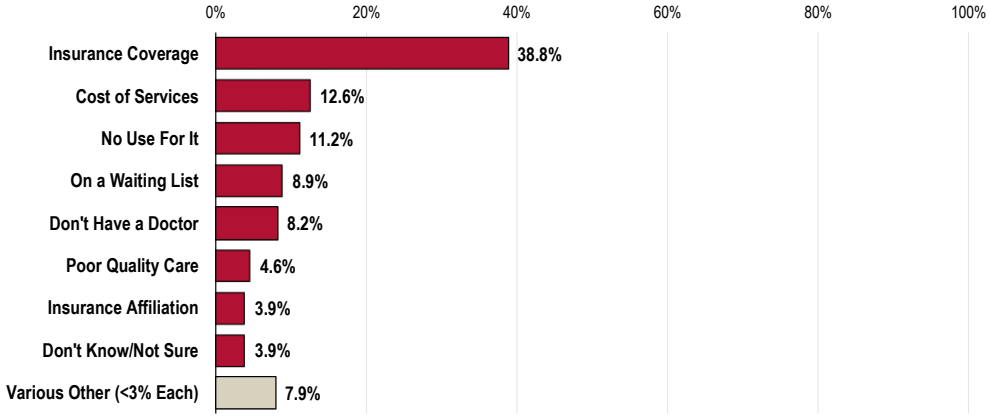


Sources: ● 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 122]
Notes: ● Asked of all respondents.
● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Among persons citing difficulties accessing mental health services in the past year, these are predominantly attributed to **insurance coverage** (mentioned by 38.8%); reasons mentioned much less frequently include barriers such as cost of services, no use for it, being put on a waiting list, or not having a doctor.

Barrier to Accessing Mental Health Services in the Past Year

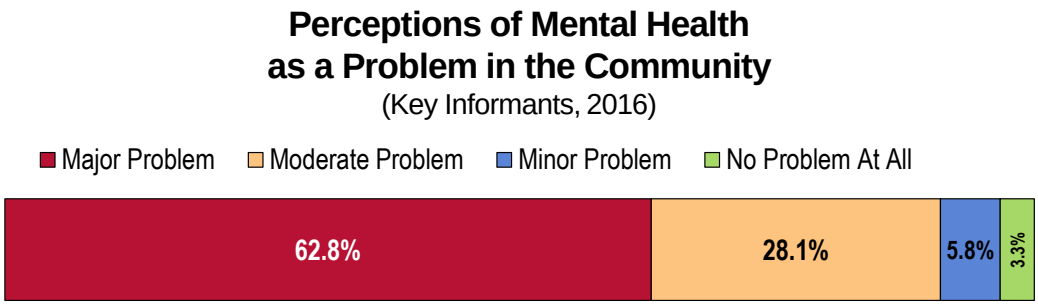
(Among Those Reporting Problems w/Access; CHOMP Service Area, 2016)



Sources: ● 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 123]
Notes: ● Asked of those respondents reporting problems obtaining mental health services in the past year.

Key Informant Input: Mental Health

The greatest share of key informants taking part in an online survey characterized *Mental Health* as a "major problem" in the community.



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

Challenges

Among those rating this issue as a "major problem," the following represent what key informants see as the main challenges for persons with mental illness:

Access to Care/Services

Both mild to moderate and severely mentally ill. Alliance members sometimes face access problems due to limited provider capacity. – Community/Business Leader

Lack of available psychiatric care. – Physician

Not enough child therapists. Expensive, hard to access programs. – Physician

There is almost no access to mental health service for the very poor, especially undocumented individuals. For children the situation is especially bad. There are no psychiatric in hospital beds for children and youth in the county. – Social Services Provider

Access to a psychologist who takes their insurance. – Physician

Severely limited assistance for insured and uninsured. – Other Health Provider

Not able to access mental health care. – Public Health Representative

Tough situation. Probably should have a legitimate "lock-down" type of facility at CHOMP or very near CHOMP. – Community/Business Leader

Access to services for the mild to moderate population. This service was carved into the Managed Care Plans and unfortunately the provider network in our county particularly in South County is very limited or non-existent. – Public Health Representative

There are not enough resources or agencies to assist in helping or dealing with those that suffer from mental health issues. A high percentage of persons living on the street often suffer from mental illness and there are few resources to deal with that. – Community/Business Leader

There is no facility for hospitalizing youth. They have to be sent out of county for treatment. There are only a few practicing psychiatrists in the area and it is hard to make a choice with what is available. – Social Services Provider

Access to BH. – Public Health Representative

The waiting lists for mental health services are long. This often impedes individuals from receiving the mental health services needed. – Community/Business Leader

Lack of access to mental health services for poor, low-income residents. – Public Health Representative

The bureaucracy to enter into the county mental health system is impossible. I have personally assisted family members and clients through the process. Housing is unaffordable. Social workers are unavailable. It takes years for conservatorship. – Public Health Representative

There isn't a good central resource for knowing what MD does what. Eating disorder vs. depression, adolescent vs. child. When physicians leave, we don't know who is available. Lack of specialists. – Physician

Access to providers, including numbers and affordability. Limited capacity for inpatient and community based treatment. Over medication, drugs are advertised everywhere. – Social Services Provider

Not enough places to refer to, family practice doctors end up seeing these patients and have nowhere to refer the underinsured on uninsured. Wait list can be up to three months. – Public Health Representative

Access to psychiatrists for definitive diagnosis. Expensive medications. Lack of recognition of psychiatric illness as the reason for abnormal behavior. – Physician

Minimal housing programs. Minimal post acute providers such as SNF's that can manage behaviors and meet mental health needs, including access to psychiatrist/psychologist. – Community/Business Leader

Lack of access to services at the time of need, for both adults and children. – Public Health Representative

Lack of needed availability of appointment and services. – Public Health Representative

We deal with people with mental health issues who have nowhere to go. On a regular basis, we see them at the library; we see them on the streets also. People come to us to ask for help, and the services, particularly in South County and North County are limited. – Community/Business Leader

Qualified local therapists in the area, access to care and probably also the persistent feelings of shame around mental health issues all are challenges the community faces. – Community/Business Leader

Lack of care and biases against those with mental illness. – Social Services Provider

Availability of effective mental health. Speedy access to mental health screening can be done by lower level, when need is established. Rapid referral to a competent resource. – Physician

Lack of affordable, accessible facilities and programs. Increased number of homeless, elderly, returned military, substance abuse. Lack of knowledge of where to find help. Stigma of mental illness. High cost of living (rents, food, transportation, etc.). – Community/Business Leader

Getting affordable and proper care. Access to help when needed. – Community/Business Leader

Cost and insurance coverage. Terrible shortage of qualified professionals, at least at the upper levels. Many mid-level providers do not accept the major third party payers, Anthem, Medical, and Medicare. The lack of recognition among our institutions. – Physician

High cost, low access, crisis, only interventions without sufficient follow-through. Insufficient availability. Lack of insurance coverage on the Peninsula. No importance or value placed on promoting good mental health. Learning good mental health. – Social Services Provider

People with mental health problems often have poor or no insurance, so it is difficulty from them to find psychiatrists. – Physician

Access to psychiatrists who take insurances, timely appointment, places for suicidal patient to receive care when urgent. Hospital is often full. – Physician

Access to Providers

Lack of licensed professional that take Medicare or Medi-Cal. Lack of providers that are bilingual. Lack of providers that are aware of caregiver needs. – Social Services Provider

Lack of psychiatrists, lack of hospital beds, lack of pediatric mental health care, poor reimbursement by Medi-Cal. Lack of coordinated resources and care plans, lack of case managers. – Physician

There is shortage of Psychiatrist to see Medicare patients. Psychiatrists also do not go to nursing facilities. – Physician

Lack of mental health providers, particularly psychiatrists. Extreme difficulty referring PCP patients to mental health providers. CCAH, in particular, has a very limited panel of psychiatrists. PCP's have difficulty diagnosing and treating common mental issues. – Community/Business Leader

Virtually no psychiatrists or psychologists available to people with Medicare or MediCal. Primary care physicians struggling with problem and prescribing often with little expertise. – Physician

Inadequate number of medical providers. – Physician

Not enough providers and poor reimbursement for the care. – Physician

Lack of psychiatrists, lack of psychiatrists taking Medicare and MediCal. Lack of psychologists, counselors across the board. – Physician

Health Education

The ways in which children are typically raised in our culture does not prepare us to lead emotionally healthy lives. Unable to heal from emotional pain leaves many people seeking relief with coping methods that are obsessive and unhealthy. – Social Services Provider

The biggest issue is ignorance on this topic. It would be helpful for the community to understand what mental health is and how to get help. – Social Services Provider

Education and acceptance by the general population, stigma, communication, fear. – Community/Business Leader

Stress, be it from lack of financial resources, threat of violence, school bullying, gangs, insane policies. This is an aspect of both mental and physical health that requires a completely new focus on health, prevention, teaching skills and healing. – Social Services Provider

Diagnosis/Treatment

Getting the help they need. – Social Services Provider

Accurate diagnosis, accessible and consistent access to care and treatment, places to live. – Community/Business Leader

Too many underdiagnosed and treated people. – Community/Business Leader

Being diagnosed correctly and taking proper medication. – Community/Business Leader

Little early diagnosis. Stigma, education, accountability, and resources. – Social Services Provider

Early intervention, access to treatment, substance abuse, lack of family. Client and community education on mental health, the jail revolving door, reasonable costs for assistance. Wait times for help, lack of crisis workers, help for law enforcement. – Social Services Provider

Homeless Population

There are so many jobs out there today, yet the homeless community exists. I think mental health issues affect the employability of many people who live on the street today. – Community/Business Leader

Homelessness, availability of services. – Social Services Provider

Homelessness. – Community/Business Leader

Incidence/Prevalence

There are many community members in need of the adequate counseling and mental healthcare that would help them live happy productive lives. – Social Services Provider

Increasing need with decreasing government support for this full-blown, nationwide crisis. – Physician

Access to Culturally Relevant Services

Access to culturally appropriate services and long waitlists. – Public Health Representative

Lack of culturally and linguistically appropriate providers. Minimal help for people with mild to moderate behavioral health issues. – Public Health Representative

Comorbidities

Many patients have co-morbidities, substance abuse, and behavioral health issues and many times resources are very scarce. – Public Health Representative

More than one third of people with diabetes suffer from depression. Mental illness can be a barrier for accessing care, and following glycemic regimen. – Other Health Provider

Denial/Stigma

Fear. Non mental health practitioners and general public while they may care are functioning with ignorance fed by fear. Medical outpatient clinics need to have a qualified medical doctor. PA and NP with MH training to address the medical needs. – Social Services Provider

Stigma, awareness of resources. – Community/Business Leader

Crime and Gang Violence

The local environment is filled with danger due to crime and gang violence. Within the gangs there are obvious mental problems and because of the gangs there are serious problems. Also a large portion of our citizens are subsistence earners and dependent. – Community/Business Leader

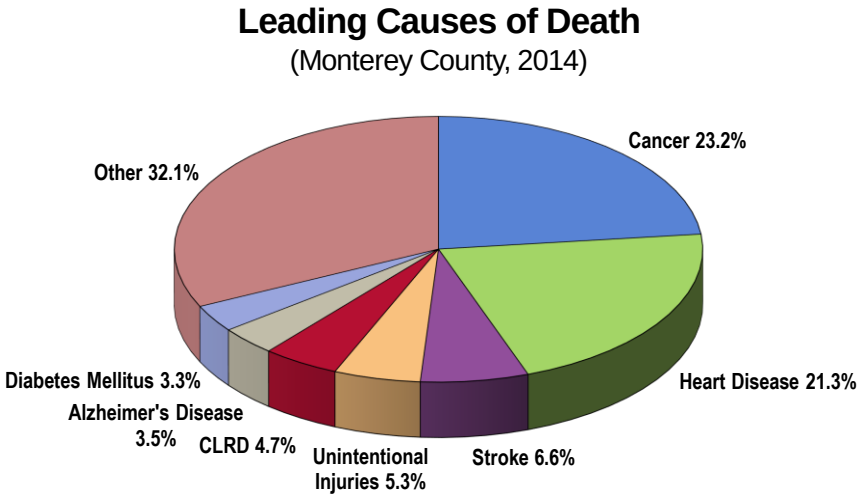
Death, Disease & Chronic Conditions

Professional Research Consultants, Inc.

Leading Causes of Death

Distribution of Deaths by Cause

Together, cardiovascular disease (heart disease and stroke) and cancers accounted for over one-half of all deaths in Monterey County in 2014.



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2016.

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 2012-2014 annual average age-adjusted death rates per 100,000 population for selected causes of death in Monterey County.

Each of these is discussed in greater detail in subsequent sections of this report.

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

Age-Adjusted Death Rates for Selected Causes

(2012-2014 Deaths per 100,000 Population)

	Monterey County	CA	US	HP2020
Malignant Neoplasms (Cancers)	136.0	147.3	163.6	161.4
Diseases of the Heart	119.3	149.1	169.1	156.9*
Cerebrovascular Disease (Stroke)	37.4	34.7	36.5	34.8
Unintentional Injuries	29.9	28.8	39.7	36.4
Chronic Lower Respiratory Disease (CLRD)	27.7	33.9	41.4	n/a
Alzheimer's Disease	20.0	30.3	24.2	n/a
Diabetes Mellitus	20.0	20.6	21.1	20.5*
Pneumonia/Influenza	12.4	15.5	15.1	n/a
Drug-Induced	12.2	11.5	14.6	11.3
Firearm-Related	11.6	7.7	10.4	9.3
Homicide	9.5	4.9	5.2	5.5
Cirrhosis/Liver Disease	9.4	11.8	10.2	8.2
Intentional Self-Harm (Suicide)	9.1	10.2	12.7	10.2
Kidney Diseases	8.3	7.4	13.2	n/a
Motor Vehicle Deaths	7.5	8.1	10.6	12.4
Fall-Related Deaths (65+)	5.2	6.2	8.8	47.0
HIV/AIDS 2004-2013	1.2	2.4	3.0	3.3

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2016.
- 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.

Cardiovascular Disease

About Heart Disease & Stroke

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)

Age-Adjusted Heart Disease & Stroke Deaths

Heart Disease Deaths

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

Between 2012 and 2014 there was an annual average age-adjusted heart disease mortality rate of 119.3 deaths per 100,000 population in Monterey County.

- Lower than the statewide and national rates.
- Satisfies the Healthy People 2020 target of 156.9 or lower (as adjusted to account for all diseases of the heart).

Heart Disease: Age-Adjusted Mortality

(2012-2014 Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 156.9 or Lower (Adjusted)

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2016.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-2]

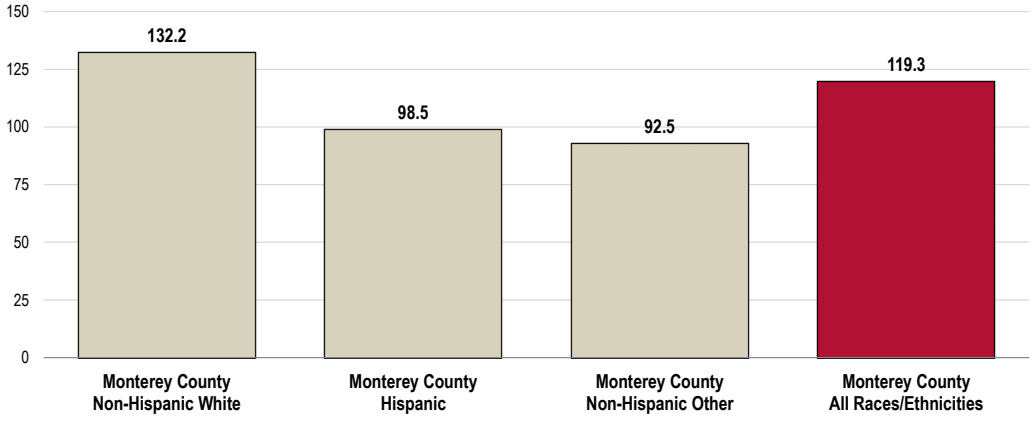
Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
- The Healthy People 2020 Heart Disease target is adjusted to account for all diseases of the heart.

- By race, 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

(2012-2014 Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 156.9 or Lower (Adjusted)



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2016.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-2]

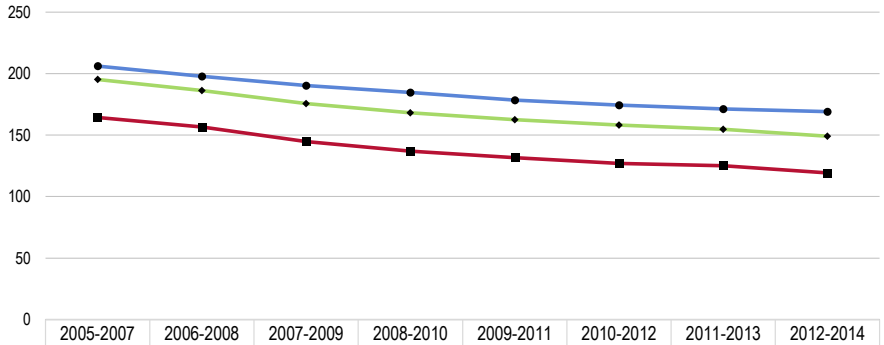
Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
- The Healthy People 2020 Heart Disease target is adjusted to account for all diseases of the heart.

- TREND: The heart disease mortality rate has decreased in Monterey County, echoing the decreasing trends across California and the US overall.

Heart Disease: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 156.9 or Lower (Adjusted)



	2005-2007	2006-2008	2007-2009	2008-2010	2009-2011	2010-2012	2011-2013	2012-2014
Monterey County	164.3	156.7	144.9	137.0	131.6	127.0	125.2	119.3
CA	195.2	186.3	175.6	168.3	162.6	158.1	154.7	149.1
US	206.1	197.9	190.3	184.7	178.5	174.4	171.3	169.1

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2016.
- 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 US Standard Population.
- The Healthy People 2020 Heart Disease target is adjusted to account for all diseases of the heart.

Stroke Deaths

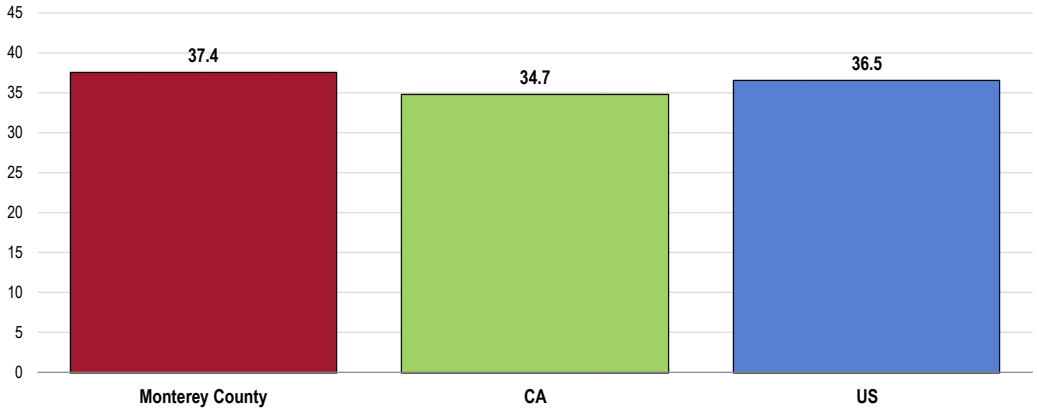
Between 2012 and 2014, there was an annual average age-adjusted stroke mortality rate of 37.4 deaths per 100,000 population in Monterey County.

- Slightly less favorable than the California rate.
- Similar to the national rate.
- Fails to satisfy the Healthy People 2020 target of 34.8 or lower.

Stroke: Age-Adjusted Mortality

(2012-2014 Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 34.8 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 April 2016.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-3]

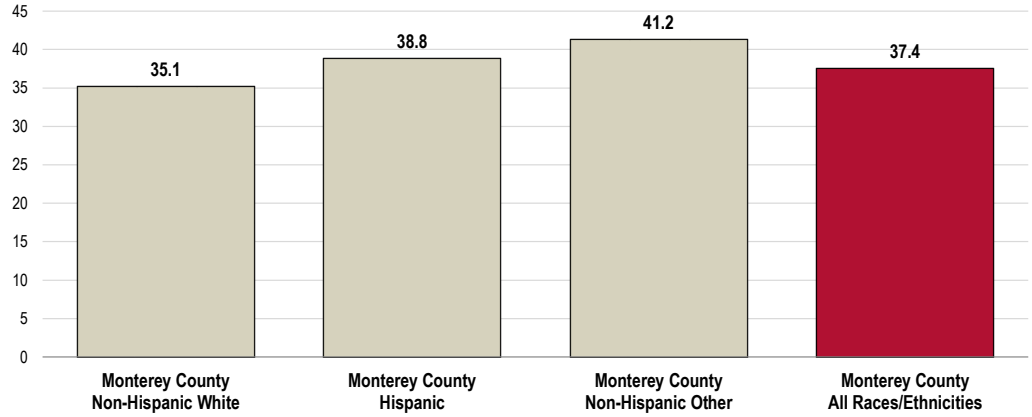
Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

- Stroke mortality is higher among Non-Hispanic "Other" race adults, followed by Hispanics and Non-Hispanic Whites.

Stroke: Age-Adjusted Mortality by Race

(2012-2014 Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 34.8 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 April 2016.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-3]

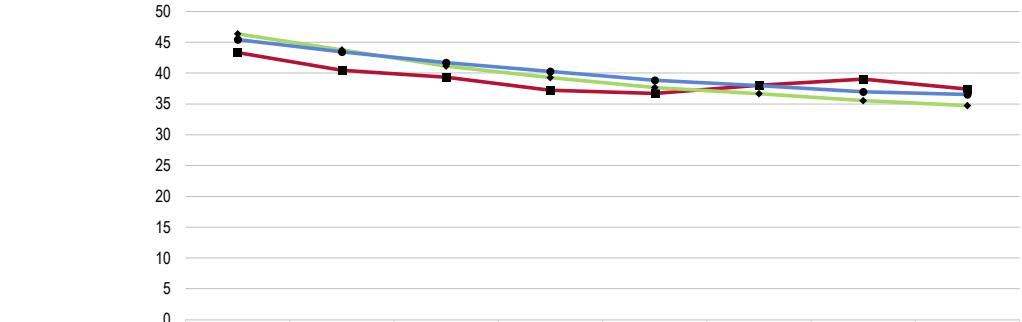
Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

- TREND: Stroke mortality in Monterey County surpassed that of the state and nation in 2012, but has since declined, echoing the trends reported across California and the US overall.

Stroke: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 34.8 or Lower



	2005-2007	2006-2008	2007-2009	2008-2010	2009-2011	2010-2012	2011-2013	2012-2014
Monterey County	43.3	40.4	39.4	37.2	36.7	38.0	39.0	37.4
CA	46.4	43.8	41.1	39.3	37.7	36.6	35.6	34.7
US	45.4	43.5	41.7	40.3	38.9	38.0	37.0	36.5

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2016.
- 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 US Standard Population.

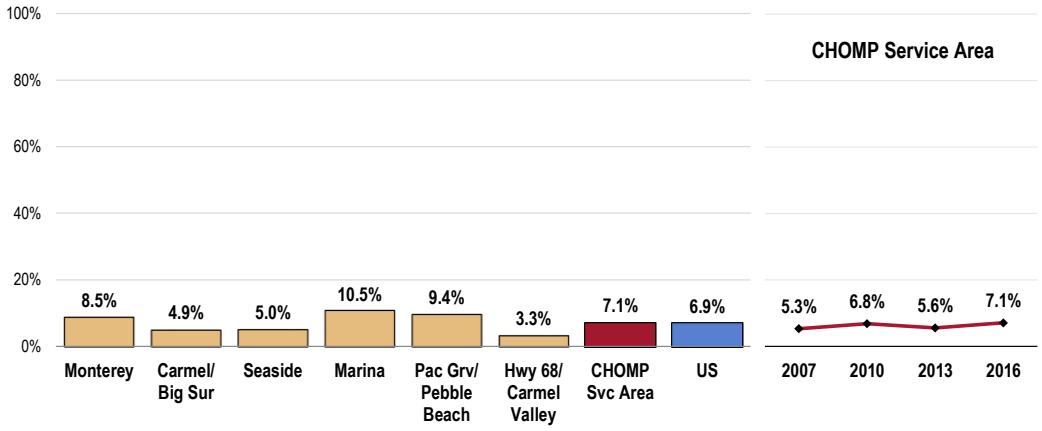
Prevalence of Heart Disease & Stroke

Prevalence of Heart Disease

A total of 7.1% 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.
- Lower in Highway 68/Carmel Valley.
- TREND: Statistically unchanged since 2007.

Prevalence of Heart Disease



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 146]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

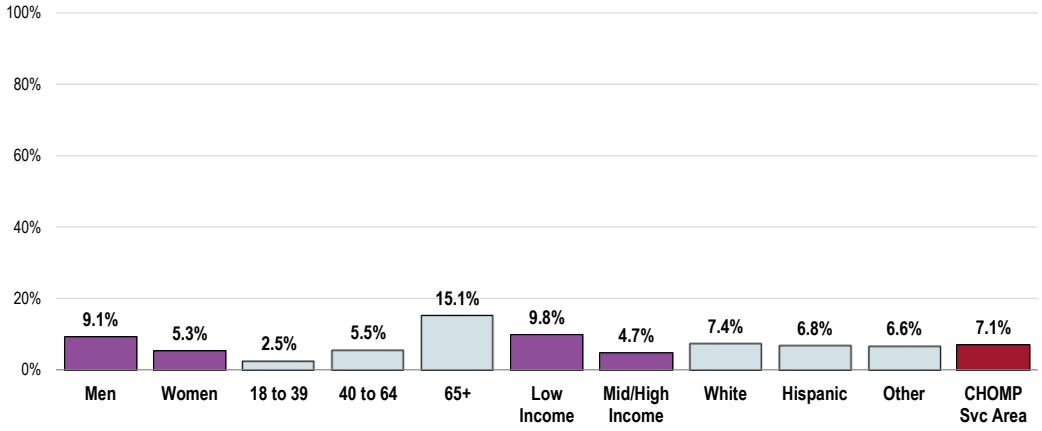
Notes:
- Asked of all respondents.
- Includes diagnoses of heart attack, angina or coronary heart disease.

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

- Men.
- Seniors (age 65+).
- Low-income residents.

Prevalence of Heart Disease

(CHOMP Service Area, 2016)



Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 146]

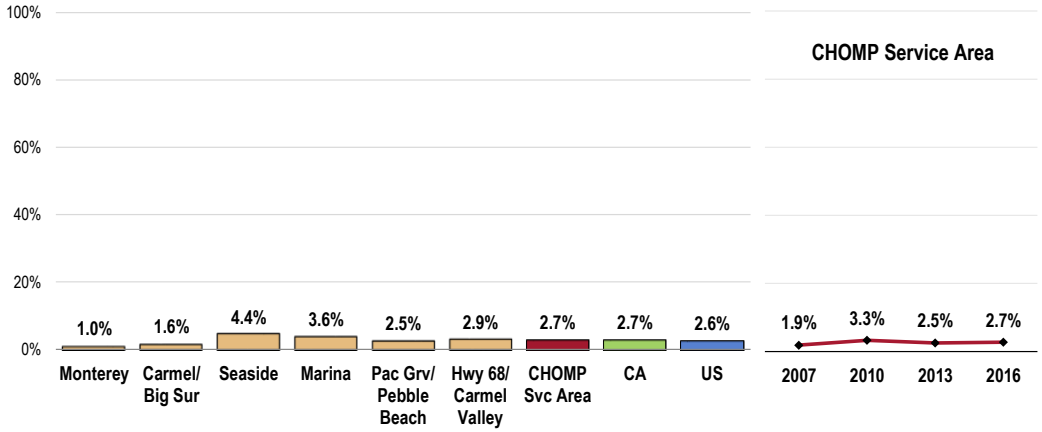
Notes:
- Asked of all respondents.
- Includes diagnoses of heart attack, angina or coronary heart disease.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Prevalence of Stroke

A total of 2.7% of surveyed adults report that they suffer from or have been diagnosed with cerebrovascular disease (a stroke).

- Nearly identical to the California and national findings.
- Lowest in Monterey.
- TREND: Statistically unchanged since 2007.

Prevalence of Stroke



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 35]
- 2015 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): 2014 California data.

Notes:
- Asked of all respondents.

Cardiovascular Risk Factors

About Cardiovascular Risk

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)

High Blood Pressure

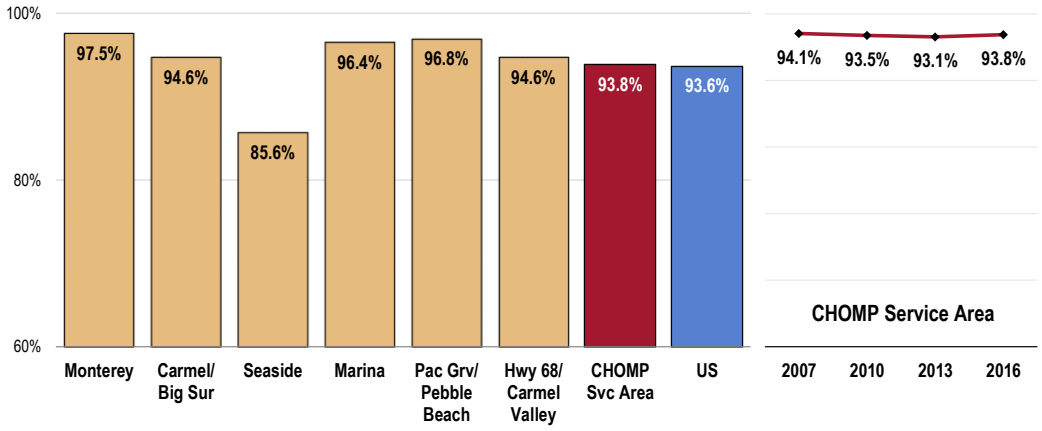
High Blood Pressure Testing

A total of 93.8% of CHOMP Service Area adults have had their blood pressure tested within the past two years.

- Similar to national findings.
- Similar to the Healthy People 2020 target (92.6% or higher).
- Higher in Monterey and Pacific Grove/Pebble Beach.
- TREND: Blood pressure testing has not changed over time.

Have Had Blood Pressure Checked in the Past Two Years

Healthy People 2020 Target = 92.6% or Higher



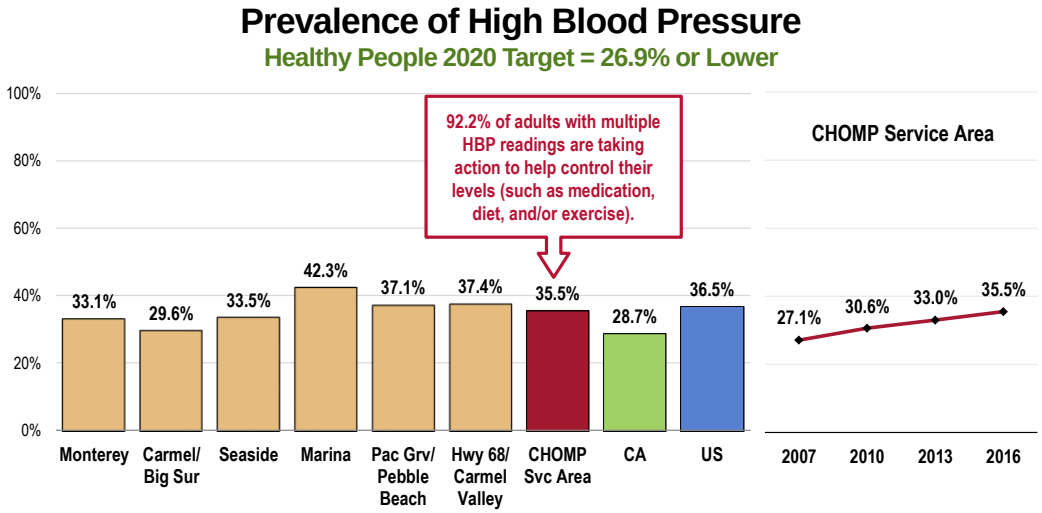
Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 44]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-4]

Notes:
- Asked of all respondents.

Prevalence of High Blood Pressure

A total of 35.5% of CHOMP Service Area 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).
- Highest in Marina.
- TREND: The proportion of adults with high blood pressure has increased significantly since 2007.
- Among adults with multiple high blood pressure readings, 92.2% are taking action to lower their blood pressure (such as medication, change in diet, and/or exercise).



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Items 43, 147]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2013 California data.
- 2015 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.

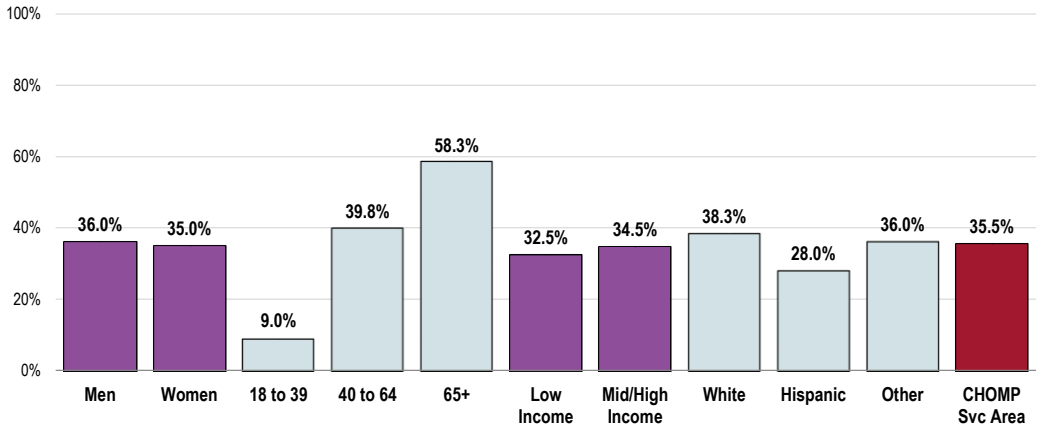
High blood pressure is more prevalent among:

- Adults age 40 and older, and especially those age 65+.
- Whites.

Prevalence of High Blood Pressure

(CHOMP Service Area, 2016)

Healthy People 2020 Target = 26.9% or Lower



Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 147]
- 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. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

High Blood Cholesterol

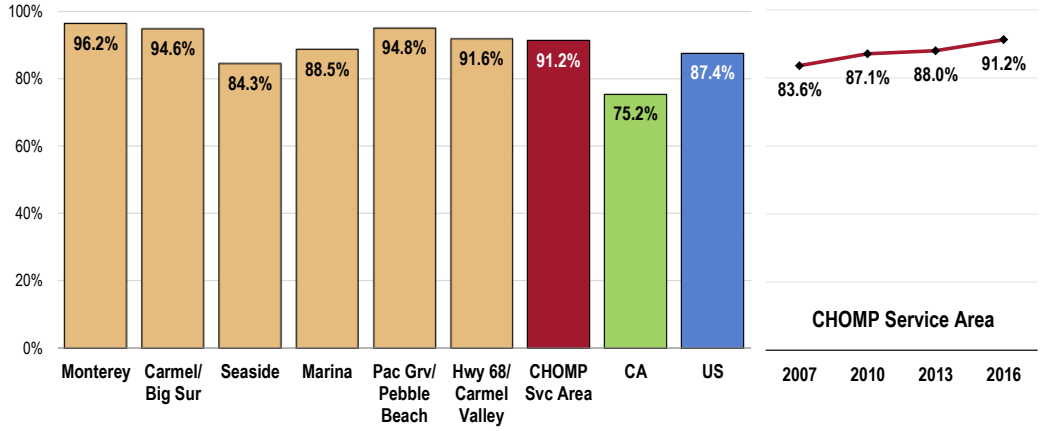
Blood Cholesterol Testing

A total of 91.2% of CHOMP Service Area adults have had their blood cholesterol checked within the past five years.

- More favorable than the California and national findings.
- Satisfies the Healthy People 2020 target (82.1% or higher).
- Lowest in Seaside.
- TREND: Denotes a statistically significant increase since 2007.

Have Had Blood Cholesterol Levels Checked in the Past Five Years

Healthy People 2020 Target = 82.1% or Higher



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 47]
- 2015 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): 2013 California data.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-6]

Notes:
- Asked of all respondents.

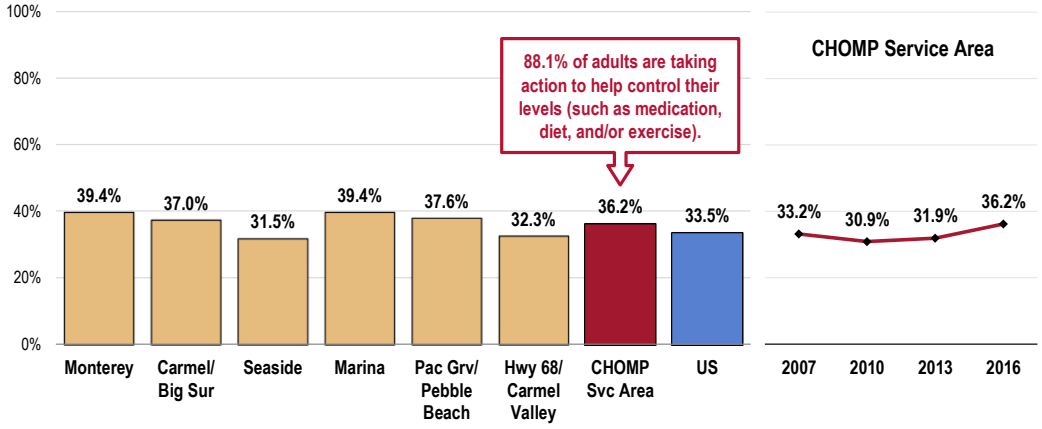
Prevalence of High Blood Cholesterol

A total of 36.2% of adults have been told by a health professional that their cholesterol level was high.

- Statistically comparable to the national prevalence.
- More than twice the Healthy People 2020 target (13.5% or lower).
- Comparable findings by community.
- TREND: Statistically unchanged since 2007.
- Among adults with high blood cholesterol readings, 88.1% are taking action to lower their levels (such as medication, change in diet, and/or exercise).

Prevalence of High Blood Cholesterol

Healthy People 2020 Target = 13.5% or Lower



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Items 46, 148]
- 2015 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]

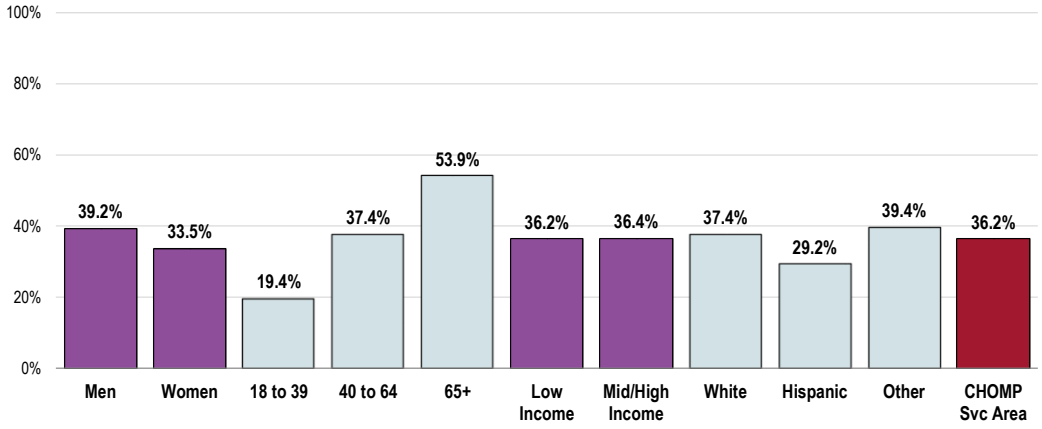
Notes:
- Asked of all respondents.

- Note the positive correlation between age and high blood cholesterol.

Prevalence of High Blood Cholesterol

(CHOMP Service Area, 2016)

Healthy People 2020 Target = 13.5% or Lower



Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 148]
- 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. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

About Cardiovascular Risk

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

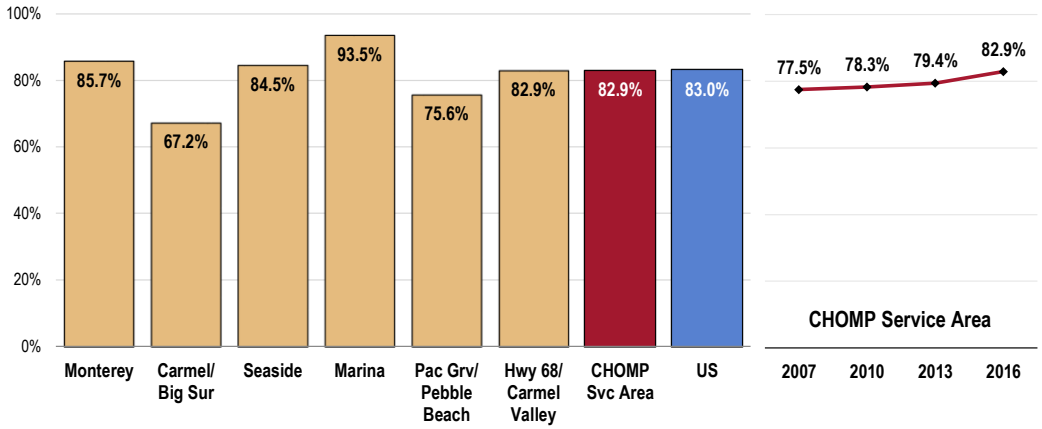
Total Cardiovascular Risk

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

A total of 82.9% 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.

- Nearly identical to national findings.
- Highest in Marina.
- TREND: The proportion of adults presenting cardiovascular risks or behaviors has increased significantly over time.

Present One or More Cardiovascular Risks or Behaviors



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 149]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

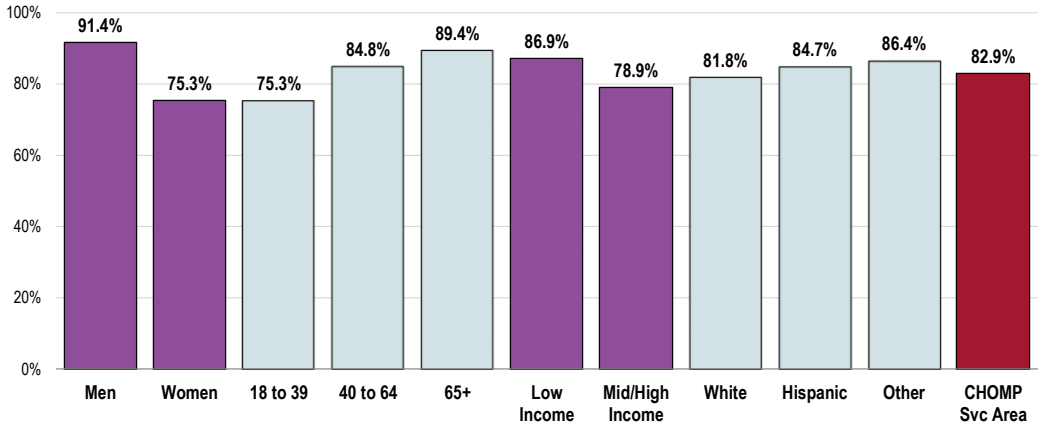
Notes:
- Asked of all respondents.
- Cardiovascular risk is defined as exhibiting one or more of the following: 1) no leisure-time physical activity; 2) regular/occasional cigarette smoking; 3) hypertension; 4) high blood cholesterol; and/or 5) being overweight/obese.

Adults more likely to exhibit cardiovascular risk factors include:

- Men.
- Adults age 40 and older, and especially seniors.
- Community members living on low incomes.

Present One or More Cardiovascular Risks or Behaviors

(CHOMP Service Area, 2016)



Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 149]

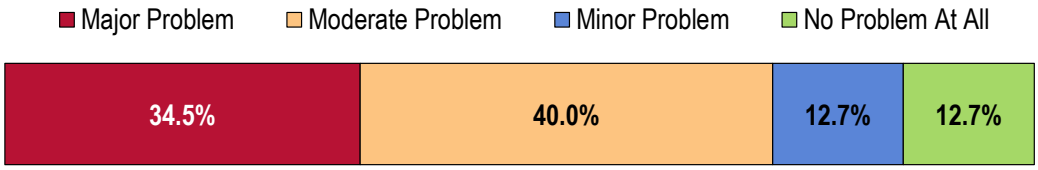
Notes:
- Asked of all respondents.
- Cardiovascular risk is defined as exhibiting one or more of the following: 1) no leisure-time physical activity; 2) regular/occasional cigarette smoking; 3) hypertension; 4) high blood cholesterol; and/or 5) being overweight/obese.
- Hispanics can be of any race. 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. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Key Informant Input: Heart Disease & Stroke

The greatest share of key informants taking part in an online survey characterized *Heart Disease & Stroke* as a "moderate problem" in the community.

Perceptions of Heart Disease and Stroke as a Problem in the Community

(Key Informants, 2016)



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

Top Concerns

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

Aging Population

Older population. – Physician

In addition to a large number of citizens living in poverty Monterey County has a growing homeless population. – Social Services Provider

Increase number of elderly and major health issues. – Social Services Provider

Elderly population. – Physician

Incidence/Prevalence

Adults who participate in our programs have heart disease or have had a heart attack or stroke and are trying to change or modify their lifestyle to recover or deal with the disease. – Community/Business Leader

Patient population in the community has high prevalence of CV disease. – Physician

Clients that we take care of in their homes are released from hospitals after having heart attacks and strokes. – Community/Business Leader

I believe heart disease and stroke are probably major problems in the community due to the larger older population as well as the large Hispanic population. Both heart disease and stroke are more prevalent among Hispanics. I assume age is a risk factor. – Community/Business Leader

Leading Cause of Death

Heart disease and stroke are the leading causes of death in Monterey County. Unhealthy lifestyles (poor diet, physical inactivity and tobacco use) which lead to. – Social Services Provider

Heart disease and stroke are the leading causes of death by illness. Lack of health education, regular exercise, good nutrition, and wellness health care and treatment, all contribute to this problem. – Social Services Provider

There are major events and can be immediately life threatening. – Social Services Provider

Heart disease and stroke are common comorbidities of diabetes. – Other Health Provider

Lifestyle

Unhealthy life styles. Unhealthy work environments. Major sources of stress include insufficient income. Insufficient, poor quality and expensive childcare, lack of qualified labor force and spurious labor and worker's comp claims. – Social Services Provider

Lifestyle, lack of information and education, again the increase in older population. – Social Services Provider

> *Our diet. – Community/Business Leader*
>
> *So many people have an unhealthy life style, eating habits and tobacco use. – Community/Business Leader*
>
> *Obesity. Lack of exercise. Regular checkups, availability. – Social Services Provider*

Disease Management

> *Again, gaining access to preventative and treatment services could be a challenge due to incapacity of existing health providers. – Public Health Representative*
>
> *Because of more obesity, we see heart disease and stroke that are preventable and we see more issues with younger people. My opinion is that more preventative exercise and diet could prevent a lot of cardiac and stroke problems. – Community/Business Leader*

Comorbidities

> *They are linked to obesity. – Community/Business Leader*
>
> *Tied to poor health behaviors over time. Obesity, diabetes and other chronic health conditions are only increasing and directly influence heart disease. – Community/Business Leader*

Access to Care/Services

> *Lack of access to health care services. – Public Health Representative*

Cancer

About 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)

Age-Adjusted Cancer Deaths

All Cancer Deaths

Between 2012 and 2014, there was an annual average age-adjusted cancer mortality rate of 136.0 deaths per 100,000 population in Monterey County.

- More favorable than the statewide and national rates.
- Satisfies the Healthy People 2020 target of 161.4 or lower.

Cancer: Age-Adjusted Mortality

(2012-2014 Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 161.4 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 April 2016.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective C-1]

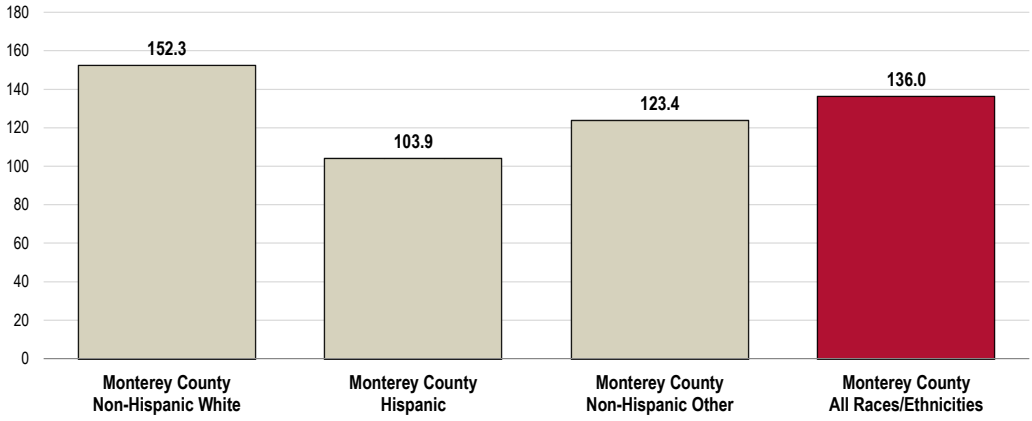
Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

- The cancer mortality rate is notably higher among Non-Hispanic Whites.

Cancer: Age-Adjusted Mortality by Race

(2012-2014 Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 161.4 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 April 2016.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective C-1]

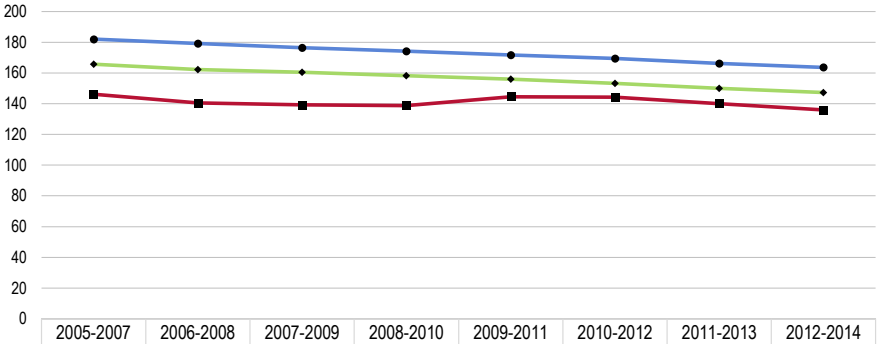
Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

- TREND: 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)

Healthy People 2020 Target = 161.4 or Lower



	2005-2007	2006-2008	2007-2009	2008-2010	2009-2011	2010-2012	2011-2013	2012-2014
Monterey County	146.2	140.6	139.2	138.7	144.6	144.3	140.0	136.0
CA	165.7	162.4	160.5	158.2	155.9	153.2	149.9	147.3
US	182.1	179.2	176.4	174.2	171.8	169.4	166.2	163.6

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2016.
- 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 US Standard Population.

Cancer Deaths by Site

Lung cancer is by far 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 2012-2014 annual average age-adjusted death rates):

- The Monterey County death rates for **lung cancer, female breast cancer,** and **colorectal cancer** are more favorable than the corresponding state and national rates.
- The Monterey County **prostate cancer** death rate is similar to both the state and national rates.

Note that each of the Monterey County cancer death rates detailed below/in the following chart satisfies the related Healthy People 2020 target.

Age-Adjusted Cancer Death Rates by Site

(2012-2014 Annual Average Deaths per 100,000 Population)

	Monterey County	CA	US	HP2020
ALL CANCERS	136.0	147.3	163.6	161.4
Lung Cancer	27.5	31.9	43.4	45.5
Prostate Cancer	19.8	19.4	19.2	21.8
Female Breast Cancer	19.0	20.4	20.9	20.7
Colorectal Cancer	9.8	13.2	14.6	14.5

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2016.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov

Cancer Incidence

Incidence rates reflect the number of newly diagnosed cases in a given population in a given year, regardless of outcome. Here, these rates are also age-adjusted.

"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.

These 2008-2012 Monterey County annual average age-adjusted cancer incidence rates are worse than US rates.

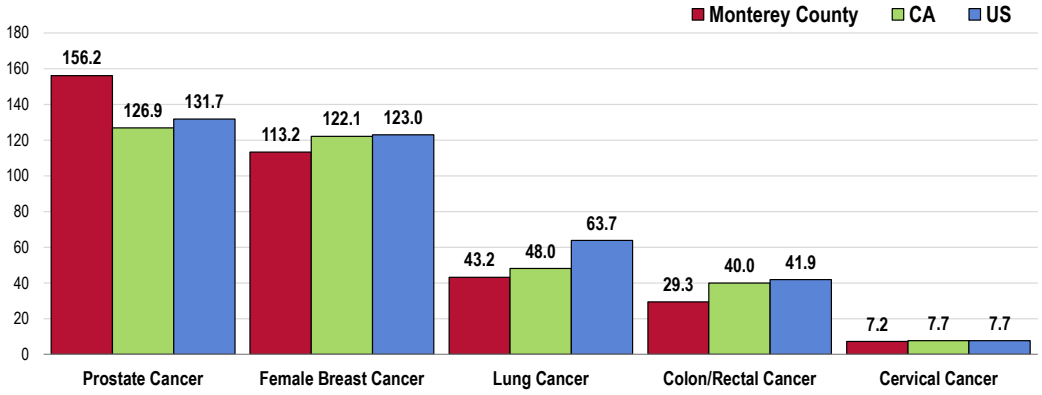
- Prostate cancer.

These Monterey County cancer incidence rates are better than state rates for the same years.

- Female breast cancer.
- Lung cancer.
- Colorectal cancer.
- Cervical cancer.

Cancer Incidence Rates by Site

(Annual Average Age-Adjusted Incidence per 100,000 Population, 2008-12)



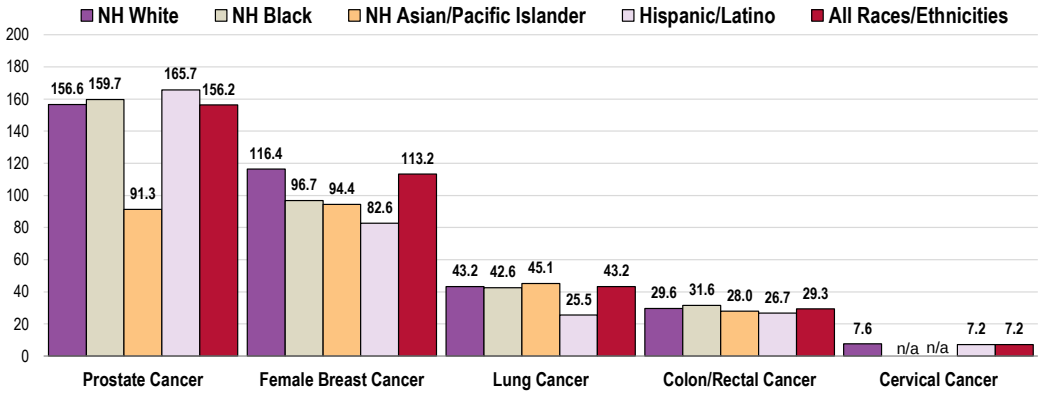
Sources:
- State Cancer Profiles.
- Retrieved April 2016 from Community Commons at http://www.chna.org.

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

- By available race data, Non-Hispanic Asian/Pacific Islanders have a much lower incidence of prostate cancer than Whites, Blacks, and Hispanics in Monterey County.
- Non-Hispanic Whites have a higher female breast cancer incidence.
- Non-Hispanic Blacks have a higher colorectal cancer incidence when compared with their demographic counterparts.
- Hispanics in Monterey County have a lower incidence of female breast cancer, lung cancer and colorectal cancer.

Cancer Incidence Rates by Site and Race/Ethnicity

(Annual Average Age-Adjusted Incidence per 100,000 Population, CHOMP Service Area 2008-12)



Sources:
- State Cancer Profiles.
- Retrieved April 2016 from Community Commons at http://www.chna.org.

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

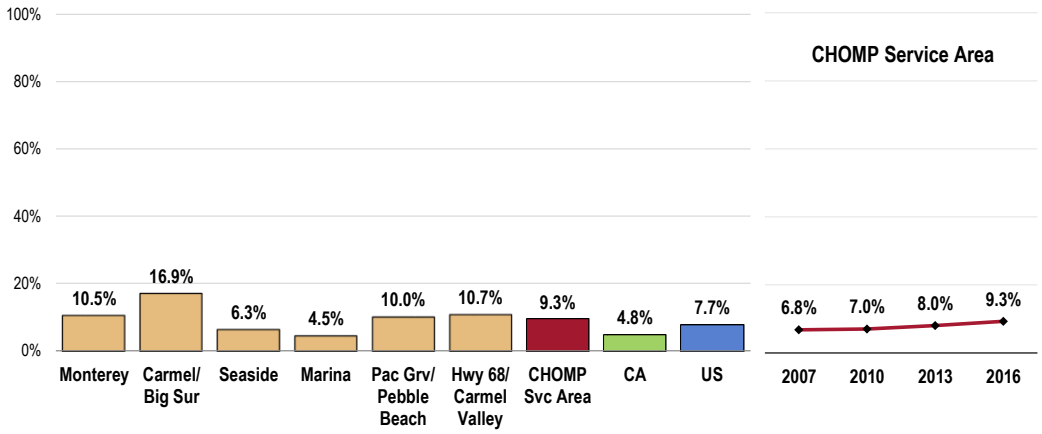
Prevalence of Cancer

Skin Cancer

A total of 9.3% of surveyed CHOMP Service Area adults report having been diagnosed with skin cancer.

- Higher than what is found statewide.
- Comparable to the national average.
- Particularly high in Carmel/Big Sur.
- TREND: The prevalence of skin cancer has statistically increased since 2007.

Prevalence of 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): 2014 California data.
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

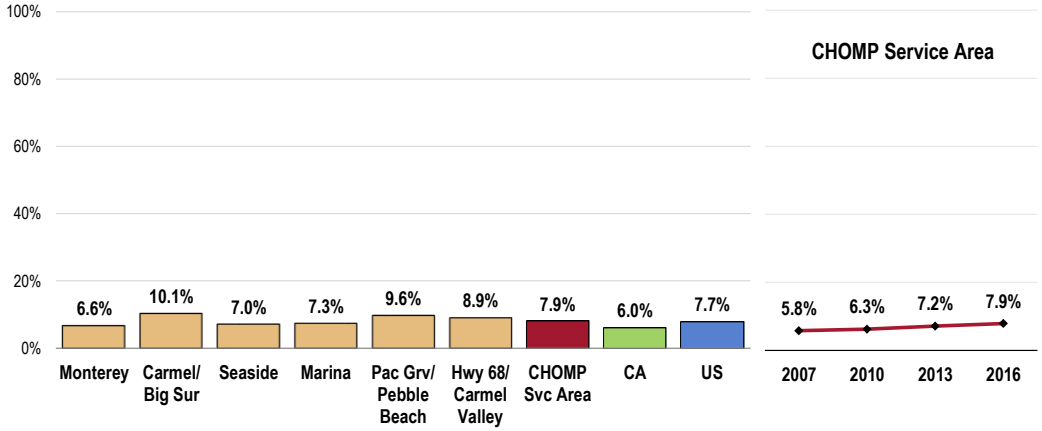
Notes:
- Asked of all respondents.

Other Cancer

A total of 7.9% of survey respondents have been diagnosed with some type of (non-skin) cancer.

- Statistically higher than the statewide percentage.
- Similar to the national percentage.
- Statistically similar findings by community.
- TREND: The change in cancer prevalence over time is not statistically significant.

Prevalence of Cancer (Other Than Skin Cancer)



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 29]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2014 California data.
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

Cancer Risk

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

About Cancer Risk

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

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

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

Cancer Screenings

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

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

Female Breast Cancer Screening

About Screening for Breast Cancer

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

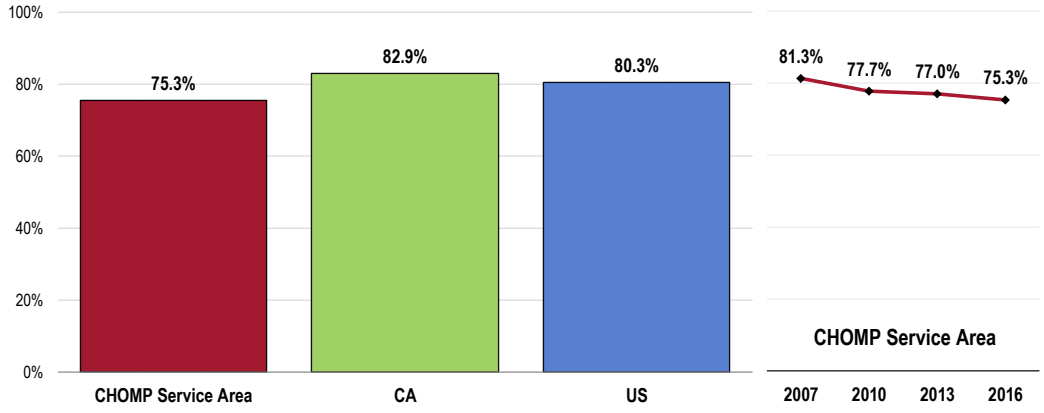
Among women age 50-74, three-fourths (75.3%) have had a mammogram within the past 2 years.

- Less favorable than statewide findings.
- Statistically similar to national findings.
- Fails to satisfy the Healthy People 2020 target (81.1% or higher).
- TREND: No statistically significant change has occurred when comparing to previous survey results.

Have Had a Mammogram in the Past Two Years

(Among Women Age 50-74)

Healthy People 2020 Target = 81.1% or Higher



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 151]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2014 California data.
- 2015 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.

Cervical Cancer Screenings

About Screening for Cervical Cancer

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 who 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 that 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

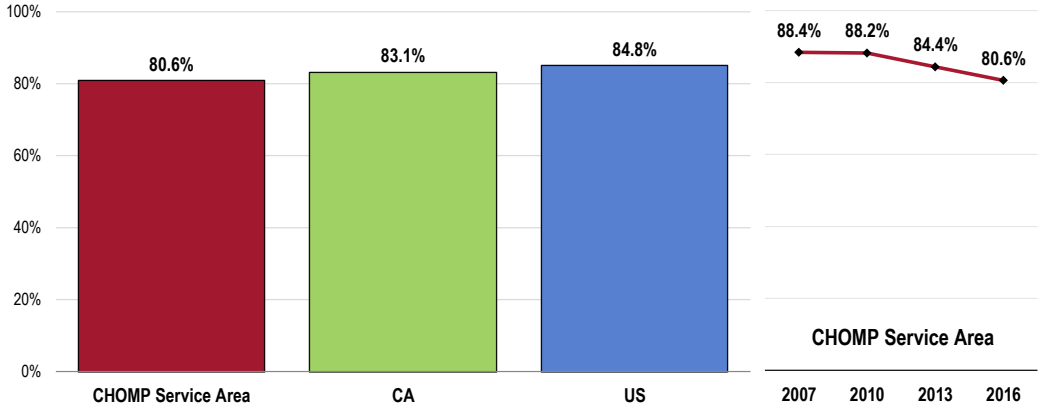
Among CHOMP Service Area women age 21 to 65, 80.6% have had a Pap smear within the past 3 years.

- Comparable to California and national findings.
- Fails to satisfy the Healthy People 2020 target (93% or higher).
- TREND: Marks a statistically significant decrease since 2007.

Have Had a Pap Smear in the Past Three Years

(Among Women Age 21-65)

Healthy People 2020 Target = 93.0% or Higher



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 152]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2014 California data.
- 2015 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.

Colorectal Cancer Screenings

About Screening for Colorectal Cancer

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, 70.8% 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).

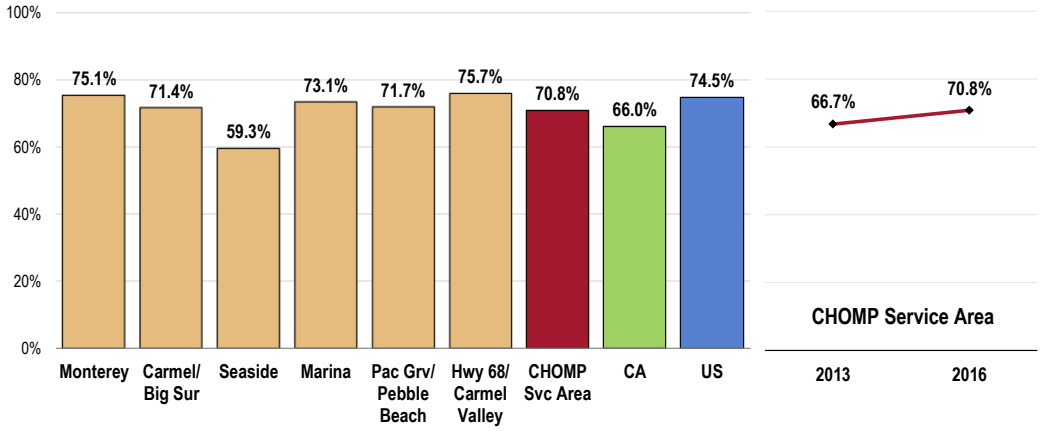
"Appropriate colorectal cancer screening" includes a fecal occult blood test within the past year and/or a lower endoscopy (sigmoidoscopy or colonoscopy) within the past 10 years.

- Better than statewide findings.
- Statistically comparable to national findings.
- Similar to the Healthy People 2020 target (70.5% or higher).
- Notably low in Seaside.
- TREND: Over time, the prevalence of colorectal cancer screenings has not changed significantly.

Have Had a Colorectal Cancer Screening

(Among Adults Age 50-75)

Healthy People 2020 Target = 70.5% or Higher



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 155]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2014 California data.
- 2015 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-16]

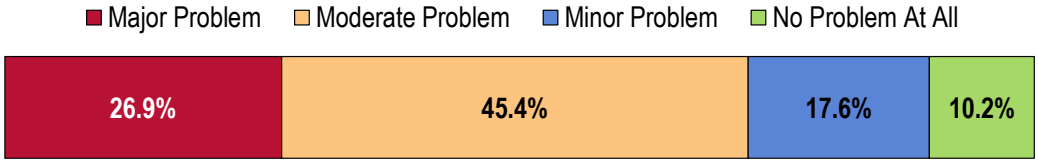
Notes:
- Asked of all respondents age 50 through 75.
- In this case, the term "colorectal screening" refers to adults age 50-75 receiving a FOBT (fecal occult blood test) in the past year and/or a lower endoscopy (sigmoidoscopy/colonoscopy) in the past 10 years.

Key Informant Input: Cancer

The greatest share of key informants taking part in an online survey characterized *Cancer* as a "moderate problem" in the community.

Perceptions of Cancer as a Problem in the Community

(Key Informants, 2016)



Sources:
- PRC Online Key Informant Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

Top Concerns

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

Incidence/Prevalence

> *Increased incidence of all kinds of cancer. Lack of confidence in the current resources available, clinicians, home care and treatment options. – Social Services Provider*
>
> *The Monterey County 2013 Community Health Assessment by Monterey County Health Department states that nearly 40% of the county residents lived at or below 200% of the federal poverty level. This makes access to care for serious diseases very difficult. – Social Services Provider*
>
> *It is a growing problem everywhere. – Community/Business Leader*
>
> *I know many people with cancer or who had cancer. – Community/Business Leader*

Breast, ovarian, and lung. – Community/Business Leader

I have heard of a lot of people who have cancer and either did not get diagnosed on time because the lack of insurance or got diagnosed and did not have access to adequate treatment because they had no health insurance. – Social Services Provider

We have quite a big number of employees and their family members that have developed cancer. There are limited doctors in the area to service all of these employees and their families. – Community/Business Leader

I believe cancer is a major problem in my community because I can easily recall 10+ people I've worked with in various capacities who have had cancer in the last few years; most of those being individuals who had breast cancer. – Community/Business Leader

Cancer seems to be a major problem in all communities as we all know of people who have suffered or succumbed to this illness. – Community/Business Leader

There appears to be a higher incident rate in the area. Diagnosis is difficult and most of the time is determined during the later stages of the disease. Access to affordable care and specifically treatment and the most effective drugs is unattainable. – Community/Business Leader

Large number of cases, low level of screening in minority populations. – Physician

Many people are getting cancer, pretty much everyone knows someone who has or had cancer or a family member has or has had it. It touches the whole community no matter what your age, and often it is successfully treated. – Social Services Provider

Increase in diagnosis of cancer but not having the care available for the poor. – Social Services Provider

Access to Care/Services

Many of patients have no or limited coverage that limits them from getting regular preventative screenings. Often it's too late for care and cancer has developed. There are also not many places to refer to. – Public Health Representative

In the families that I see usually someone in their family has/had some form of it. Some of the families are a single parent family looking for financial assistance for our programs so their children can participate while they undergo treatment. – Community/Business Leader

Lack of care, education. – Public Health Representative

Affordable Care/Services

If you don't have insurance it's most difficult if you do. Our cancer centers are excellent. – Social Services Provider

People cannot afford treatment so they don't seek medical treatment until the disease has spread. – Community/Business Leader

Environmental Contributors

Exposures to chemicals, pesticides. Late diagnosis, poverty, racism. – Public Health Representative

Exposure to toxic substances in agriculture. – Public Health Representative

Prevention Efforts

I'm focusing on the Salinas and South Communities that Harmony At Home primarily serves. It seems that many of our clients' parents are not seeking out preventative care and that there are significant instances of illness and death from cancer. – Community/Business Leader

Consequences of Disease

It's a horrible disease that causes death and suffering. Affects the family and friends as well. Treatment is expensive and often ineffective. Several opinions are needed and it's not straightforward in terms of where to go. – Community/Business Leader

Devastating. Scary. Life changing. – Physician

Aging Population

Higher average age for the community leading to a higher cancer rate. – Physician

Respiratory Disease

About Asthma & COPD

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.

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)

[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)

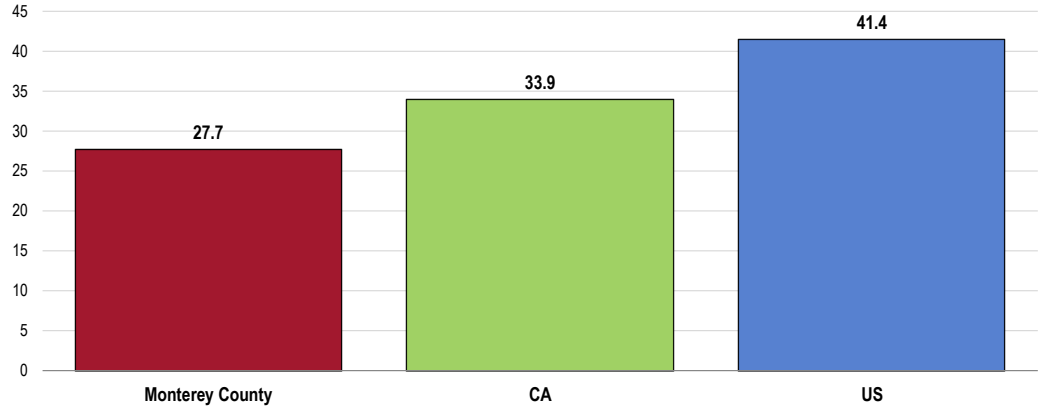
Note: COPD was changed to chronic lower respiratory disease (CLRD) in 1999 with the introduction of ICD-10 codes. CLRD is used in vital statistics reporting, but COPD is still widely used and commonly found in surveillance reports.

Between 2012 and 2014, there was an annual average age-adjusted CLRD mortality rate of 27.7 deaths per 100,000 population in Monterey County.

- Lower than found statewide and nationally.

CLRD: Age-Adjusted Mortality

(2012-2014 Annual Average Deaths per 100,000 Population)



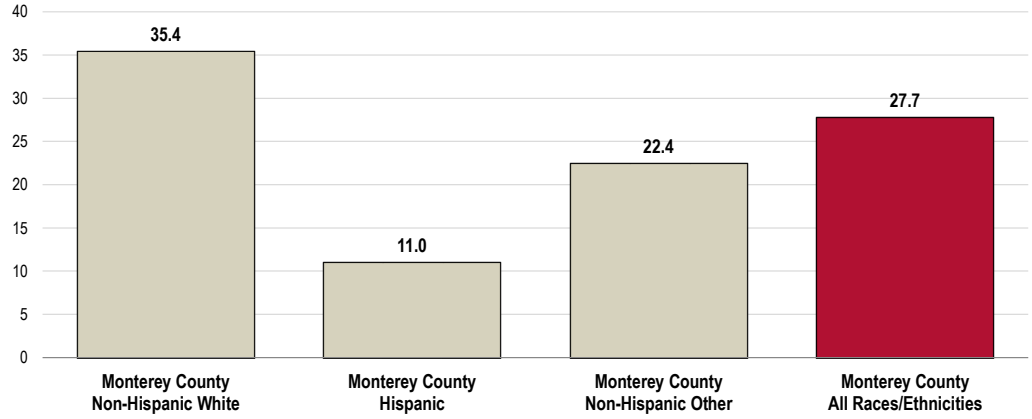
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2016.

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.
- CLRD is chronic lower respiratory disease.

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

CLRD: Age-Adjusted Mortality by Race

(2012-2014 Annual Average Deaths per 100,000 Population)

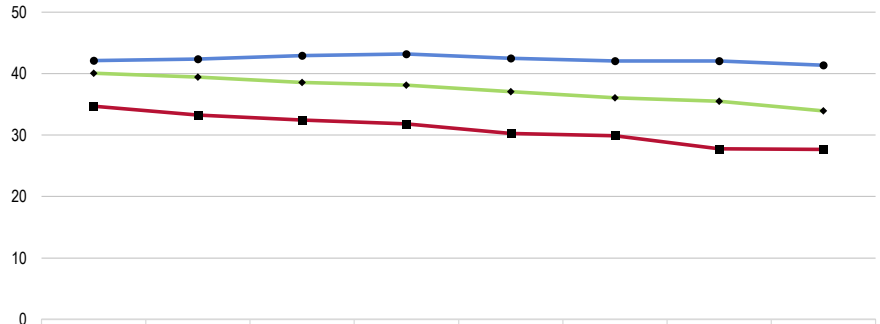


Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and. Informatics. Data extracted April 2016.

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.
- CLRD is chronic lower respiratory disease.

- TREND: CLRD mortality in Monterey County has decreased over time, mirroring the trend reported statewide. The national rate has stayed relatively constant.

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



	2005-2007	2006-2008	2007-2009	2008-2010	2009-2011	2010-2012	2011-2013	2012-2014
Monterey County	34.7	33.2	32.5	31.8	30.2	29.9	27.8	27.7
CA	40.1	39.4	38.6	38.1	37.1	36.1	35.5	33.9
US	42.1	42.4	42.9	43.2	42.5	42.1	42.0	41.4

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2016.

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.
- CLRD is chronic lower respiratory disease.

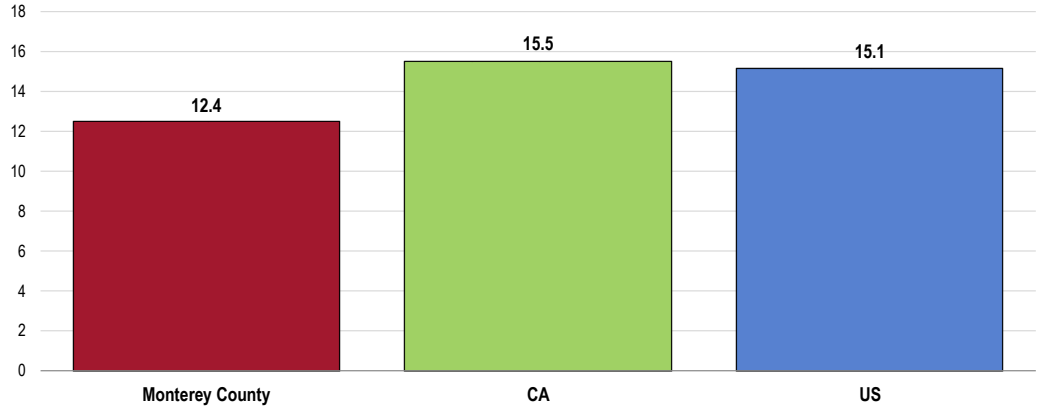
Pneumonia/Influenza Deaths

Between 2012 and 2014, Monterey County reported an annual average age-adjusted pneumonia influenza mortality rate of 12.4 deaths per 100,000 population.

- Somewhat lower than found statewide and nationally.

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

Pneumonia/Influenza: Age-Adjusted Mortality
(2012-2014 Annual Average Deaths per 100,000 Population)



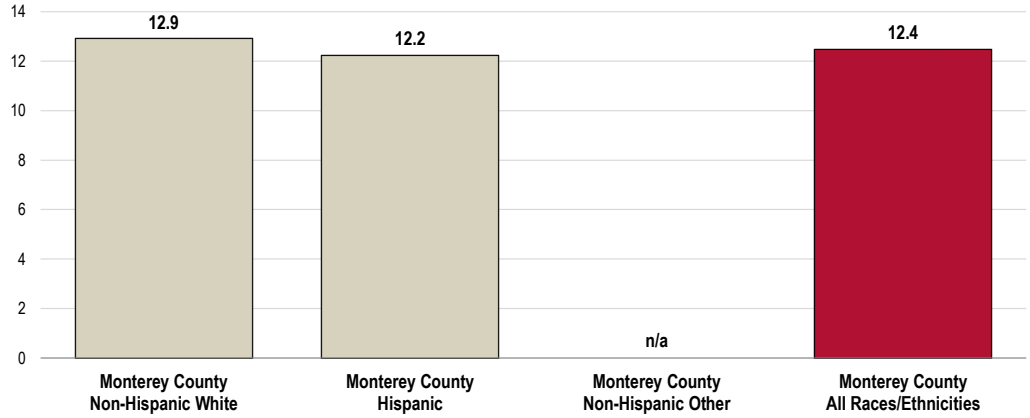
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2016.

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.

- The pneumonia/influenza mortality rate in Monterey County is slightly higher among Non-Hispanic Whites than Hispanics.

Pneumonia/Influenza: Age-Adjusted Mortality by Race

(2012-2014 Annual Average Deaths per 100,000 Population)



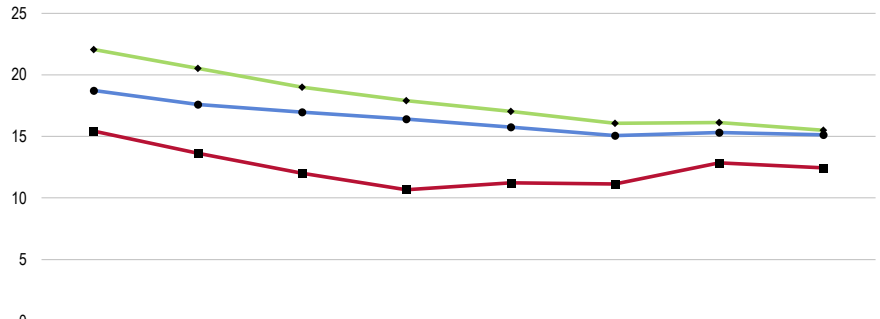
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2016.

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.

- TREND: Toward the beginning of the decade, the Monterey County pneumonia/influenza mortality rate echoed the declining state and national trends, but since 2010, no clear trend has been apparent.

Pneumonia/Influenza: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)



	2005-2007	2006-2008	2007-2009	2008-2010	2009-2011	2010-2012	2011-2013	2012-2014
Monterey County	15.4	13.6	12.0	10.7	11.2	11.1	12.9	12.4
CA	22.1	20.5	19.0	17.9	17.0	16.1	16.1	15.5
US	18.7	17.6	17.0	16.4	15.8	15.1	15.3	15.1

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2016.

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.

Asthma

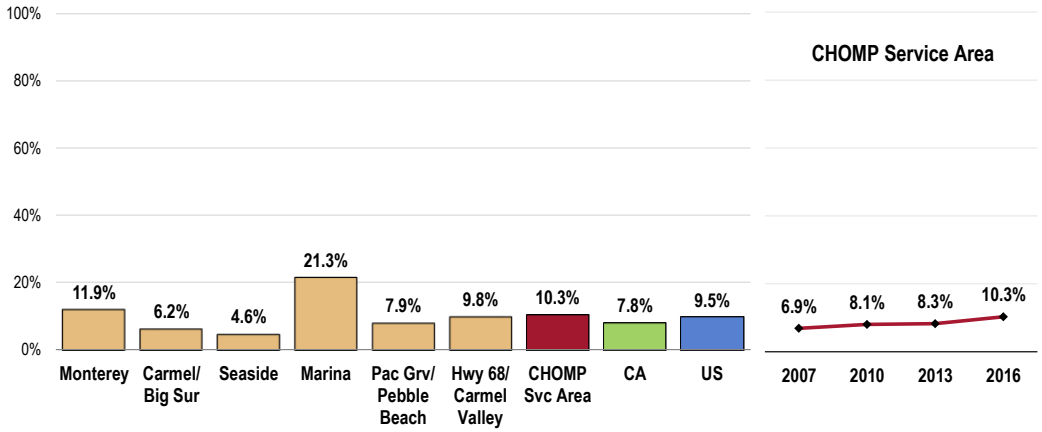
Adults

Survey respondents were next asked to indicate whether they suffer from or have been diagnosed with various respiratory conditions, including asthma and COPD.

A total of 10.3% of CHOMP Service Area adults currently suffer from asthma.

- Higher than the statewide prevalence.
- Similar to the national prevalence.
- Particularly high in Marina.
- TREND: The prevalence of adults with current asthma has increased significantly since 2007.

Adult Asthma: Current Prevalence

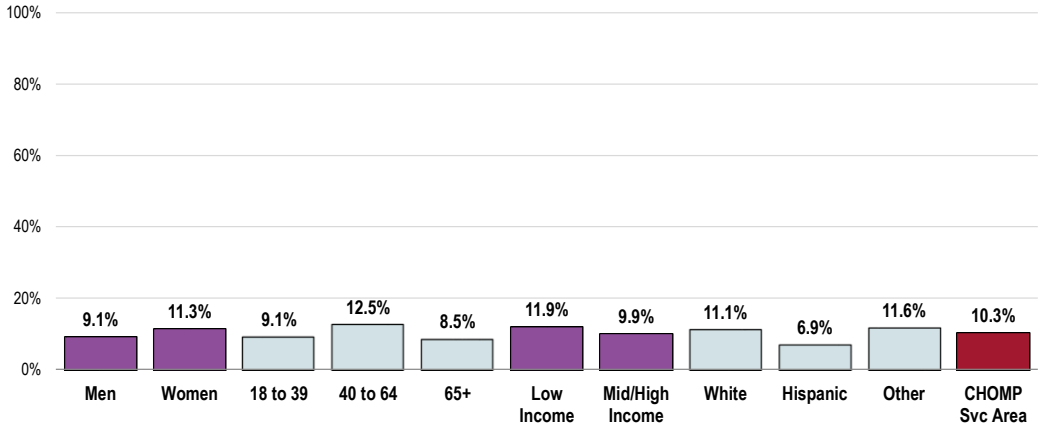


Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 156]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2014 California data.

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

- The proportion of service area adults currently suffering from asthma is statistically similar among the following demographic segments.

Currently Have Asthma
(CHOMP Service Area, 2016)



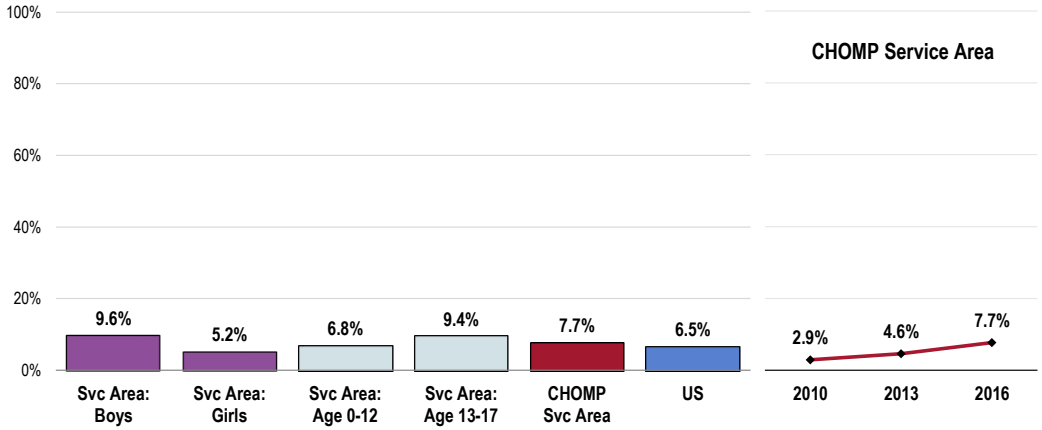
Sources: ● 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 156]
Notes: ● Asked of all respondents.
● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Children

Among CHOMP Service Area children under age 18, 7.7% currently have asthma.

- Similar to the national figure.
- TREND: Childhood asthma appears to have increased in the service area since 2010.
- Viewed by age and gender, differences in children's asthma prevalence are not statistically significant.

Childhood Asthma: Current Prevalence
(Among Parents of Children Age 0-17)



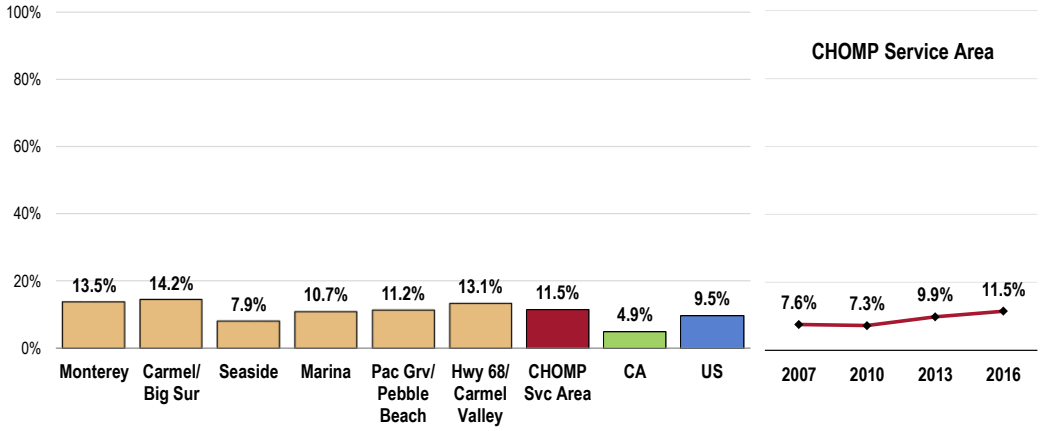
Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 157]
● 2015 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all respondents with children 0 to 17 in the household.
● Includes children who have ever been diagnosed with asthma, and whom are reported to still have asthma.

Chronic Obstructive Pulmonary Disease (COPD)

A total of 11.5% of CHOMP Service Area adults suffer from chronic obstructive pulmonary disease (COPD, including emphysema and bronchitis).

- Less favorable than the prevalence reported statewide.
- Similar to the national prevalence.
- Least prevalent in Seaside.
- TREND: Over time, the COPD prevalence has increased significantly.
- *NOTE: in prior data, this question was asked slightly differently; respondents in 2007, 2010, and 2013 were asked if they had ever been diagnosed with "chronic lung disease, including bronchitis or emphysema," rather than "COPD or chronic obstructive pulmonary disease, including bronchitis or emphysema" as is asked currently.*

Prevalence of Chronic Obstructive Pulmonary Disease (COPD)



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 24]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2014 California data.
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

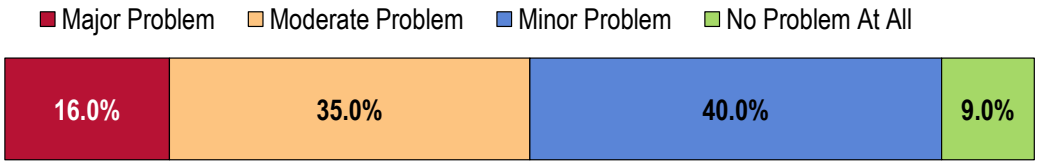
Notes:
- Asked of all respondents.
- Includes those having ever suffered from or been diagnosed with COPD or chronic obstructive pulmonary disease, including bronchitis or emphysema.
- In prior data, the term "chronic lung disease" was used, which also included bronchitis or emphysema.

Key Informant Input: Respiratory Disease

The greatest share of key informants taking part in an online survey characterized *Respiratory Disease* as a "minor problem" in the community.

Perceptions of Respiratory Diseases as a Problem in the Community

(Key Informants, 2016)



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

Top Concerns

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

Access to Care/Services

Difficulty in establishing care with a pulmonologist for preventive treatments to avoid Emergency Room visits and hospitalizations. – Physician

Due to inadequate housing access, expensive and not well maintained, there are a lot of respiratory diseases. Lack of access to healthcare and medications make it harder. – Social Services Provider

Accessibility to treatment. Education. Lack of early detection. – Social Services Provider

Contributing Factors

Chemicals, pesticides. – Public Health Representative

Pesticides and lack of education. – Public Health Representative

Poverty and extensive farm worker population, exposure to dust and pesticides. – Social Services Provider

Smoking and living conditions. – Community/Business Leader

Lifestyle

So many people have an unhealthy life style. They don't exercise; have unhealthy diets and tobacco use. – Community/Business Leader

Injury & Violence

About 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)

Unintentional Injury

Age-Adjusted Unintentional Injury Deaths

Between 2012 and 2014, there was an annual average age-adjusted unintentional injury mortality rate of 29.9 deaths per 100,000 population in Monterey County.

- Similar to the California rate.
- Lower than the national rate.
- Satisfies the Healthy People 2020 target (36.4 or lower).

Unintentional Injuries: Age-Adjusted Mortality

(2012-2014 Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 36.4 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 April 2016.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IVP-11]

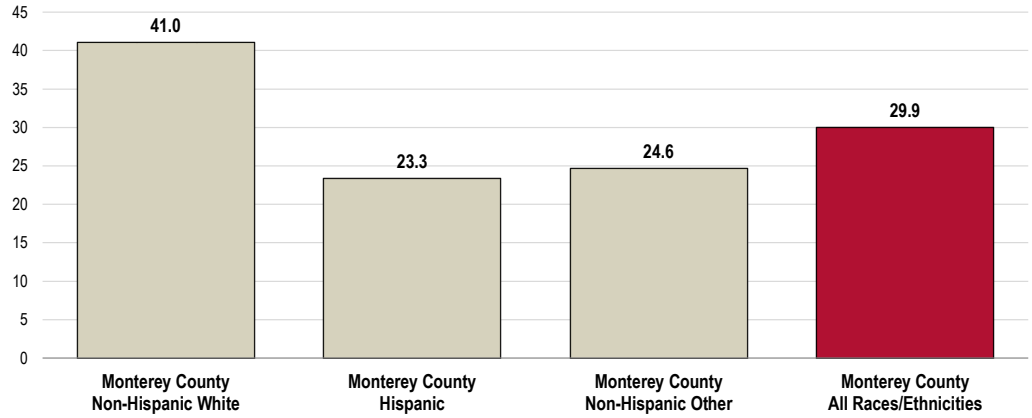
Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

- The mortality rate is notably higher among Non-Hispanic Whites in Monterey County.

Unintentional Injuries: Age-Adjusted Mortality by Race

(2012-2014 Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 36.4 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 April 2016.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IVP-11]

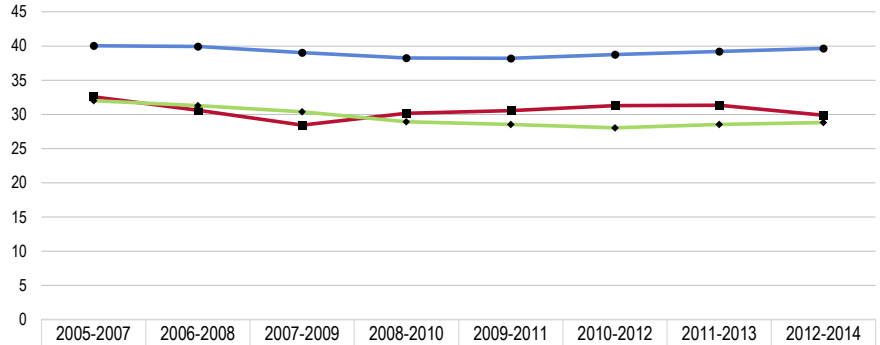
Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

- TREND: The Monterey County unintentional mortality rate overtook that of the state as they both experienced slight overall decreases in the past decade. The US rate remained relatively constant during this time.

Unintentional Injuries: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 36.4 or Lower



	2005-2007	2006-2008	2007-2009	2008-2010	2009-2011	2010-2012	2011-2013	2012-2014
Monterey County	32.6	30.6	28.4	30.1	30.5	31.3	31.3	29.9
CA	32.0	31.3	30.4	28.9	28.5	28.0	28.5	28.8
US	40.0	39.9	39.0	38.2	38.2	38.7	39.2	39.7

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2016.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IVP-11]

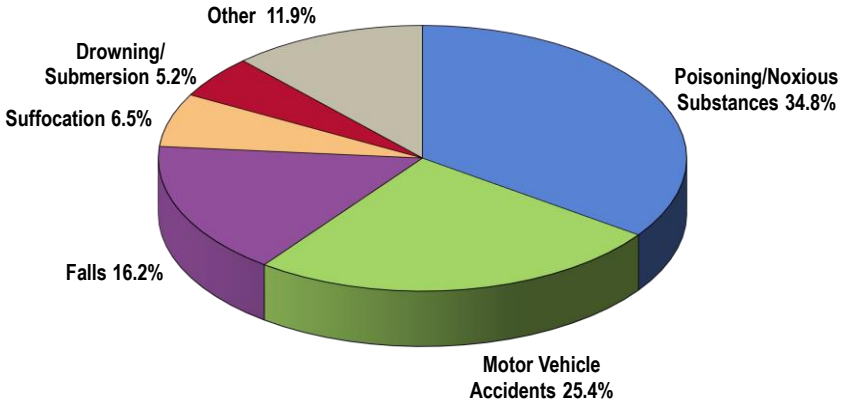
Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Leading Causes of Accidental Death

Poisoning (including accidental drug overdose), motor vehicle accidents, falls, and suffocation accounted for most accidental deaths in Monterey County between 2012 and 2014.

Leading Causes of Accidental Death

(CHOMP Service Area, 2012-2014)



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2016.

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

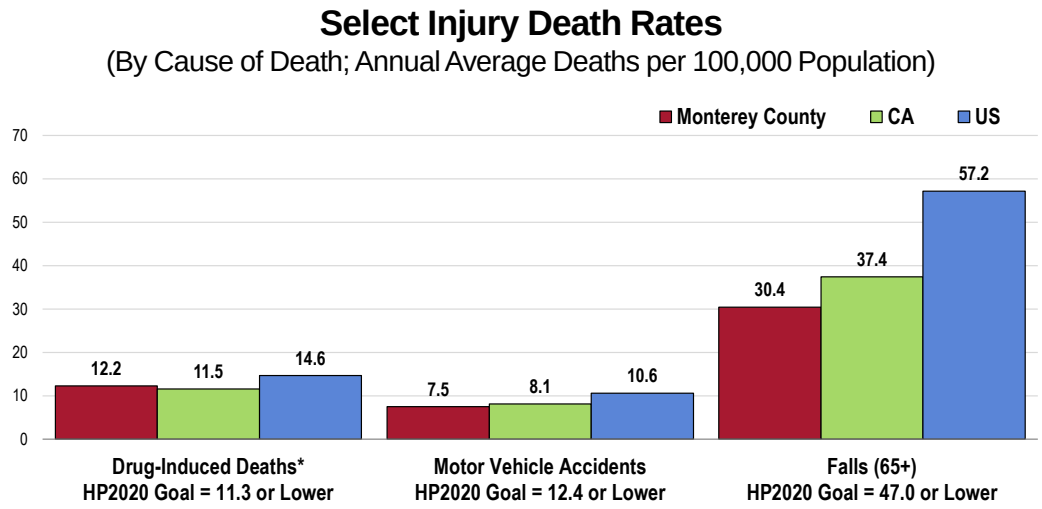
Selected Injury Deaths

The following chart outlines mortality rates for drug-induced deaths (both intentional and unintentional overdoses), motor vehicle crashes, and falls (among adults age 65 and older).

The Monterey County annual average age-adjusted mortality rates are <u>better</u> than US rates.

Monterey County mortality rates are <u>worse</u> than state rates for:

- Drug-related deaths.



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2016.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IVP-13.1, IVP-23.2, 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.
- *Drug-induced deaths include both intentional and unintentional drug overdoses.

Falls

Falls

Each year, an estimated one-third of older adults fall, and the likelihood of falling increases substantially with advancing age. In 2005, a total of 15,802 persons age ≥65 years died as a result of injuries from falls.

Falls are the leading cause of fatal and nonfatal injuries for persons aged ≥65 years … in 2006, approximately 1.8 million persons aged ≥65 years (nearly 5% of all persons in that age group) sustained some type of recent fall-related injury. Even when those injuries are minor, they can seriously affect older adults' quality of life by inducing a fear of falling, which can lead to self-imposed activity restrictions, social isolation, and depression.

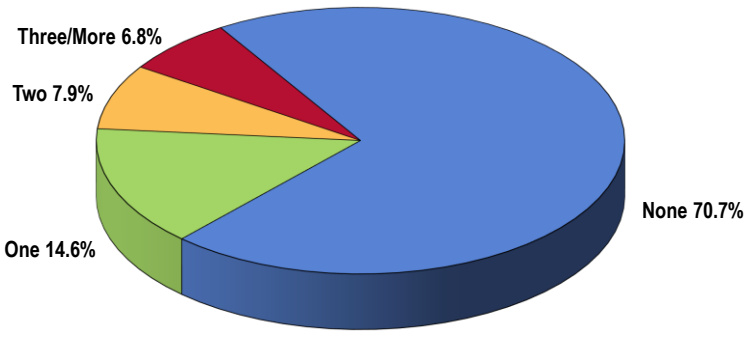
In addition, fall-related medical treatment places a burden on US healthcare services. In 2000, direct medical costs for fall-related injuries totaled approximately $19 billion. A recent study determined that 31.8% of older adults who sustained a fall-related injury required help with activities of daily living as a result, and among them, 58.5% were expected to require help for at least 6 months.

Modifiable fall risk factors include muscle weakness, gait and balance problems, poor vision, use of psychoactive medications, and home hazards. Falls among older adults can be reduced through evidence-based fall-prevention programs that address these modifiable risk factors. Most effective interventions focus on exercise, alone or as part of a multifaceted approach that includes medication management, vision correction, and home modifications.

- Division of Unintentional Injury Prevention, National Center for Injury Prevention and Control, CDC

Among surveyed CHOMP Service Area adults age 45 and older, 29.3% fell at least once in the past year, including 6.8% who fell three or more times.

Number of Falls in Past 12 Months
(Among Adults Age 45 and Older; CHOMP Service Area, 2016)



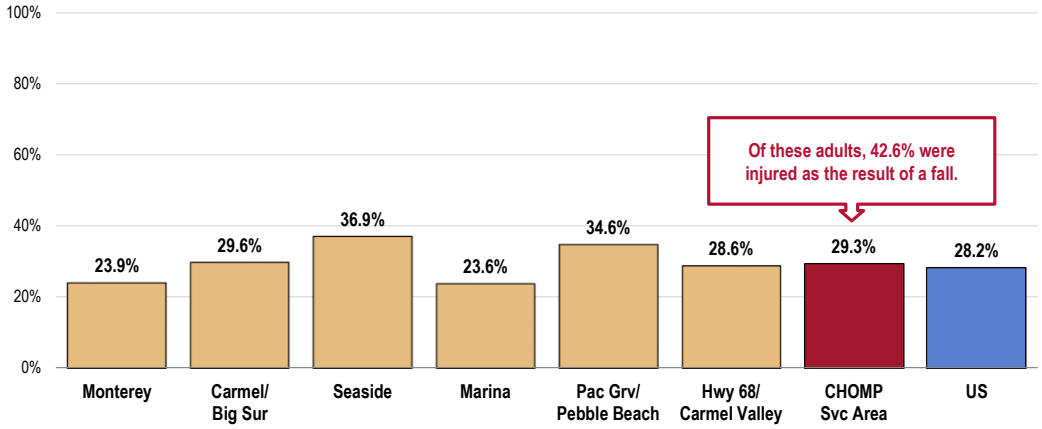
Sources: ● 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 125]
Notes: ● Asked of all respondents age 45+.

- The prevalence of adults age 45+ who fell at least once in the past year is similar to the national proportion.
- Statistically higher in Seaside.

Among those who fell in the past year, 42.6% were injured as a result of the fall.

Fell One or More Times in the Past Year

(Among Respondents Age 45 and Older)



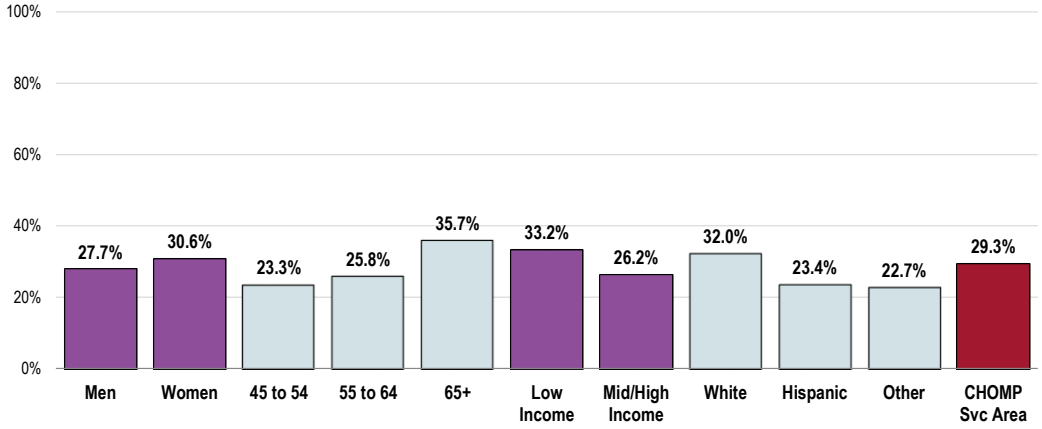
Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 125, 126]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of those respondents age 45 and older.

- Of the service area adults age 45+, seniors (65+) were more likely to have fallen in the past year (positive correlation with age).

Fell One or More Times in the Past Year

(Among Respondents Age 45 and Older; CHOMP Service Area, 2016)



Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 125]

Notes:
- Asked of those respondents age 45 and older.
- 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. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Firearm Safety

Age-Adjusted Firearm-Related Deaths

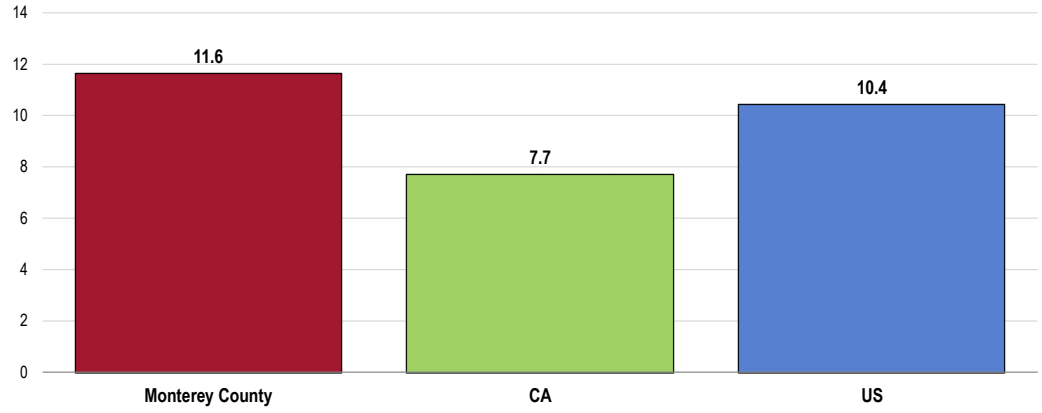
Between 2012 and 2014, there was an annual average age-adjusted rate of 11.6 deaths per 100,000 population due to firearms in Monterey County.

- Higher than found statewide and nationally.
- Fails to satisfy the Healthy People 2020 objective (9.3 or lower).

Firearms-Related Deaths: Age-Adjusted Mortality

(2012-2014 Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 9.3 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 April 2016.
- 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.

Intentional Injury (Violence)

Age-Adjusted Homicide Deaths

Between 2012 and 2014, there was an annual average age-adjusted homicide rate of 9.5 deaths per 100,000 population in Monterey County.

- Less favorable than both the state and national rates.
- Fails to satisfy the Healthy People 2020 target of 5.5 or lower.

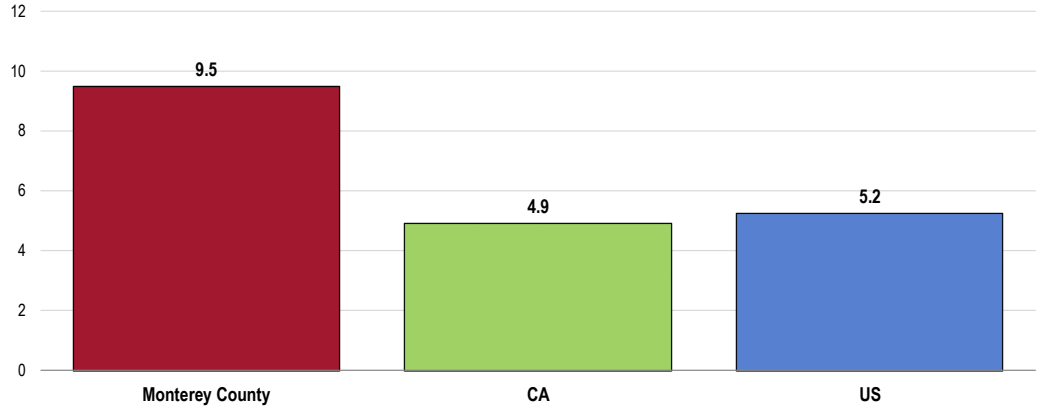
RELATED ISSUE:

See also *Suicide* in the **Mental Health** section of this report.

Homicide: Age-Adjusted Mortality

(2012-2014 Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 5.5 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 April 2016.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IVP-29]

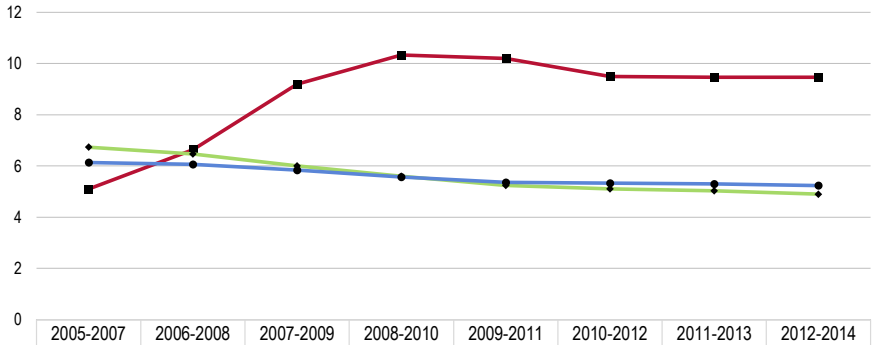
Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

- TREND: Since 2005, the homicide rate in Monterey County has increased significantly: in contrast, the California and US rates have slowly declined over time.

Homicide: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 5.5 or Lower



	2005-2007	2006-2008	2007-2009	2008-2010	2009-2011	2010-2012	2011-2013	2012-2014
Monterey County	5.1	6.6	9.2	10.3	10.2	9.5	9.5	9.5
CA	6.7	6.5	6.0	5.6	5.2	5.1	5.0	4.9
US	6.1	6.1	5.8	5.6	5.4	5.3	5.3	5.2

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2016.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IVP-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 US Standard Population.

Violent Crime

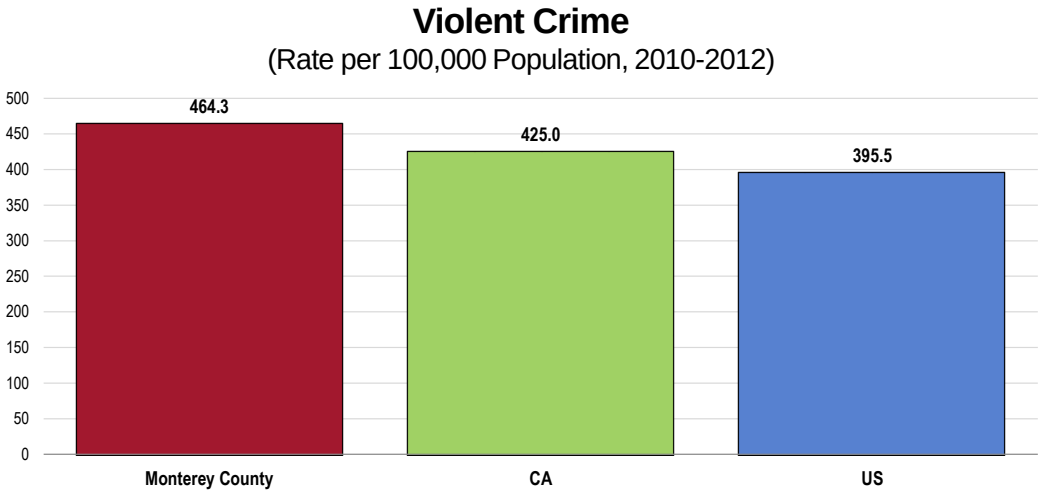
Violent Crime Rates

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.

Between 2010 and 2012, there were a reported 464.3 violent crimes per 100,000 population in Monterey County.

- Less favorable than the California and national rates for the same time period.



Sources:
- Federal Bureau of Investigation, FBI Uniform Crime Reports.
- Retrieved April 2016 from Community Commons at http://www.chna.org.

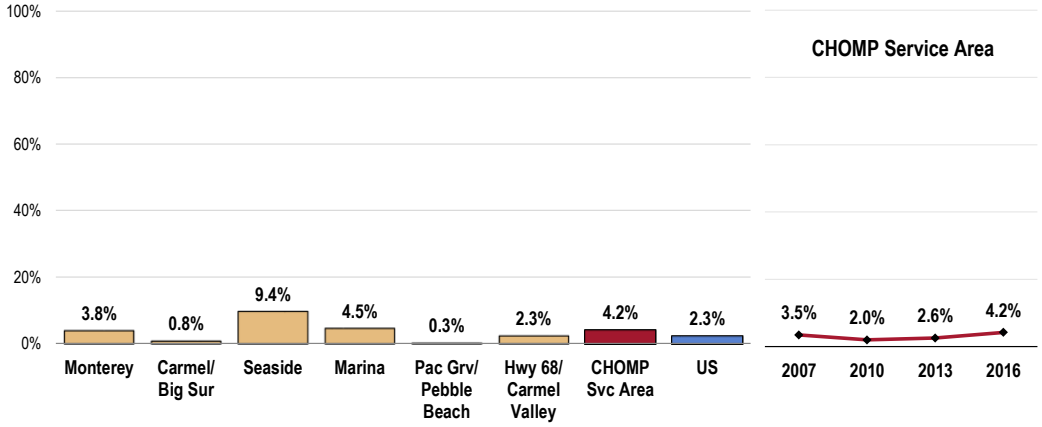
Notes:
- This indicator reports the rate of violent crime offenses reported by the sheriff's office or county police department per 100,000 residents. Violent crime includes homicide, rape, robbery, and aggravated assault. This indicator is relevant because it assesses community safety.
- Participation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

Community Violence

A total of 4.2% of surveyed CHOMP Service Area adults acknowledge being the victim of a violent crime in the area in the past five years.

- Worse than national findings.
- Highest in Seaside.
- TREND: Has not varied significantly over time.

Victim of a Violent Crime in the Past Five Years

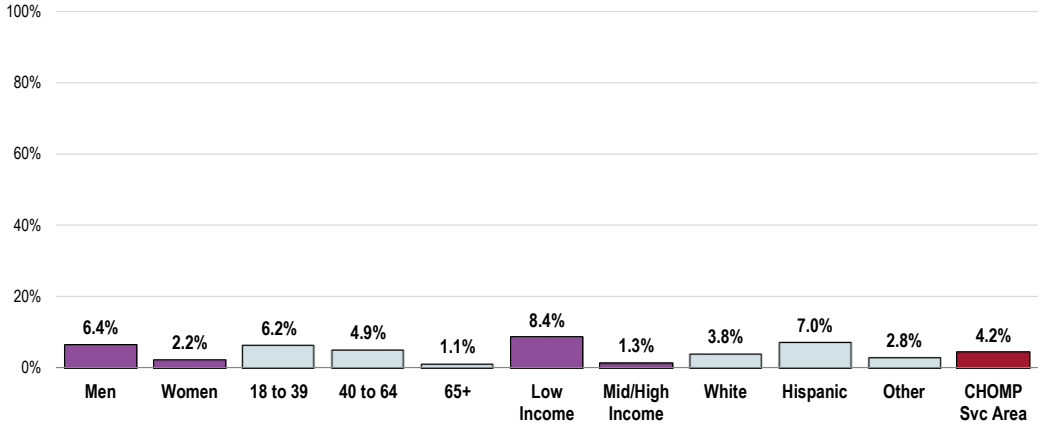


Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 49]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

- Reports of violence are notably higher among men, adults under age 65, and residents living with lower incomes.

Victim of a Violent Crime in the Past Five Years
(CHOMP Service Area, 2016)



Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 49]

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. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Family Violence

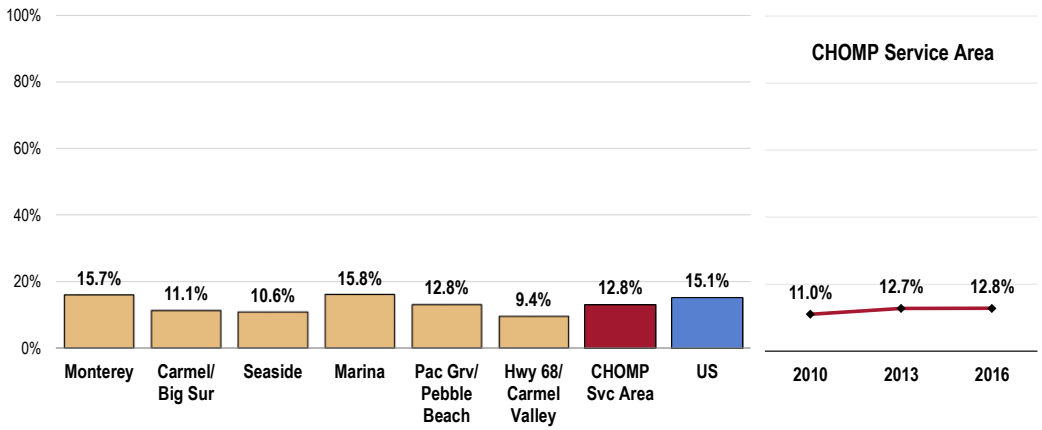
A total of 12.8% of CHOMP Service Area adults acknowledge that they have ever been hit, slapped, pushed, kicked, or otherwise hurt by an intimate partner.

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."

- Comparable to national findings.
- No statistical difference by community.
- TREND: Over time, reports of domestic violence have remained statistically unchanged.

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. [Item 50]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

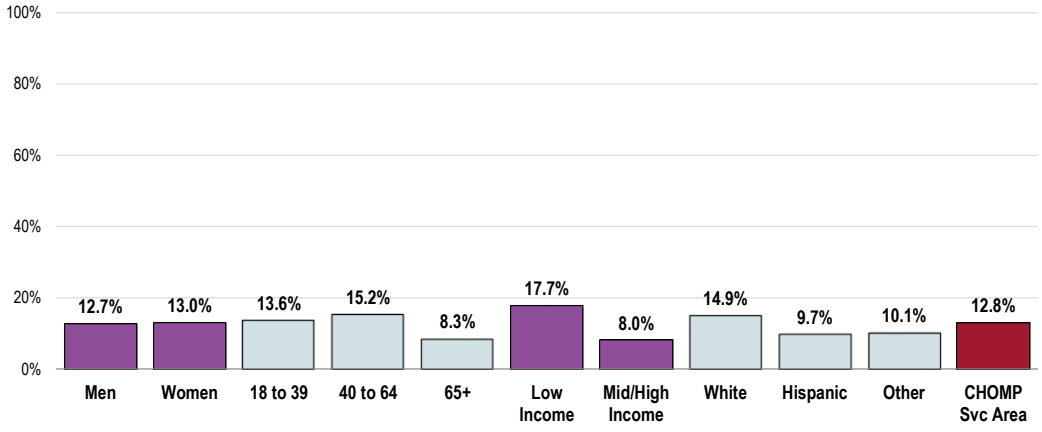
Notes:
- Asked of all respondents.

Reports of domestic violence are also higher among:

- Adults between the ages of 40 and 64.
- Those with lower incomes.

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

(CHOMP Service Area, 2016)



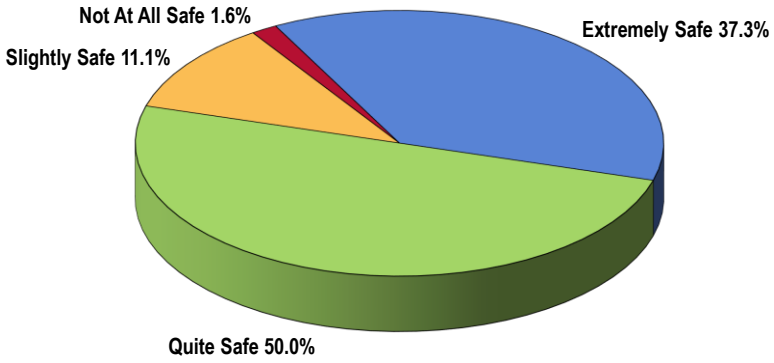
Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 50]

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. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Perceived Neighborhood Safety

While most CHOMP Service Area adults consider their own neighborhoods to be "extremely safe" or "quite safe," 12.7% consider it "not at all safe" or only "slightly safe."

Perceived Safety of Own Neighborhood
(CHOMP Service Area, 2016)

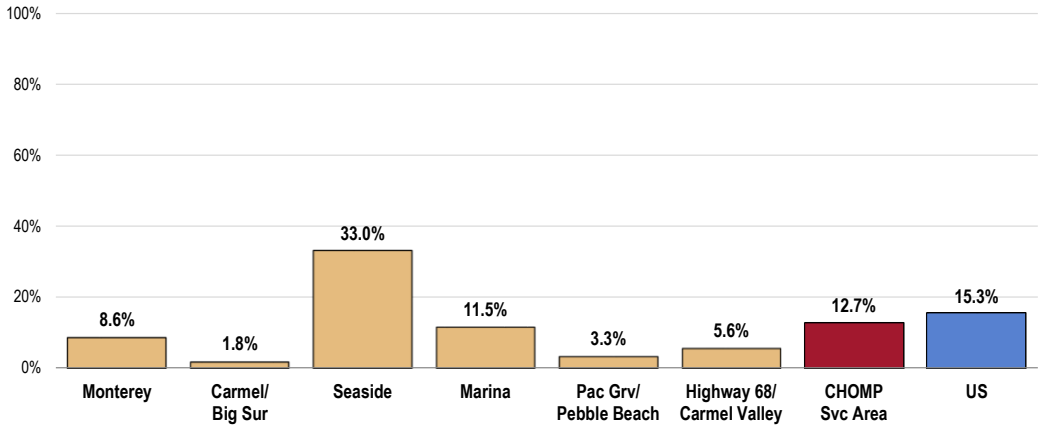


Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 48]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

- Similar to the US prevalence.
- By community, nearly one-third of Seaside residents consider their neighborhoods to be unsafe.

Perceive Own Neighborhood as "Slightly" or "Not At All" Safe



Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 48]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

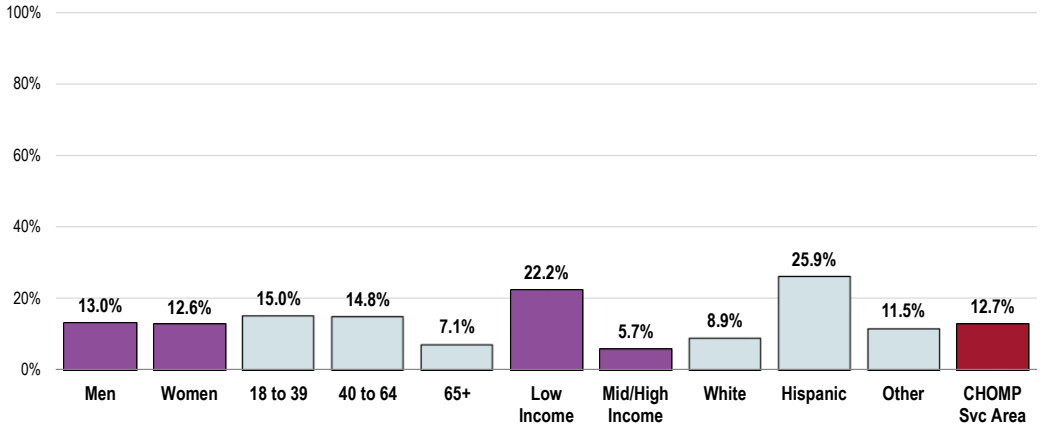
Notes:
- Asked of all respondents.

Reports of unsafe neighborhoods are notably higher among these residents:

- Adults under age 65.
- Lower income.
- Hispanics.

Perceive Own Neighborhood as "Slightly" or "Not At All" Safe

(CHOMP Service Area, 2016)



Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 48]

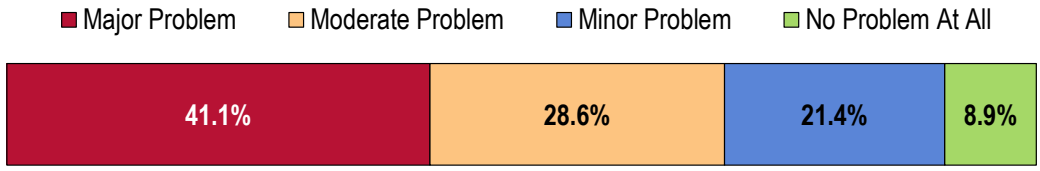
Notes:
- Asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Key Informant Input: Injury & Violence

The largest share of key informants taking part in an online survey characterized *Injury & Violence* as a "major problem" in the community.

Perceptions of Injury and Violence as a Problem in the Community

(Key Informants, 2016)



Sources:
- PRC Online Key Informant Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

Top Concerns

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

Incidence/Prevalence

High rate of violent crime and homicides in the Salinas area. – Social Services Provider

People always talk about violence being a concern in their communities. – Public Health Representative

East Salinas continues to live with violence on a weekly basis. – Community/Business Leader

Major problems in Salinas area, part of our larger community. One of highest murder rates in country. – Physician

Salinas has major issues with youth violence and gang issues. Injury is always a concern, especially vehicular accidents, increase in texting related accidents. – Community/Business Leader

Crime, vandalism and homicide are rampant and in the news all the time. It may not be as high as it has often been, but it is still too high the way it is. Anecdotal reports fully support the existence of this problem. – Community/Business Leader

Increase in violent crimes, gangs and bullying. – Social Services Provider

Safety, security and public health risks and hazards. – Physician

We live in a community where we value more the prison business than the investment in its members. We lack youth programs, affordable housing, and job trainings among other issues that could help the residents be successful, so our youth ends up in prison. – Social Services Provider

With Salinas being one of the top cities with the highest murder and gang violence, it spreads to neighboring communities. – Social Services Provider

This is just from following the news. It seems that violence is on the rise. – Community/Business Leader

Our community has experienced a growing violence problem. There are not enough programs to keep kids out of the streets. Many have been injured or lost their lives due to violence in the community. – Public Health Representative

Violence is a major issue in the county, and specifically in Salinas. Shootings and gang related activity take place regularly. – Public Health Representative

Most years Monterey has the highest, or one of the highest youth homicide rates in the Nation. A 2015 Report published by the University of California at Monterey Bay gave details of a two-year study of over 4,000 Monterey County residents. – Social Services Provider

Salinas has one of the highest rates of homicide in the US. – Physician

Violence is endemic and pervasive. Anger is one of the few emotions that our culture encourages men to express. As a society we do not raise children well. Many men need help un-learning the lessons they were taught about what it means to be a real man. – Social Services Provider

Salinas holds the unfortunate title of having the highest violence rate amongst male youth up to age 24. Most of this violence is gang related. Unfortunately this is now also affecting south county cities and neighboring Watsonville communities. – Public Health Representative

Record homicides last year of 40. Total gun and penetrating trauma incidents were up 150%. – Community/Business Leader

Gang Violence

Gang violence and collateral damage. Kids and youth growing up with little or no family support and, or community connectedness. Vehicle accidents from distracted driving and driving under the influence. – Public Health Representative

Gang violence throughout Monterey County. – Public Health Representative

Gang violence. – Public Health Representative

Gang violence in Salinas. – Physician

Our youth involved in gangs. Parents working long hours, not home, kids alone unsupervised so a lot of times these kids join gangs. – Public Health Representative

Gang related. – Community/Business Leader

Incidence of gang violence seems to be ongoing problem. – Community/Business Leader

High crime rate due to gang related violence. – Physician

Horrific gang violence. Occupational injuries. – Physician

Salinas has a horrible gang problem as well as a community that is afraid to speak up and identify gang members. Too much violent television, movies and video games teach kids a culture of violence. Cell phone use while driving. – Community/Business Leader

Gangs and illegal drug activity. – Other Health Provider

Gang violence and domestic violence are issues that our child clients in Salinas and South County experience on a daily basis. – Community/Business Leader

The gangs in Salinas are a major problem, needs no more comment. – Social Services Provider

Salinas Valley/Monterey County is a dangerous place to live. Gangs and random acts of violence are a big problem. – Community/Business Leader

The gang and drug culture are spreading throughout our community. Once naively thought to be localized to the Salinas Valley, it is now clearly present in Seaside as well as other areas of the peninsula and outlying cities such as Castroville and Watsonville. – Community/Business Leader

Gun violence and gangs are a big problem in Salinas and areas on the peninsula. Breakdown of family and family values. Poor education. – Physician

Accidental Injuries

Increasing volume of visitors to the area bring in increased numbers of accidental injuries like drowning, auto injuries, as well as the spill-over from increased violent actions in Salinas. – Physician

Contributing Factors

Poverty, lack of community resources providing alternatives to crime and the two state prisons in South Monterey County. – Community/Business Leader

Drugs and mental health issues. Little behavioral health access. – Social Services Provider

Health Education

The underlying social and educational problems are not being addressed. Some people feel excluded from the "American Dream" and seek acceptance and success in a different subculture. – Public Health Representative

Work Conditions

We have adults in our programs that have been injured on the job or at home. We also have single parents who have children who participate in our programs who have been witness to violence at home or in their environment. – Community/Business Leader

Domestic Violence

Abuse and sexual violence affecting women and children. Seen as a "domestic" problem and not a societal issue and concern. – Community/Business Leader

Diabetes

About 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.

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.

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)

Age-Adjusted Diabetes Deaths

Between 2012 and 2014, there was an annual average age-adjusted diabetes mortality rate of 20.0 deaths per 100,000 population in Monterey County.

- Similar to the California rate.
- Statistically more favorable than found nationally.
- Similar to the Healthy People 2020 target (20.5 or lower, adjusted to account for diabetes mellitus-coded deaths).

Diabetes: Age-Adjusted Mortality

(2012-2014 Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 20.5 or Lower (Adjusted)

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2016.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective D-3]

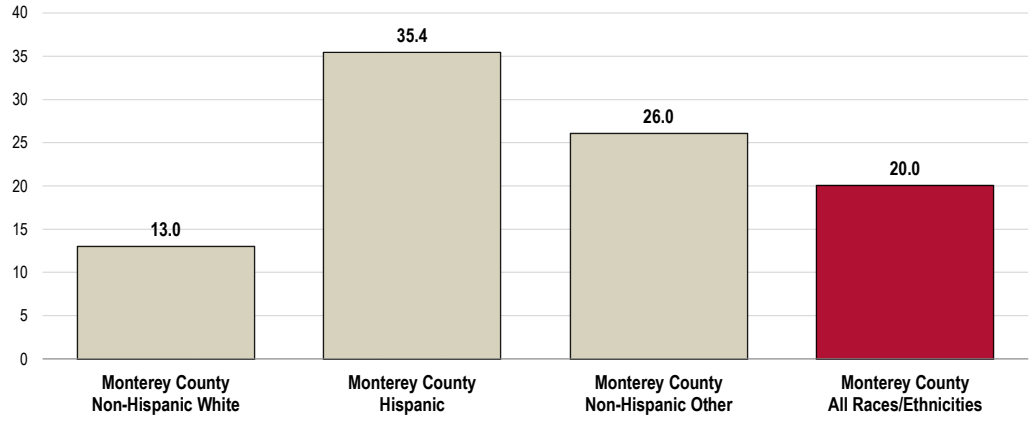
Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
- The Healthy People 2020 target for Diabetes is adjusted to account for only diabetes mellitus coded deaths.

- The diabetes mortality rate in Monterey County is notably higher among Hispanics.

Diabetes: Age-Adjusted Mortality by Race

(2012-2014 Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 20.5 or Lower (Adjusted)



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2016.
- 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 US Standard Population.
- The Healthy People 2020 target for Diabetes is adjusted to account for only diabetes mellitus coded deaths.

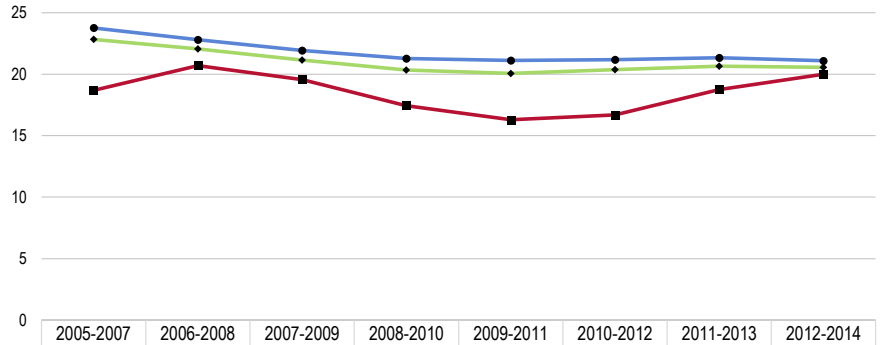
- TREND: No clear diabetes mortality trend is apparent in Monterey County. The state

and national rates have decreased slightly since 2005.

Diabetes: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 20.5 or Lower (Adjusted)



	2005-2007	2006-2008	2007-2009	2008-2010	2009-2011	2010-2012	2011-2013	2012-2014
Monterey County	18.7	20.7	19.6	17.4	16.3	16.7	18.8	20.0
CA	22.8	22.1	21.2	20.3	20.1	20.4	20.7	20.6
US	23.8	22.8	21.9	21.3	21.1	21.2	21.3	21.1

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2016.
- 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 US Standard Population.
- The Healthy People 2020 target for Diabetes is adjusted to account for only diabetes mellitus coded deaths.

Prevalence of Diabetes

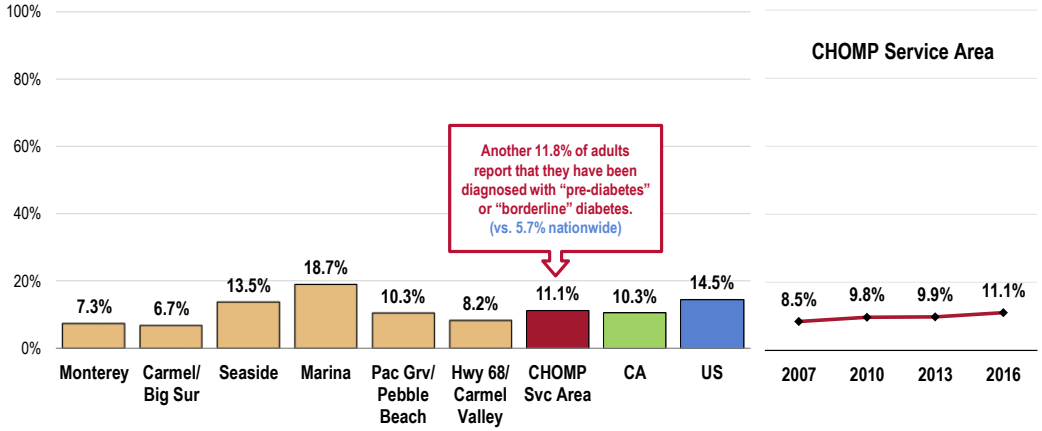
A total of 11.1% of CHOMP Service Area adults report having been diagnosed with diabetes.

- Similar to the statewide proportion.
- Better than the national proportion.
- Most prevalent in Marina.
- TREND: Statistically unchanged since 2007.

In addition to the prevalence of diagnosed diabetes referenced above, another 11.8% of CHOMP Service Area adults report that they have "pre-diabetes" or "borderline diabetes."

- Higher than the US prevalence.
- Highest in Marina (not shown).

Prevalence of Diabetes



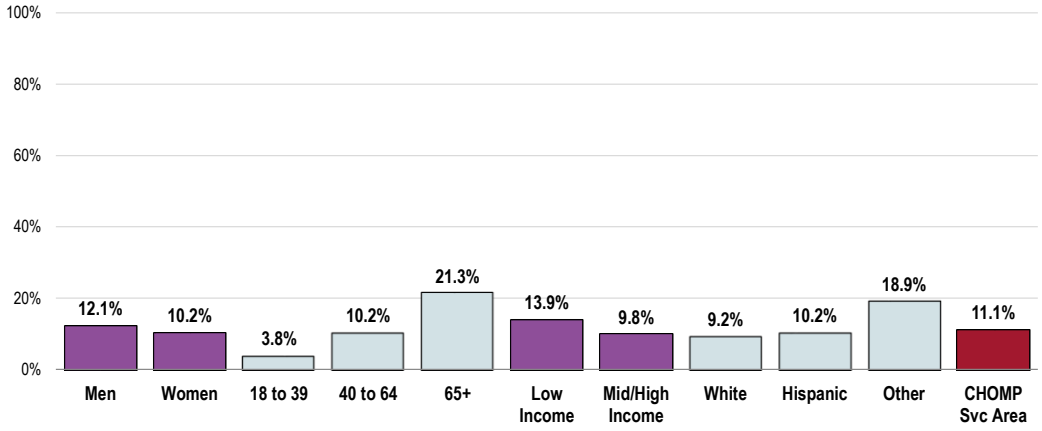
Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 158]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2014 California data.

Notes:
- Asked of all respondents.

A higher prevalence of diagnosed diabetes (excluding pre-diabetes or borderline diabetes) is reported among:

- Older adults (note the strong positive correlation between diabetes and age, with 21.3% of seniors with diabetes).
- "Other" race adults.

Prevalence of Diabetes
(CHOMP Service Area, 2016)



Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 158]

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. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
- Excludes gestational diabetes (occurring only during pregnancy).

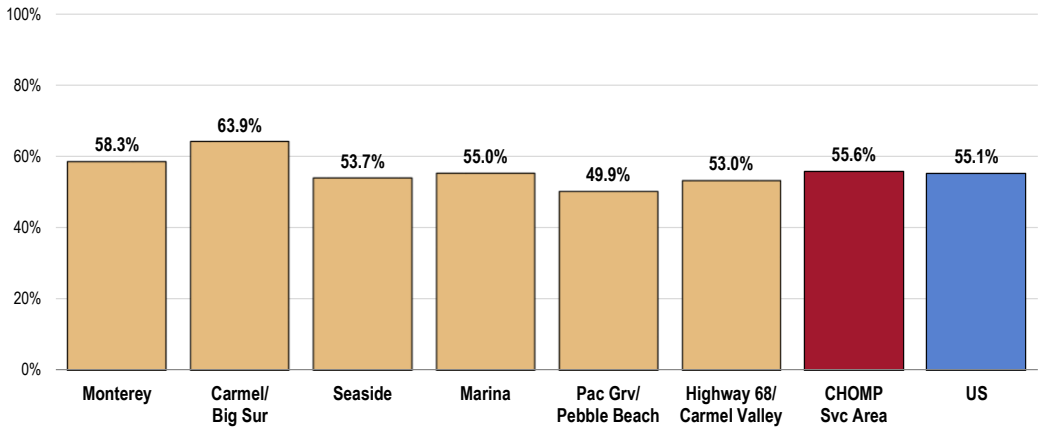
Diabetes Testing

Of area adults who have <u>not</u> been diagnosed with diabetes, 55.6% report having had their blood sugar level tested within the past three years.

- Similar to the national proportion.
- Statistically similar by community.

Have Had Blood Sugar Tested in the Past Three Years

(Among Nondiabetics)



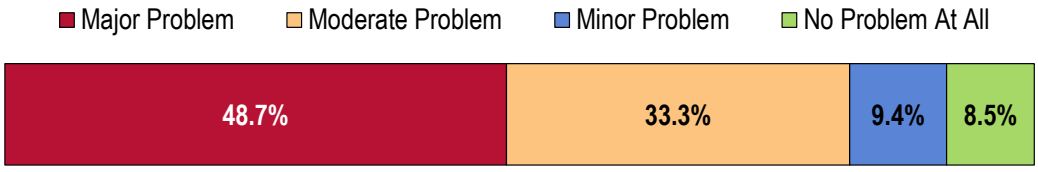
Sources: ● 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 39]
● 2015 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Asked of respondents who have not been diagnosed with diabetes.

Key Informant Input: Diabetes

A high percentage of key informants taking part in an online survey characterized *Diabetes* as a "major problem" in the community.

Perceptions of Diabetes as a Problem in the Community

(Key Informants, 2016)



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

Challenges

Among those rating diabetes as a "major problem," the biggest challenges for people with diabetes are seen as:

Health Education

Access to diabetic education. – Other Health Provider

Education, access to service and willingness to participate in available programs. – Social Services Provider

Education and prevention, cost. Though there is more awareness these days of the problems associated with diabetes and obesity that often causes it, diet is a major challenge in many poor households. People face the challenge of knowing how to make better choices. – Community/Business Leader

Lack of education/awareness about health habits and resources, cultural barriers influencing health and behavior. – Community/Business Leader

Training people to understand how to deal with their diabetes, cultures and cost. – Community/Business Leader

Prevention of Type II Diabetes due to deficiencies in nutrition and physical activity. Cost of treatment, cost of untreated complications. – Social Services Provider

Education, monitoring and mentoring. – Community/Business Leader

Information and education. – Social Services Provider

Lack of education, linguistic and cultural barriers regarding nutrition, and poverty. Healthy food is more expensive and it is absurd to tell people to eat things they don't usually eat and can't afford. Hispanic population is disproportionately affected. – Physician

Education on how to prevent and reduce diabetes type two. – Community/Business Leader

Education and prevention. – Other Health Provider

Challenges for people with, or at risk for, diabetes include education about, and access to, affordable, easy, nutritious meal preparation for those people and families who are able to prepare food.- Social Services Provider

Access to Care/Services

Understanding that they need the assistance and having it affordable to them. – Social Services Provider

Lack of care, appointments, transportation and education. Some clients cannot read or write Spanish or English. – Public Health Representative

Uninsurable residents don't have access to needed care or medication. – Social Services Provider

Lack of endocrinology for expert management of difficult cases. – Physician

Lack of programs and providers dedicated to diabetes. Variation in approaches and treatment, rather than community adoption of best practices. – Community/Business Leader

Getting patients in to see endocrinologists in timely manner. – Physician

Due to access challenges, individuals needing initial appointment to become an established patient and ongoing appointments are having to wait weeks before being able to be seen by primary care doctors. – Public Health Representative

Access to specialist. Primary providers unwilling to refer their patients with uncontrolled diabetes to Endocrinologist, Diabetes specialist. Patients are unable to refer themselves to specialist when it is obvious they need help. – Other Health Provider

Not having the resources or insurance to pay for medication. – Social Services Provider

Incidence/Prevalence

Diabetes has become pervasive in our society and it affects your entire state of health. Obesity is one of the problems but it is a large problem. – Social Services Provider

Again, I see this through my company and my brother has diabetes. – Community/Business Leader

There is a significant problem with obesity in our community as in much of the US which has led to increased incidence of Type II diabetes. – Physician

Diagnosis/Treatment

No preventative care, environments that do not allow for healthy eating and physical activity, difficulty for those with diabetes to follow what to do. – Public Health Representative

Early intervention in lifestyle. Nutrition and activity level to control pre-diabetes. – Community/Business Leader

Early detection and education. Obesity. – Social Services Provider

Disease Management

I believe the biggest challenge(s) for people with diabetes in our community, in any community actually, is the ability to make long term changes that result in weight loss and thus disease management. – Community/Business Leader

Getting them to stop drinking sodas. – Physician

Following up on care regimens. – Physician

Resources to manage it and life style change support. – Community/Business Leader

Nutrition

Food choice changes. – Community/Business Leader

Learning how to eat right and what consumption of fatty foods and sugar can due to oneself. – Community/Business Leader

Nutritional counseling and access to healthy, affordable dietary options. Also inadequate endocrinology providers. – Physician

Diet/Exercise

Healthy eating and exercise. Sustained behavior change. Cost of and access to healthy foods and safe, inexpensive ways to exercise. – Public Health Representative

Weight loss. – Physician

Healthy food is more expensive than cheap fast food. Working families have little time to plan and cook healthy meals. Some neighborhoods aren't safe for children to play outside, or working parents aren't. – Community/Business Leader

Obesity

Because of more obesity, we see diabetes in children more and younger people. Hard to diagnose. My opinion is that more preventative exercise and diet could prevent a lot of diabetes. Challenge would be whether to become life-long dependent on drugs. – Community/Business Leader

Common obesity. – Physician

Poverty

Poverty, lack of medical insurance and access to health care services. – Public Health Representative

Poverty can lead to poor diet which contributes to diabetes. – Social Services Provider

Access to Culturally Relevant Services

Lack of culturally and linguistically friendly pre-diabetes and diabetes education and management programs, starting in elementary school. – Public Health Representative

Proper education, bilingual Spanish and education, one time is not enough. Family involvement in education is culturally important. Cost of medications. Complex system doesn't support a quick consult from a qualified professional. – Social Services Provider

Access to Providers

Lack of endocrinologists. There is a need for more diabetic education locations beyond what is offered at present time. – Physician

Vulnerable Populations

Diabetes is very prevalent in the Hispanic community and is a risk factor for other issues. There is a need for more education in regards to diet and managing and avoiding this condition. – Community/Business Leader

Alzheimer's Disease

About Dementia

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.

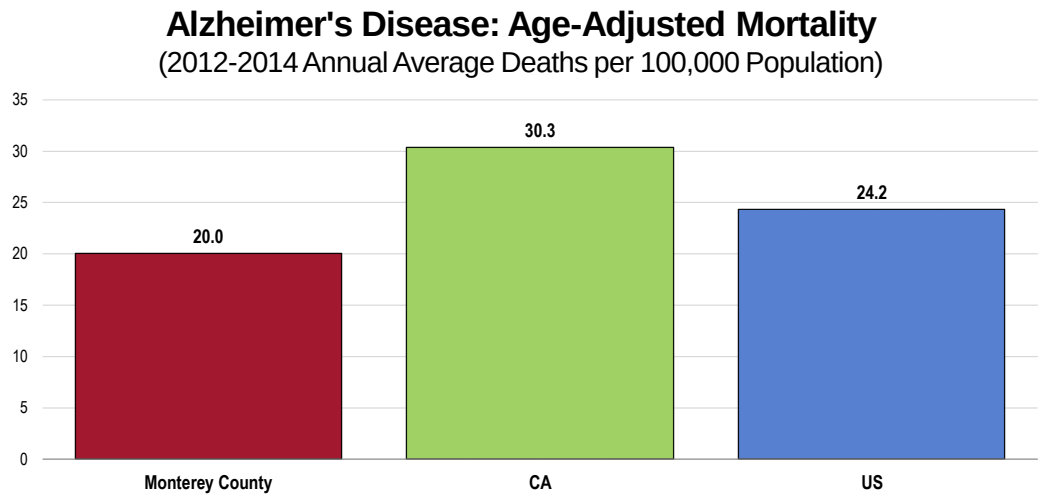
Alzheimer's disease is the 6th leading cause of death among adults age 18 years and older. Estimates vary, but experts suggest that up to 5.1 million Americans age 65 years and older have Alzheimer's disease. These numbers are predicted to more than double by 2050 unless more effective ways to treat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

- Healthy People 2020 (www.healthypeople.gov)

Age-Adjusted Alzheimer's Disease Deaths

Between 2012 and 2014, there was an annual average age-adjusted Alzheimer's disease mortality rate of 20.0 deaths per 100,000 population in Monterey County.

- More favorable than the statewide and national rates.



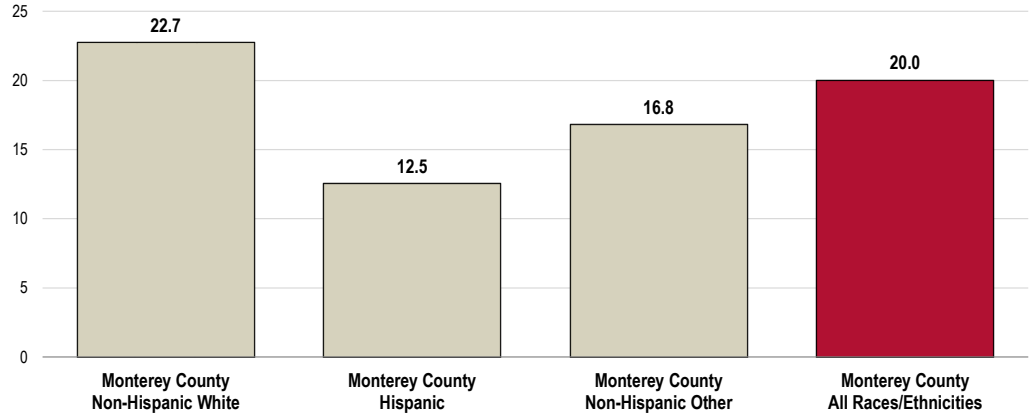
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2016.

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.

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

Alzheimer's Disease: Age-Adjusted Mortality by Race

(2012-2014 Annual Average Deaths per 100,000 Population)



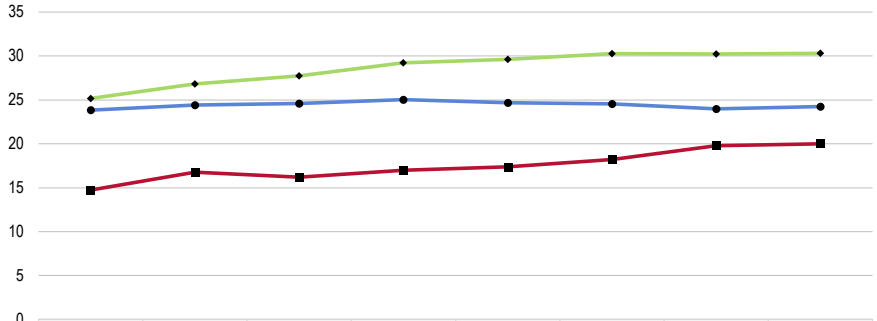
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2016.

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.

- TREND: The Alzheimer's disease mortality rate in Monterey County has trended upward over the past decade. The California rate has increased as well, while across the US the rate has remained constant.

Alzheimer's Disease: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)



	2005-2007	2006-2008	2007-2009	2008-2010	2009-2011	2010-2012	2011-2013	2012-2014
Monterey County	14.7	16.8	16.2	17.0	17.4	18.2	19.8	20.0
CA	25.2	26.8	27.7	29.2	29.6	30.3	30.2	30.3
US	23.8	24.4	24.6	25.0	24.7	24.5	24.0	24.2

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2016.

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.

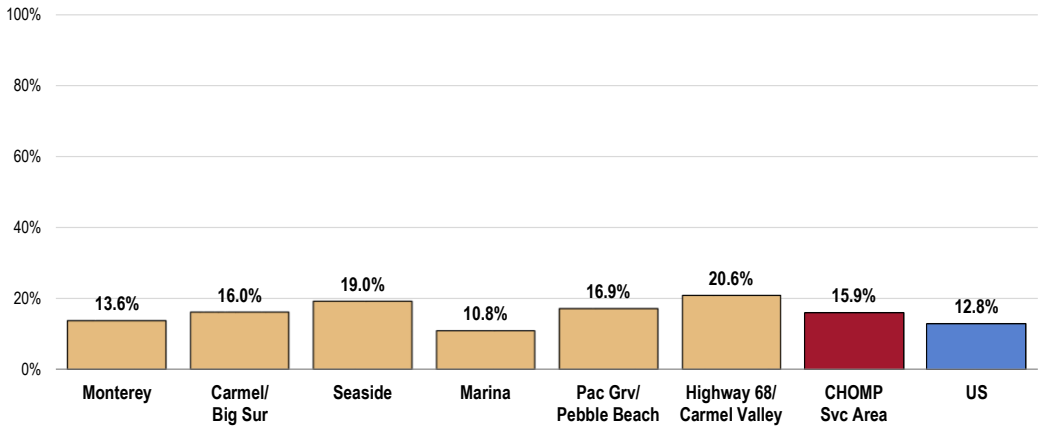
Progressive Confusion/Memory Loss

A total of 15.9% of adults age 45 and older report experiencing confusion or memory loss in the past year that is happening more often or getting worse.

- Statistically comparable to the US prevalence.
- Lowest in Marina.

Experienced Increasing Confusion/Memory Loss in Past Year

(Among Respondents Age 45 and Older)



Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 127]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

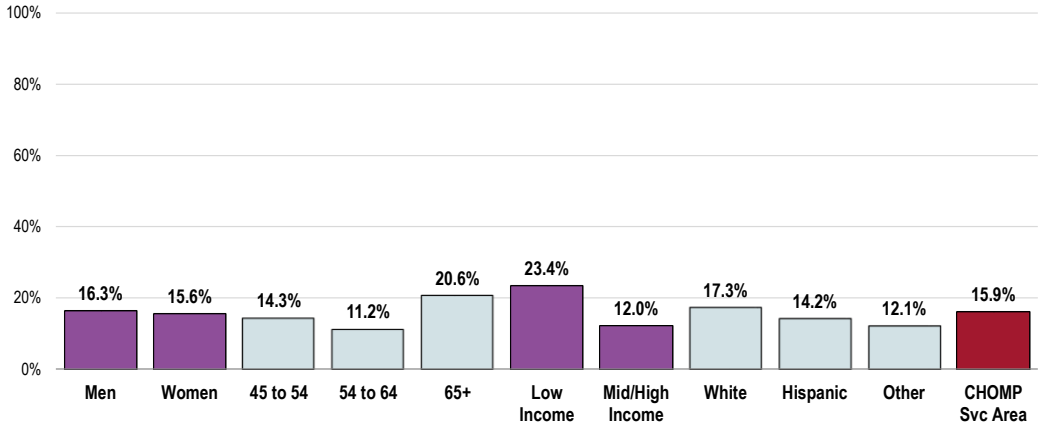
Notes:
- Asked of those respondents age 45 and older.

A higher prevalence of progressive confusion/memory loss is reported among:

- Seniors (65+).
- Low-income residents.

Experienced Increasing Confusion/Memory Loss in Past Year

(Among Respondents Age 45 and Older; CHOMP Service Area, 2016)



Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 127]

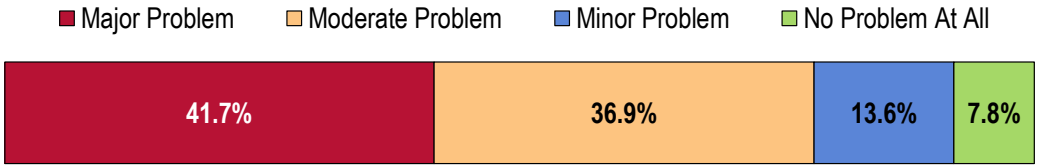
Notes:
- Asked of those respondents age 45 and older.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Key Informant Input: Dementias, Including Alzheimer's Disease

Key informants taking part in an online survey are most likely to consider *Dementias, Including Alzheimer's Disease* as a "major problem" in the community.

Perceptions of Dementia/Alzheimer's Disease as a Problem in the Community

(Key Informants, 2016)



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

Top Concerns

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

Aging Population

The growing number of seniors that will only increase each year. – Social Services Provider

As our population lives longer, dementia becomes more of a problem. Since we live longer the problem necessarily is increasing. – Community/Business Leader

Older population. – Physician

We have a very senior-aged population in greater Carmel. Many of my patients seem to have major barriers to access to care and services regarding same for them or their spouse. – Physician

It is a concern for those of us with aging parents and the need for caretakers. – Community/Business Leader

We have a senior growing population in our community with limited income. A great majority of them don't have family here so they are dealing with their health issues on their own. Some of them have early signs of the disease or spouses who have it. – Community/Business Leader

In my business this is the biggest problem that I see. We take care of the elderly and 90% of my clients have some form of dementia/Alzheimer's. – Community/Business Leader

The aging population, families not equipped to handle family member with dementia/Alzheimer's. Cost for service. – Community/Business Leader

Aging community, lack of services. – Social Services Provider

With an aging population and the demographics on the Monterey Peninsula, it is pervasive, as people age, may get Alzheimer's and most ultimately get dementia and in this case, there is no cure. So it is even scarier than cancer. – Social Services Provider

Aging population and few service/support centers in county. – Community/Business Leader

Increasing number of seniors in the community who suffer with the disease of Alzheimer's and dementia. – Social Services Provider

We have an elderly population and many are affected with Dementia, Alzheimer's which leads to a multitude of other problems such as proper care. – Community/Business Leader

Higher average age of the community with large retired community leading to higher rate. – Physician

Incidence/Prevalence

There are a lot of seniors and many are dealing with this issue. I see many with I believe to be substandard care and it is very difficult to fund adequate resources. – Community/Business Leader

More and more people get it now and there is no cure. It is a disease that affects family and caregivers as well. I think most people have trouble diagnosing the issues in their own family members. – Community/Business Leader

I see it in my practice. This population is getting older. – Physician

Huge number of people with dementia. Extremely difficult for families. People become isolated. Extremely expensive to care for these people. – Physician

These conditions are major health concerns nationally and even beyond. There is still much research to be done but the incidence of these conditions continues to rise each year. – Community/Business Leader

I see it happening. – Social Services Provider

I see an abundance of patients with dementia and Alzheimer's diagnosis and very limited resources for them and their caregivers. There are even less options for housing or care if they do not have a family or private caregiver. – Community/Business Leader

Very common diagnosis now. – Public Health Representative

Affordable Care/Services

Lack of ongoing funds to provide respite services, lack of affordable adult day care in South County area. Need to increase community awareness to support caregiver burn out. – Social Services Provider

We have an increasing number of seniors in this community who are unable to access or afford care. There are insufficient and few affordable senior living programs that include sufficient medical and mental care. In-home care is poor, expensive. – Social Services Provider

I am unaware of any free/low cost resources for the poor for this disease. – Social Services Provider

A Dementia, Alzheimer's patient requires 24 hour care as they progress in their disease. People cannot afford assistance, so they have to stay home to care for their loved one, so they can't work. – Community/Business Leader

Diagnosis/Treatment

It's the access to timely diagnosis and supportive care at home that is a problem. Many older adults have no long term care insurance and no plan for help when they need it. Families are not cohesive or engaged, and often not local. – Community/Business Leader

Often misunderstood and misdiagnosed. Training and care unaffordable without coverage. – Social Services Provider

Long term care needs for elderly population. – Physician

Impact on Families/Caregivers

Exacts tremendous toll on the family caregivers. – Physician

The care for an individual with this disease requires the continued presence of a caretaker. The majority of families do not have the resources to pay for a caretaker or stay at home 24/7. The conditions of institutionalized care are poor. – Public Health Representative

Treatment of depression due to caregiver burden or burnout. Lack of emotional support services to caregivers that are not able to get away from their care-receiver. Need to have some kind of call in web cam support program that caregivers can access. – Social Services Provider

Access to Care/Services

There are not a lot of places to treat patients with dementia or Alzheimer's. Very minimal internal medications providers out there. Uninsured or under insured patients will often not seek medical care. – Public Health Representative

Health Education

Awareness and cultural acceptance of the condition. – Social Services Provider

Lack of education. – Public Health Representative

Language Barrier

There is not enough bilingual support in Spanish. – Public Health Representative

Kidney Disease

About Chronic 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)

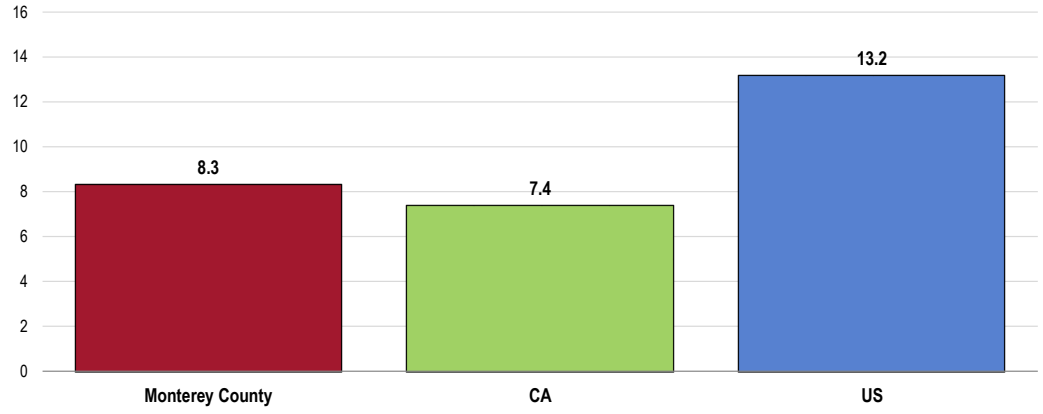
Age-Adjusted Kidney Disease Deaths

Between 2012 and 2014 there was an annual average age-adjusted kidney disease mortality rate of 8.3 deaths per 100,000 population in Monterey County.

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

Kidney Disease: Age-Adjusted Mortality

(2012-2014 Annual Average Deaths per 100,000 Population)



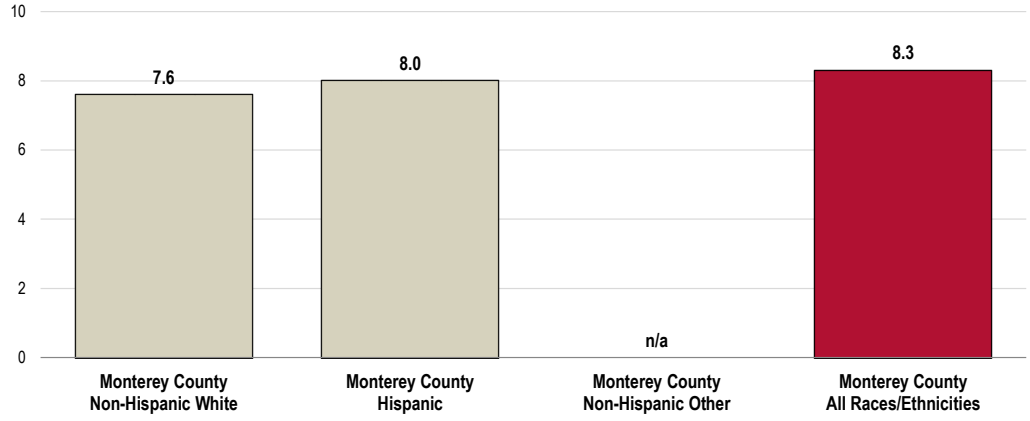
Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2016.

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.

- The kidney disease mortality rate in Monterey County appears similar among Non-Hispanic Whites and Hispanics.

Kidney Disease: Age-Adjusted Mortality by Race

(2012-2014 Annual Average Deaths per 100,000 Population)



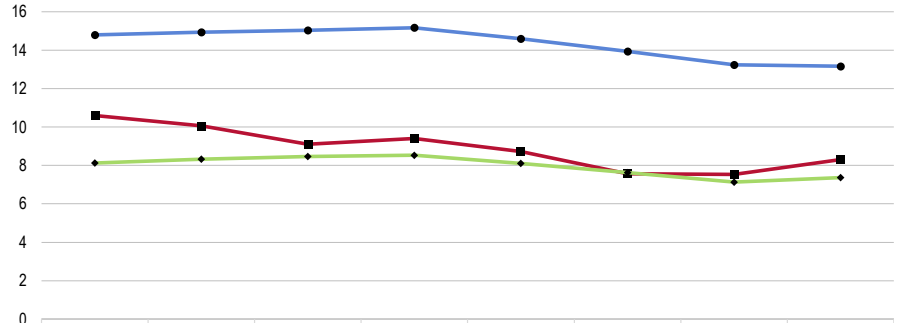
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2016.

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.

- TREND: Despite fluctuation, the death rate has decreased over the past decade in Monterey County. Across the state and nation, rates have also decreased.

Kidney Disease: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)



	2005-2007	2006-2008	2007-2009	2008-2010	2009-2011	2010-2012	2011-2013	2012-2014
Monterey County	10.6	10.1	9.1	9.4	8.7	7.6	7.5	8.3
CA	8.1	8.3	8.5	8.5	8.1	7.6	7.1	7.4
US	14.8	14.9	15.0	15.2	14.6	13.9	13.2	13.2

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2016.

Notes:
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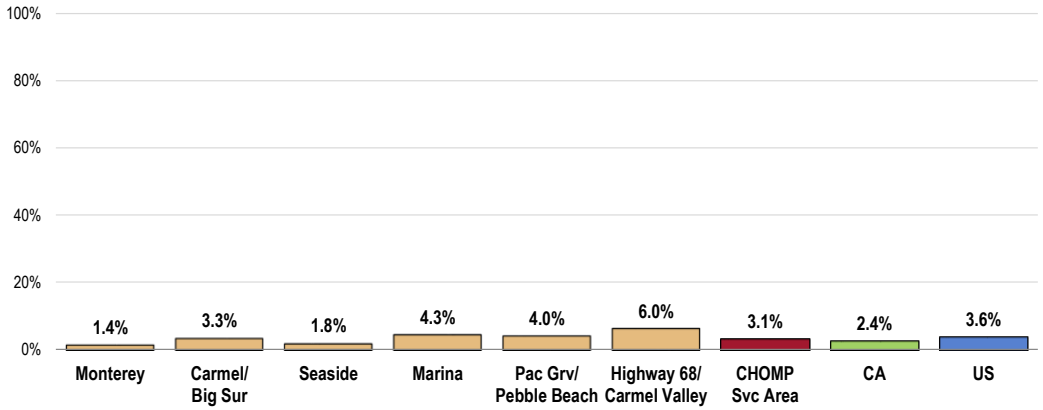
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Prevalence of Kidney Disease

A total of 3.1% of CHOMP Service Area adults report having been diagnosed with kidney disease.

- Similar to the state and national proportions.
- By community, lower in Monterey.

Prevalence of Kidney Disease

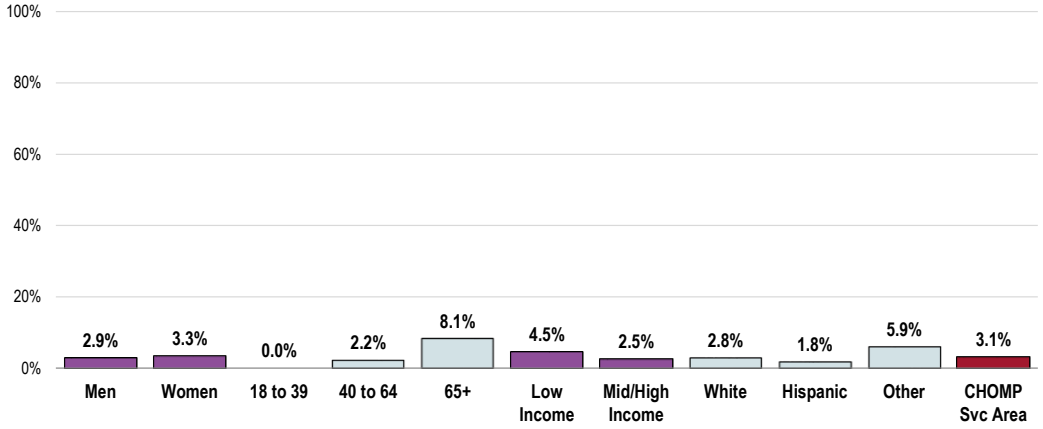


Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 32]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2014 California data.
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

- A higher prevalence of kidney disease is reported among older respondents in the CHOMP Service Area (note the positive correlation with age).

Prevalence of Kidney Disease
(CHOMP Service Area, 2016)



Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 32]

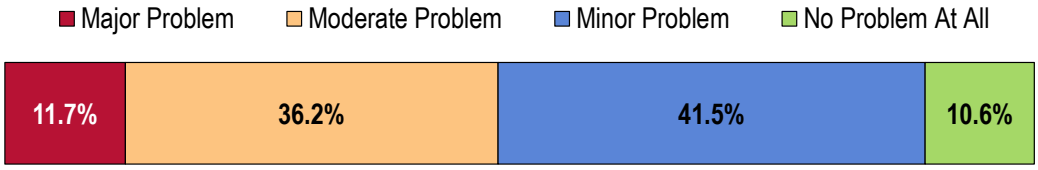
Notes:
- Asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Key Informant Input: Chronic Kidney Disease

Key informants taking part in an online survey generally characterized *Chronic Kidney Disease* as a "minor problem" in the community.

Perceptions of Chronic Kidney Disease as a Problem in the Community

(Key Informants, 2016)



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

Top Concerns

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

Access to Care/Services

Lack of access to medical resources. – Public Health Representative

Underinsured or uninsured patients usually will not see a provider unless they really have to due to cost of medical visits and testing. – Public Health Representative

Lack of educational services. – Public Health Representative

Lack of Specialists

Lack of urological services. – Physician

Shortage of urologists. An aging group of surgeons who will need to be replaced in the next few years. Only one dermatologist who will see MediCal and she is in her eighties. – Physician

Urologic care. Limited number of urologists in the community that are accepting patients. – Physician

There is shortage of Nephrologists. It takes three to six months to get appointment for my patients. Process to get a patient to be seen by a Nephrologist is quite difficult and overwhelming for both doctor and patient. – Physician

Large number of patients with diabetes and kidney disease without access to nephrology services. Blood pressure control is not at optimal target to delay kidney disease progression. – Other Health Provider

Comorbidities

Diabetes is the leading cause of Kidney Disease and is tied to both poverty and culture. Both blacks and Hispanics have a higher rate of diabetes than whites. Eleven percent of Monterey county residents had diagnosed diabetes in 2009. – Social Services Provider

Nutrition

Eating habits, diet content, and resistance to disease prevention. – Community/Business Leader

Potentially Disabling Conditions

About Arthritis, Osteoporosis & Chronic Back 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:

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

Arthritis, Osteoporosis, & Chronic Back Conditions

A total of 31.4% of CHOMP Service Area adults age 50 and older reports suffering from arthritis or rheumatism.

RELATED ISSUE:

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

- Similar to that found nationwide.

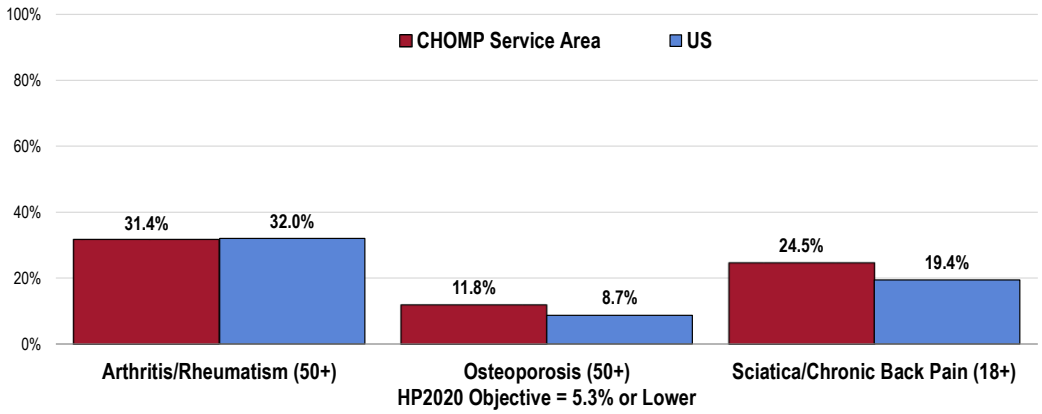
A total of 11.8% CHOMP Service Area adults age 50 and older have osteoporosis.

- Similar to that found nationwide.
- More than twice the Healthy People 2020 target of 5.3% or lower.

Nearly one-fourth (24.5%) of CHOMP Service Area adults (18 and older) suffer from chronic back pain or sciatica.

- Less favorable than that found nationwide.
- Least favorable in Pacific Grove/Pebble Beach (not shown).

Prevalence of Potentially Disabling Conditions



Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 28, 161-162]
- 2015 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]

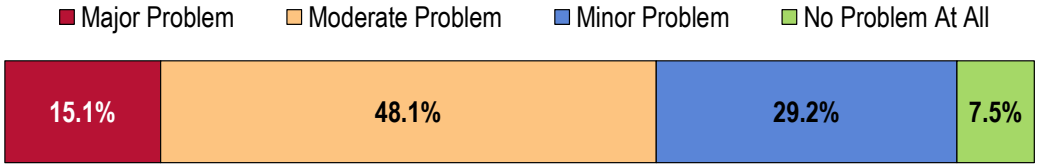
Notes:
- The sciatica indicator reflects the total sample of respondents; the arthritis and osteoporosis columns reflect adults age 50+.

Key Informant Input: Arthritis, Osteoporosis & Chronic Back Conditions

A plurality of key informants taking part in an online survey characterized *Arthritis, Osteoporosis & Chronic Back Conditions* as a "moderate problem" in the community.

Perceptions of Arthritis/Osteoporosis/Back Conditions as a Problem in the Community

(Key Informants, 2016)



Sources:
- PRC Online Key Informant Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

Top Concerns

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

Aging Population

> *The median age of the population is higher in Monterey and diseases and conditions that affect an aging population must be considered when determining the overall health of the community. – Community/Business Leader*
>
> *Elderly people have much arthritis and osteoporosis. – Physician*
>
> *Geriatric populations have back and arthritic problems. Mostly this is tied in with appropriate pain control and pain management for those who are not surgical candidates. Ties in to the pain management issues. – Physician*

With an aging population comes an increased with age-related health conditions such as osteoporosis. Also, with the nature of most work environments (sedentary), back pain/issues are on the rise. – Community/Business Leader

Aging population. – Other Health Provider

Older population and a fall and fracture is the most likely event to terminate their ability to live independently. – Physician

Incidence/Prevalence

I believe that both are chronic illnesses that impact many residents of Monterey County. – Public Health Representative

More than half of all adults and more than one-fourth of all people in the US will be diagnosed with some form of arthritis, at a cost of more than 1% of the nation's GDP. Although various forms of arthritis affect all ages, osteoarthritis is common. – Social Services Provider

I have watched friends with severe rheumatoid arthritis suffer with inadequate care in our area and having to go to Stanford, UCSF, and other out of area providers to receive the care they need. – Social Services Provider

Work Conditions

Lack of education to prevent these conditions. Also lack of employers educating employees on good body mechanics to prevent injuries. – Public Health Representative

We have a huge farm worker population, some documented and some not. All medical care for these people is hard to come by and for the undocumented, who are often afraid to come forward, almost impossible. – Social Services Provider

Back conditions are responsible for leaving sufferers unable to participate in the workforce and essentially nonfunctional. Can lead to addiction. Have known two people who have committed suicide due to unresolved pain. – Social Services Provider

Access to Care/Services

Specialists in this area are scarce especially those taking MediCal or uninsured. – Public Health Representative

Not enough pain specialists who can take MediCal. – Public Health Representative

Vision & Hearing Impairment

About Vision

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)

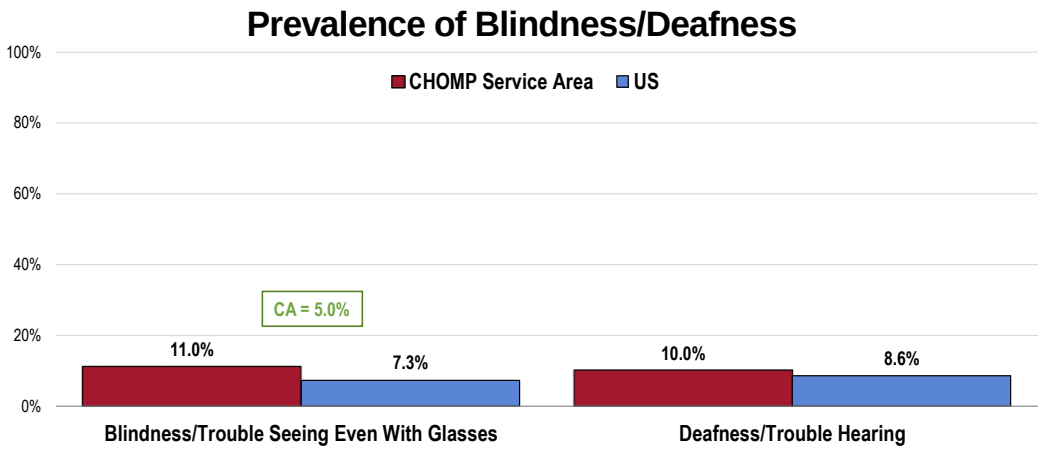
RELATED ISSUE:

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

Vision and Hearing Trouble

A total of 11.0% of CHOMP Service Area adults are blind or have trouble seeing even when wearing corrective lenses, and 10.0% are deaf or have trouble hearing.

- The proportion of adults with vision trouble is worse than reported across California and nationally.
- Compared with the US prevalence, a similar proportion of adults have hearing trouble.



Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 25-26]
- 2015 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): 2014 California data.

Notes:
- Reflects the total sample of respondents.

Hearing Trouble

About Hearing & Other Sensory or Communication Disorders

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.

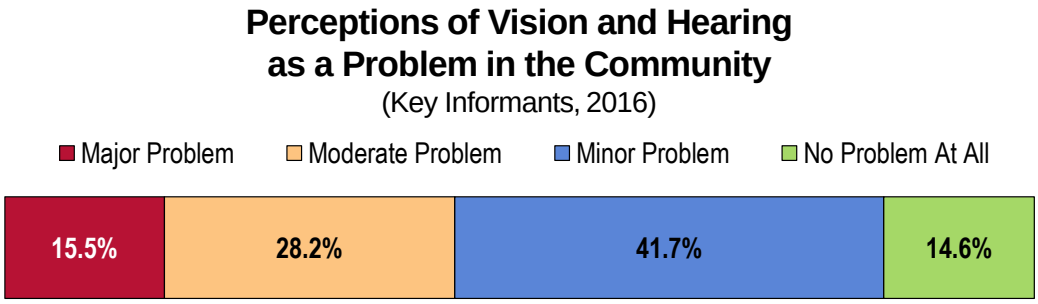
Many factors influence the numbers of Americans who are diagnosed and treated for hearing and other sensory or communication disorders, such a social determinants (social and economic standings, age of diagnosis, cost and stigma of wearing a hearing aid, and unhealthy lifestyle choices). In addition, 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)

Key Informant Input: Vision & Hearing

Key informants taking part in an online survey most often characterized *Vision & Hearing* as a "minor problem" in the community.



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

Top Concerns

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

Aging Population

As you age and lose your sight due to macular degeneration and/or lose your hearing, it significantly impacts your quality of life and sometimes your ability to live independently or leads to depression. There is way more to it than just the loss. – Social Services Provider

Monterey County has both a growing elder population and a large number of people living in poverty; both groups need free/low cost access to hearing and vision experts. – Social Services Provider

My frame of reference is the senior community. Hearing and vision decline happen with age. As the losses occur, sometimes there are fixes and many times lifestyles and activities change. – Social Services Provider

Affordable Care/Services

Cost involved. Older people on budgets. – Community/Business Leader

Some folks can't afford glasses and probably same as it pertains to hearing issues. – Public Health Representative

Resources for people in low income situations. – Social Services Provider

Comorbidities

Retinopathy is a common complication in patients with diabetes. Early access may prevent blindness. – Other Health Provider

Insurance Issues

Most insurance plans in the area do not offer vision; uninsurable residents don't have access to checkups or glasses. – Social Services Provider

Environmental Health

Indoor Air Pollution

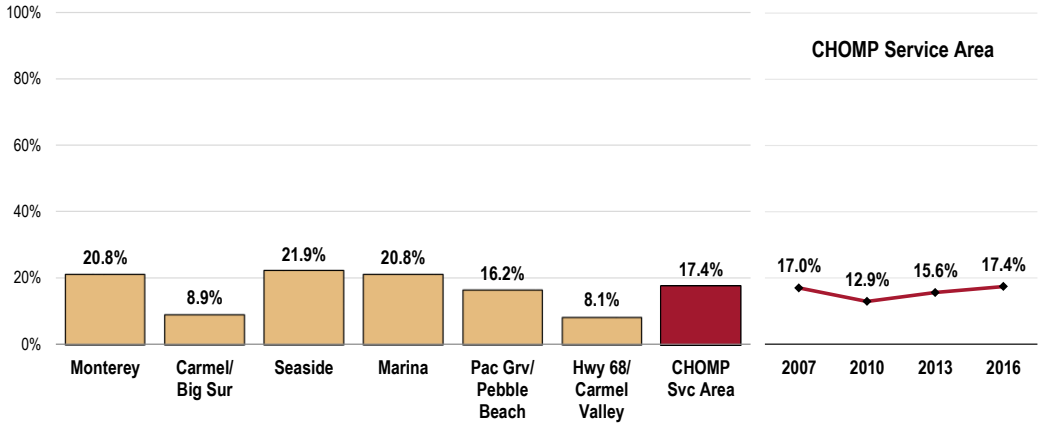
Things like dust, mold, smoke, and chemicals inside the home or office can cause poor indoor air quality.

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?

A total of 17.4% of CHOMP Service Area adults report having an illness or symptoms in the past year believed to be caused by indoor air contaminants.

- Favorably low in Carmel/Big Sur and Highway 68/Carmel Valley.
- TREND: Statistically unchanged since 2007.

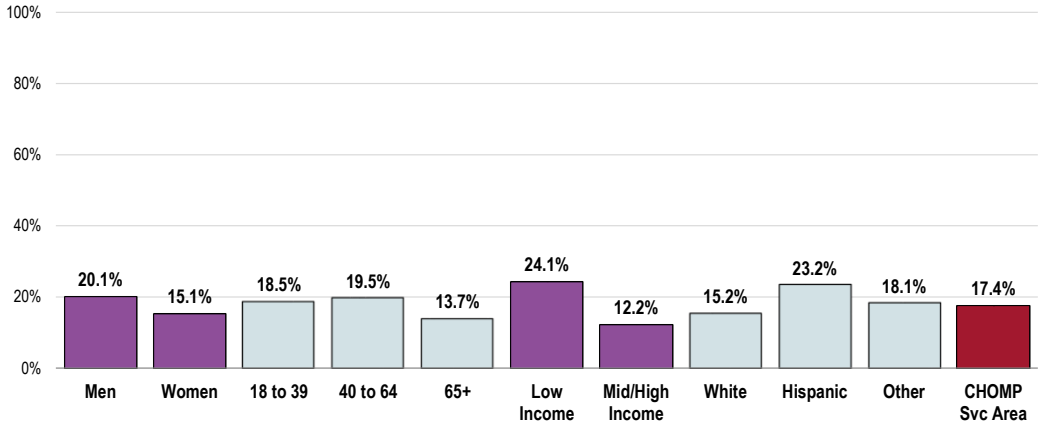
Had an Illness or Symptoms in the Past Year Believed to be Caused by Indoor Air Contaminants



Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 302]
Notes: ● Asked of all respondents.

- A higher prevalence of indoor air illness is reported among adults age 40 to 64, low-income residents, and Hispanics.

Had an Illness or Symptoms in the Past Year Believed to be Caused by Indoor Air Contaminants
(CHOMP Service Area, 2016)



Sources: ● 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 302]
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. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Outdoor Air Pollution

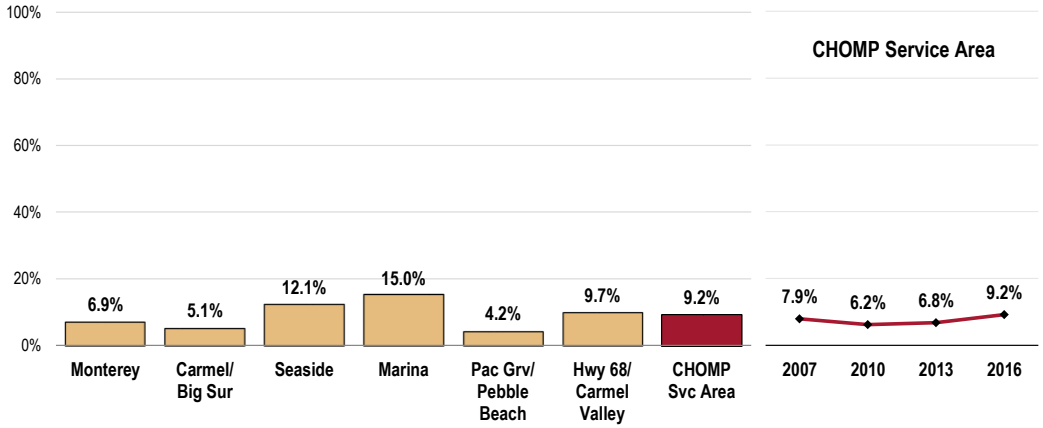
Things like smog, automobile exhaust, and chemicals can cause outdoor pollution.

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 (9.2%) report having an illness or symptoms in the past year believed to be caused by outdoor pollution.

- Highest in Marina.
- TREND: Statistically unchanged from previous survey findings.

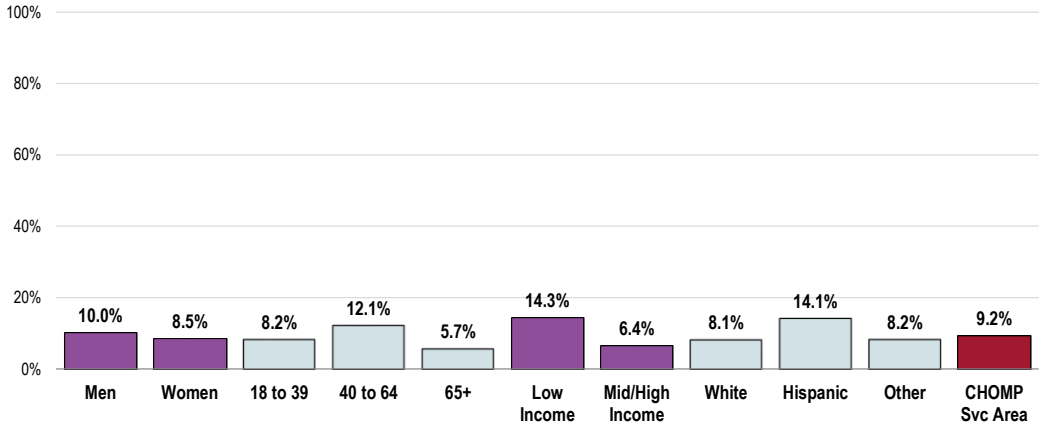
Had an Illness or Symptoms in the Past Year Believed to be Caused by Outdoor Air Contaminants



Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 303]
Notes: ● Asked of all respondents.

- Adults more likely to report illness or symptoms related to outdoor air include adults age 40 to 64 and community members living on low incomes.

Had an Illness or Symptoms in the Past Year Believed to be Caused by Outdoor Air Contaminants
(CHOMP Service Area, 2016)



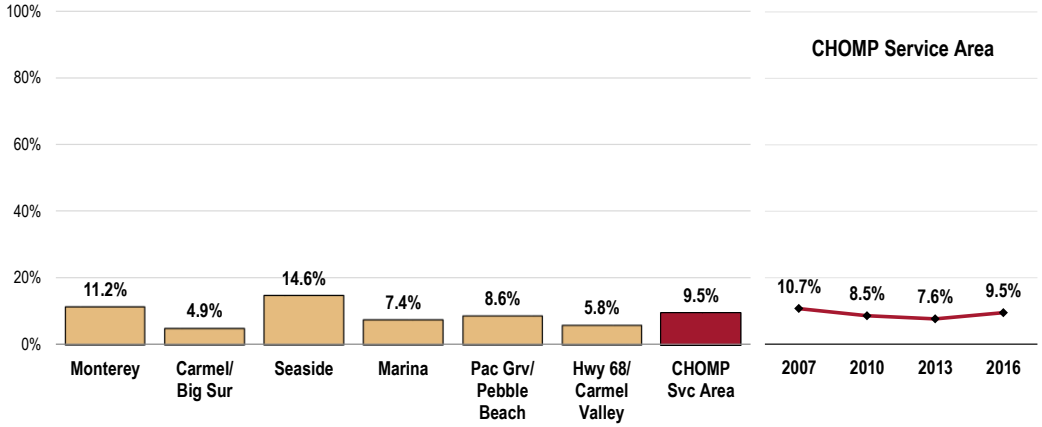
Sources: ● 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 303]
Notes: ● Asked of all respondents.
● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Mold in the Home

Of survey respondents, 9.5% report having an area of mold in the home greater than the size of a dollar bill.

- Particularly high in Seaside.
- TREND: Statistically similar to the 2007 findings.

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 304]
Notes: ● Asked of all respondents.

Infectious Disease

Professional Research Consultants, Inc.

Influenza & Pneumonia Vaccination

About Influenza & Pneumonia

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)

Flu Vaccinations

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

Among CHOMP Service Area seniors, 54.2% received a flu shot (or FluMist®) within the past year.

- Statistically comparable to the California and national findings.
- Fails to satisfy the Healthy People 2020 target (70% or higher).
- Much lower in Seaside.
- TREND: Significantly lower than reported in 2007.

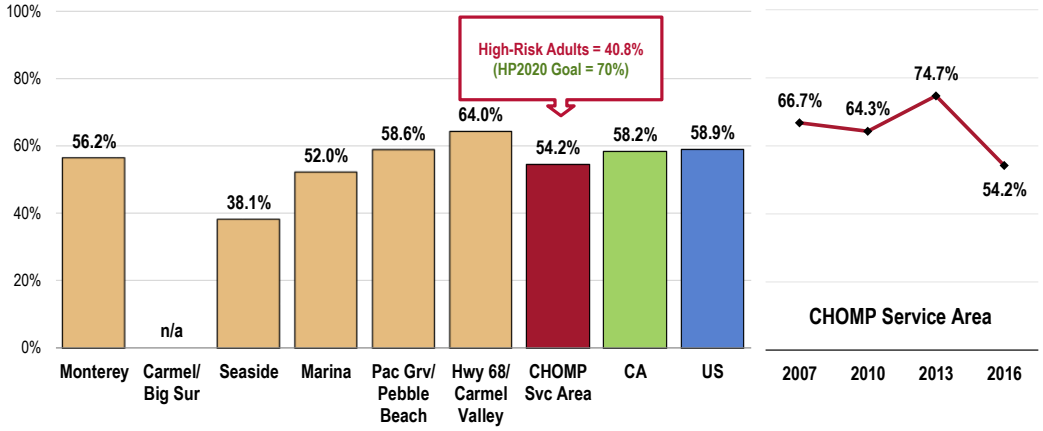
"High-risk" includes adults who report having been diagnosed with heart disease, diabetes or respiratory disease.

A total of 40.8% of high-risk adults age 18 to 64 received a flu vaccination (flu shot or FluMist®) within the past year.

Older Adults: Have Had a Flu Vaccination in the Past Year

(Among Adults Age 65+)

Healthy People 2020 Target = 70.0% or Higher



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Items 163-164]
- 2015 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): 2014 California data.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IID-12.12]

Notes:
- Reflects respondents 65 and older.
- "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 CHOMP Service Area adults age 65 and older, 74.6% have received a pneumonia vaccination at some point in their lives.

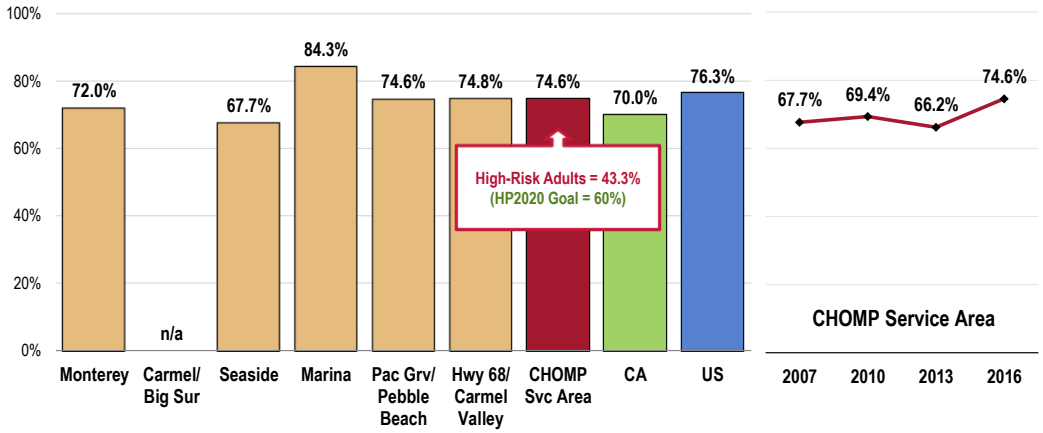
- Higher than the California finding.
- Similar to the national finding.
- Fails to satisfy the Healthy People 2020 target of 90% or higher.
- Favorably high in Marina.
- TREND: Marks a statistically significant increase since 2007.

A total of 43.3% of high-risk adults age 18 to 64 have ever received a pneumonia vaccination.

Older Adults: Have Ever Had a Pneumonia Vaccine

(Among Adults Age 65+)

Healthy People 2020 Target = 90.0% or Higher



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Items 165-166]
- 2015 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): 2014 California data.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objectives IID-13.1, IID-13.2]

Notes:
- Reflects respondents 65 and older.
- "High-Risk" includes adults age 18 to 64 who have been diagnosed with heart disease, diabetes or respiratory disease.

HIV

About 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)

Age-Adjusted HIV/AIDS Deaths

Between 2004 and 2013, there was an annual average age-adjusted HIV/AIDS mortality rate of 1.2 deaths per 100,000 population in Monterey County.

- Lower than found statewide
- Less than half the rate reported nationally.
- Satisfies the Healthy People 2020 target (3.3 or lower).

HIV/AIDS: Age-Adjusted Mortality

(2004-2013 Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 3.3 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 April 2016.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HIV-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.

HIV Prevalence

In 2013, there was a prevalence of 187.4 HIV cases per 100,000 population in Monterey County.

- Much more favorable than the prevalence reported statewide or nationally.

HIV Prevalence

(Prevalence Rate of HIV per 100,000 Population, 2013)

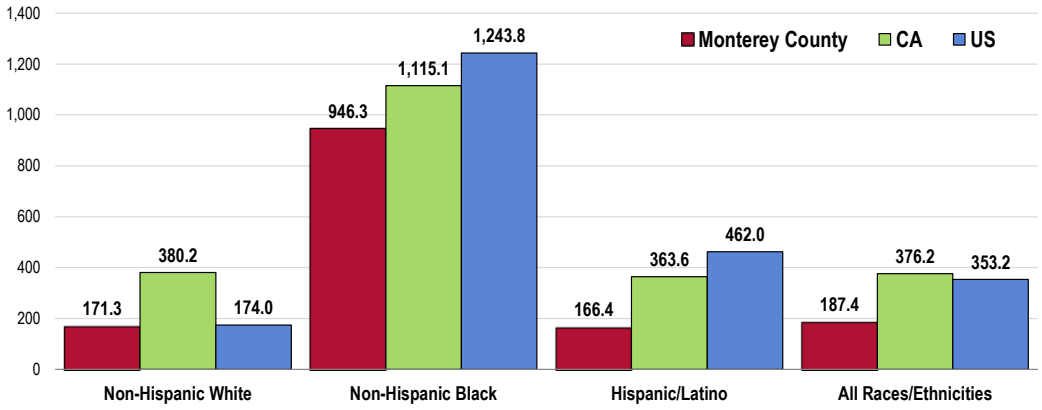
Sources:
- Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
- Retrieved April 2016 from Community Commons at http://www.chna.org.

Notes:
- This indicator is relevant because HIV is a life-threatening communicable disease that disproportionately affects minority populations and may also indicate the prevalence of unsafe sex practices.

- By race and ethnicity, HIV/AIDS prevalence in Monterey County is particularly high among non-Hispanic Blacks, although to a lesser degree than found statewide or nationally.

HIV Prevalence Rate by Race/Ethnicity

(Prevalence Rate of HIV per 100,000 Population, 2013)



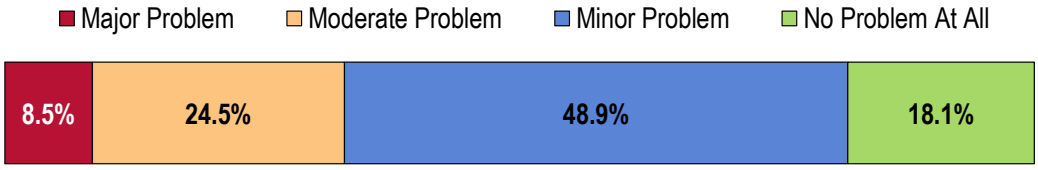
Sources:
- Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
- Retrieved April 2016 from Community Commons at http://www.chna.org.

Notes:
- This indicator is relevant because HIV is a life-threatening communicable disease that disproportionately affects minority populations and may also indicate the prevalence of unsafe sex practices.

Key Informant Input: HIV/AIDS

Key informants taking part in an online survey most often characterized *HIV/AIDS* as a "minor problem" in the community.

Perceptions of HIV/AIDS as a Problem in the Community
(Key Informants, 2016)



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

Top Concerns

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

Access to Care/Services

Services for individuals with the disease have been closed in Monterey County for some time. The program from San Luis Obispo County is working to fill a much needed gap in services but it is not enough. – Public Health Representative

Lack of access to care. – Public Health Representative

Extremely small resource of physicians to care for this complex disease process. – Physician

High Risk Behaviors

Intravenous drug use and unprotected sex. – Community/Business Leader

The rate of HIV infection among Monterey County residents has increased steadily over the 10 year period from 2004 to 2013. – Social Services Provider

Health Education

Awareness and shame. Education. – Social Services Provider

Sexually Transmitted Diseases

About 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.

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. 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; poverty and marginalization; access to healthcare; substance abuse; sexuality and secrecy (stigma and discomfort discussing sex); and sexual networks (persons “linked” by sequential or concurrent sexual partners).

- Healthy People 2020 (www.healthypeople.gov)

Chlamydia & Gonorrhea

In 2014, the chlamydia incidence rate in Monterey County was 397.1 cases per 100,000 population.

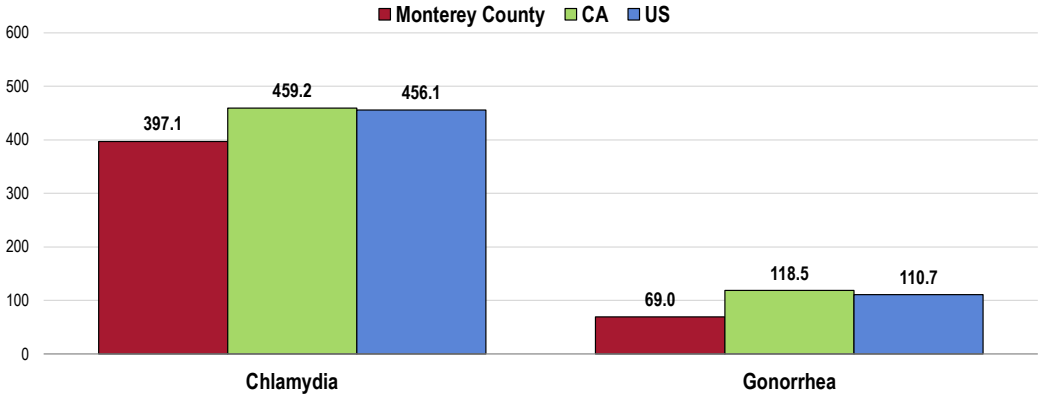
- Notably lower than the California and national incidence rates.

The Monterey County gonorrhea incidence rate in 2014 was 69.0 cases per 100,000 population.

- Notably lower than the California and national incidence rates.

Chlamydia & Gonorrhea Incidence

(Incidence Rate per 100,000 Population, 2014)



Sources:
- Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
- Retrieved April 2016 from Community Commons at http://www.chna.org.

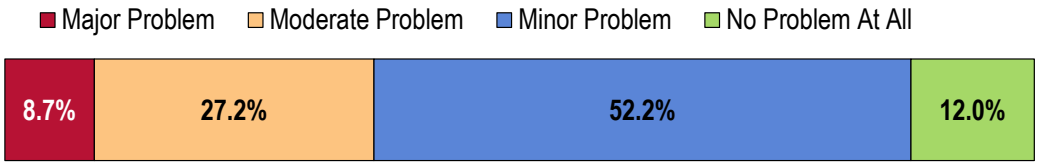
Notes:
- This indicator is relevant because it is a measure of poor health status and indicates the prevalence of unsafe sex practices.

Key Informant Input: Sexually Transmitted Diseases

A plurality of key informants taking part in an online survey characterized *Sexually Transmitted Diseases* as a "minor problem" in the community.

Perceptions of Sexually Transmitted Diseases as a Problem in the Community

(Key Informants, 2016)



Sources:
- PRC Online Key Informant Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

Top Concerns

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

Health Education

Education. Acknowledgement. – Social Services Provider

Lack of education. Late appointments for clients working late hours. – Public Health Representative

Lack of education. Not enough confidential access to services. – Public Health Representative

High Risk Behaviors

There have been problems for years. More young adults, more sex. – Community/Business Leader

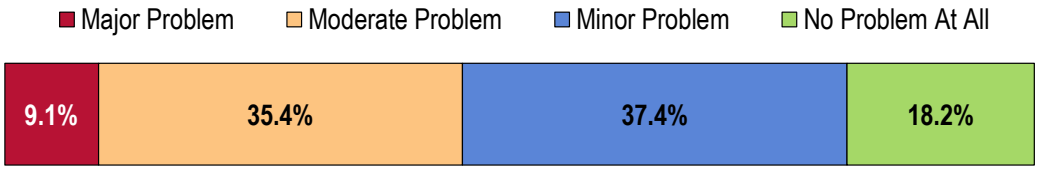
Immunization & Infectious Diseases

Key Informant Input: Immunization & Infectious Diseases

Key informants taking part in an online survey most often characterized *Immunization & Infectious Diseases* as a "minor problem" in the community.

Perceptions of Immunization and Infectious Diseases as a Problem in the Community

(Key Informants, 2016)



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

Top Concerns

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

Vulnerable Populations

Since this is a country of immigrants, many diseases can be brought to the US. Individuals need to protect themselves and the community with immunizations. – Community/Business Leader

Mostly provision to middle and low income individuals. Also, among very low income, education individuals, lack of knowledge. – Physician

Those living below the Federal Poverty line, regardless of race/ethnicity, compared to children living at or above the poverty level. – Social Services Provider

Cultural/Personal Beliefs

We have a large number of students who do not have immunizations up to date for school entry. With the new SB 277 law, a large percentage of our students are still not in compliance. For example, over 200 of our 6th graders are currently not up to date. – Community/Business Leader

Some folks do not get their children immunized on time. – Public Health Representative

Incidence/Prevalence

Increasingly complex disease processes, only one infectious disease specialist at CHOMP. – Physician

Infectious disease is a problem in most communities. – Physician

Access to Care/Services

Lack of access and therefore resources to make recommendations for good preventative care. This leads to poor care and illness. – Physician

Access to Providers

Limited physicians to see when have acute or chronic problems. Access is slow, locations are inconvenient. – Physician

Affordable Care/Services

Affordable health care. Education. – Social Services Provider

Births

Professional Research Consultants, Inc.

Prenatal Care

About Infant & Child Health

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)

Early and continuous prenatal care is the best assurance of infant health.

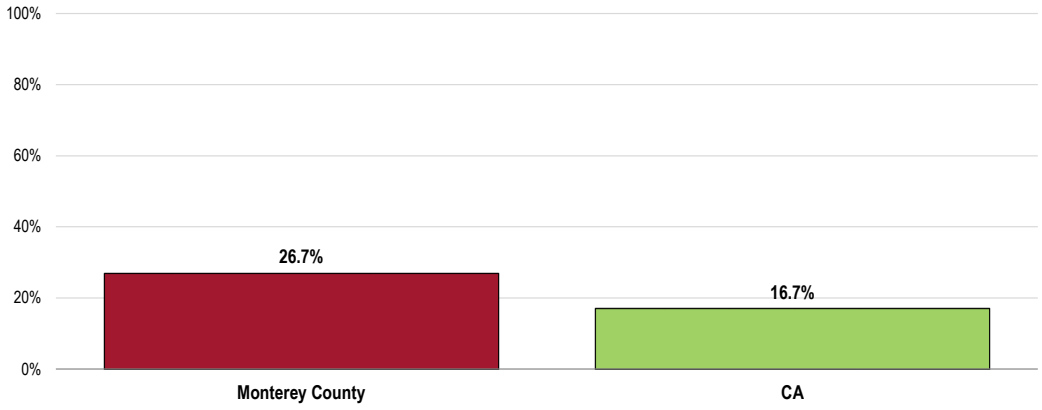
Between 2012 and 2014, 26.7% of all Monterey County births did <u>not</u> receive prenatal care in the first trimester of pregnancy.

- Considerably less favorable than the California proportion.
- Fails to satisfy the Healthy People 2020 target (22.1% or lower).

Lack of Prenatal Care in the First Trimester

(Percentage of Live Births, 2012-2014)

Healthy People 2020 Target = 22.1% or Lower



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics. Data extracted April 2016.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective MICH-10.1]

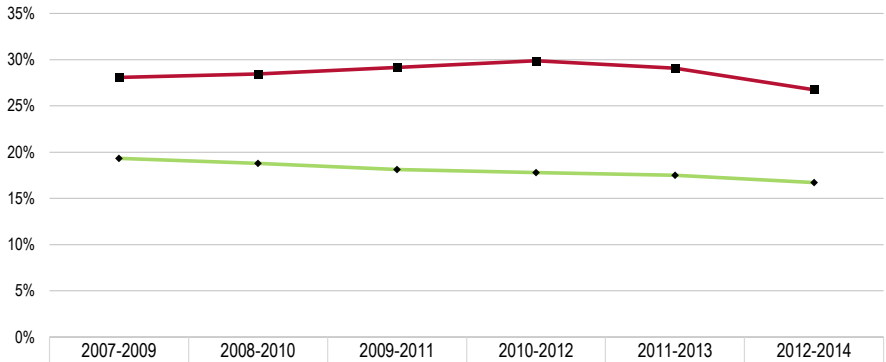
Note:
- This indicator reports the percentage of women who do not obtain prenatal care during their first trimester of pregnancy. This indicator is relevant because engaging in prenatal care decreases the likelihood of maternal and infant health risks. This indicator can also highlight a lack of access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

- TREND: Though not displaying a clear trend, the proportion of Monterey County births not receiving prenatal care is statistically lower than it was in 2007. The California proportion decreased steadily over time.

Lack of Prenatal Care in the First Trimester

(Percentage of Live Births)

Healthy People 2020 Target = 22.1% or Lower



	2007-2009	2008-2010	2009-2011	2010-2012	2011-2013	2012-2014
Monterey County	28.1%	28.4%	29.2%	29.9%	29.1%	26.7%
CA	19.3%	18.8%	18.1%	17.8%	17.5%	16.7%

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics. Data extracted April 2016.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective MICH-10.1]

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

Birth Outcomes & Risks

Low-Weight Births

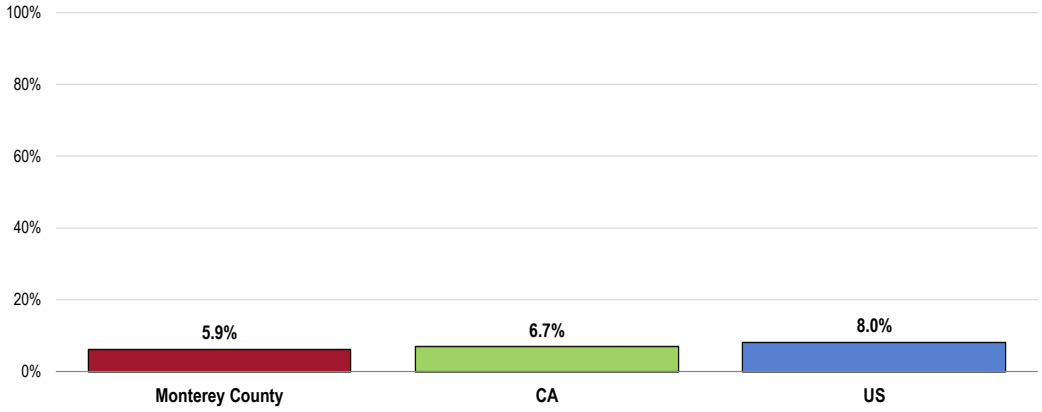
Low birthweight babies, those who weigh less than 2,500 grams (5 pounds, 8 ounces) at birth, are much more prone to illness and neonatal death than are babies of normal birthweight.

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

A total of 5.9% of 2012-2014 Monterey County births were low-weight.

- Better than the California and national proportions.
- Satisfies the Healthy People 2020 target (7.8% or lower).

Low-Weight Births
(Percent of Live Births, 2012-2014)
Healthy People 2020 Target = 7.8% or Lower



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics. Data extracted April 2016.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective MICH-8.1]

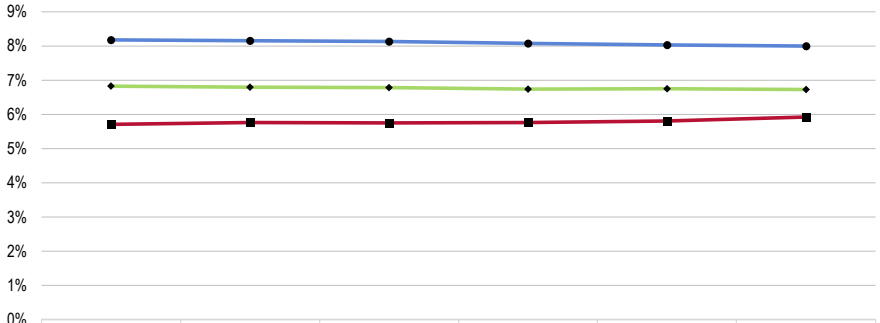
Note:
- This indicator reports the percentage of total births that are low birth weight (Under 2500g). This indicator is relevant because low birth weight infants are at high risk for health problems. This indicator can also highlight the existence of health disparities.

- TREND: Over time, the proportion of low-weight births has been relatively stable in Monterey County, mirroring the trends seen both statewide and nationwide.

Low-Weight Births

(Percent of Live Births)

Healthy People 2020 Target = 7.8% or Lower



	2007-2009	2008-2010	2009-2011	2010-2012	2011-2013	2012-2014
Monterey County	5.7%	5.8%	5.8%	5.8%	5.8%	5.9%
CA	6.8%	6.8%	6.8%	6.7%	6.8%	6.7%
US	8.2%	8.2%	8.1%	8.1%	8.0%	8.0%

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics. Data extracted April 2016.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective MICH-8.1]

Note:
- This indicator reports the percentage of total births that are low birth weight (Under 2500g). This indicator is relevant because low birth weight infants are at high risk for health problems. This indicator can also highlight the existence of health disparities.

Infant Mortality

Between 2012 and 2014, there was an annual average of 4.5 infant deaths per 1,000 live births.

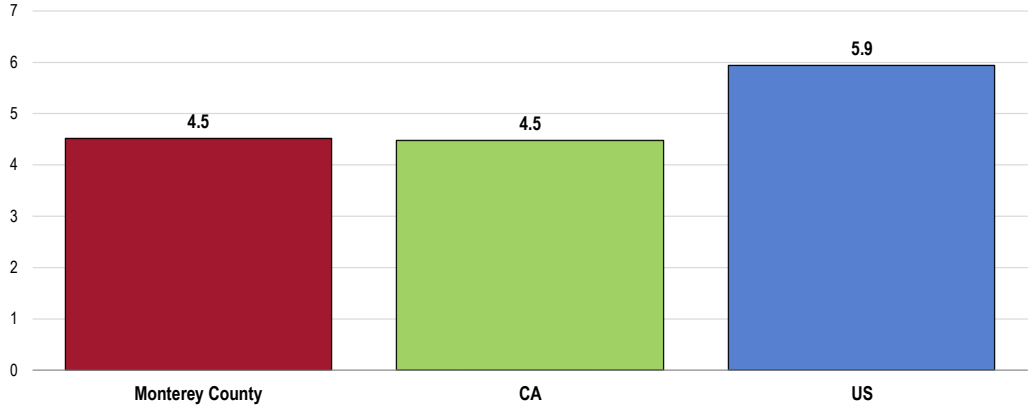
- Identical to the California rate.
- More favorable than the national rate.
- Satisfies the Healthy People 2020 target of 6.0 per 1,000 live births.

Infant mortality rates reflect deaths of children less than one year old per 1,000 live births.

Infant Mortality Rate

(Annual Average Infant Deaths per 1,000 Live Births, 2012-2014)

Healthy People 2020 Target = 6.0 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 April 2016.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective MICH-1.3]

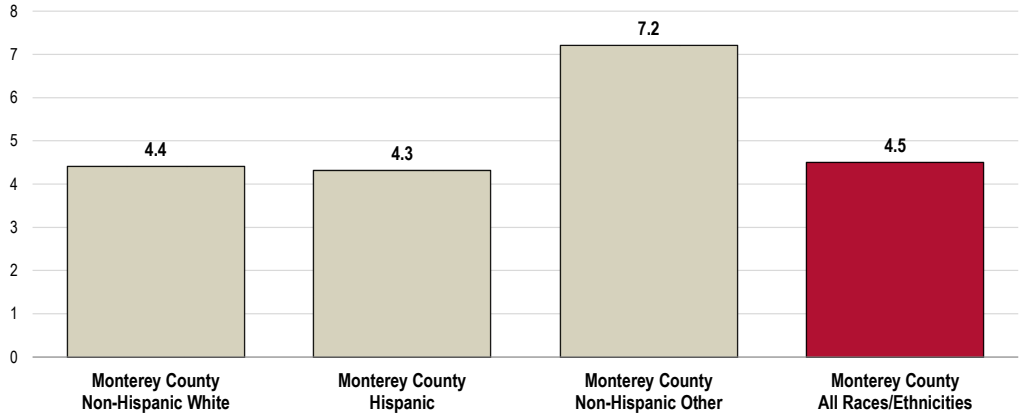
Notes:
- Infant deaths include deaths of children under 1 year old.
- This indicator is relevant because high rates of infant mortality indicate the existence of broader issues pertaining to access to care and maternal and child health.

- The infant mortality rate is notably higher among births to Non-Hispanic "Other" race mothers.

Infant Mortality Rate by Race

(Annual Average Infant Deaths per 1,000 Live Births, 2012-2014)

Healthy People 2020 Target = 6.0 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 April 2016.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective MICH-1.3]

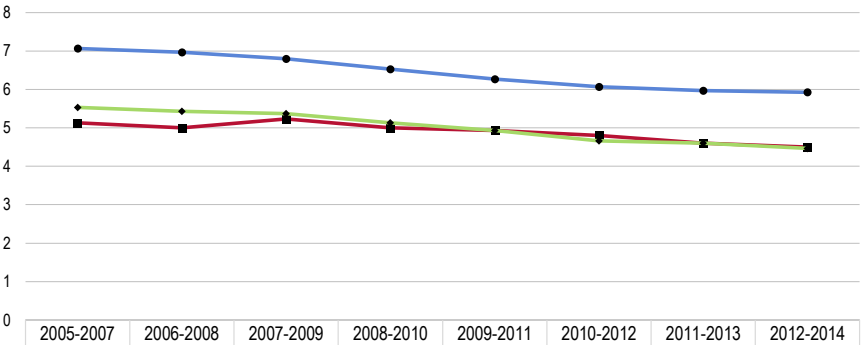
Notes:
- Infant deaths include deaths of children under 1 year old.
- This indicator is relevant because high rates of infant mortality indicate the existence of broader issues pertaining to access to care and maternal and child health.

- TREND: The Monterey County infant mortality rate has trended downward slightly in recent years; echoing both statewide and national trends.

Infant Mortality Rate

(Annual Average Infant Deaths per 1,000 Live Births)

Healthy People 2020 Target = 6.0 or Lower



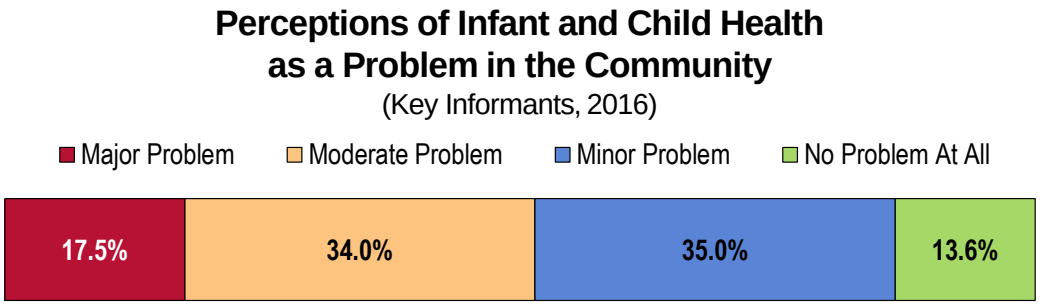
	2005-2007	2006-2008	2007-2009	2008-2010	2009-2011	2010-2012	2011-2013	2012-2014
Monterey County	5.1	5.0	5.2	5.0	4.9	4.8	4.6	4.5
CA	5.5	5.4	5.4	5.1	4.9	4.7	4.6	4.5
US	7.1	7.0	6.8	6.5	6.3	6.1	6.0	5.9

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2016.
- 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.

Key Informant Input: Infant & Child Health

Slightly more key informants taking part in an online survey characterized *Infant & Child Health* as a "minor problem" than a "moderate problem" in the community.



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

Top Concerns

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

Health Education

A lot of the population doesn't have a clue about how to take care of their infants and proper nutrition and exercise for children. Too much screen time. Not enough exercise. Both parents working and some families leave kids alone in houses. – Community/Business Leader

Lack of parent insight as to what is needed for prenatal and infant care. – Community/Business Leader

Without properly cared for infants we will face a future of serious health problems. – Community/ Business Leader

Working parents in need of parenting classes. More appointment slots needed. – Public Health Representative

I see more and more of our low risk OB patients choosing an out-of-hospital birth despite our willingness to accommodate their choices at CHOMP. Home birth in the US is not safe and, in my opinion, a terrifying threat to women and children. – Physician

Many in the Salinas and South County communities don't have sufficient access or knowledge of resources to help infants and child health. – Community/Business Leader

Incidence/Prevalence

A greater number of children are being diagnosed with disabilities, including those on the autism spectrum. Government funding has been cut to the San Andreas Regional Center and the Monterey County Office of Education to provide support services for children. – Social Services Provider

Infant mortality rate in the county. Nationally the link between child poverty and child chronic illness is well documented. – Social Services Provider

Affordable Care/Services

Cost of medical care, hazardous field work and exposure to chemicals, high number of young mothers giving birth, difficulty in transportation to medical facilities. Families in poverty. – Community/Business Leader

Affordability. Education. – Social Services Provider

Contributing Factors

Children are constantly wandering around unsupervised and are very vulnerable in multiple ways. There is overcrowding in homes, and we see little children as young as six and seven taking care of younger siblings. They are often hungry, have lice, coughing. – Community/Business Leader

> *Perinatal depression impacts infant, child growth and development. Violence in the home, familial traumas. – Public Health Representative*

Access to Care/Services

> *Lack of access. – Social Services Provider*

Family Planning

Births to Teen Mothers

About Teen Births

The negative outcomes associated with unintended pregnancies are compounded for adolescents. Teen mothers:

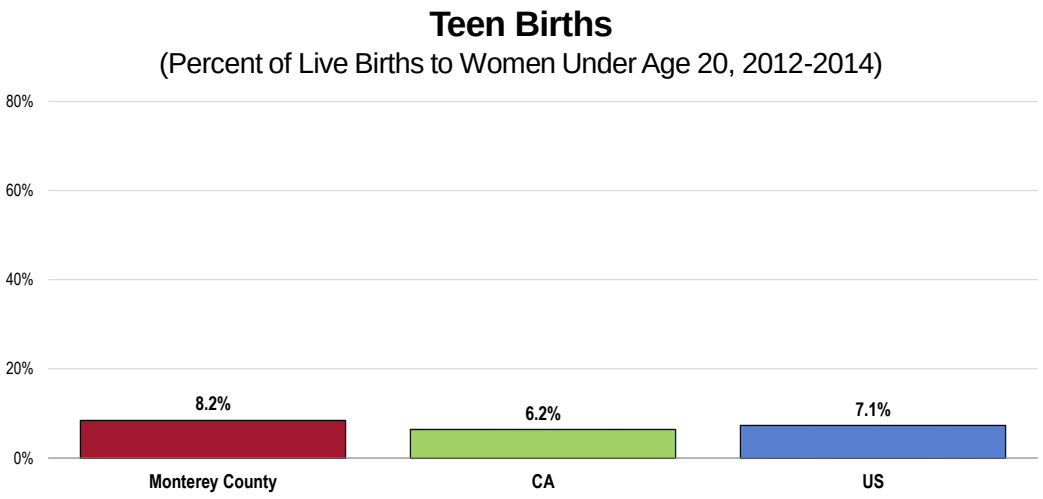
- Are less likely to graduate from high school or attain a GED by the time they reach age 30.
- Earn an average of approximately $3,500 less per year, when compared with those who delay childbearing.
- Receive nearly twice as much Federal aid for nearly twice as long.

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)

Between 2012 and 2014, a total of 8.2% of all live births in Monterey County were to women under age 20.

- Statistically higher than the California and national proportions.



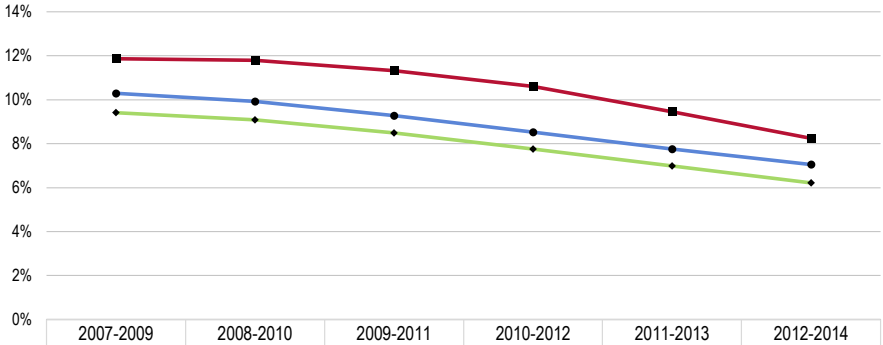
Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics. Data extracted April 2016.

Notes: • This indicator reports the percentage of live births to women under the age of 20. This indicator is relevant because in many cases, teen parents have unique social, economic, and health support services. Additionally, high rates of teen pregnancy may indicate the prevalence of unsafe sex practices.

- TREND: This percentage has decreased in Monterey County over the past decade, echoing the state and national trends.

Teen Births

(Percent of Live Births to Women Under Age 20)



	2007-2009	2008-2010	2009-2011	2010-2012	2011-2013	2012-2014
Monterey County	11.9%	11.8%	11.3%	10.6%	9.4%	8.2%
CA	9.4%	9.1%	8.5%	7.8%	7.0%	6.2%
US	10.3%	9.9%	9.3%	8.5%	7.8%	7.1%

Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics. Data extracted April 2016.

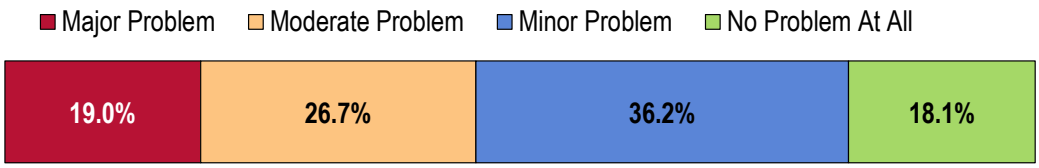
Notes: ● This indicator reports the percentage of live births to women under the age of 20. This indicator is relevant because in many cases, teen parents have unique social, economic, and health support services. Additionally, high rates of teen pregnancy may indicate the prevalence of unsafe sex practices.

Key Informant Input: Family Planning

Key informants taking part in an online survey largely characterized *Family Planning* as a "minor problem" in the community.

Perceptions of Family Planning as a Problem in the Community

(Key Informants, 2016)



Sources: ● PRC Online Key Informant Survey, Professional Research Consultants, Inc.

Notes: ● Asked of all respondents.

Top Concerns

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

Health Education

Lack of education. Need of teen clinics in high schools. – Public Health Representative

Lack of knowledge about options. – Community/Business Leader

Awareness of sexual activity by parents. Overcrowding in housing leads to sexual abuse. – Social Services Provider

Teen Pregnancy

Teen parenthood and excessively large families continue to be a major problem on the County. So many children, young men and women, are becoming parents before they have the maturity, financial stability, or other skills needed to provide. – Community/Business Leader

Many teens are getting pregnant in Salinas and South County. – Community/Business Leader

Access to Care/Services

Not enough OBGYN's. – Physician

Access for teens. Folks who don't have transportation. – Public Health Representative

Planned Parenthood is under attack nationwide. – Social Services Provider

Access to Culturally Relevant Services

There could be cultural reasons, religious reasons. – Public Health Representative

We have too many people on the planet as it is. Culturally having a large family is acceptable and this culture has to change in order for life to be sustainable. – Community/Business Leader

Affordable Care/Services

Children being born to families that don't have the tools or financial means to support them. – Social Services Provider

Modifiable Health Risks

Professional Research Consultants, Inc.

Actual Causes of Death

About Contributors to Mortality

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.

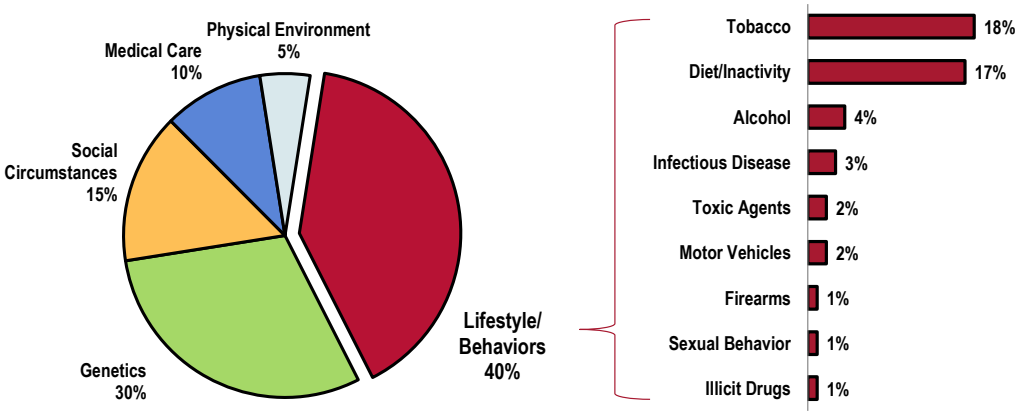
The most prominent contributors to mortality in the United States in 2000 were **tobacco** (an estimated 435,000 deaths), **diet and activity** patterns (400,000), **alcohol** (85,000), **microbial agents** (75,000), **toxic agents** (55,000), **motor vehicles** (43,000), **firearms** (29,000), **sexual 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.

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.

Factors Contributing to Premature Deaths in the United States



Sources: ● "The Case For More Active Policy Attention to Health Promotion"; (McGinnis, Williams-Russo, Knickman) Health Affairs. Vol. 32. 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

About Healthful Diet & Healthy Weight

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)

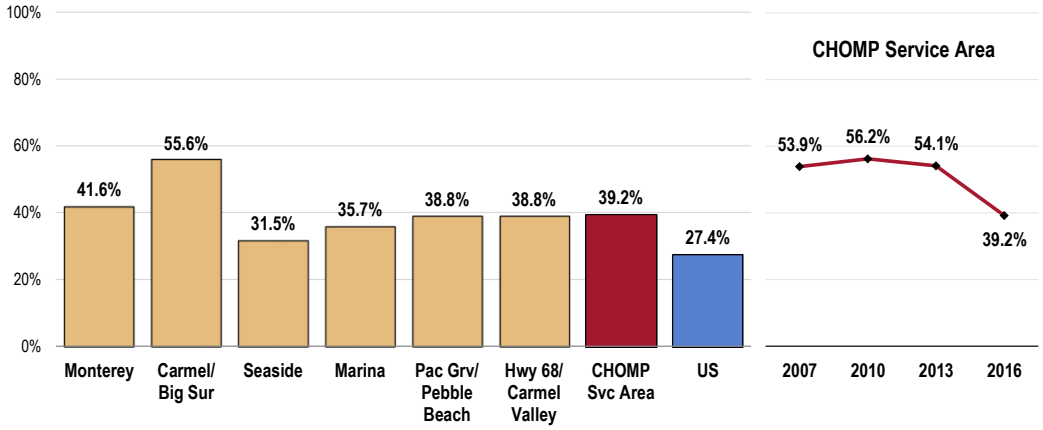
Daily Recommendation of Fruits/Vegetables

A total of 39.2% of CHOMP Service Area adults report eating five or more servings of fruits and/or vegetables per day.

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.

- Notably more favorable than national findings.
- Particularly low in Seaside.
- TREND: Fruit/vegetable consumption has declined significantly since 2007.

Consume Five or More Servings of Fruits/Vegetables Per Day



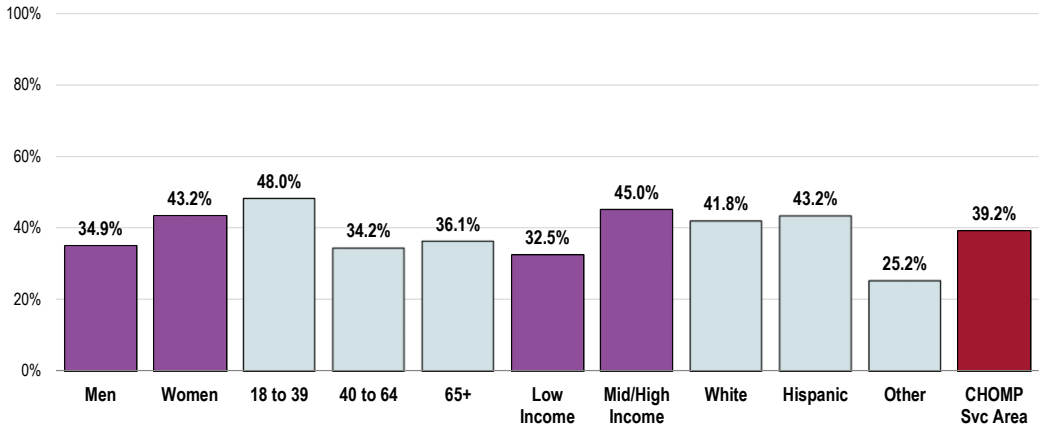
Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 168]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

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 adults age 40 and over, low-income adults, and those of "Other" races.

Consume Five or More Servings of Fruits/Vegetables Per Day

(CHOMP Service Area, 2016)



Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 168]

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. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
- For this issue, respondents were asked to recall their food intake on the previous day.

Access to Fresh Produce

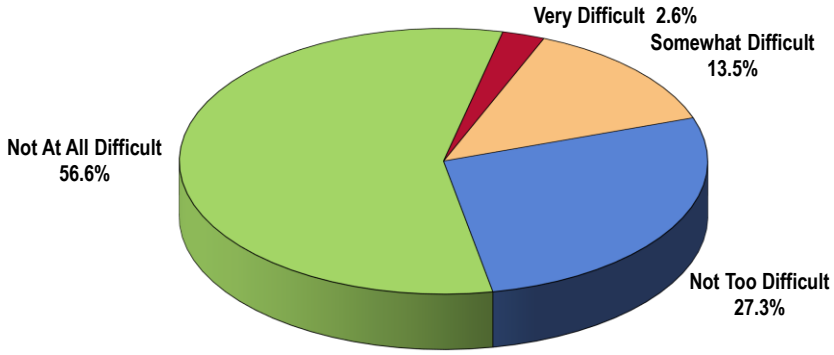
Difficulty Accessing Fresh Produce

While most report little or no difficulty, 16.1% of CHOMP Service Area adults find it "very" or "somewhat" difficult to access affordable, fresh fruits and vegetables.

Respondents were asked:

"How difficult is it for you to buy fresh produce like fruits and vegetables at a price you can afford? Would you say: Very Difficult, Somewhat Difficult, Not Too Difficult, or Not At All Difficult?"

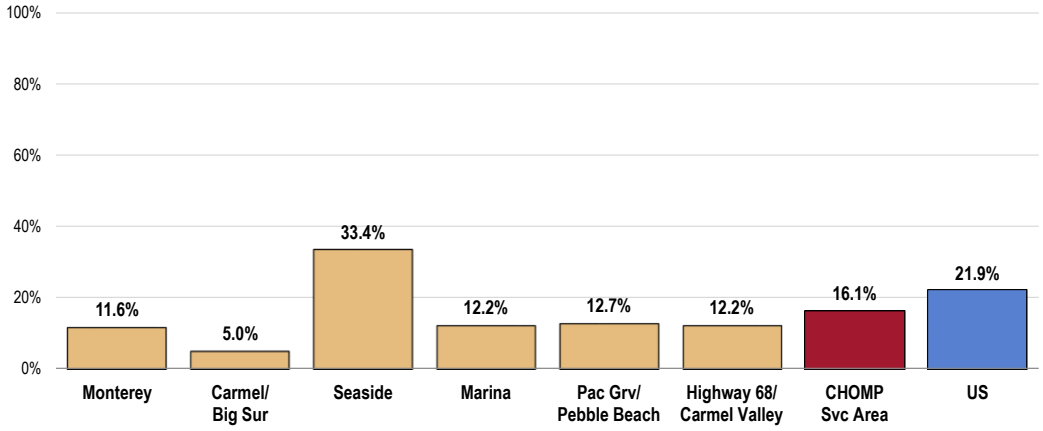
Level of Difficulty Finding Fresh Produce at an Affordable Price
(CHOMP Service Area, 2016)



Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 103]
Notes: • Asked of all respondents.

- Lower than national findings.
- More than twice as high in Seaside; lower in Monterey and especially Carmel/ Big Sur.

Find It "Very" or "Somewhat" Difficult to Buy Affordable Fresh Produce

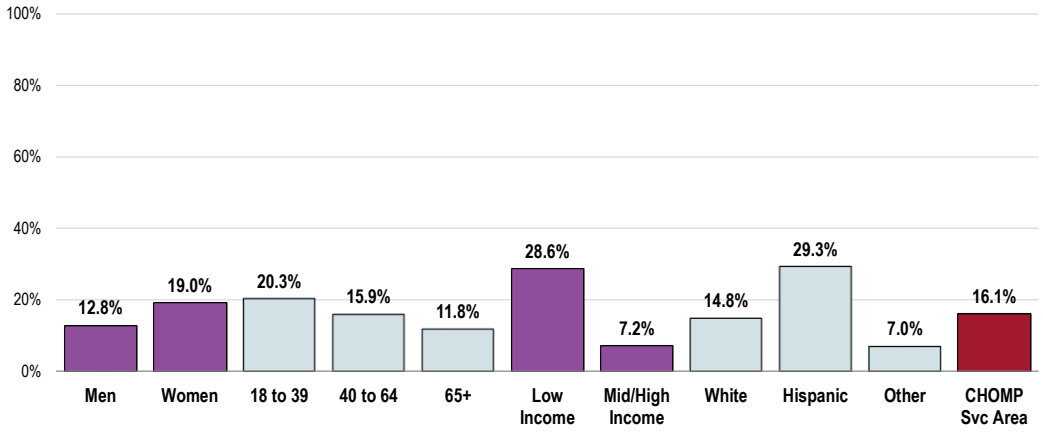


Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 103]
• 2015 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

Those more likely to report difficulty getting fresh fruits and vegetables include:

- Women.
- Younger adults (negative correlation with age).
- Lower-income residents.
- Hispanics.

Find It "Very" or "Somewhat" Difficult to Buy Affordable Fresh Produce
(CHOMP Service Area, 2016)



Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 103]
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. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Low Food Access (Food Deserts)

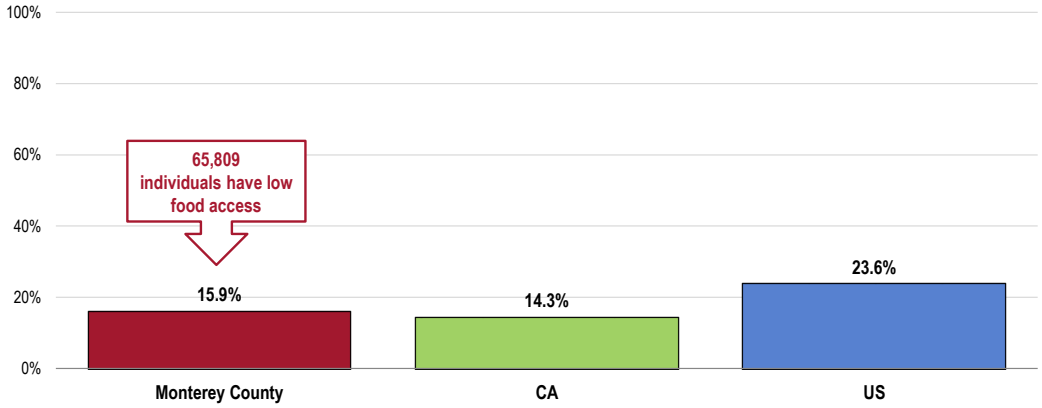
A food desert is defined as a low-income area where a significant number or share of residents is far from a supermarket, where "far" is more than 1 mile in urban areas and more than 10 miles in rural areas.

US Department of Agriculture data show that 15.9% of the Monterey County population (representing over 65,800 residents) have low food access or live in a "food desert," meaning that they do not live near a supermarket or large grocery store.

- Slightly less favorable than statewide findings.
- More favorable than national findings.

Population With Low Food Access

(Percent of Population That Is Far From a Supermarket or Large Grocery Store, 2010)

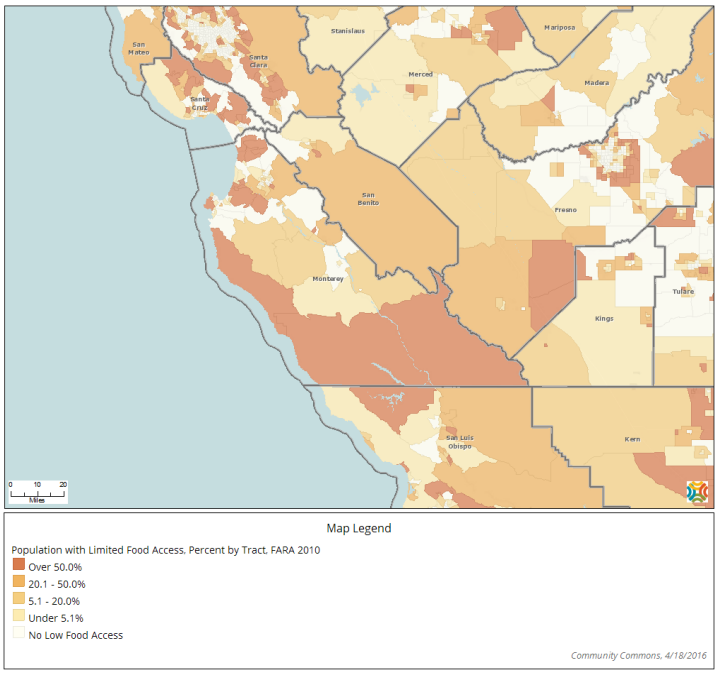


Sources:
- US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas (FARA).
- Retrieved April 2016 from Community Commons at http://www.chna.org.

Notes:
- This indicator reports the percentage of the population living in census tracts designated as food deserts. A food desert is defined as low-income areas where a significant number or share of residents is far from a supermarket, where "far" is more than 1 mile in urban areas and more than 10 miles in rural areas. This indicator is relevant because it highlights populations and geographies facing food insecurity.

- The following map provides an illustration of food deserts by census tract. Note the large share of residents with limited food access along the coastline and in southern Monterey County.

Population With Limited Food Access, Percent by Tract, FARA 2010

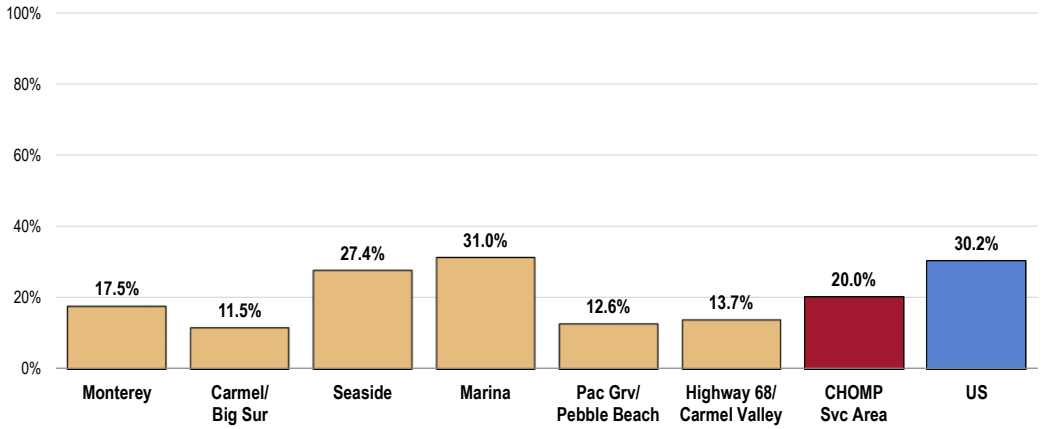


Sugar-Sweetened Beverages

One-fifth (20.0%) of CHOMP Service Area adults reports drinking an average of at least one sugar-sweetened beverage per day in the past week.

- Notably more favorable than national findings.
- Least favorable in Seaside and Marina.

Had Seven or More Sugar-Sweetened Beverages in the Past Week



Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 212]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

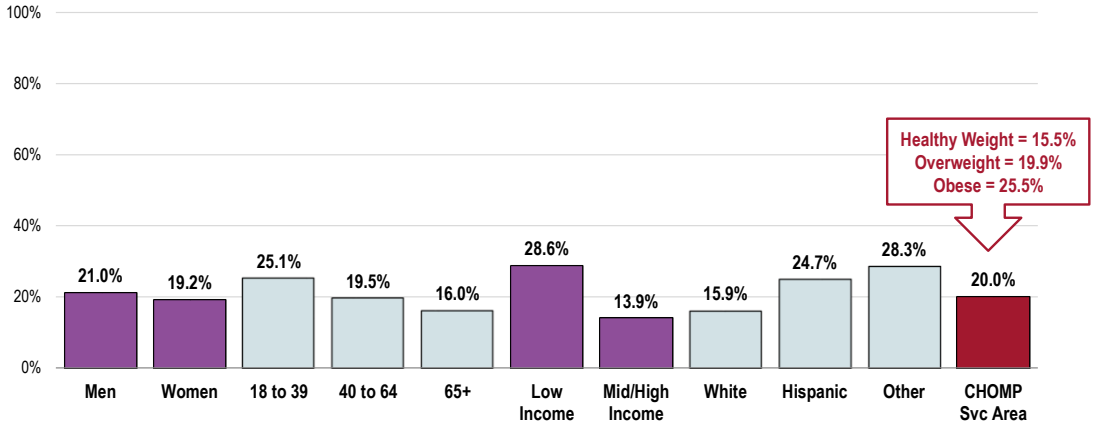
Notes:
- Asked of all respondents.

Those more likely to consume this level of sugar-sweetened beverages include:

- Younger adults (negative correlation with age).
- Lower-income residents.
- Hispanics and “Other” race adults.
- Obese residents.

Had Seven or More Sugar-Sweetened Beverages in the Past Week

(CHOMP Service Area, 2016)



Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 212]

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. "Low Income" includes households with defined poverty status up to incomes just above the FPL, earning up to twice the poverty threshold; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

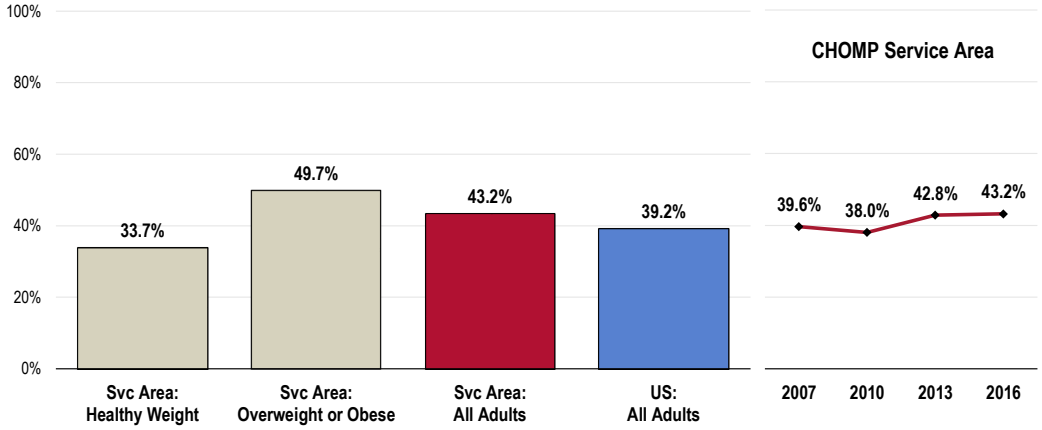
Health Advice About Diet & Nutrition

A total of 43.2% of survey respondents acknowledge that a physician counseled them about diet and nutrition in the past year.

- Statistically similar to national findings.
- No statistical difference by community.
- TREND: Statistically unchanged since 2007.
- Note: Among overweight/obese respondents, 49.7% report receiving diet/nutrition advice (meaning that one-half 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 301]
- 2013 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

Physical Activity

About 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); and 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); and 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)

Leisure-Time Physical Activity

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.

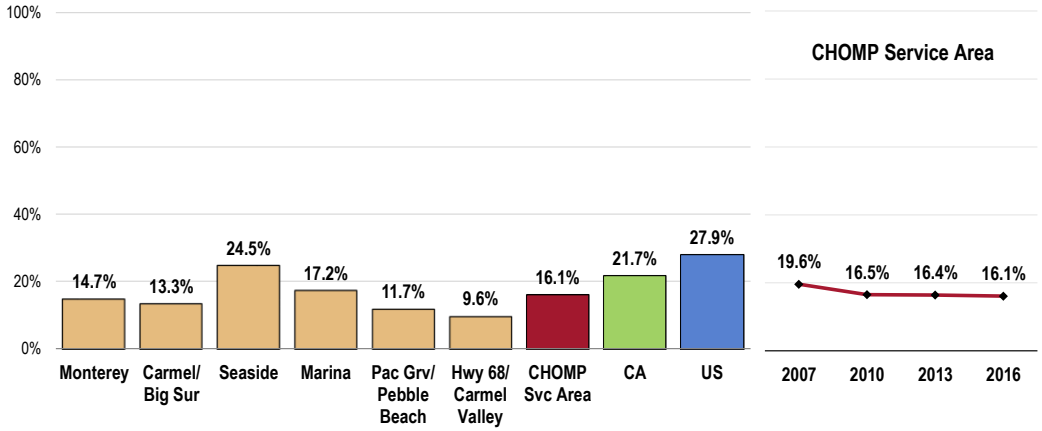
A total of 16.1% of CHOMP Service Area adults report no leisure-time physical activity in the past month.

- More favorable than statewide and national findings.
- Satisfies the Healthy People 2020 target (32.6% or lower).

- Less favorable in Seaside.
- TREND: A statistical increase in leisure-time physical activity has occurred since 2007.

No Leisure-Time Physical Activity in the Past Month

Healthy People 2020 Target = 32.6% or Lower



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): 2014 California data.
- 2015 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.

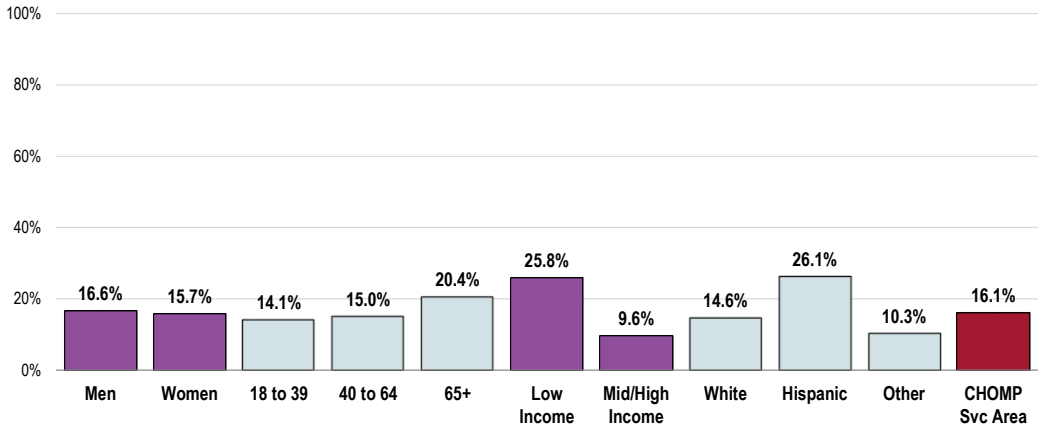
Lack of leisure-time physical activity in the area is higher among:

- Seniors (65+).
- Lower-income residents.
- Hispanics.

No Leisure-Time Physical Activity in the Past Month

(CHOMP Service Area, 2016)

Healthy People 2020 Target = 32.6% or Lower



Sources:
- 2016 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. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Activity Levels

Adults

Recommended Levels of Physical Activity

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

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

- 2013 Physical Activity Guidelines for Americans, US Department of Health and Human Services. www.cdc.gov/physicalactivity
- Learn more about CDC's efforts to promote walking by visiting http://www.cdc.gov/vitalsigns/walking.

Aerobic & Strengthening Physical Activity

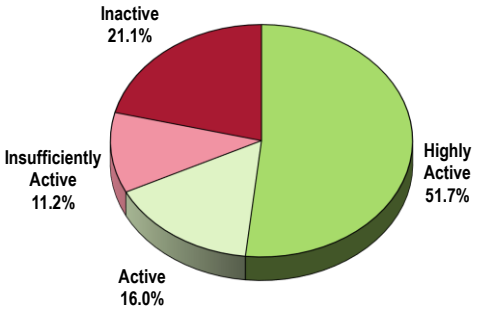
Survey respondents were asked about the types of physical activities they engaged in during the past month, as well as the frequency and duration of these activities.

- "Inactive" includes those reporting no aerobic physical activity in the past month.
- "Insufficiently active" includes those with the equivalent of 1-150 minutes of aerobic physical activity per week.
- "Active" includes those with 150-300 minutes of weekly aerobic physical activity.
- "Highly active" includes those with >300 minutes of weekly aerobic physical activity.

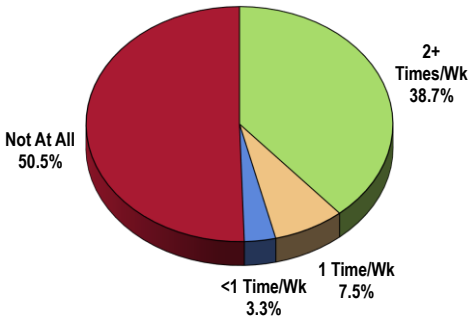
Based on reported physical activity intensity, frequency and duration over the past month, 32.3% of CHOMP Service Area adults are found to be "insufficiently active" or "inactive."

A total of 50.5% of CHOMP Service Area adults do not participate in any types of physical activities or exercises to strengthen their muscles.

Participation in Physical Activities
(CHOMP Service Area, 2016)



Aerobic Activity



Strengthening Activity

Sources: ● 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 113, 173]
Notes: ● Reflects the total sample of respondents.
● In this case, "inactive" aerobic activity represents those adults participating in no aerobic activity in the past week; "insufficiently active" reflects those respondents with 1–149 minutes of aerobic activity in the past week; "active" adults are those with 150–300 minutes of aerobic activity per week; and "highly active" adults participate in 301+ minutes of aerobic activity weekly.

Recommended Levels of Physical Activity

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

Aerobic activity is at least 150 minutes per week of light to moderate activity or 75 minutes per week of vigorous physical activity or an equivalent combination of both; and

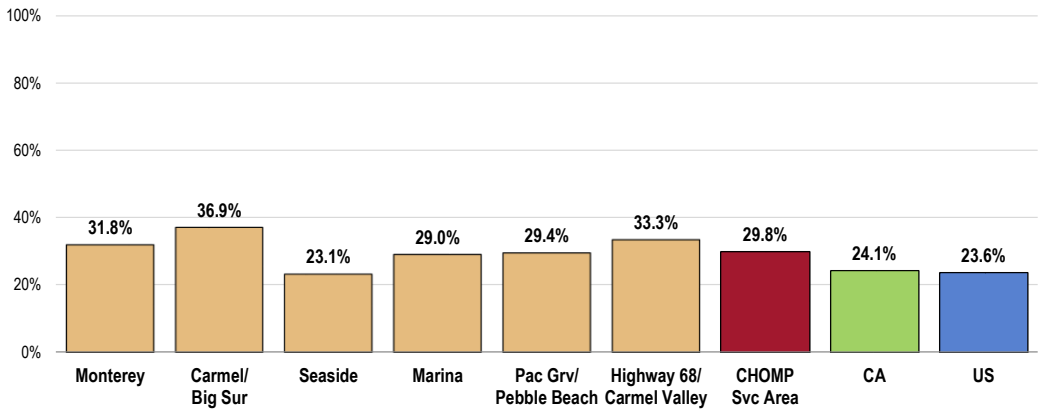
Strengthening activity is at least 2 sessions per week of exercise designed to strengthen muscles.

A total of 29.8% of CHOMP Service Area adults regularly participate in adequate levels of both aerobic and strengthening activities (meeting physical activity recommendations).

- More favorable than statewide and national findings.
- Satisfies the Healthy People 2020 target (20.1% or higher)

Meets Physical Activity Recommendations

Healthy People 2020 Target = 20.1% or Higher



Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 174]
- 2015 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): 2013 California data.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective PA-4]

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

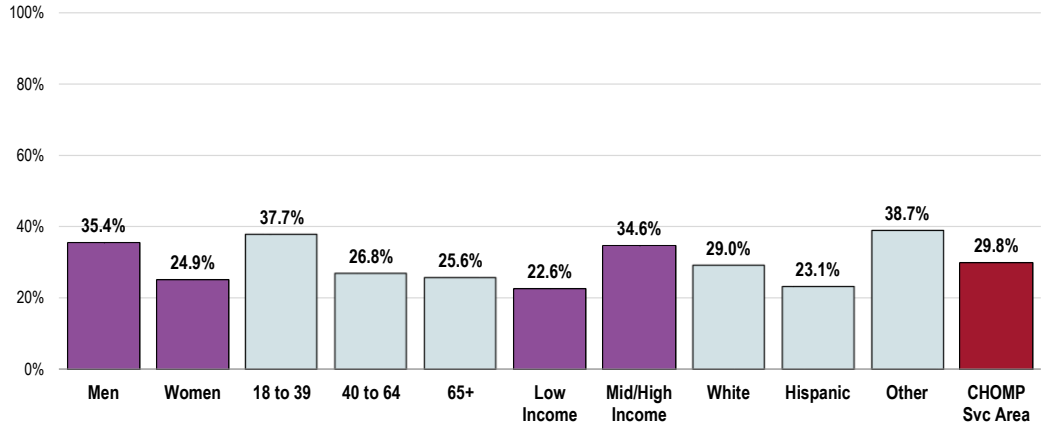
Those less likely to meet physical activity requirements include:

- Women.
- Adults age 40 and older.
- Residents with low incomes.
- Hispanics.

Meets Physical Activity Recommendations

(CHOMP Service Area, 2016)

Healthy People 2020 Target = 20.1% or Higher



Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 174]
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective PA-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. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
- Meeting both guidelines is defined as the number of persons age 18+ who report light or moderate aerobic activity for at least 150 minutes per week or who report vigorous physical activity 75 minutes per week or an equivalent combination of moderate and vigorous-intensity activity *and* report doing physical activities specifically designed to strengthen muscles at least twice per week.

Children

Recommended Levels of Physical Activity

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

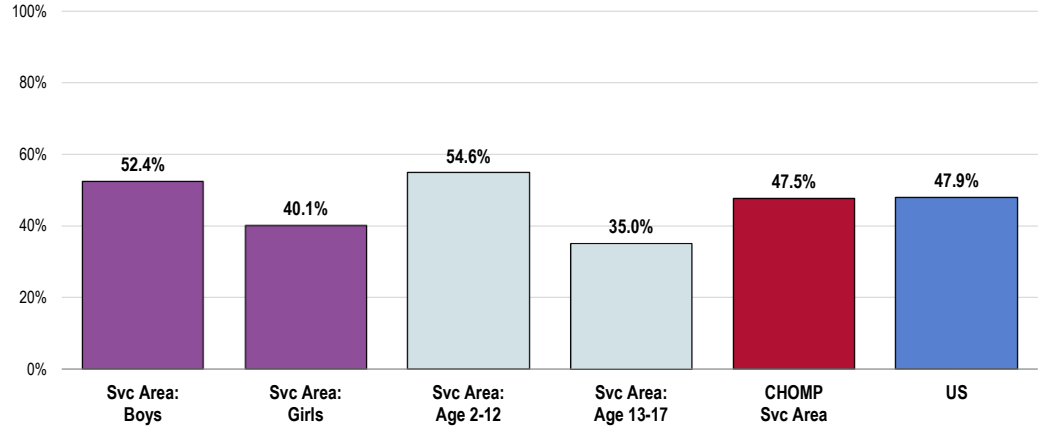
- 2013 Physical Activity Guidelines for Americans, US Department of Health and Human Services. www.cdc.gov/physicalactivity

Among CHOMP Service Area children age 2 to 17, 47.5% are reported to have had 60 minutes of physical activity on each of the seven days preceding the interview (1+ hours per day).

- Similar to national findings.
- No statistical difference by gender.
- By age, children 2-12 are more likely than teenagers to be physically active for 1+ hours per day.

Child Is Physically Active for One or More Hours per Day

(Among Children Age 2-17)



Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 142]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

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

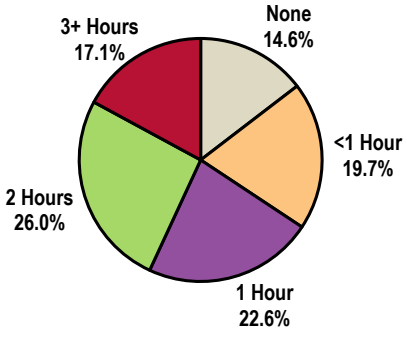
Television Watching & Other Screen Time

Among children aged 5 through 17, 17.1% are reported to watch three or more hours of <u>television</u> per day; 19.7% are reported to spend three or more hours on <u>other types of screen time</u> for entertainment (video games, Internet, etc.).

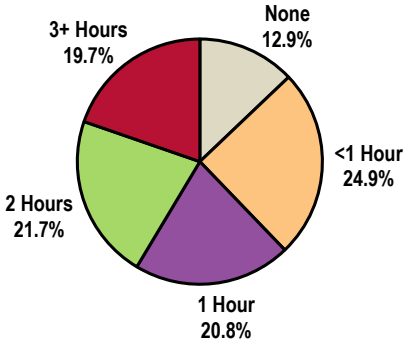
- More favorable than found nationally (not shown).

Children's Screen Time

(Among Parents of Children Age 5-17; CHOMP Service Area, 2016)



Hours per Day of Television



Hours per Day of Other Screen Time

(i.e., video games, computer/Internet for entertainment)

Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 307-308]

Notes:
- Asked of respondents with a child aged 5 to 17 in the household.

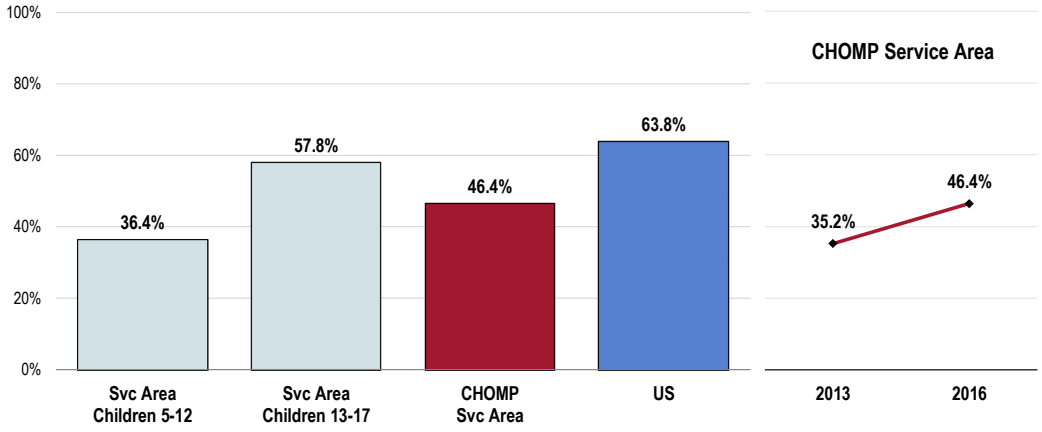
Total Screen Time

When combined, 46.4% 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.

- Much more favorable than found nationally.
- By age, teenagers are statistically more likely to have 3+ hours of screen time per school day than children age 5 to 12.
- TREND: Denotes a statistically significant increase from 2013 survey findings.

Children With Three or More Hours per School Day of Total Screen Time [TV, Computer, Video Games, Etc. for Entertainment]

(Among Parents of Children Age 5-17)



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 218]
- 2014 PRC National Children & Adolescent 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.

Access to Physical Activity

In 2013, there were 5.3 recreation/fitness facilities for every 100,000 population in Monterey County.

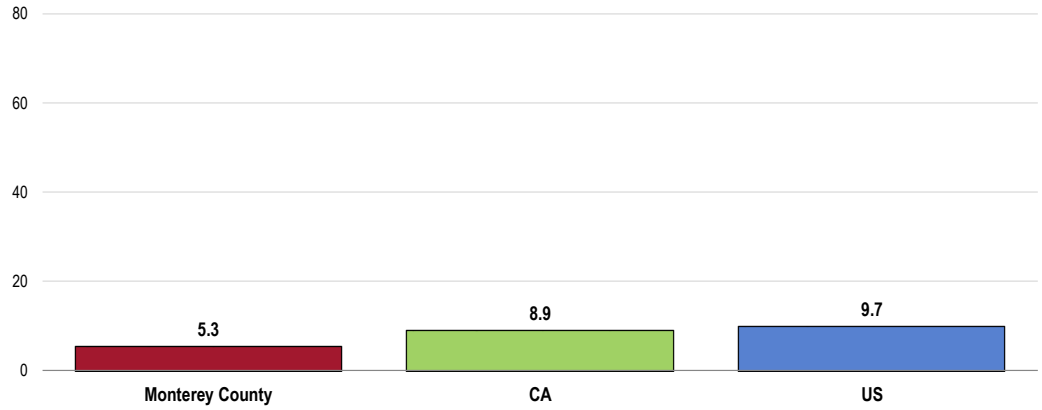
Here, recreation/fitness facilities include establishments engaged in operating facilities which offer "exercise and other active physical fitness conditioning or recreational sports activities."

Examples include athletic clubs, gymnasiums, dance centers, tennis clubs, and swimming pools.

- Below what is found statewide and nationally.

Population With Recreation & Fitness Facility Access

(Number of Recreation & Fitness Facilities per 100,000 Population, 2013)



Sources:
- US Census Bureau, County Business Patterns. Additional data analysis by CARES.
- Retrieved April 2016 from Community Commons at http://www.chna.org.

Notes:
- Recreation and fitness facilities are defined by North American Industry Classification System (NAICS) Code 713940 , which include *Establishments engaged in operating facilities which offer "exercise and other active physical fitness conditioning or recreational sports activities". Examples include athletic clubs, gymnasiums, dance centers, tennis clubs, and swimming pools.* This indicator is relevant because access to recreation and fitness facilities encourages physical activity and other healthy behaviors.

Weight Status

About Overweight & Obesity

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)

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

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

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

Adult Weight Status

Classification of Overweight and Obesity by BMI	BMI (kg/m^2)
Underweight	<18.5
Normal	18.5 – 24.9
Overweight	25.0 – 29.9
Obese	≥30.0

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

Overweight Status

Just over 6 in 10 CHOMP Service Area adults (62.2%) are overweight.

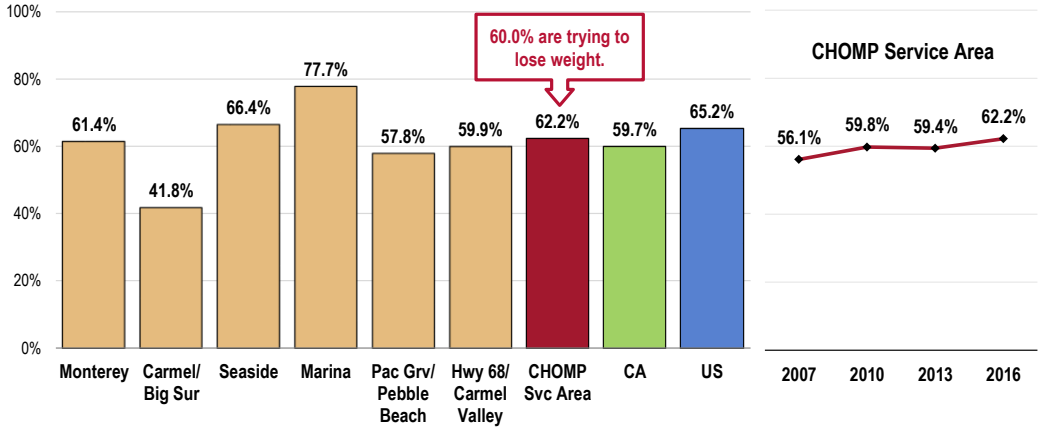
Here, "overweight" includes those respondents with a BMI value ≥25.

- Statistically comparable to both the California prevalence and US prevalence.
- Least favorable in Marina.
- TREND: The prevalence of overweight adults has risen since 2007.

Note that 60.0% of overweight adults are currently trying to lose weight.

Prevalence of Total Overweight

(Percent of Adults With a Body Mass Index of 25.0 or Higher)



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Items 176-177]
- 2015 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): 2014 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.

Further, 24.6% of CHOMP Service Area adults are obese.

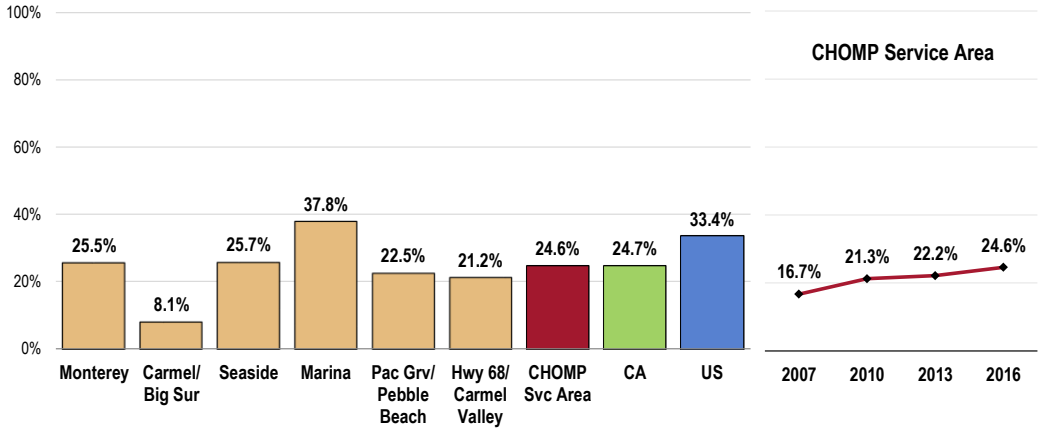
"Obese" (also included in overweight prevalence discussed previously) includes respondents with a BMI value ≥30.

- Nearly identical to California findings.
- More favorable than US findings.
- Satisfies the Healthy People 2020 target (30.5% or lower).
- Particularly high in Marina.
- TREND: Findings show that obesity has increased significantly over the past nine years.

Prevalence of Obesity

(Percent of Adults With a Body Mass Index of 30.0 or Higher)

Healthy People 2020 Target = 30.5% or Lower



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 176]
- 2015 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): 2014 California data.

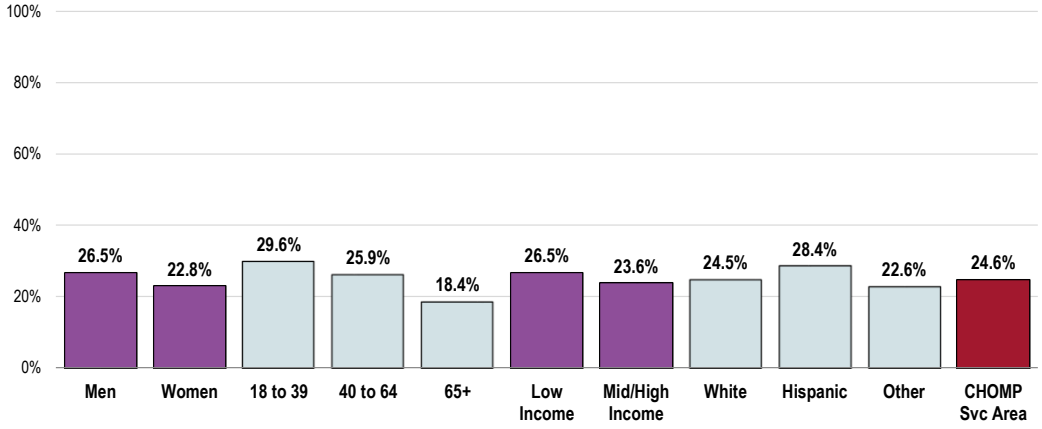
Notes:
- Based on reported heights and weights, asked of all respondents.
- The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0, regardless of gender.

- Note the negative correlation between obesity and age.

Prevalence of Obesity

(Percent of Adults With a BMI of 30.0 or Higher; CHOMP Service Area, 2016)

Healthy People 2020 Target = 30.5% or Lower



Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 176]
- 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. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of 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.

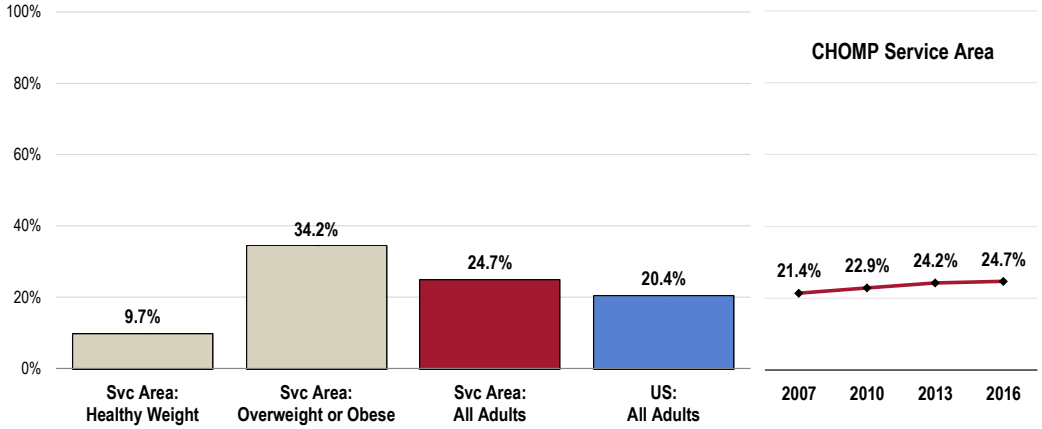
Health Advice

One-fourth (24.7%) of adults has been given advice about their weight by a doctor, nurse or other health professional in the past year.

- Higher than national findings.
- Higher in Marina; lower in Carmel/Big Sur (not shown).
- TREND: Statistically unchanged from previous findings.
- Note that 34.2% of overweight/obese adults have been given advice about their weight by a health professional in the past year (while over one-half have not).

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 115, 178-179]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

Relationship of Overweight With Other Health Issues

Overweight and obese adults are more likely to report a number of adverse health conditions. Among these are:

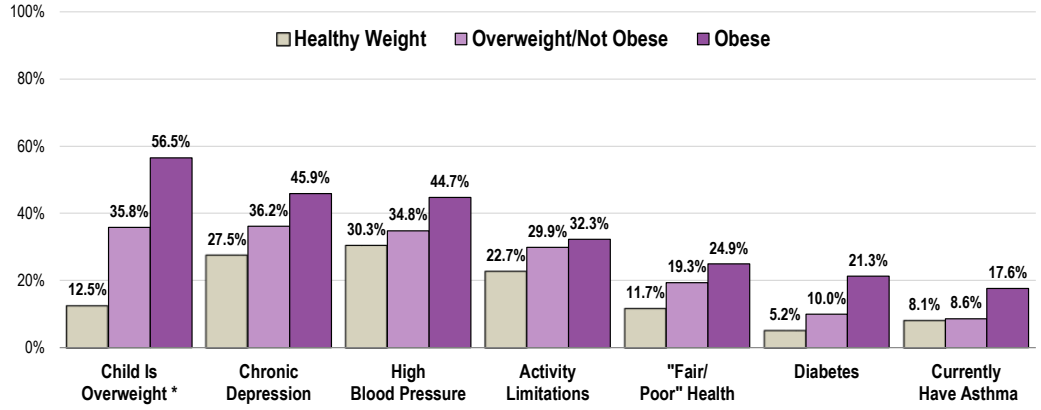
The correlation between overweight and various health issues cannot be disputed.

- Chronic depression.
- High blood pressure
- Activity limitations.
- "Fair" or "poor" physical health.
- Diabetes.
- Current asthma.

Overweight/obese residents are also more likely to have overweight children.

Relationship of Overweight With Other Health Issues

(By Weight Classification; CHOMP Service Area, 2016)



Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 5, 117, 128, 147, 156, 158, 180]

Notes:
- Based on reported heights and weights, asked of all respondents.
- *Use caution when interpreting as sample sizes are small (<50).

Children's Weight Status

About Weight Status in Children & Teens

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

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

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

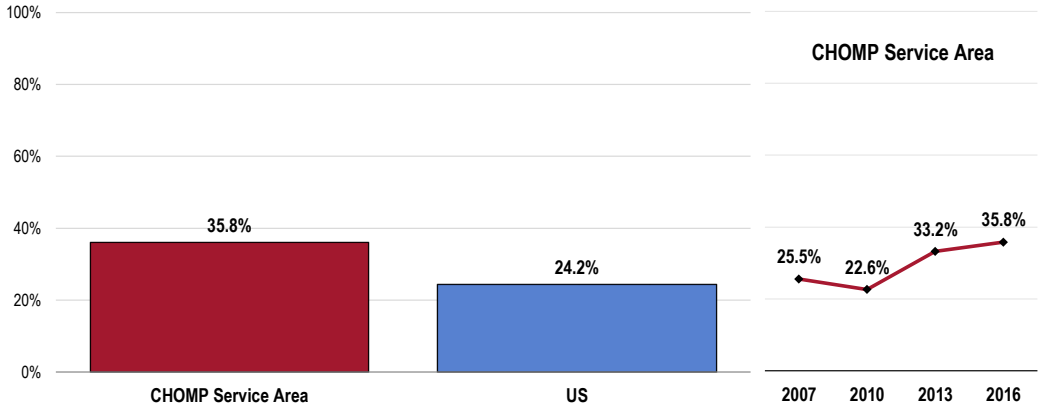
- Centers for Disease Control and Prevention

Based on the heights/weights reported by surveyed parents, 35.8% of CHOMP Service Area children age 5 to 17 are overweight or obese (≥85th percentile).

- Much less favorable than found nationally.
- TREND: Statistically unchanged since 2007.

Child Total Overweight Prevalence

(Children Age 5-17 Who Are Overweight/Obese; BMI in the 85th Percentile or Higher)



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 180]
- 2015 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 85th percentile of US growth charts by gender and age.

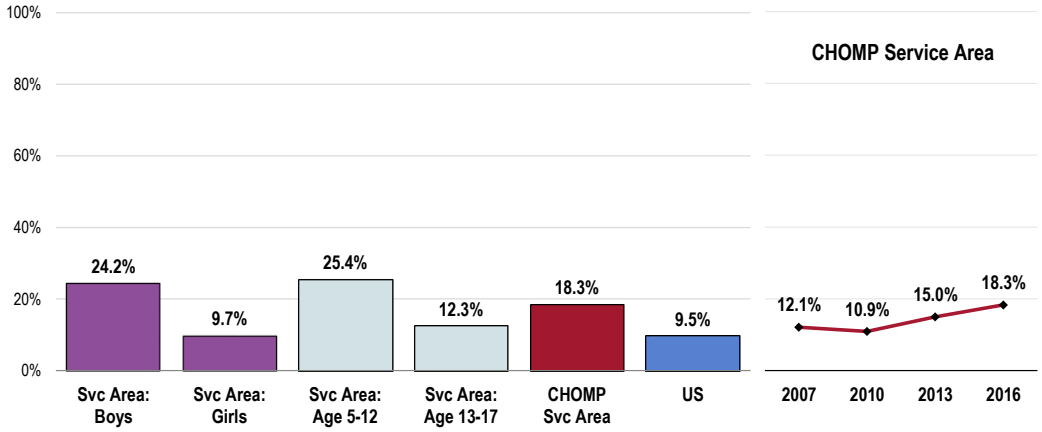
Further, 18.3% of area children age 5 to 17 are obese (≥95th percentile).

- Less favorable than the national percentage.
- Statistically comparable to the Healthy People 2020 target (14.5% or lower for children age 2-19).
- TREND: Statistically unchanged since 2007.
- Obesity is more prevalent among boys than girls in the service area.
- Statistically similar by child's age.

Child Obesity Prevalence

(Children Age 5-17 Who Are Obese; BMI in the 95th Percentile or Higher)

Healthy People 2020 Target = 14.5% or Lower



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 180]
- 2015 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]

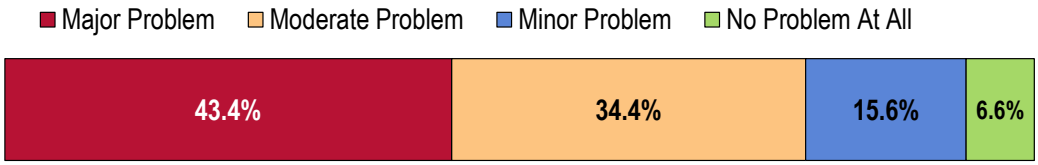
Notes:
- Asked of all respondents with children age 5-17 at home.
- Obesity among children is determined by children's Body Mass Index status equal to or above the 95th percentile of US growth charts by gender and age.

Key Informant Input: Nutrition, Physical Activity & Weight

Key informants taking part in an online survey most often characterized *Nutrition, Physical Activity & Weight* as a "major problem" in the community.

Perceptions of Nutrition, Physical Activity, and Weight as a Problem in the Community

(Key Informants, 2016)



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

Top Concerns

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

Weight Status

The poor are at a higher risk for obesity due to lower costs of takeout food vs. nutrition packed foods or veggies. – Public Health Representative

Monterey county overall has a very high obesity when compared to the national average or the state average. – Community/Business Leader

Obesity, as a result of a sedentary lifestyle for many Americans, is at epidemic proportions. – Physician

Obesity and diabetes rates continue to rise. – Public Health Representative

Too many obese people and especially children and increasing. Improper diet, not enough exercise, no regular P.E. in schools. Too much screen time. Portions too big in restaurants. Too much fast food. Improper food labeling that is misleading. – Community/Business Leader

Most people are overweight due to their diets and inactivity. – Community/Business Leader

Rampant childhood obesity. Lack of physical activity in children's daily lives. Financial incentives for the poor to eat terrible foods. Compare a Happy Meal to fruits and veggies. Lack of a concerted community-wide multi-disciplinary effort to raise awareness. – Physician

Health Education

Lack of education, community gardens and farmers markets. – Public Health Representative

Lack of education about the issues. Lack of education in the appropriate languages about these issues. Poverty. No time for parents who are working so hard to spend time with their children and provide opportunities for their children. Poor quality childcare. – Community/Business Leader

Poor education about nutrition and health. Lack of physical activities. – Community/Business Leader

Many people remain ignorant of the serious health challenges from being overweight and lack of exercise and proper nutrition. I applaud the recent focus in many schools. I also want work places to both educate and promote exercise and healthy eating. – Social Services Provider

Education, family tradition, lack of affordable food, lack of healthy food available, ready to eat fast. – Community/Business Leader

It relates to all of the above. We need to be more proactive in preventing all these diseases by school based programs teaching health, aerobic activity such as running, nutrition education. – Community/Business Leader

Prevalent in children. Changes needed in information transmission changes in big advertisement. Clear direct links of behavior to health. – Physician

Lack of structured programs. – Community/Business Leader

Many members of the community work long hours and, or two jobs. There are no gyms or other places to exercise or to get guidance with exercise programs. The state park and some local trails are available when the days are longer and it is neither safe nor weatherproof. – Other Health Provider

Diet/Exercise

Societal pressures for extreme calorie consumption. Large portions, high concentrations of sugars and salts. Starbucks addictions to high fat and sweetened drinks. Not enough emphasis on physical activity in some communities. – Social Services Provider

This is big time lacking in this community. – Physician

Cultural challenges with respect to food choices. Time element for physical activity and food choices for weight. – Community/Business Leader

Nutrition and weight control are the 31 treatment for patient with pre-diabetes and diabetes. – Other Health Provider

Loss of cultural expectations about cooking and personal preparation of food in favor of processed foods. Poor urban planning makes it easy to drive, difficult to walk. – Physician

If we get more people active and eating correctly, we eliminate a root cause for many illnesses. – Community/Business Leader

Low income diet. Education and affordability to participate in physical activities. – Social Services Provider

Greater access and opportunities are needed for affordable nutrition, physical activity. Support services for elders, people with disabilities and chronic conditions, and children with special needs. – Social Services Provider

Changing habits, culture, cost. Non-healthy food is cheaper. – Community/Business Leader

Built Environment

Availability, access to good quality, affordable food, time and education to prepare and eat it. Time and access to physical activity. No value placed on physical health, only on looks. No or insufficient insurance reimbursement for physical therapy. – Social Services Provider

Lack of walkable streets. Violence. – Public Health Representative

The built environments that do not encourage healthy lifestyles. – Public Health Representative

Built environment and easy access to non-nutritious foods. – Community/Business Leader

People are struggling to work multiple jobs or work long hours. They may live in environments that do not support this so this makes it harder for them. – Public Health Representative

Access to Healthful Food

Healthy food is more expensive than unhealthy. If you have a numerous family, which is the case for many in this community, you have to opt for unhealthy because that's what you can afford. This impacts directly nutrition and weight. – Social Services Provider

Community members do not have access to fresh foods and green space equitably. Many households work long hours and therefore do not have time to prepare healthy meals from scratch. Many rely on convenient, not so nutritious, foods to feed their families. – Public Health Representative

Healthy food is too expensive and less available, unhealthy food is cheaper and more accessible. People do not know how to prepare healthy food. – Social Services Provider

Access and education to healthy foods, lifestyle. – Community/Business Leader

Disease Management

Patient commitment. – Public Health Representative

Ability to make long term, sustainable activity and dietary changes are probably the biggest challenges to be found in any community. – Community/Business Leader

Currently less than 1% of the population and no children ages 12 to 19 meet the criteria for ideal cardiovascular health. Yet in a survey, 39% of the population rate themselves as being in ideal CV health. More children are at risk for high blood pressure. – Social Services Provider

Affordable Care/Services

> *It is unrealistic, the cost of a fitness program with a mentor or a coach. – Social Services Provider*
>
> *Insurance doesn't cover this, so, it's hard to pay for these resources. – Physician*

Sleep

Sleep

Sleep is an important part of good health, but an estimated 35% of US adults do not get enough sleep. Approximately 83 million US adults report usually sleeping less than 7 hours in a 24-hour period. According to professional sleep societies, adults aged 18 to 60 years should sleep at least 7 hours each night for the best health and wellness.

Sleeping less than 7 hours per night is linked to increased risk of chronic diseases such as diabetes, stroke, high blood pressure, heart disease, obesity, and poor mental health, as well as early death. Not getting the recommended amount of sleep can affect one's ability to make good decisions and increases the chances of motor vehicle crashes.

Habits for improving sleep health can include:

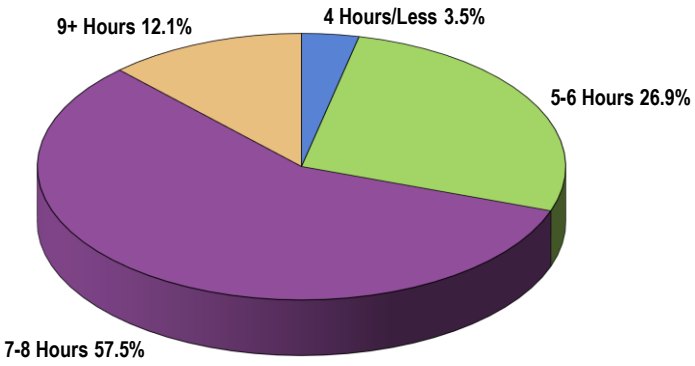
- Be consistent. Go to bed at the same time each night and get up at the same time each morning, including on the weekends.
- Make sure your bedroom is quiet, dark, relaxing, and at a comfortable temperature.
- Remove electronic devices, such as TVs, computers, and smart phones, from the bedroom.
- Avoid large meals, caffeine, and alcohol before bedtime.
- Avoid tobacco/nicotine.
- Get some exercise. Being physically active during the day can help you fall asleep more easily at night.

- Institute of Medicine (US) Committee on Sleep Medicine and Research; 2014 Behavioral Risk Factor Surveillance System (BRFSS), CDC

When asked how many hours of sleep they average per night, 57.5% of survey respondents stated between 7 and 8 hours, and 12.1% get 9+ hours of sleep per night.

- On the other hand, 30.4% of local adults sleep **fewer than 7 hours** per night (including 3.5% who report sleeping 4 hours or less on an average night).

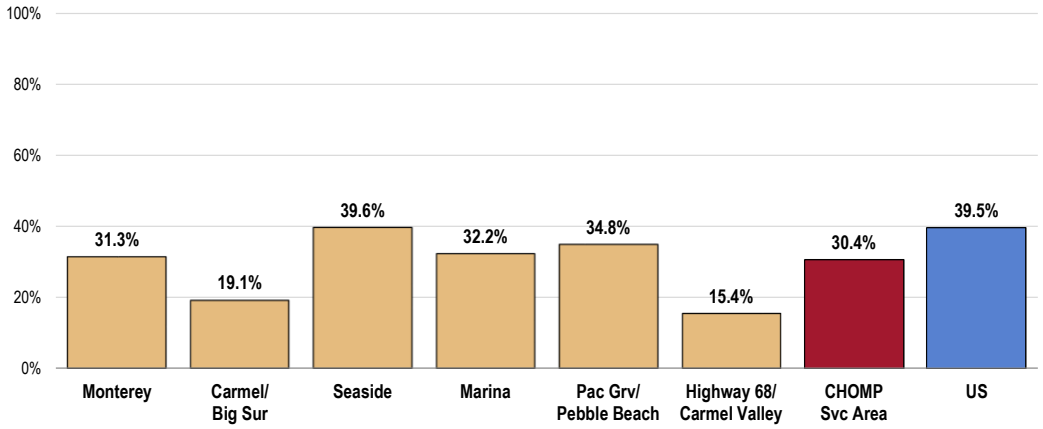
Average Hours of Sleep Per Night
(CHOMP Service Area, 2016)



Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 124]
Notes: • Asked of all respondents.

- The percentage of survey respondents averaging fewer than 7 hours per night is more favorable than the national figure.
- Less favorable in Seaside.

Generally Sleep Less Than Seven Hours Per Night



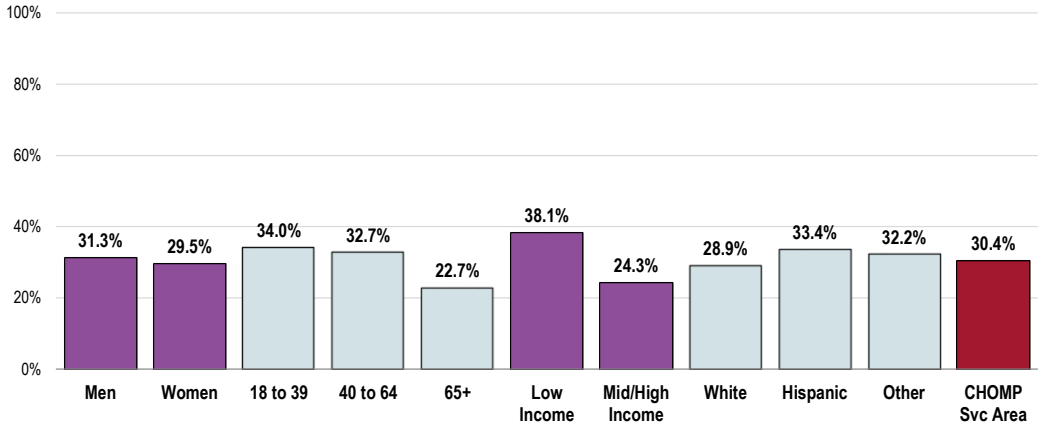
Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 213]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

These adults are more likely to sleep fewer than 7 hours on an average night:

- Younger adults (negative correlation with age).
- Low income.

Generally Sleep Less Than Seven Hours Per Night
(CHOMP Service Area, 2016)



Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 213]

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. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Substance Abuse

About Substance Abuse

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

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)

Age-Adjusted Cirrhosis/Liver Disease Deaths

Between 2012 and 2014, Monterey County reported an annual average age-adjusted cirrhosis/liver disease mortality rate of 9.4 deaths per 100,000 population.

- Lower than the statewide and national rates.
- Fails to satisfy the Healthy People 2020 target (8.2 or lower).

Cirrhosis/Liver Disease: Age-Adjusted Mortality

(2012-2014 Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 8.2 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 April 2016.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective SA-11]

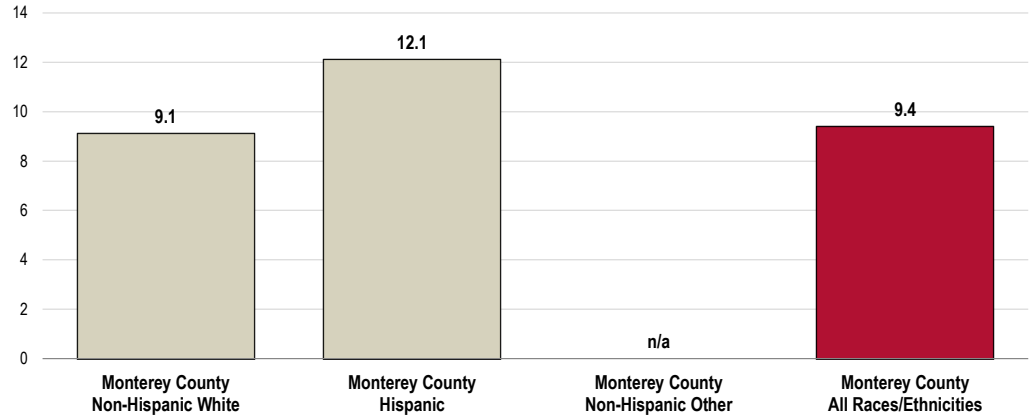
Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

- The cirrhosis mortality rate appears to be higher among Hispanics when compared with Non-Hispanic Whites.

Cirrhosis/Liver Disease: Age-Adjusted Mortality by Race

(2012-2014 Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 8.2 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 April 2016.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective SA-11]

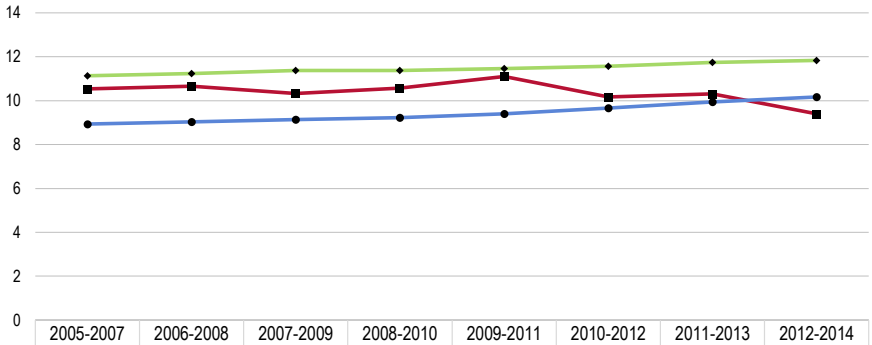
Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

- TREND: The mortality rate has fluctuated widely in the region, showing no clear trend. Statewide and nationwide, rates have increased slightly.

Cirrhosis/Liver Disease: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 8.2 or Lower



	2005-2007	2006-2008	2007-2009	2008-2010	2009-2011	2010-2012	2011-2013	2012-2014
Monterey County	10.5	10.7	10.3	10.6	11.1	10.2	10.3	9.4
CA	11.1	11.2	11.4	11.4	11.5	11.6	11.7	11.8
US	8.9	9.0	9.1	9.2	9.4	9.7	9.9	10.2

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2016.
- 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 US Standard Population.

Alcohol Use

Excessive Drinking

"**Excessive drinking**" includes heavy **and/or** binge drinkers:

- **Heavy drinkers** include men reporting 2+ alcoholic drinks per day or women reporting 1+ alcoholic drink per day in the month preceding the interview.
- **Binge drinkers** include men reporting 5+ alcoholic drinks or women reporting 4+ alcoholic drinks on any single occasion during the past month.

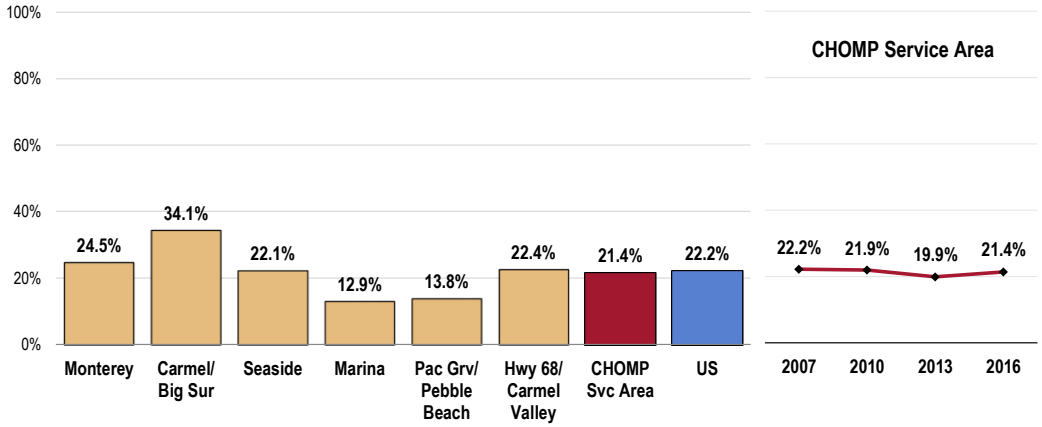
RELATED ISSUE:
See also *Stress* in the **Mental Health** section of this report.

A total of 21.4% of area adults are excessive drinkers (heavy and/or binge drinkers).

- Similar to the national proportion.
- Satisfies the Healthy People 2020 target (25.4% or lower).
- Notably high in Carmel/Big Sur.
- TREND: Statistically unchanged since 2007.

Excessive Drinkers

Healthy People 2020 Target = 25.4% or Lower



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 189]
- 2015 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-15]

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

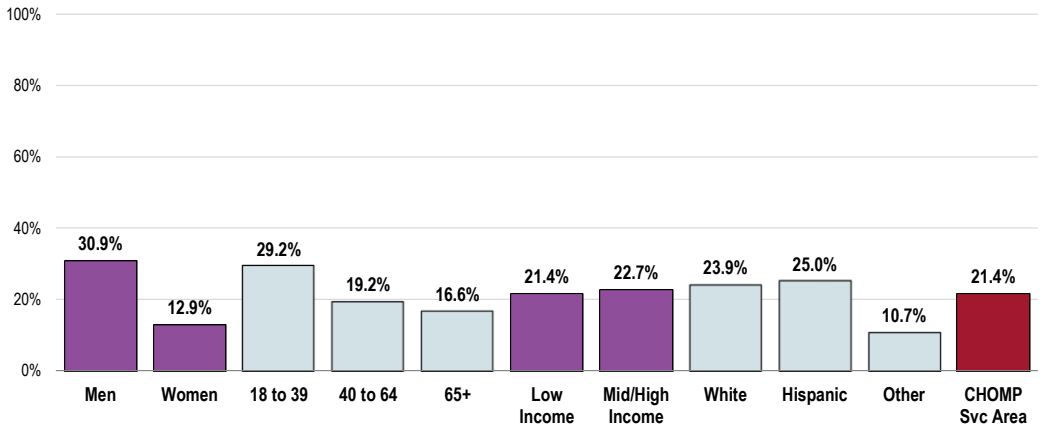
Excessive drinking is more prevalent among:

- Men.
- Young adults (negative correlation with age).
- Whites and Hispanics.

Excessive Drinkers

(CHOMP Service Area, 2016)

Healthy People 2020 Target = 25.4% or Lower



Sources:
- 2016 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-15]

Notes:
- Asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "NH 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. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
- Excessive drinking reflects the number of persons aged 18 years and over who drank more than two drinks per day on average (for men) or more than one drink per day on average (for women) OR who drank 5 or more drinks during a single occasion (for men) or 4 or more drinks during a single occasion (for women) during the past 30 days.

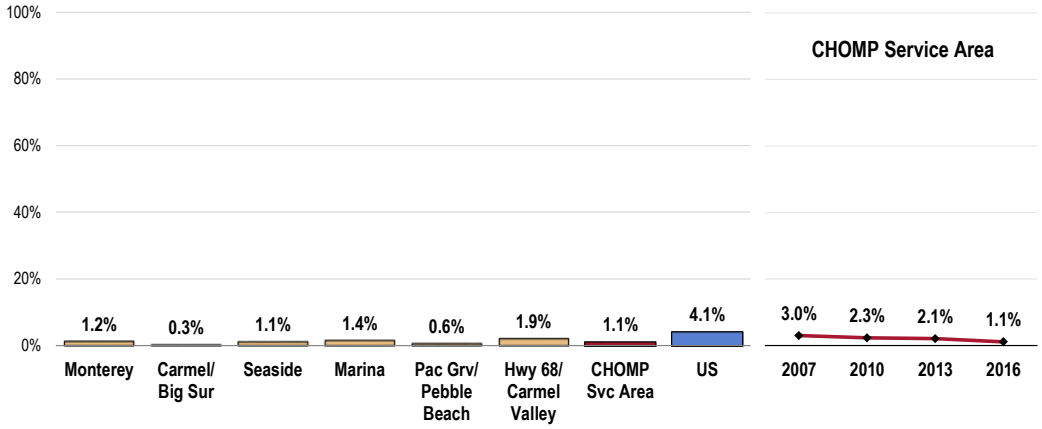
Drinking & Driving

A total of 1.1% of CHOMP Service Area adults acknowledge having driven a vehicle in the past month after they had perhaps too much to drink.

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.

- More favorable than national findings.
- Similar findings by community.
- TREND: The drinking and driving prevalence has decreased significantly since 2007.

Have Driven in the Past Month After Perhaps Having Too Much to Drink



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 66]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

Age-Adjusted Drug-Induced Deaths

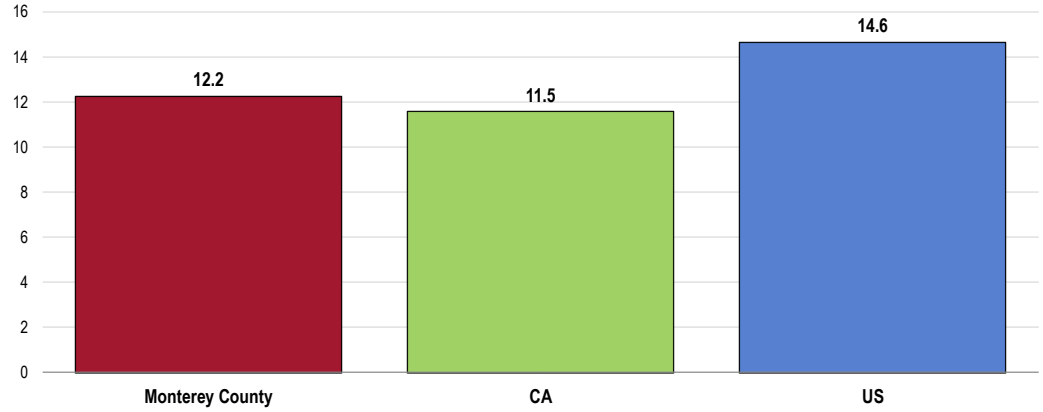
Between 2012 and 2014, there was an annual average age-adjusted drug-induced mortality rate of 12.2 deaths per 100,000 population in Monterey County.

- Slightly higher than the statewide rate.
- Lower than the national rate.
- Fails to satisfy the Healthy People 2020 target (11.3 or lower).

Drug-Induced Deaths: Age-Adjusted Mortality

(2012-2014 Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 11.3 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 April 2016.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective SA-12]

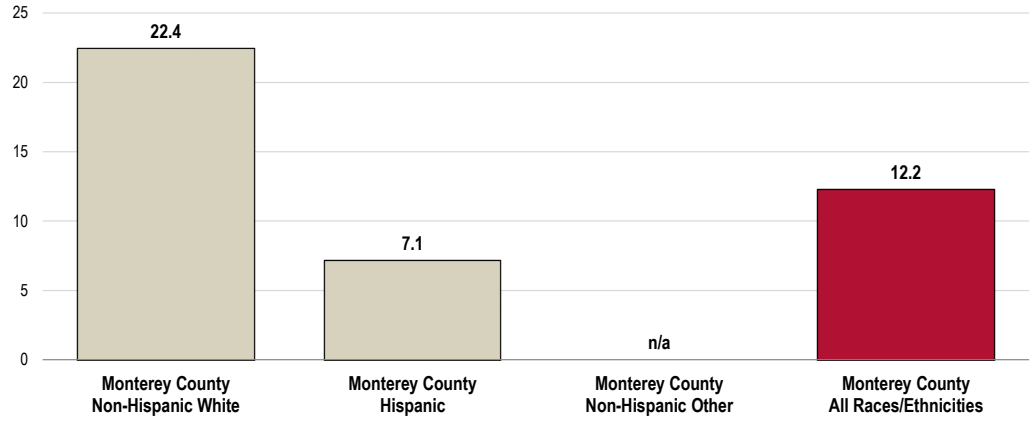
Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

- The drug-induced mortality rate appears to be more than three times higher among Non-Hispanic Whites than Hispanics.

Drug-Induced Deaths: Age-Adjusted Mortality by Race

(2012-2014 Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 11.3 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 April 2016.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective SA-12]

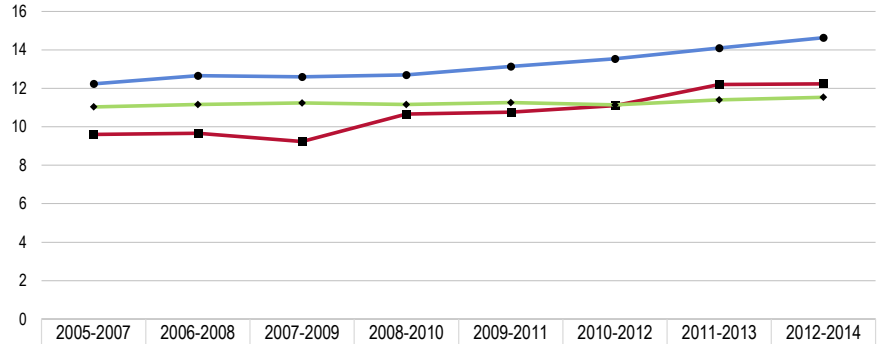
Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

- TREND: Despite fluctuations, the mortality rate in Monterey County has increased over the past decade. Nationally the trend has increased steadily, whereas the statewide rate remains relatively stable during this time.

Drug-Induced Deaths: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 11.3 or Lower



	2005-2007	2006-2008	2007-2009	2008-2010	2009-2011	2010-2012	2011-2013	2012-2014
Monterey County	9.6	9.7	9.2	10.7	10.8	11.1	12.2	12.2
CA	11.0	11.2	11.2	11.2	11.3	11.1	11.4	11.5
US	12.2	12.7	12.6	12.7	13.1	13.5	14.1	14.6

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2016.
- UD 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.

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.

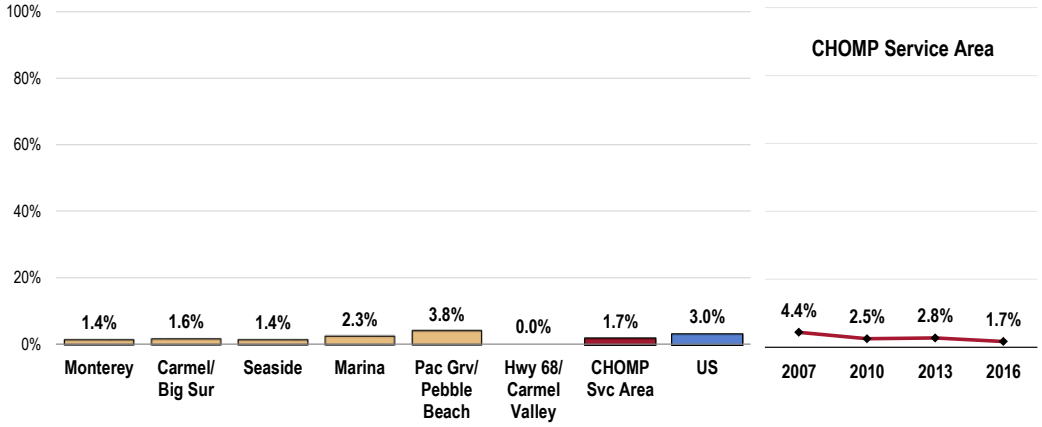
Note: As a self-reported measure – and because this indicator reflects potentially illegal behavior – it is reasonable to expect that it might be underreported, and that actual illicit drug use in the community is likely higher.

A total of 1.7% of CHOMP Service Area adults acknowledge using an illicit drug in the past month.

- Comparable to the proportion found nationally.
- Satisfies the Healthy People 2020 target of 7.1% or lower.
- Reportedly non-existent in Highway 68/Carmel Valley.
- TREND: Marks a statistically significant decrease over time.

Illicit Drug Use in the Past Month

Healthy People 2020 Target = 7.1% or Lower

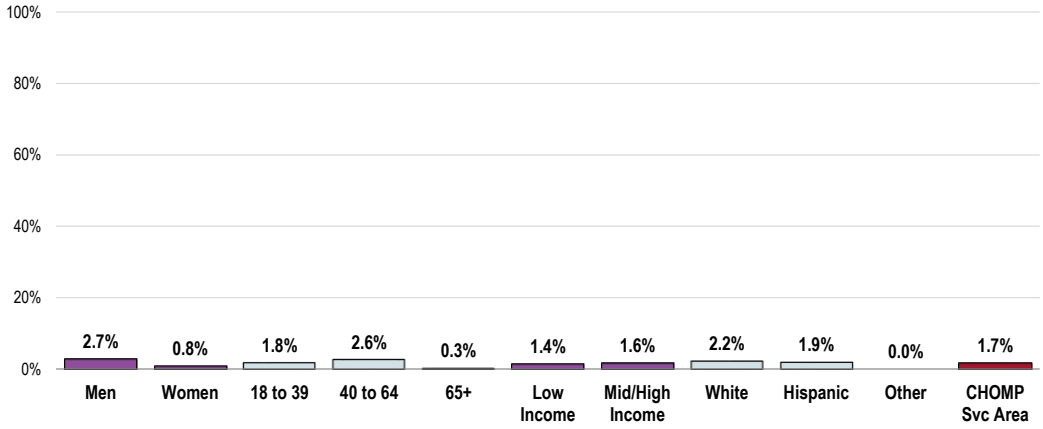


Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 67]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective SA-13.3]

Notes:
- Asked of all respondents.

- Illicit drug use is more prevalent among adults age 40 to 64 and Whites.

Illicit Drug Use in the Past Month
(CHOMP Service Area, 2016)
Healthy People 2020 Target = 7.1% or Lower



Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 67]
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective SA-13.3]

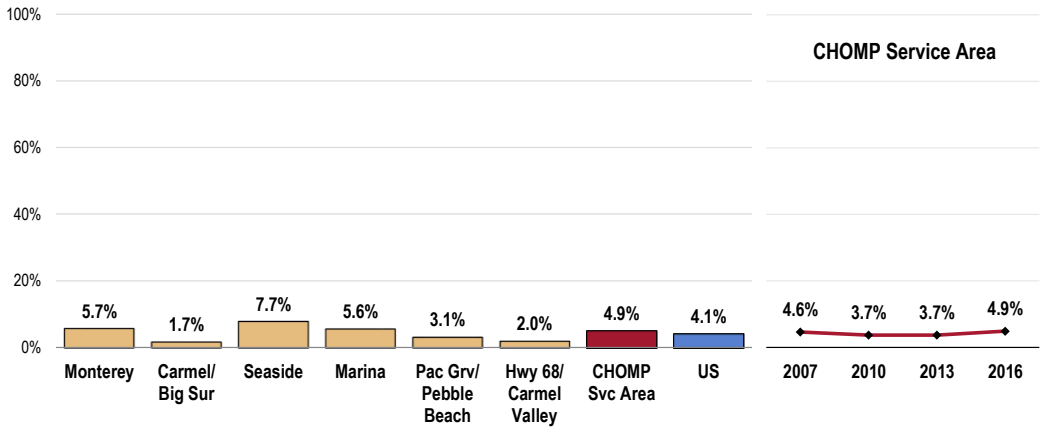
Notes:
- Asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "NH White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Alcohol & Drug Treatment

A total of 4.9% 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.
- Lowest in Carmel/Big Sur and Highway 68/Carmel Valley.
- TREND: Similar to the prevalence in 2007.

Have Ever Sought Professional Help for an Alcohol/Drug-Related Problem



Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 68]
● 2015 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all respondents.

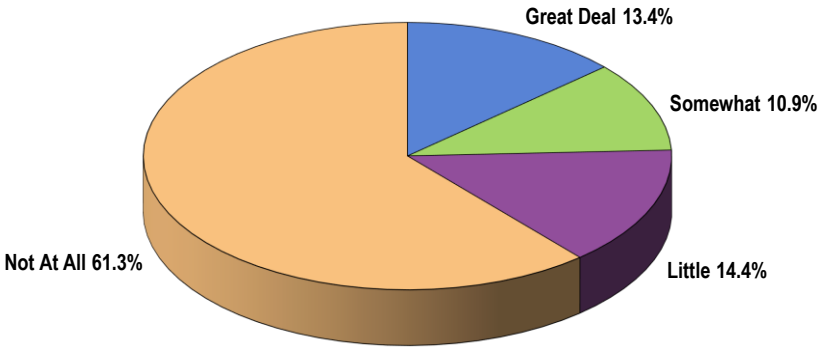
Negative Effects of Substance Abuse

Area adults were also asked to what degree their lives have been negatively affected by substance abuse (whether their own abuse or that of another).

In all, most respondents have not been negatively affected (61.3% "not at all" responses).

Degree to Which Life Has Been Negatively Affected by Substance Abuse (Self or Other's)

(CHOMP Service Area, 2016)

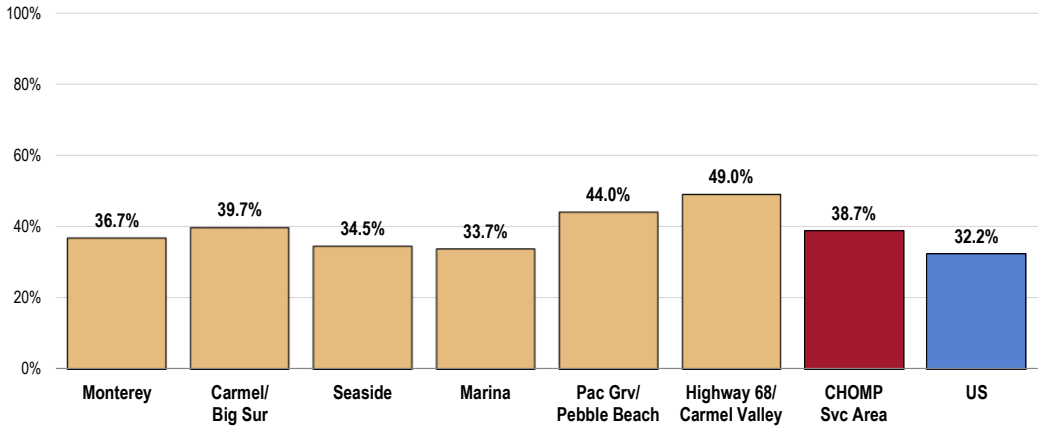


Sources: ● 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 69]
Notes: ● Asked of all respondents.

In contrast, 38.7% of survey respondents indicate that their lives have been negatively affected by substance abuse, including 13.4% who gave "a great deal" responses.

- The prevalence of area adults whose lives have been negatively affected by substance abuse is higher than the national response.
- Particularly high in Highway 68/Carmel Valley.

Life Has Been Negatively Affected by Substance Abuse (by Self or Someone Else)



Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 69]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

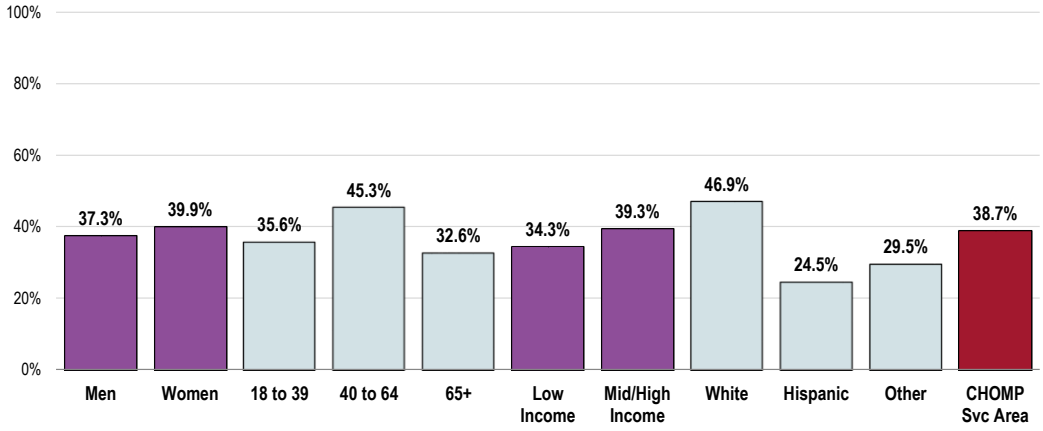
Notes:
- Asked of all respondents.

The prevalence of survey respondents whose lives have been negatively impacted by substance abuse, whether their own abuse or that of another, is higher among the following:

- Adults age 40 to 64.
- Whites.

Life Has Been Negatively Affected by Substance Abuse (by Self or Someone Else)

(CHOMP Service Area, 2016)



Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 69]

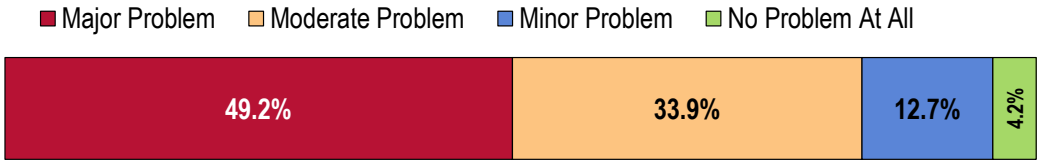
Notes:
- Asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Key Informant Input: Substance Abuse

The greatest share of key informants taking part in an online survey characterized *Substance Abuse* as a "major problem" in the community.

Perceptions of Substance Abuse as a Problem in the Community

(Key Informants, 2016)



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

Barriers to Treatment

Among those rating this issue as a "major problem," the greatest barriers to accessing substance abuse treatment are viewed as:

Access to Care/Services

Limited centers that focus on this. – Public Health Representative

Lack of treatment facilities, lack of doctors addressing substance abuse, lack of coordinated pathways for treatment. – Physician

Not sure. We have the Recovery Center at Hartnell, but I hear it is underutilized and now The Camp is moving in at Ryan Ranch. Marketing, accessibility, cost, aftercare services. – Community/Business Leader

Lack of beds in residential facilities. – Public Health Representative

Not enough resources at a suitable cost to families. – Social Services Provider

The 12 step approach can be very helpful in attaining sobriety. Often the sobriety achieved is only temporary. The 12 step model is much less effective at resolving the emotional problems that led to substance abuse in the first place. – Social Services Provider

Difficulty getting patients seen for detox and rehab, unless they have money or insurance. – Physician

Having the appropriate resource of substance abuse providers to help with the problem. – Physician

Substance abuse treatment is not financially accessible to many families. Treatment or therapy for youth is extremely expensive and almost always not covered though insurance. – Social Services Provider

Availability of services. – Social Services Provider

Lack of facilities. Questionable efficacy of treatment. – Physician

Not enough resources, waiting lists, poor reimbursements, not on the same par as mental health services, discourages organizations from expanding or new ones from coming into the market. Marijuana legalization does not encourage health related coverage. – Social Services Provider

Few pain management specialists and few rehab options for the neediest residents. – Physician

Not enough good services and very expensive. – Physician

Limited resources, proximity, transportation, language and cultural barriers, ignorance, mental health concerns, cultural isolation, fear of gangs and also of legal status issues. – Community/Business Leader

Getting a handle on the growing number of drugs being brought in. Education of the public on what they are, where they are, access to treatment. More rehab facilities are needed, many more along with qualified workers, continued care after they stop. – Social Services Provider

Denial/Stigma

Willingness of those addicted to seek help or assistance. – Community/Business Leader

Substance abuse is a brain disease. People who are active in the disease may not think about accessing help, when they do want/need help. They often have no health insurance because they often have no job due to a dual diagnosis or inability to work. – Public Health Representative

Stigma, and cost of treatment. Long, long waiting times, no cost options. – Other Health Provider

Denial that there is a problem. – Community/Business Leader

The user doesn't recognize they have a problem and doesn't want to go to treatment. It seems there are plenty of places that do treatment as outpatient or inpatient. – Community/Business Leader

Willingness of the abuser and cost of treatment. – Community/Business Leader

Recognition of what is a problem and early intervention with education. Sources of support. Sources for parents that would be supportive rather than punitive. Creative resources, speedy resources. Think outside the box. – Physician

Affordable Care/Services

We have none that is affordable. We have no one in the community helping with substance abuse. No Resources to refer people to. - Community/Business Leader

Affordable substance abuse programs. – Physician

Not enough affordable treatment programs. – Public Health Representative

Cost of treatment, lack of available treatment facilities, stigma, cheap and strong street drugs. – Community/Business Leader

Treatment programs that are affordable. – Community/Business Leader

Access to Culturally Relevant Services

Cultural influences. – Community/Business Leader

Lack of culturally and linguistically appropriate services that are available to meet the needs of our population, plus confusion on how to access the limited existing programs. – Public Health Representative

Access to Providers

I understand the demand for treatment exceeds provider capacity. – Community/Business Leader

Lack of providers specializing in addiction medicine. Some who do specialize often do not focus on root cause of addition like chronic pain, mental health. – Community/Business Leader

Diagnosis/Treatment

Identification and access to treatment centers ASAP. – Physician

Correct diagnosis, lack of housing and treatment facilities. – Community/Business Leader

Incidence/Prevalence

High use of narcotics in our community. It is very difficult to wing patients off benzos, narcotic or illicit drugs. A lot of these patients end up homeless and with no medical help. – Public Health Representative

Most who work with this population think substance abuse is severely underreported do to the large undocumented population. – Social Services Provider

Insurance Issues

Insurance covering stabilization crisis care only. – Social Services Provider

Lack of reimbursement source and limited provider capacity to provide treatment services. – Public Health Representative

Aging Population

There are a lot of seniors and people that stay at home and a big majority seems to have substance abuse problems. – Community/Business Leader

Generational Patterns

> *Generational repeat of patterns. Abandonment issues. Mental health and low self-esteem. – Social Services Provider*

Lifestyle

> *Individual lifestyle choice, education and support. – Community/Business Leader*

Coordinated Efforts

> *Not enough coordination among providers and schools. – Community/Business Leader*

Most Problematic Substances

Key informants (who rated this as a "major problem") clearly identified **alcohol** as the most problematic substance abused in the community, followed by **methamphetamine/other amphetamines**.

	Most Problematic	Second-Most Problematic	Third-Most Problematic	Total Mentions
Alcohol	66.7%	12.5%	12.5%	8
Methamphetamines or Other Amphetamines	11.1%	25.0%	12.5%	4
Prescription Medications	11.1%	12.5%	12.5%	3
Heroin or Other Opioids	0.0%	0.0%	37.5%	3
Club Drugs (e.g. MDMA, GHB, Ecstasy, Molly)	11.1%	12.5%	0.0%	2
Marijuana	0.0%	12.5%	12.5%	2
Cocaine or Crack	0.0%	12.5%	0.0%	1
Over-The-Counter Medications	0.0%	12.5%	0.0%	1
Inhalants	0.0%	0.0%	12.5%	1

Tobacco Use

About Tobacco Use

Tobacco use is the single most preventable cause of death and disease in the United States. 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.

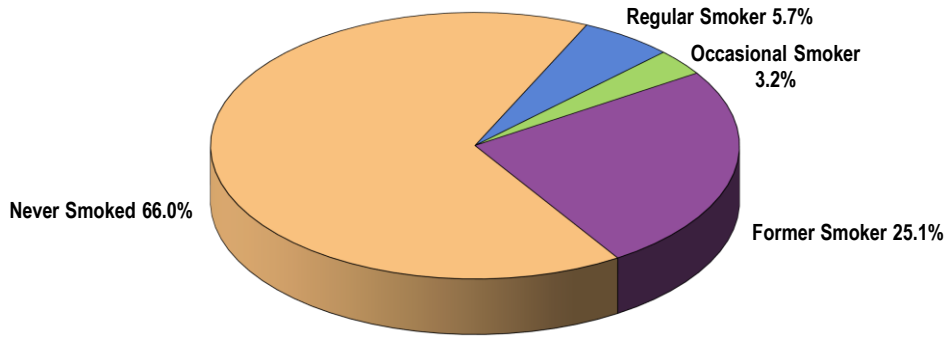
- Healthy People 2020 (www.healthypeople.gov)

Cigarette Smoking

Cigarette Smoking Prevalence

A total of 8.9% of CHOMP Service Area adults currently smoke cigarettes, either regularly (5.7% every day) or occasionally (3.2% on some days).

Cigarette Smoking Prevalence
(CHOMP Service Area, 2016)

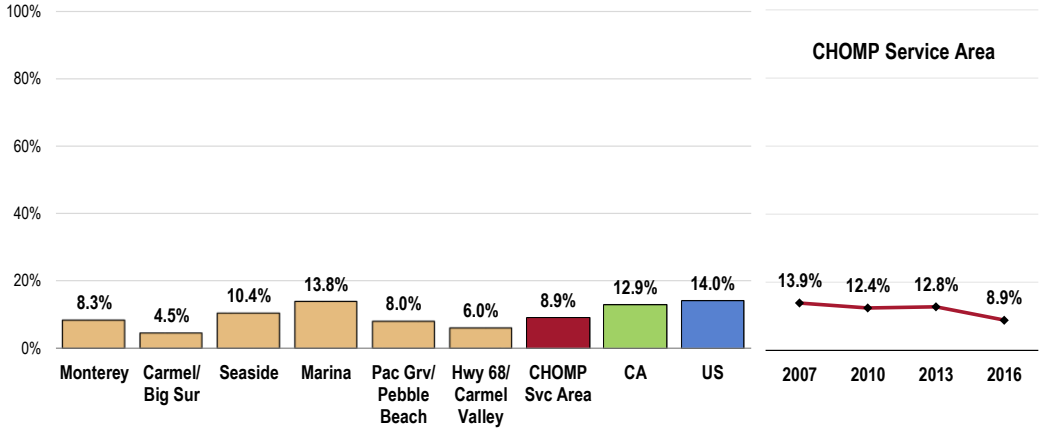


Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 181]
Notes: • Asked of all respondents.

- More favorable than statewide and national findings.
- Satisfies the Healthy People 2020 target (12% or lower).
- Less favorable in Marina.
- TREND: The current smoking percentage has decreased significantly since 2007.

Current Smokers

Healthy People 2020 Target = 12.0% or Lower



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 181]
- 2015 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): 2014 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 (those who smoke cigarettes every day or on some days).

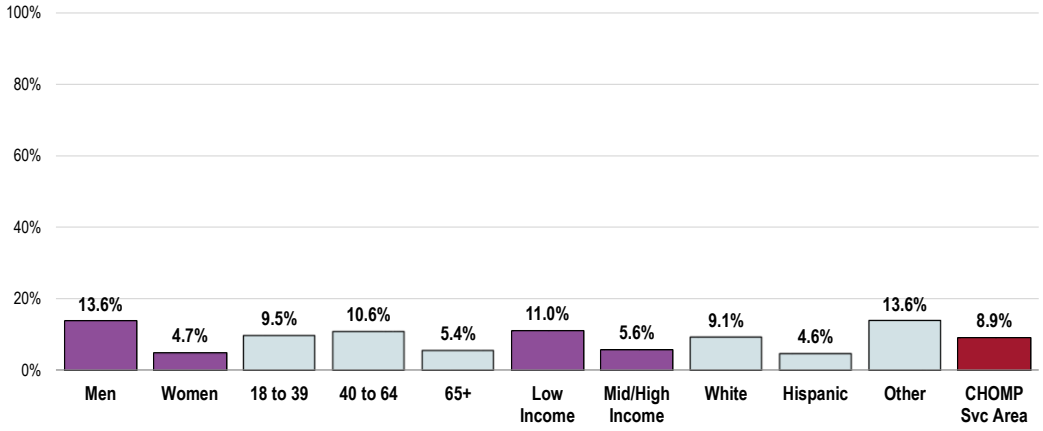
Cigarette smoking is more prevalent among:

- Men.
- Adults age 40 to 64.
- Lower-income residents.
- Whites and "Other" races.

Current Smokers

(CHOMP Service Area, 2016)

Healthy People 2020 Target = 12.0% or Lower



Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 181]
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective TU-1.1]

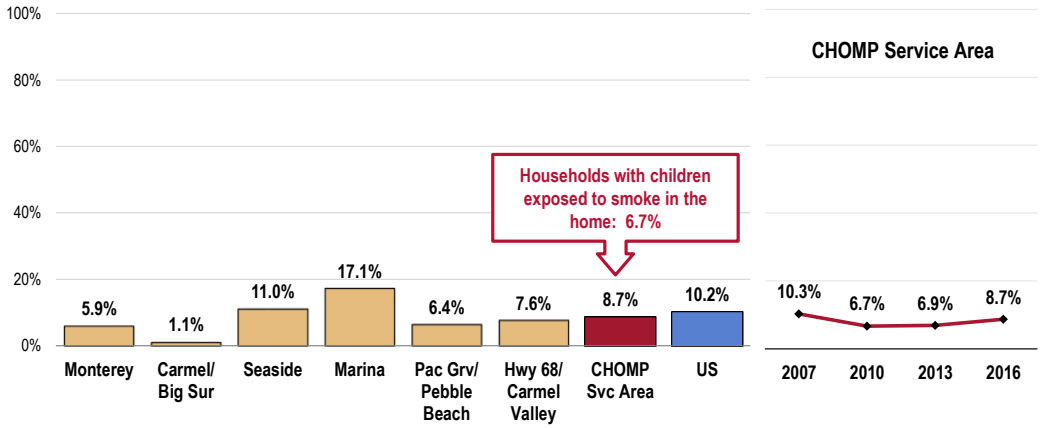
Notes:
- Asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
- Includes regular and occasion smokers (every day and some days).

Environmental Tobacco Smoke

A total of 8.7% of CHOMP Service Area adults (including smokers and nonsmokers) report that a member of their household has smoked cigarettes in the home an average of 4+ times per week over the past month.

- Similar to national findings.
- Least favorable in Marina.
- TREND: Statistically unchanged from the prevalence reported in 2007.
- Note that 6.7% of CHOMP Service Area children are exposed to cigarette smoke at home, statistically similar to what is found nationally.

Member of Household Smokes at Home



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Items 58, 184]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

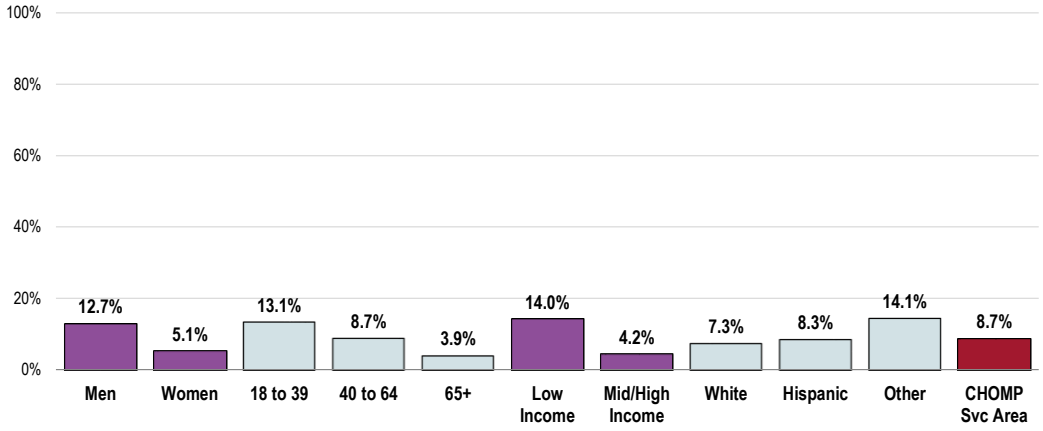
Notes:
- Asked of all respondents.
- "Smokes at home" refers to someone smoking cigarettes, cigars, or a pipe in the home an average of four or more times per week in the past month.

Notably higher among:

- Men.
- Younger adults (negative correlation with age).
- Residents with lower incomes.

Member of Household Smokes At Home

(CHOMP Service Area, 2016)



Sources:
- 2016 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. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of 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.

Smoking Cessation

About Reducing Tobacco Use

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)

Smoking Cessation Attempts

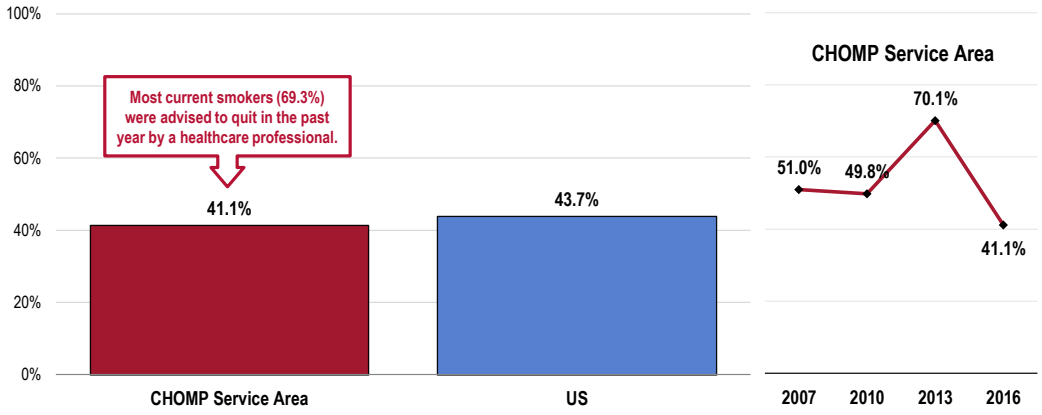
A total of 41.1% of regular smokers went without smoking for one day or longer in the past year because they were trying to quit smoking.

- Similar to the national percentage.
- Fails to satisfy the Healthy People 2020 target (80% or higher).
- TREND: Has decreased significantly in the past three years, but is statistically similar to the 2007 findings.
- Most current smokers (69.3%) have been advised by a healthcare professional in the past year to quit smoking.

Have Stopped Smoking for One Day or Longer in the Past Year in an Attempt to Quit Smoking

(Among Everyday Smokers)

Healthy People 2020 Target = 80.0% or Higher



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Items 56-57]
- 2015 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.
- *Use caution when interpreting as data is based on a small sample size (<50).

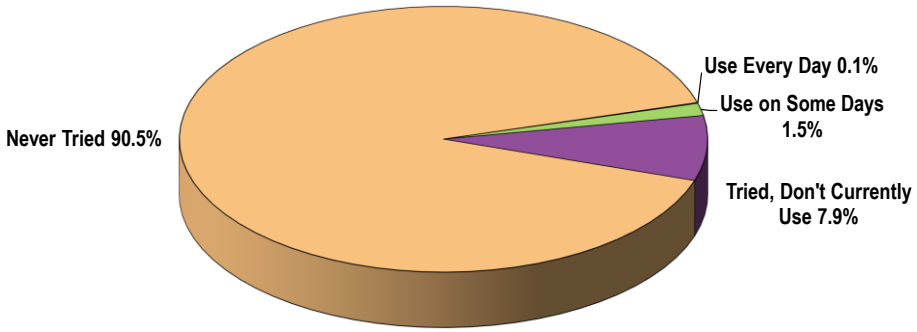
Other Tobacco Use

Electronic Cigarettes

A total of 1.6% of CHOMP Service Area adults currently use electronic cigarettes ("e-cigarettes"), either regularly (0.1% every day) or occasionally (1.5% on some days).

Electronic Cigarette Use

(CHOMP Service Area, 2016)

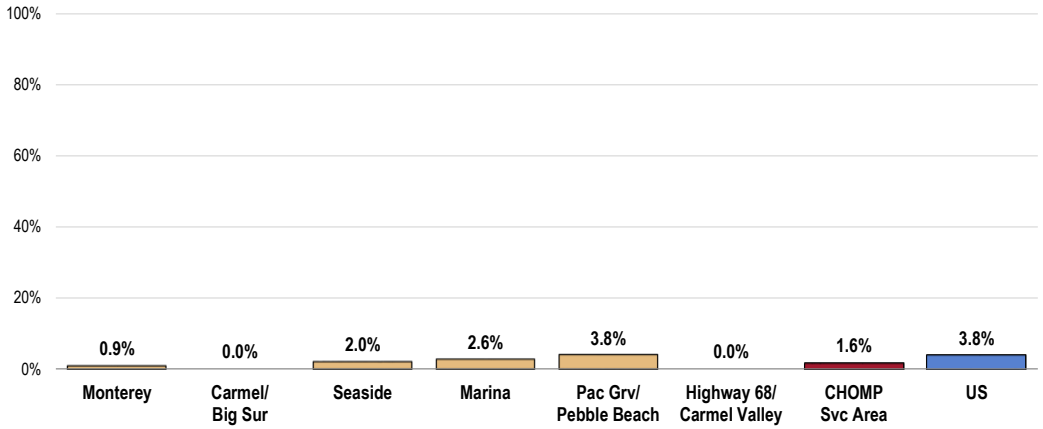


Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 208]

Notes:
- Asked of all respondents.

- Lower than national findings.
- There were no reports of electronic cigarette usage in Carmel/Big Sur and in Highway 68/Carmel Valley.

Currently Use Electronic Cigarettes
(Every Day or on Some Days)

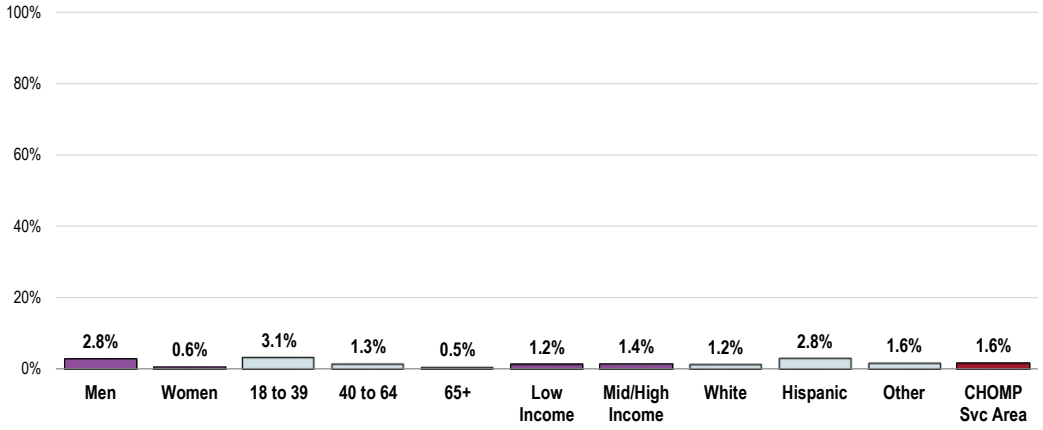


Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 208]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.
- Includes regular and occasional users (those who smoke e-cigarettes every day or on some days).

- Electronic cigarette use is more prevalent among men than women in the service area.

Currently Use Electronic Cigarettes
(CHOMP Service Area, 2016)



Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 208]

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. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
- Includes regular and occasional users (those who smoke e-cigarettes every day or on some days).

Cigars & Smokeless Tobacco

A total of 3.7% of CHOMP Service Area adults use cigars every day or on some days.

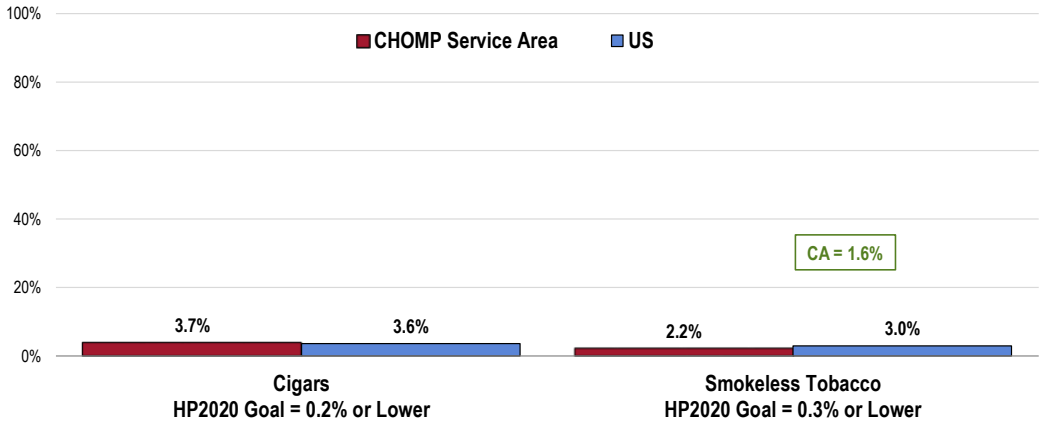
- Nearly identical to the national percentage.
- Fails to satisfy the Healthy People 2020 target (0.2% or lower).
- Highest in Marina; lowest in Pacific Grove/Pebble Beach and Highway 68/Carmel Valley (not shown).
- TREND: No statistically significant change since 2007 (not shown).

Examples of smokeless tobacco include chewing tobacco, snuff, or "snus."

A total of 2.2% of CHOMP Service Area adults use some type of smokeless tobacco every day or on some days.

- Comparable to the state and national percentages.
- Fails to satisfy the Healthy People 2020 target (0.3% or lower).
- No reports in Highway 68/Carmel Valley (not shown).
- TREND: Identical to 2007 findings.

Other Tobacco Use



Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 59-60]
- 2015 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): 2014 California data.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objectives TU-1.2, TU-1.3]

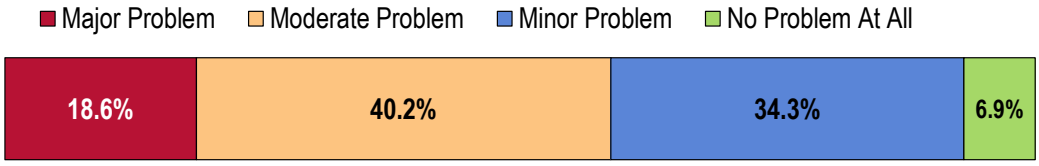
Notes:
- Reflects the total sample of respondents.
- Smokeless tobacco includes chewing tobacco or snuff.

Key Informant Input: Tobacco Use

The greatest share of key informants taking part in an online survey characterized *Tobacco Use* as a "moderate problem" in the community.

Perceptions of Tobacco Use as a Problem in the Community

(Key Informants, 2016)



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

Top Concerns

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

Incidence/Prevalence

Younger generation is still choosing to smoke. Legalization of marijuana will make the problem worse. – Physician

Regardless of marketing efforts of serious health issues related to tobacco people still smoke as it's one of the most addictive substances one can have. – Community/Business Leader

It is very obvious that tobacco use is very common in certain areas and in certain communities in our county. It is particularly common in many immigrant communities, and in certain demographic groups. – Community/Business Leader

Addiction

It is highly addictive. Not enough low income resources to kick this habit. It is legal. Marijuana and vapor smoking is encouraging and leading to cigarette and other tobacco smoking. – Social Services Provider

Addictions. – Public Health Representative

Tobacco is an addiction. People who smoke will generally have other health issues. – Community/ Business Leader

Comorbidities

For both young and older residents, smoking and secondhand smoke cause considerable and detrimental health problems. Much of the overall community smokes despite indications that support the many complications that result from tobacco use. – Community/Business Leader

Leading Cause of Death

It kills people who smoke and potentially kills those who are around their second hand smoke. Filthy Dirty habit that should be banned everywhere. Costs the public billions and billions in medical costs for those that smoke. – Community/Business Leader

Media

Media glorification of smoking. Big tobacco trying to snare younger people, vaping. – Public Health Representative

Health Education

Easy access for minors and lack of educational information for them. – Community/Business Leader

Access to Health Services

Professional Research Consultants, Inc.

Health Insurance Coverage

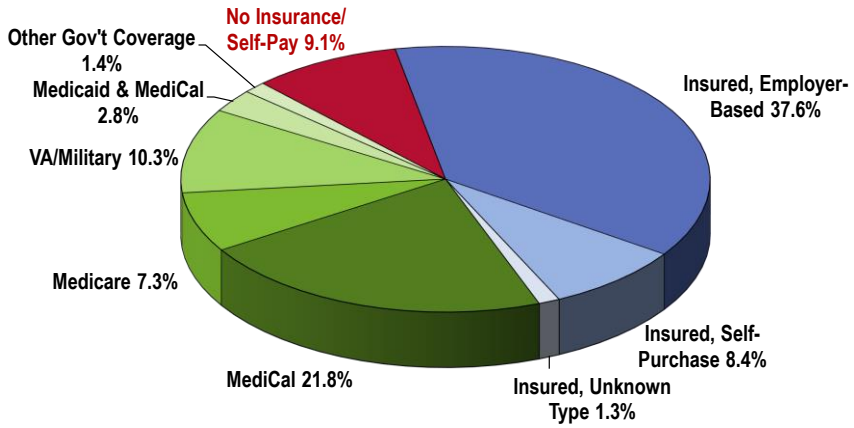
Type of Healthcare Coverage

Survey respondents were asked a series of questions to determine their healthcare insurance coverage, if any, from either private or government-sponsored sources.

A total of 47.3% of CHOMP Service Area adults age 18 to 64 report having healthcare coverage through private insurance. Another 43.6% report coverage through a government-sponsored program (e.g., Medicaid, Medicare, military benefits).

Healthcare Insurance Coverage

(Among Adults Age 18-64; CHOMP Service Area, 2016)



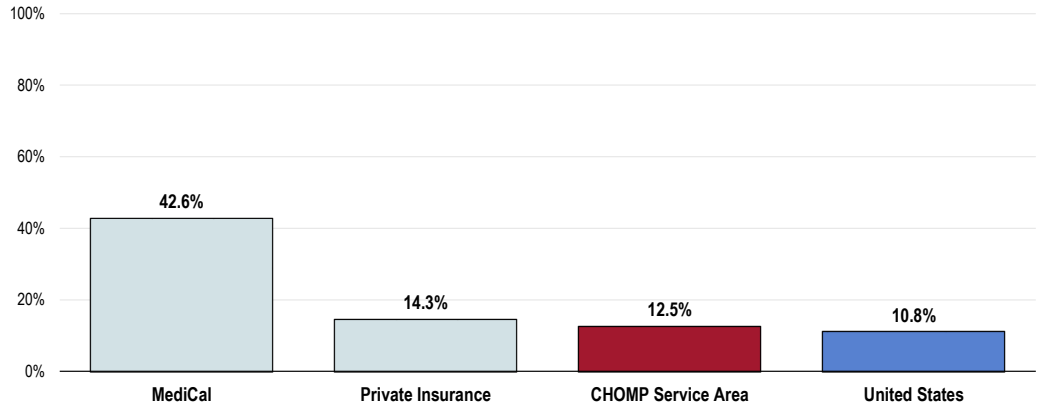
Sources: ● 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 190]
Notes: ● Reflects respondents age 18 to 64.

A total of 12.5% of residents under 65 with private coverage or Medicaid secured their coverage under the Affordable Care Act (ACA), otherwise known as "Obamacare."

- Similar to the national finding.
- Note the 42.6% of affirmative responses among adults with MediCal compared with privately insured individuals (14.3%).

Insurance Was Secured Under the Affordable Care Act/"Obamacare"

(Insured Adults Age 18-64, By Type of Coverage)



Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 84]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents under 65 with private insurance or Medicaid.

Lack of Health Insurance Coverage

Among adults age 18 to 64, 9.1% report having no insurance coverage for healthcare expenses.

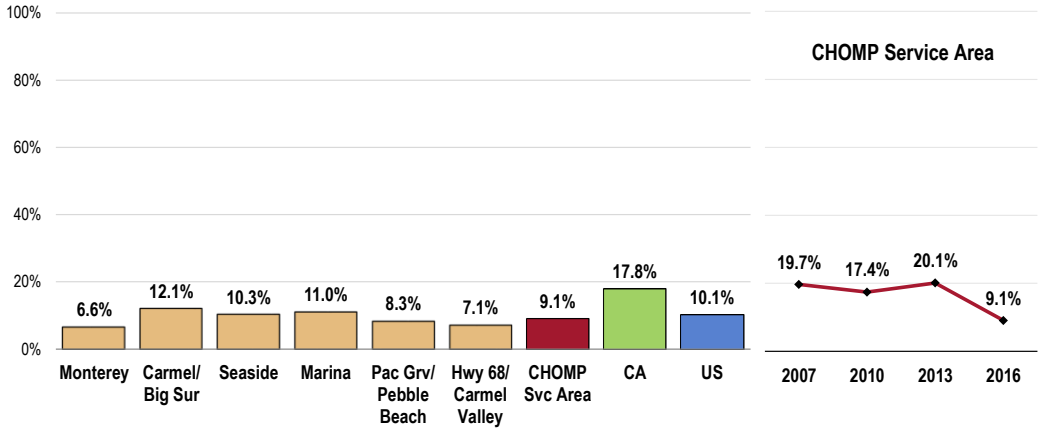
Here, lack of health insurance coverage reflects respondents age 18 to 64 (thus, excluding the Medicare population) who have no type of insurance coverage for healthcare services – neither private insurance nor government-sponsored plans (e.g., Medicaid).

- Better than the state finding.
- Similar to the national finding.
- The Healthy People 2020 target is universal coverage (0% uninsured).
- Similar findings by community.
- TREND: Marks a statistically significant improvement (increase) in insurance coverage over time.

Lack of Healthcare Insurance Coverage

(Among Adults Age 18-64)

Healthy People 2020 Target = 0.0% (Universal Coverage)



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 190]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2014 California data.
- 2015 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.

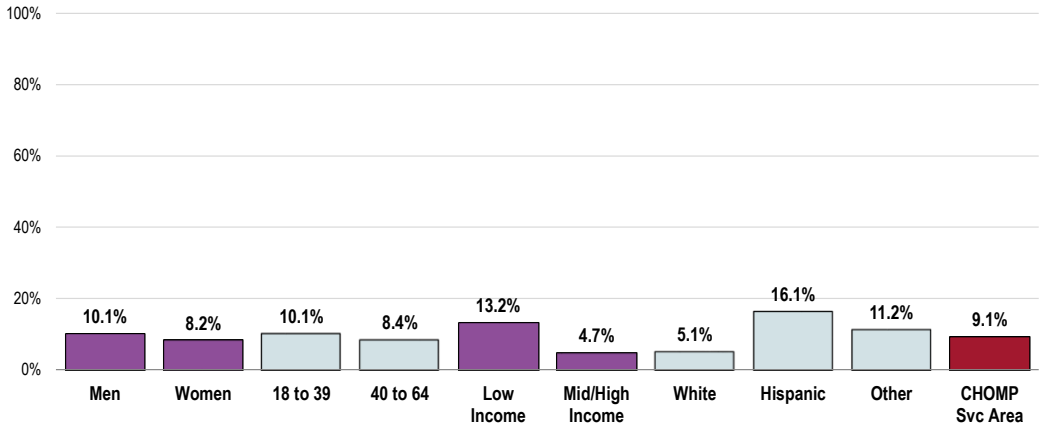
The following population segments are more likely to be without healthcare insurance coverage:

- Residents living at lower incomes.
- Hispanics.

Lack of Healthcare Insurance Coverage

(Among Adults Age 18-64; CHOMP Service Area, 2016)

Healthy People 2020 Target = 0.0% (Universal Coverage)



Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 190]
- 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. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

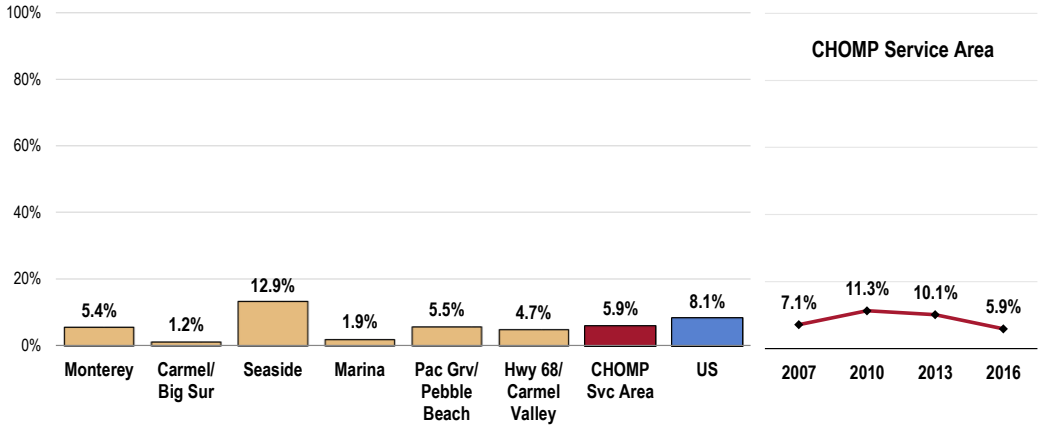
Recent Lack of Coverage

Among currently insured adults in the CHOMP Service Area, 5.9% report that they were without healthcare coverage at some point in the past year.

- Lower than US findings.
- Highest in Seaside.
- TREND: Overall, insurance instability in the area is unchanged from 2007 findings.

Went Without Healthcare Insurance Coverage At Some Point in the Past Year

(Among Insured Adults)



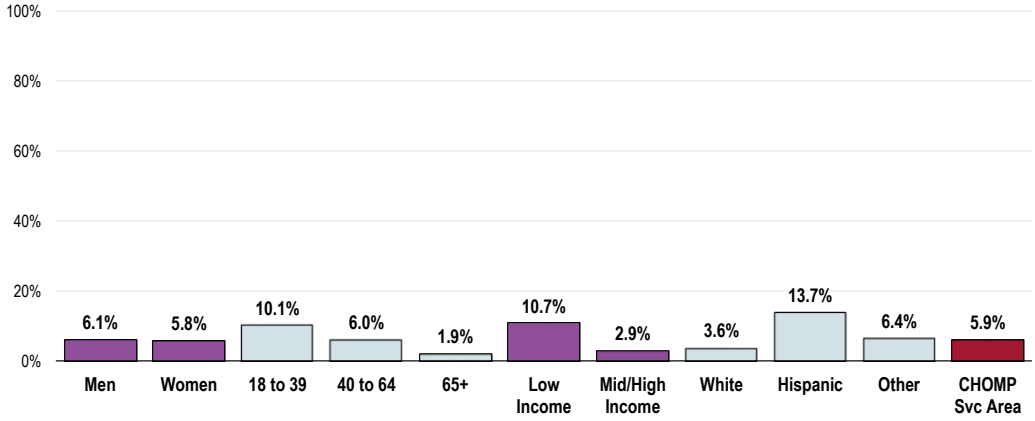
Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 305]
● 2013 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all insured respondents.

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 65 (negative correlation with age).
- Lower-income residents.
- Hispanics.

Went Without Healthcare Insurance Coverage At Some Point in the Past Year

(Among Insured Adults; CHOMP Service Area, 2016)



Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 305]

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. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Difficulties Accessing Healthcare

About Access to 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)

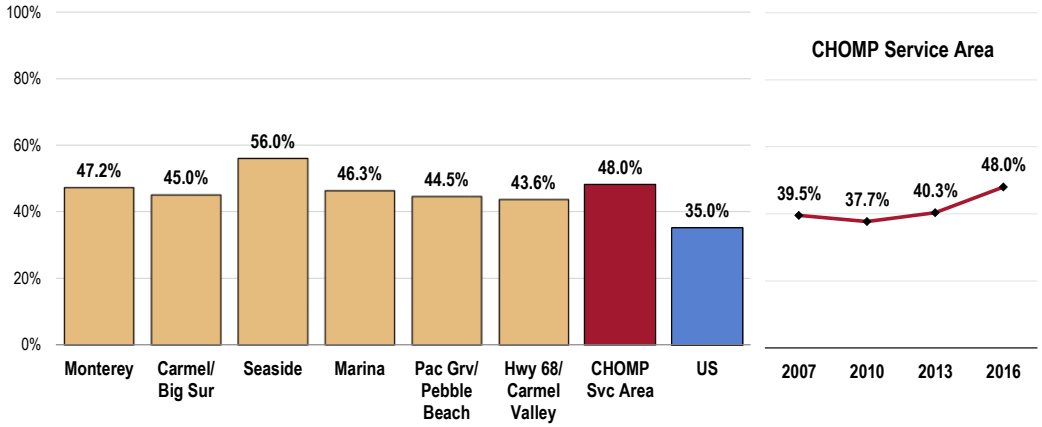
Difficulties Accessing Services

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.

A total of 48.0% of CHOMP Service Area adults report some type of difficulty or delay in obtaining healthcare services in the past year.

- Considerably less favorable than national findings.
- Least favorable in Seaside.
- TREND: Denotes a statistically significant increase since 2007.

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 194]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

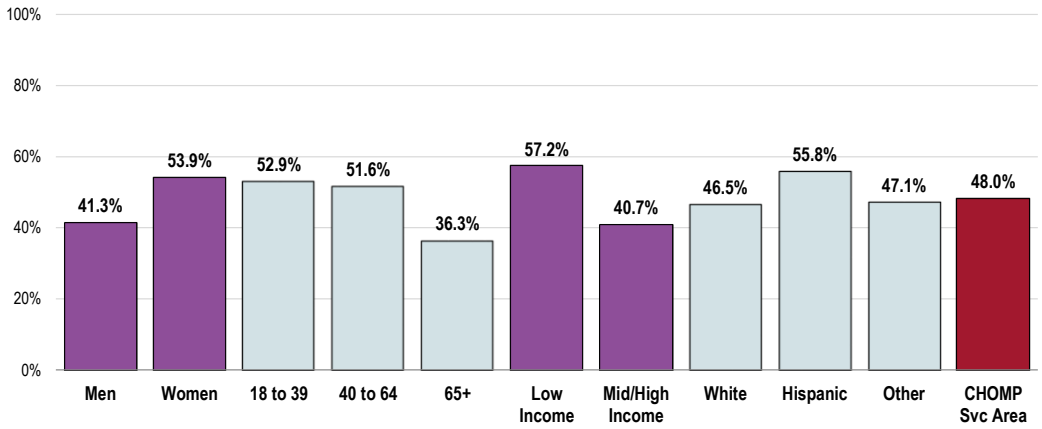
Notes:
- Asked of all respondents.
- Represents the percentage of respondents experiencing one or more barriers to accessing healthcare in the past 12 months.

Note that the following demographic groups more often report difficulties accessing healthcare services:

- Women.
- Adults under the age of 65.
- Lower-income residents.

Experienced Difficulties or Delays of Some Kind in Receiving Needed Healthcare in the Past Year

(CHOMP Service Area, 2016)



Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 194]

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. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Barriers to Healthcare Access

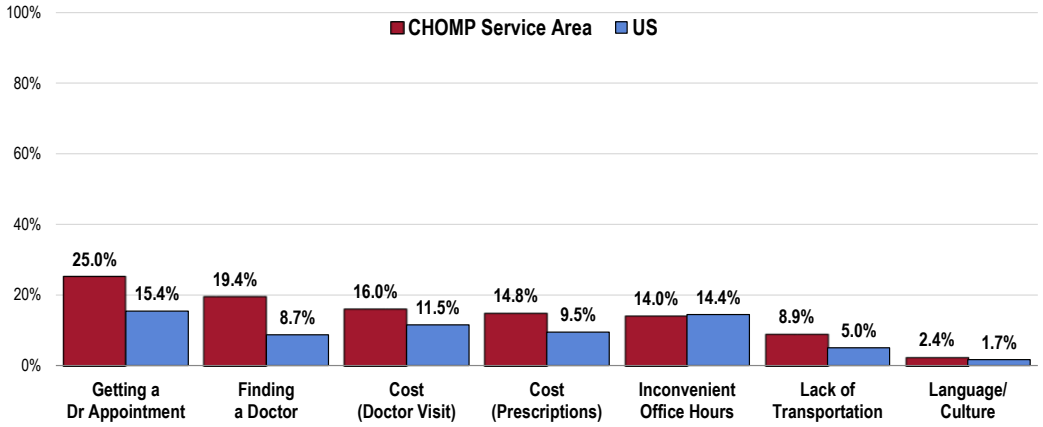
To better understand healthcare access barriers, survey participants were asked whether any of seven types of barriers to access prevented them from seeing a physician or obtaining a needed prescription in the past year.

Again, these percentages reflect the total population, regardless of whether medical care was needed or sought.

Of the tested barriers, getting a doctor's appointment impacted the greatest share of CHOMP Service Area adults (25.0% say that lack of appointment availability 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 inconvenient office hours and language/cultural differences. All of the other tested barriers compared unfavorably to the national figure.
- By community (not shown), Seaside residents reported a higher prevalence of barriers due to cost (doctor visit and Rx), inconvenient office hours, and language/cultural differences. Highway 68/Carmel Valley also reported a high prevalence of language/cultural differences inhibiting access to healthcare.

Barriers to Access Have Prevented Medical Care in the Past Year



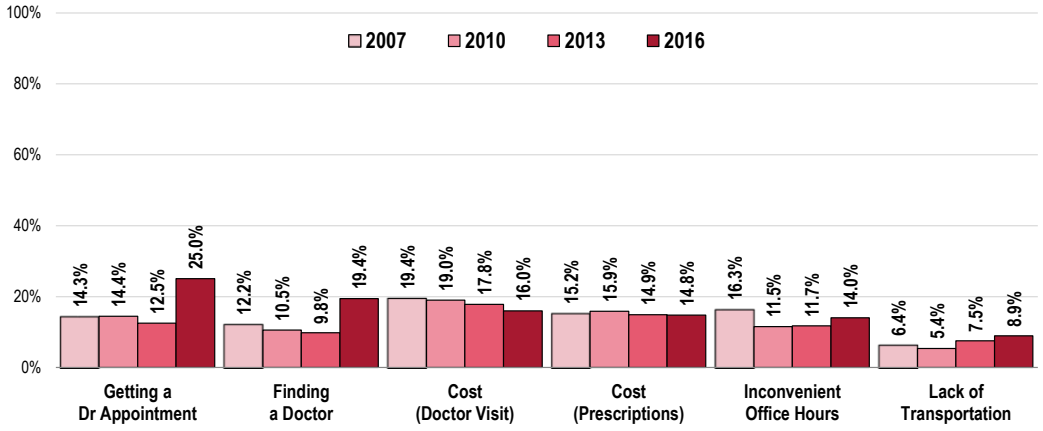
Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 7-13]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

- TREND: Compared to 2007 data, the CHOMP Service Area has seen a significant increase in regard to the following barriers: difficulty finding a physician, difficulty getting an appointment, and lack of transportation. Access problems due to the cost of a physician visit decreased over time and all other barriers remained stable.

Barriers to Access Have Prevented Medical Care in the Past Year

(CHOMP Service Area)



Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 7-13]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

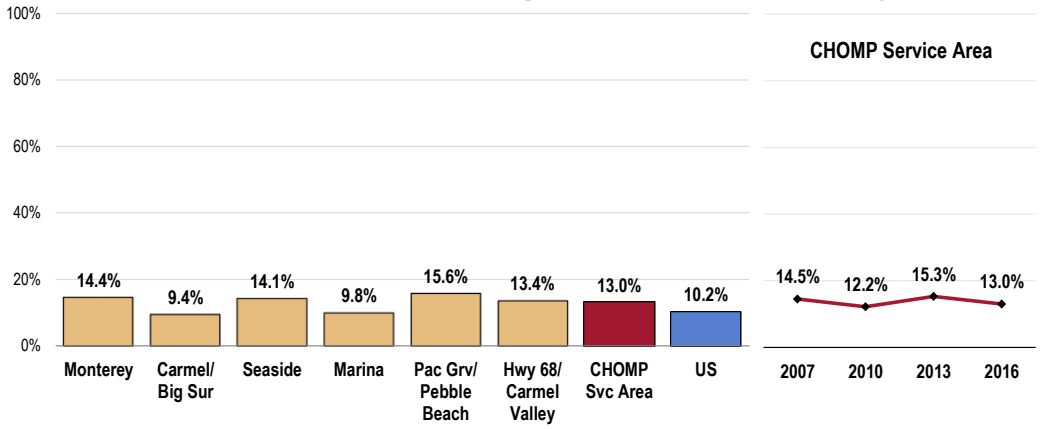
Notes:
- Asked of all respondents.

Prescriptions

Among all CHOMP Service Area adults, 13.0% skipped or reduced medication doses in the past year in order to stretch a prescription and save money.

- Comparable to national findings.
- Statistically comparable by community.
- TREND: Statistically similar to 2007 findings.

Skipped or Reduced Prescription Doses in Order to Stretch Prescriptions and Save Money



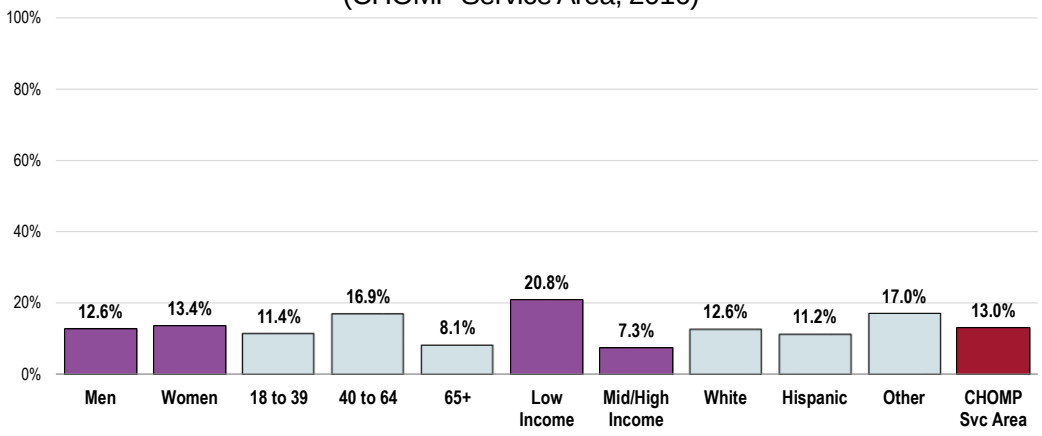
Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 14]
● 2015 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all respondents.

Adults more likely to have skipped or reduced their prescription doses include:

- Adults age 40 to 64.
- Respondents with lower incomes.

Skipped or Reduced Prescription Doses in Order to Stretch Prescriptions and Save Money

(CHOMP Service Area, 2016)



Sources: ● 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 14]
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. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Accessing Healthcare for Children

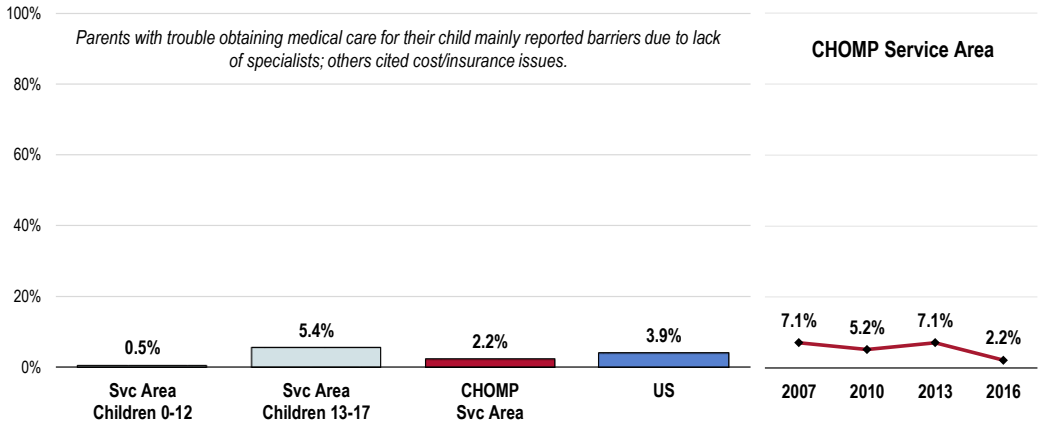
A total of 2.2% of parents say there was a time in the past year when they needed medical care for their child, but were unable to get it.

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.

- Statistically similar to what is reported nationwide.
- TREND: Has decreased significantly since 2007.
- Lowest (0.5%) among parents of children under age 12.

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 136-137]
● 2015 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all respondents with children 0 to 17 in the household.

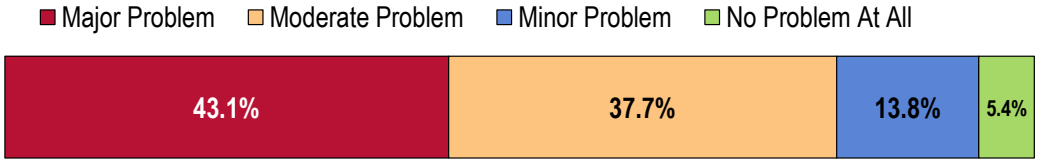
Among the parents experiencing difficulties, the majority cited **lack of specialists** as the primary reason; others cited **cost/insurance issues.**

Key Informant Input: Access to Healthcare Services

Key informants taking part in an online survey most often characterized *Access to Healthcare Services* as a "major problem" in the community.

Perceptions of Access to Healthcare Services as a Problem in the Community

(Key Informants, 2016)



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

Top Concerns

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

Access to Care/Services

One of the largest problems to access health services is who gets to access these services. Not everyone in our community has health coverage and so there exists a large gap of access. Undocumented residents do not have health coverage. – Community/Business Leader

I work closely with the community and I hear that going to the doctor is still a challenge because of the cost. It is expensive for those who are low income. – Public Health Representative

Access for the poor. Because of it only the extreme poverty level of Monterey County in addition to undocumented immigrants access is minimal. Long lines, accessible hours and fear are major challenges. – Social Services Provider

Not enough doctors are accepting new patients. – Social Services Provider

While the wealthy have access to all of the items listed the poor do not. – Social Services Provider

Few doctors who provide generalized care. Inability to get in urgently and long waits for routine care. Expensive insurance with huge deductibles. – Physician

We are experiencing a tsunami of seniors who have multiple acute and chronic conditions which require effective assessment, treatment and management. Declining incentives for physicians and other health professionals are having the effect of reducing health risks. – Social Services Provider

A big challenge is the lack of accessible and affordable wellness care, with a focus on disease prevention through nutrition, exercise, well-care checkups, and social support systems. These are particularly important for people with chronic conditions. – Social Services Provider

Availability and transportation. Affordability. – Social Services Provider

Finding a qualified health professional that takes time with the patient rather than herd them in and out. Uninsured people not having access to care and using high cost Emergency Rooms for things which could be easily and less costly addressed with a clinic. – Social Services Provider

Clinics are impacted with little access to new patients. – Public Health Representative

Lack of availability to get services like an appointment. It can take a month or more to be seen in a clinic. A specialty clinic even longer time. Transportation is a big problem. – Public Health Representative

Frustration with medical systems that are overwhelming and cut corners, low quality of service. Appointments are set too far away and too short time with the patient. Lack of access to Psychiatrist for mental health. Psychiatric initial assessment for medication. – Social Services Provider

With the passage of ACA, many more community members were able to gain access to coverage through Medicaid or Covered California. The provider network for these two major groups is not

sufficient to be able to provide timely access to care. – Public Health Representative

Lack of knowledge as to services available. Willingness to take advantage of services available. – Community/Business Leader

Availability, proximity of providers to users. Cost of transportation, unable to travel to providers. Childcare, adults unable to go to centers because they have to look after their children. Language and cultural barriers. – Community/Business Leader

Hard to find a physician. Overwhelming demand for physician services. Decreased reimbursement for physician services. Overwhelming IT and computer work for physicians. Physicians being forced out of private practice. – Physician

Available doctors taking MediCal patients. Health insurance for undocumented families and individuals. – Social Services Provider

We do not have enough physicians, especially specialists. Physicians have told me that it is difficult to maintain a practice in this high-cost community. Many of the best doctors are changing to concierge practice making it even more difficult for those . – Social Services Provider

Access to Providers

Safety net primary, urgent and specialty care extended wait times. – Public Health Representative

Insufficient primary care, internal medicine, and gynecological health providers. Too few providers lead to very few providers accepting new patients. Insufficient reimbursement rates leads to too many providers, including CHOMP. – Social Services Provider

Still the number of doctors available and the wait time to see them. – Community/Business Leader

Inadequate primary care. Cost, especially hospitals. Lower socio-economic status individuals with inadequate personal capabilities to seek and follow-up with care. Inadequate organization of lower level other than hospitals and physicians care provision. – Physician

Lack of primary care physicians and mental health professionals. Inadequate Medi-Cal reimbursement and overburdened clinics, causing Medi-Cal patients to use the Emergency Department inappropriately for care. – Physician

Lack of access to primary care physicians and specialists for acute and urgent issues. Physicians working beyond capacity and yet, timeliness in seeing acute issues is a challenge. – Physician

Too few PCP's and certain specialists, making it difficult for an established patient to sometimes get into his or her PCP timely and very difficult for new patients to find a PCP. There is a shortage in some specialties and subspecialties. – Community/Business Leader

Limited number of primary care physician. Many patients telling me that they do not have a PCP because it is difficult to get an appointment. Many PCP are booked months out. Especially true for patients with Aspired Health Plan. – Physician

Virtually no access to good primary care outside of concierge practices and limited availability through Peninsula Primary Care. Severe shortage of practitioners. – Physician

We don't have enough primary care providers and those who are entering practice are increasingly just acting as referrers, rather than doing real primary care. – Physician

Not enough primary care physicians. – Physician

Access to physicians. – Physician

Low reimbursement and dwindling physician supply, combined with increased paperwork and PCMH demands on PCP's, are some of the challenges to accessing health care here. A lack of specialists willing to accept government insurance and the uninsured. – Public Health Representative

Limited physician/provider supply. – Community/Business Leader

Scarcity of providers that accept government provided health care due to low reimbursement to health care providers. – Social Services Provider

Lack of physician capacity to quickly schedule new patients, especially for primary care. Wait times of several months are typical for new patients to establish care. – Physician

Affordable Care/Services

Not all community residents are insured or qualify for government issued medical coverage. Even for those with medical insurance of some sort, may have challenges with access because of limited access. Clinics have wait lists. – Public Health Representative

Cost, difficulty in getting doctors' appointments, difficulty getting doctors' appointments at times when you can get there. – Community/Business Leader

Lack of affordable health insurance and lack of adequate insurance coverage even for those with

health insurance. No options for uninsurable residents. All this leads to acute health issues on preventable diseases. – Social Services Provider

Insurance coverage or lack thereof limiting access to physicians. Paneling, limiting physician access to patients. Mental health services. Case management. Affordable multicultural or a-cultural ancillary services. – Physician

Affordability of co-pay, affordability for undocumented, for services, access to medical specialists, lack of specialists. – Social Services Provider

Lack of health coverage, lack of affordable health benefits, high deductible, co-pays for medical and prescription. Share cost of monthly premium with employer who often does not provide dependent coverage, lack of primary and specialty care. – Social Services Provider

We have a large percentage of low income residents. Accessing health care is challenging. – Social Services Provider

Finding affordable coverage and doctors who care about you. – Social Services Provider

Cost of health care for those who are working and an extreme lack of providers for those on Covered California medical and dental, due to poor reimbursement rates. – Other Health Provider

Affordability, transportation to services from remote locations. The amount of time spent in waiting rooms, getting an appointment for subsidized care. Family members deferring preventative care because of cost. Language barriers throughout county. – Community/Business Leader

The cost of health care is unbelievable. Even with insurance, a $5,000 deductible is enough to put a family in debt for years. – Community/Business Leader

Cost. – Physician

Affordability and finding a practitioner that takes insurance or Medicare assignment. – Social Services Provider

Far too many people cannot afford quality healthcare, there are too few family practitioners in our community, and transportation to healthcare facilities is an additional obstacle. There is a growing disparity in our community between the haves and have nots. – Community/Business Leader

Cost to patients. – Physician

High cost of health care. – Community/Business Leader

Cost of medical care. Our hospitals are much more expensive than most other hospitals in the country for insured patients. This particularly impacts the most deserving, the working poor who have insurance but cannot afford deductibles, copays, share. – Physician

Good health is a life-long endeavor. Affordable access to opportunities for underserved people in our communities to improve and maintain health throughout their lifetimes is needed. Nonprofit organizations try to address critical needs with a meal. – Social Services Provider

Healthcare System Concerns

Hospital medical record should integrate with office EMR. It takes a long time to schedule or get reports for sleep study. This is because there is monopoly limited to one physician to read study. I have never had a report done less than two weeks after. – Physician

Sham peer review for physicians, increasing levels of burn out. – Physician

Terrible waste of resources on high-dollar medical responses to illness, many without much value, rather than preventive, organized health promotion and real disease management. Recent efforts noted, but our two major hospitals wasting our precious resources. – Physician

The biggest provider has unethical and unprofessional bill collecting. They act as though you made mistakes when they and your system is broke. – Social Services Provider

Transportation

South and North Monterey County, perhaps Big Sur Area too, have transportation issues for many residents in terms of accessing medical services. – Public Health Representative

Lack of transportation to treatment. – Social Services Provider

Limited transportation for low income seniors to make their appointments, particularly if they have to travel from Carmel to Salinas to receive low income care. This occurs frequently for dentistry. – Social Services Provider

Vulnerable Populations

Diseases and conditions affecting the homeless population who have difficulty accessing adequate health, mental health and dental care. – Social Services Provider

> *Homelessness. – Social Services Provider*
>
> *Poverty, which results in an inability to purchase adequate nutrition and/or needed medications, which contributes to poor health outcomes. – Social Services Provider*
>
> *As a provider of legal services to seniors, challenges for those seniors include focus on the financial ability to choose either health care or other necessities of life, but never both. Which means seniors health or living situation suffers. – Social Services Provider*

Insurance Issues

> *We need a shift to a single payer for health care coverage, like the rest of the industrialized world. – Social Services Provider*
>
> *Patients lack insurance coverage, as well as lack of providers who accept patients on state insurance such as MediCal. – Other Health Provider*

Type of Care Most Difficult to Access

Key informants (who rated this as a "major problem") most often identified **mental health care**, **primary care**, **substance abuse treatment,** and **specialty care** as the most difficult to access in the community.

	Most Difficult to Access	Second-Most Difficult to Access	Third-Most Difficult to Access	Total Mentions
Mental Health Care	49.0%	16.7%	8.5%	36
Primary Care	28.6%	16.7%	8.5%	26
Substance Abuse Treatment	6.1%	25.0%	12.8%	21
Specialty Care	6.1%	12.5%	12.8%	15
Elder Care	2.0%	4.2%	19.1%	12
Chronic Disease Care	2.0%	8.3%	10.6%	10
Dental Care	0.0%	6.3%	12.8%	9
Pain Management	2.0%	4.2%	6.4%	6
Hospice Care	2.0%	4.2%	2.1%	4
Palliative Care	0.0%	0.0%	4.3%	2
Professional Care	2.0%	0.0%	0.0%	1
Prenatal Care	0.0%	2.1%	0.0%	1
Back Injuries	0.0%	0.0%	2.1%	1

Health Literacy

Understanding Health Information

Written & Spoken Information

Respondents were read:

"You can find written health information on the internet, in newspapers and magazines, on medications, at the doctor's office, in clinics, and many other places.

How often is health information **written** in a way that is easy for you to understand?

How often is health information **spoken** in a way that is easy for you to understand?"

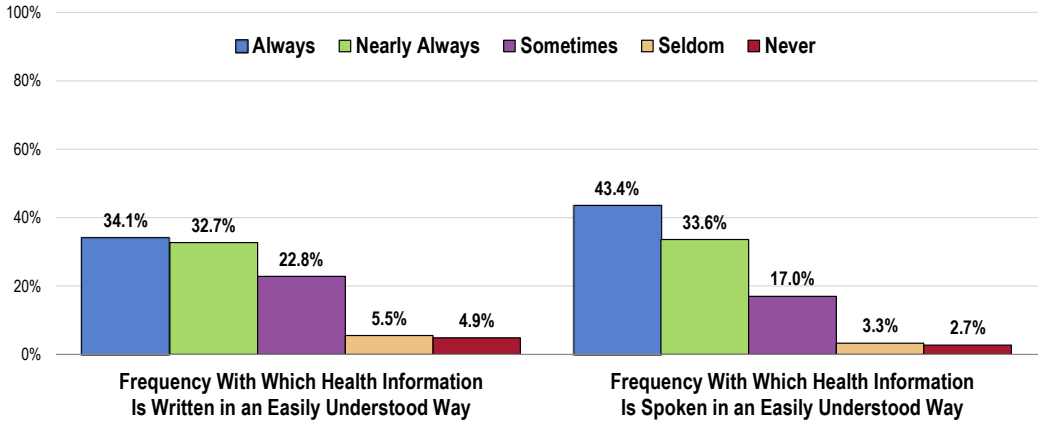
When asked about the frequency with which health information is written in an easily understood way, 66.8% of CHOMP Service Area adults said "always" or "nearly always."

- On the other hand, 33.2% of CHOMP Service Area adults consider **written** health information to be difficult to understand, including 4.9% who gave "never" reports.

When asked about spoken health information, 77.0% stated that this is "always" or "nearly always" easy for them to understand.

- On the other hand, 23.0% of CHOMP Service Area adults consider **spoken** health information to be difficult to understand, including 2.7% who gave "never" reports.

Understanding Health Information
(CHOMP Service Area, 2016)



Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 87, 89]
Notes: • Asked of all respondents.

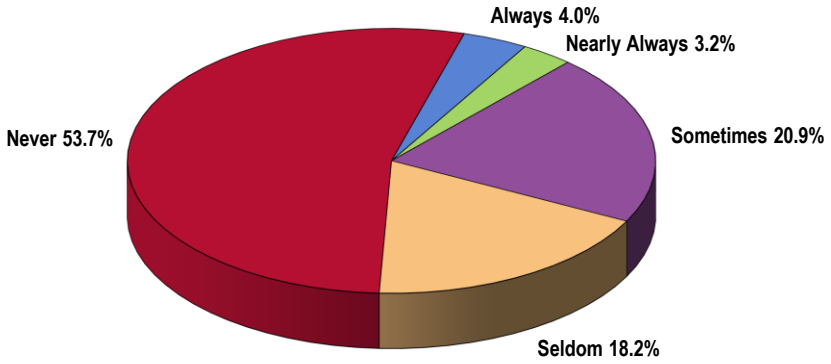
Help Reading Health Information

A total of 71.9% of CHOMP Service Area adults report "seldom" or "never" needing help reading health information.

- Another 20.9% of community adults "sometimes" need someone to help them read health information.
- Note that 7.2% of residents "always" or "nearly always" need help reading health information.

Frequency of Needing Someone to Help Read Health Information

(CHOMP Service Area, 2016)



Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 88]
Notes: • Asked of all respondents.

Completing Health Forms

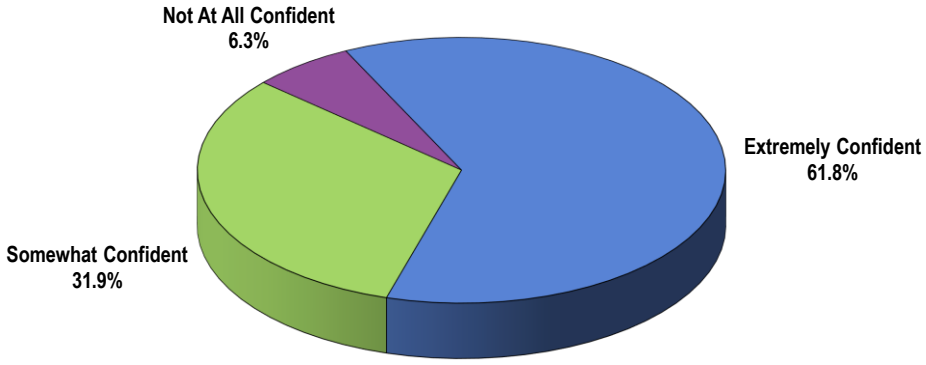
Asked to describe their confidence in filling out health forms, most survey respondents are "extremely confident" (61.8%).

Examples of health forms include insurance forms, questionnaires, doctor's office forms, and other forms related to health and healthcare.

- Another 31.9% of community adults are "somewhat confident" in their own ability to fill out health forms.
- However, 6.3% of respondents gave "not at all confident" ratings.

Self-Perceived Confidence in Ability to Fill Out Health Forms

(CHOMP Service Area, 2016)



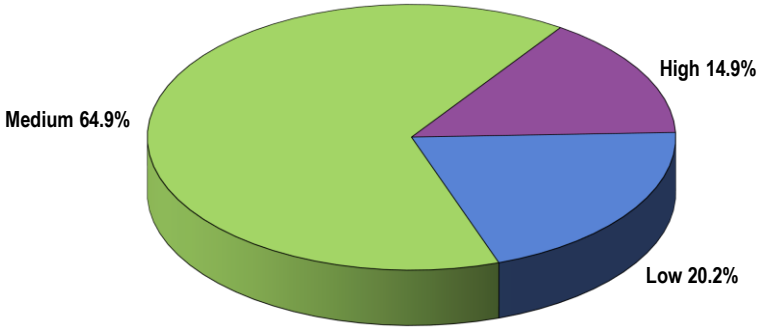
Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 90]
Notes: • Asked of all respondents.
• In this case, health forms include insurance forms, questionnaires, doctor's office forms, and other forms related to health and healthcare.

Population With Low Health Literacy

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

Among CHOMP Service Area survey respondents, 14.9% are considered to be of high health literacy, while 64.9% have medium health literacy, and the remaining 20.2% are considered to be of low health literacy.

Level of Health Literacy
(CHOMP Service Area, 2016)

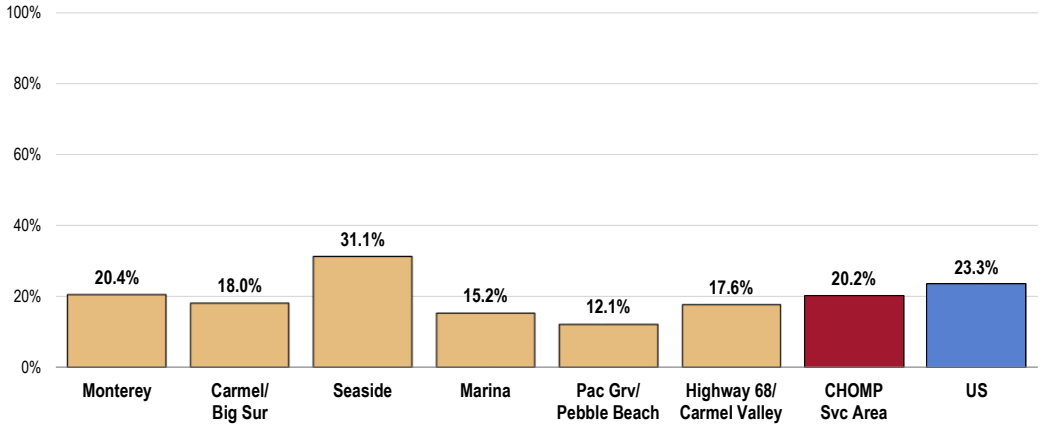


Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 195]

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

- The prevalence of CHOMP Service Area adults with low levels of health literacy is statistically similar to the national average.
- Low health literacy is more prevalent in Seaside.

Low Health Literacy



Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 195]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

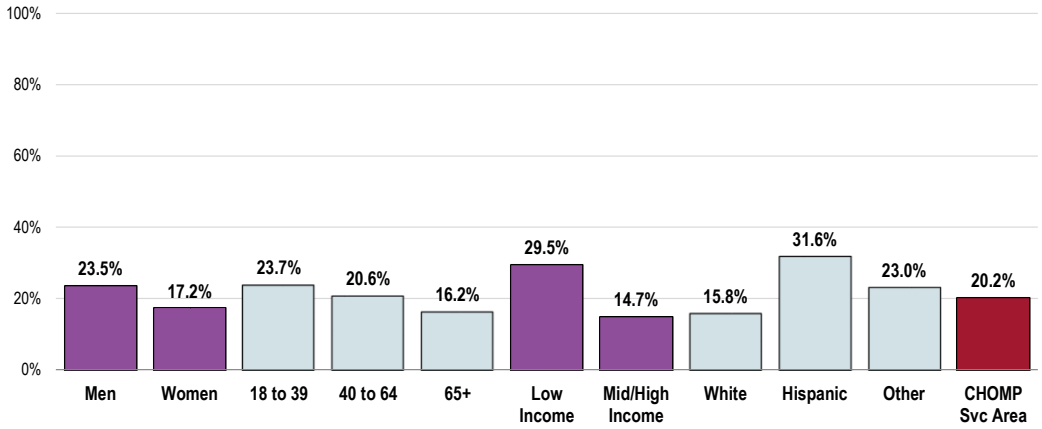
Notes:
- Asked of all respondents.
- Respondents with low health literacy are those who "seldom/never" find written or spoken health information easy to understand, and/or who "always/nearly always" need help reading health information, and/or who are "not at all confident" in filling out health forms.

These local adults are more likely to have low health literacy levels:

- Men.
- Low-income residents.
- Hispanics.

Low Health Literacy

(CHOMP Service Area, 2016)



Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 195]

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. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
- Respondents with low health literacy are those who "seldom/never" find written or spoken health information easy to understand, and/or who "always/nearly always" need help reading health information, and/or who are "not at all confident" in filling out health forms.

Primary Care Services

About Primary Care

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

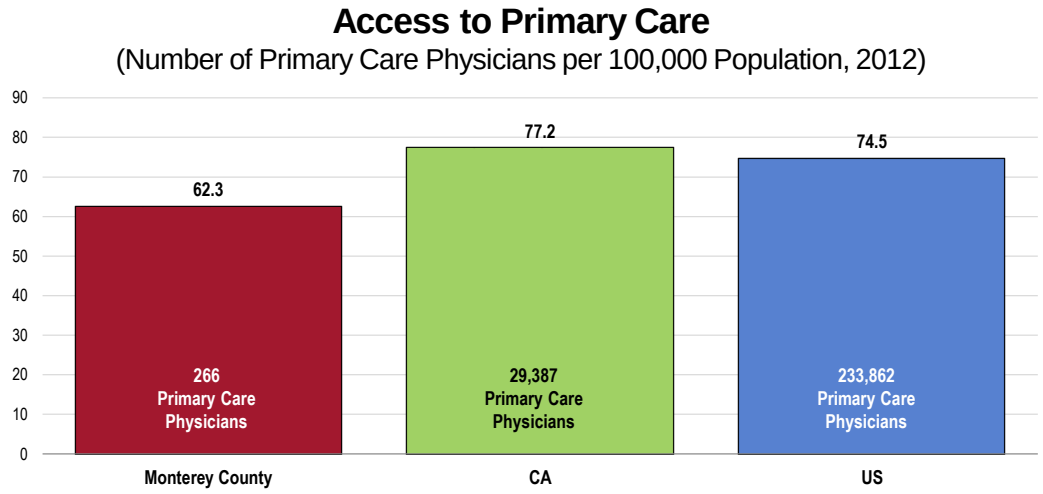
Improving health care services includes increasing access to and use of evidence-based preventive services. Clinical preventive services are services that: **prevent** illness by detecting early warning signs or symptoms before they develop into a disease (primary prevention); or **detect** a disease at an earlier, and often more treatable, stage (secondary prevention).

- Healthy People 2020 (www.healthypeople.gov)

Access to Primary Care

In Monterey County in 2012, there were 266 primary care physicians, translating to a rate of 62.3 primary care physicians per 100,000 population.

- Well below the primary care physician-to-population ratios found statewide and nationally.



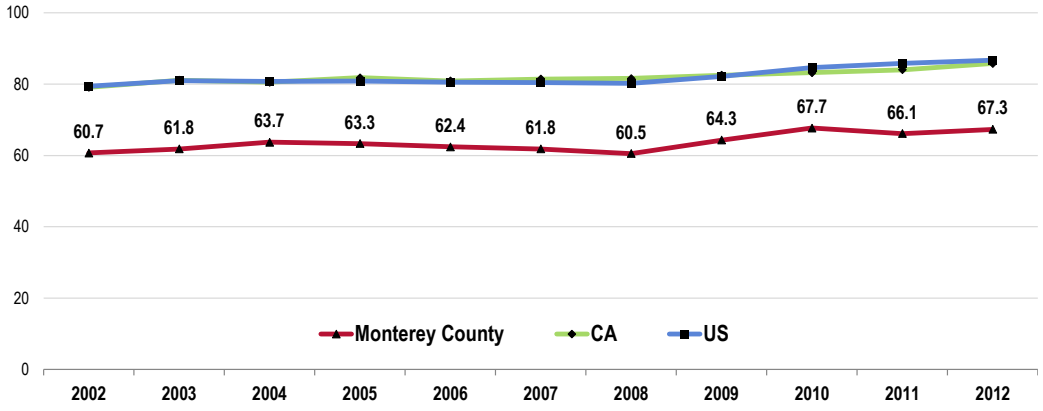
Sources:
- US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File.
- Retrieved April 2016 from Community Commons at http://www.chna.org.

Notes:
- This indicator is relevant because a shortage of health professionals contributes to access and health status issues.

- TREND: Access to primary care (in terms of the ratio of primary care physicians to population) has increased slightly over the past decade in Monterey County, echoing the trends seen across the state and nation.

Trends in Access to Primary Care

(Number of Primary Care Physicians per 100,000 Population)



Sources:
- US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File.
- Retrieved April 2016 from Community Commons at http://www.chna.org.

Notes:
- This indicator is relevant because a shortage of health professionals contributes to access and health status issues.
- These figures represent all primary care physicians practicing patient care, including hospital residents. In counties with teaching hospitals, this figure may differ from the rate reported in the previous chart.

Specific Source of Ongoing Care

A total of 72.9% of CHOMP Service Area adults were determined to have a specific source of ongoing medical care.

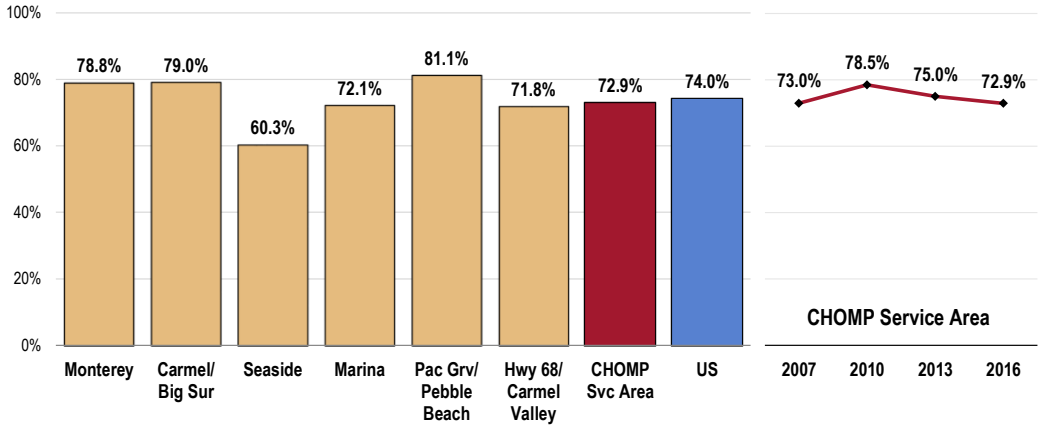
- Similar to national findings.
- Fails to satisfy the Healthy People 2020 objective (95% or higher).
- Lowest in Seaside.
- TREND: Nearly identical to 2007 findings.

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 crucial to the concept of "patient-centered medical homes" (PCMH).

A hospital emergency room is not considered a specific source of ongoing care in this instance.

Have a Specific Source of Ongoing Medical Care

Healthy People 2020 Target = 95.0% or Higher



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 191]
- 2015 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.

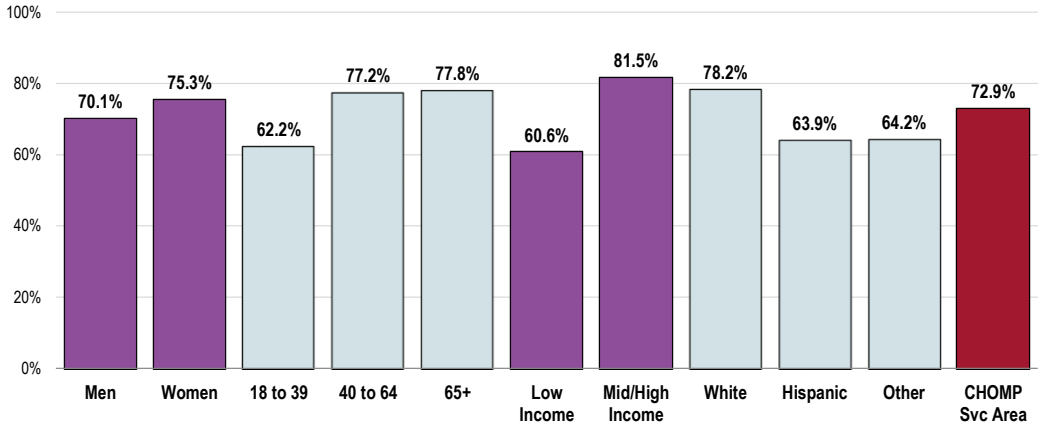
When viewed by demographic characteristics, the following population segments are less likely to have a specific source of care:

- Adults under age 40.
- Lower-income adults.
- Hispanics and "Other" race adults.

Have a Specific Source of Ongoing Medical Care

(CHOMP Service Area, 2016)

Healthy People 2020 Target = 95.0% or Higher



Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 191-193]
- 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.
- 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. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

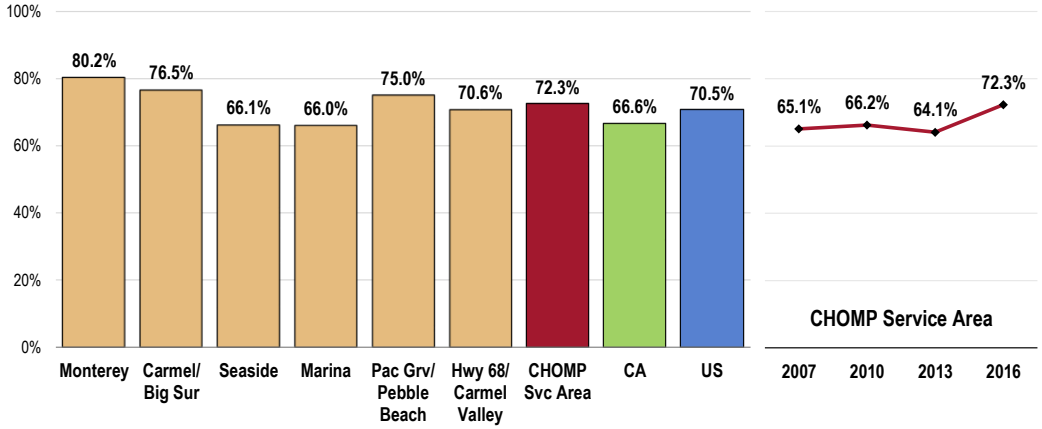
Utilization of Primary Care Services

Adults

A total of 72.3% of adults visited a physician for a routine checkup in the past year.

- More favorable than state findings.
- Similar to national findings.
- Least favorable in Seaside and Marina.
- TREND: Marks a statistically significant increase since 2007.

Have Visited a Physician for a Checkup in the Past Year



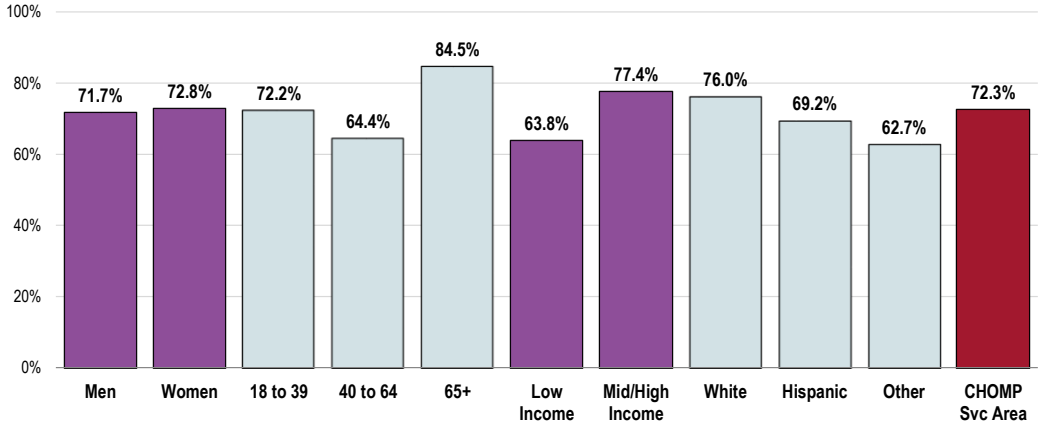
Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 18]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2014 California data.
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

Those <u>less likely</u> to have received routine care in the past year include:

- Adults under age 65, especially those age 40 to 64.
- Low-income residents.
- Hispanics and "Other" race adults.

Have Visited a Physician for a Checkup in the Past Year
(CHOMP Service Area, 2016)



Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 18]

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. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

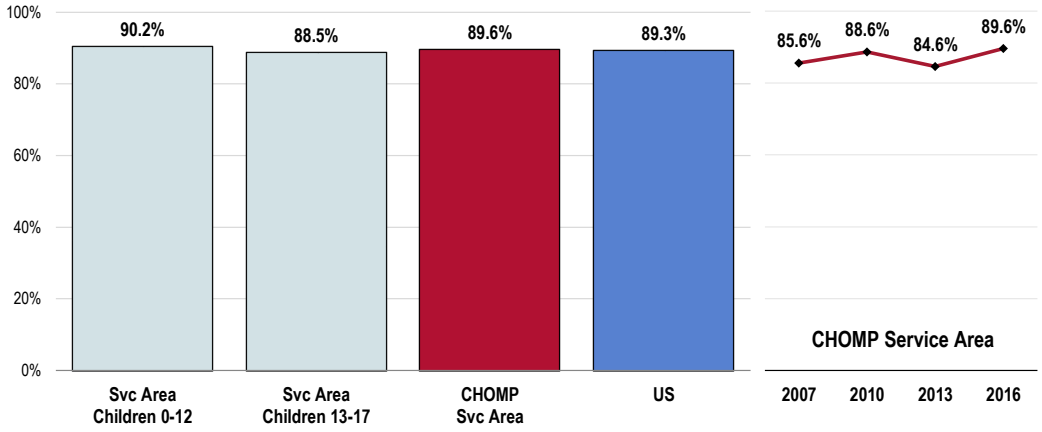
Children

Among surveyed parents, 89.6% report that their child has had a routine checkup in the past year.

- Similar to national findings.
- TREND: Statistically unchanged from previous survey findings.
- Note that the prevalence of routine checkups is not statistically different by child's age.

Child Has Visited a Physician for a Routine Checkup in the Past Year

(Among Parents of Children 0-17)



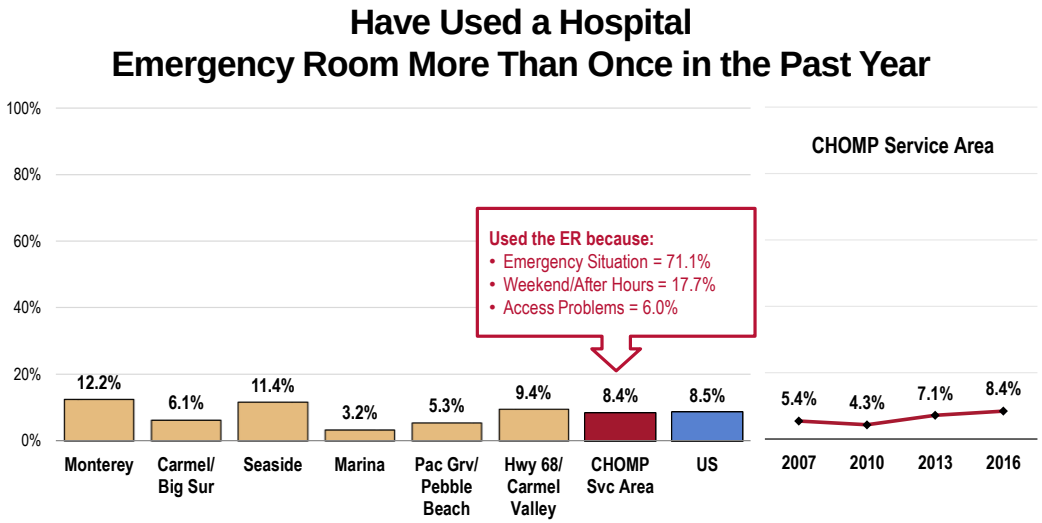
Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 138]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents with children 0 to 17 in the household.

Emergency Room Utilization

A total of 8.4% of CHOMP Service Area adults have gone to a hospital emergency room more than once in the past year about their own health.

- Nearly identical to national findings.
- Lower in Marina.
- TREND: An increase in emergency room utilization is apparent over time.



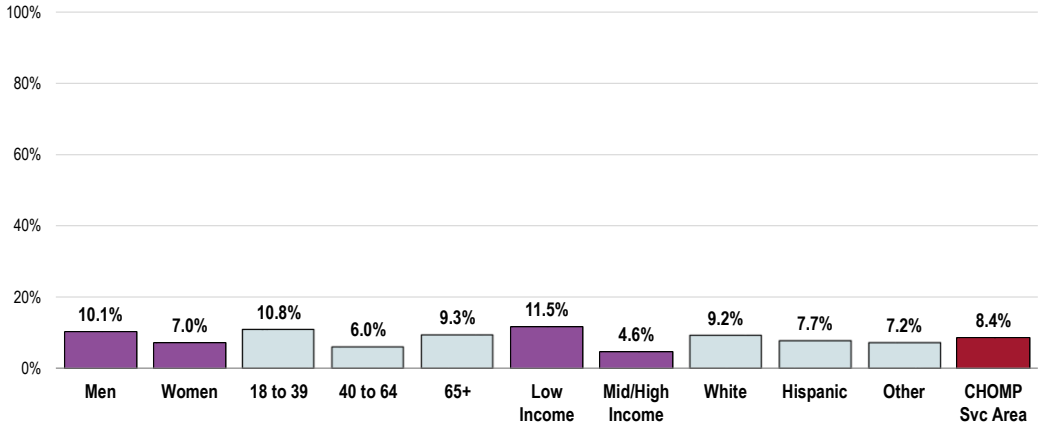
Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Items 22-23]
● 2015 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all respondents.

Of those using a hospital ER, 71.1% say this was due to an **emergency or life-threatening situation**, while 17.7% indicated that the visit was during **after-hours or on the weekend**. A total of 6.0% cited **difficulties accessing primary care** for various reasons.

- Community members living at low incomes are more likely to have used an ER for their medical care more than once in the past year.

Have Used a Hospital Emergency Room More Than Once in the Past Year

(CHOMP Service Area, 2016)



Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 22]

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. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Advance Directives

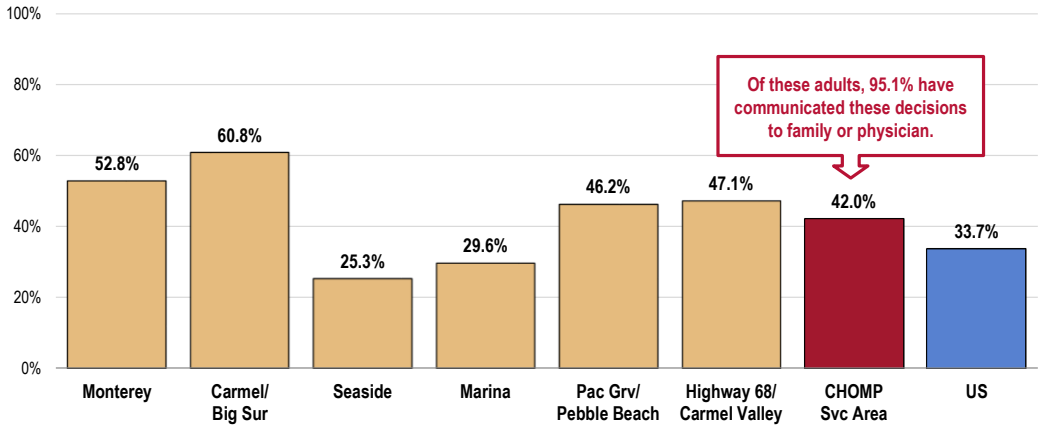
A total of 42.0% of CHOMP Service Area adults have completed Advance Directive documents.

An Advance Directive document is a set of directions given about the medical health-care a person wants if he/she ever loses the ability to make those decisions. Formal Advance Directives include Living Wills and Healthcare Powers of Attorney.

- The prevalence is higher than the US figure.
- Notably lower in Seaside and Marina.
- Of those local adults who have completed Advance Directive documents, 95.1% have communicated these decisions to family and/or a physician.

An Advance Directive document is a set of directions given about the medical health-care a person wants if he/she ever loses the ability to make those decisions. Formal Advance Directives include Living Wills and Healthcare Powers of Attorney.

Have Completed Advance Directive Documents



Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 85-86]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

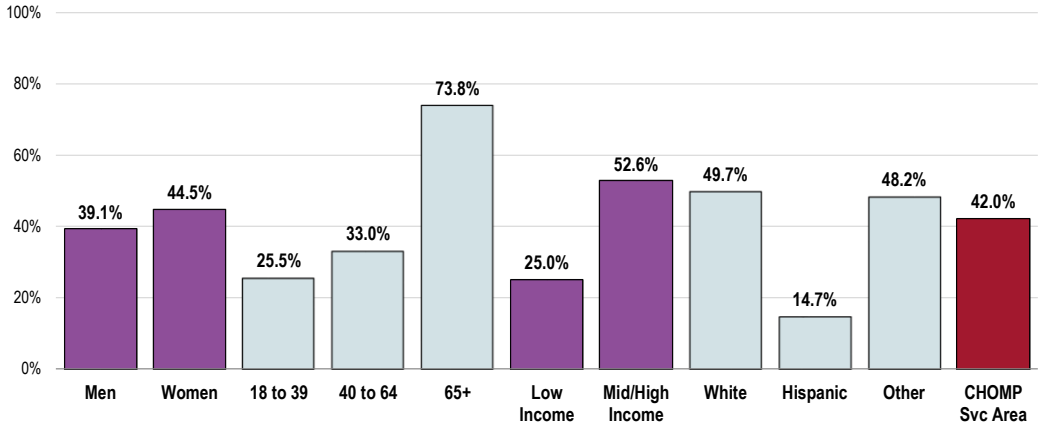
Notes:
- Asked of all respondents.
- An Advance Directive is a set of directions given about the medical healthcare a person wants if he/she ever loses the ability to make those decisions. Formal Advance Directives include Living Wills and Health Care Powers of Attorney.

These survey respondents are considerably less likely to have filled out Advance Directive documents:

- Younger adults (note the strong positive correlation with age).
- Individuals living at the lower income level.
- Hispanics.

Have Completed Advance Directive Documents

(CHOMP Service Area, 2016)



Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 85]

Notes:
- Asked of all respondents.
- An Advance Directive is a set of directions given about the medical healthcare a person wants if he/she ever loses the ability to make those decisions. Formal Advance Directives include Living Wills and Health Care Powers of Attorney.
- 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. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Oral Health

About Oral Health

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;** and **poor dietary choices**.

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.

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; and 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.

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.

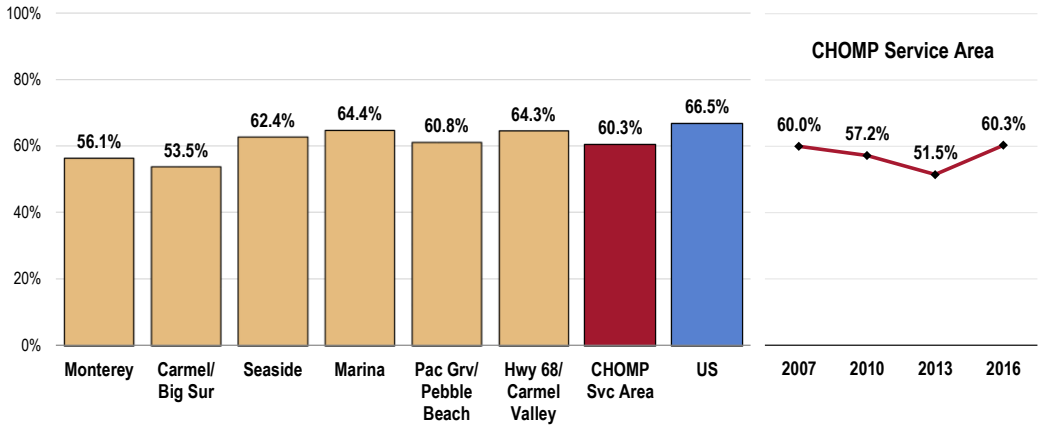
- Healthy People 2020 (www.healthypeople.gov)

Dental Insurance

6 in 10 CHOMP Service Area adults (60.3%) have dental insurance that covers all or part of their dental care costs.

- Lower than the national finding.
- Statistically similar by community.
- TREND: Dental insurance has become more prevalent in the CHOMP Service Area since 2013, but is statistically similar to that reported in 2007 and 2010.

Have Insurance Coverage That Pays All or Part of Dental Care Costs



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 21]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

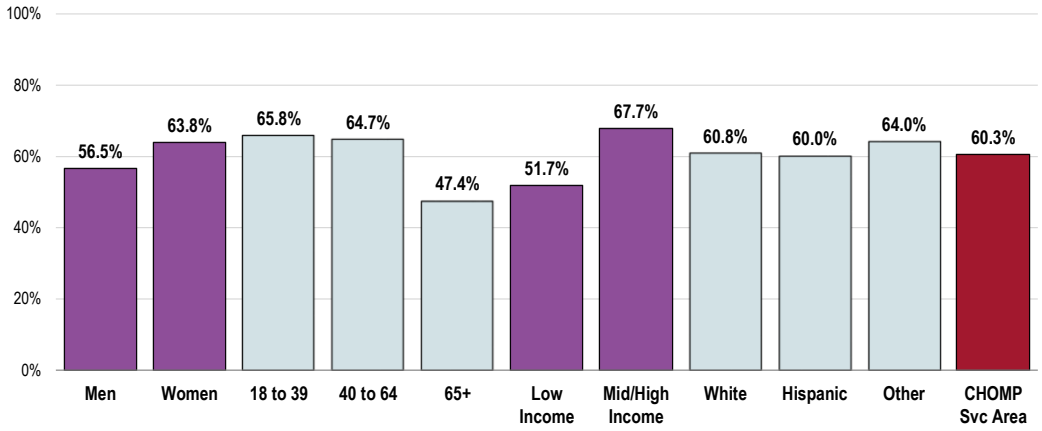
Notes:
- Asked of all respondents.

These adults are less likely to be covered by dental insurance:

- Men.
- Seniors (65+).
- Low income.

Have Insurance Coverage That Pays All or Part of Dental Care Costs

(CHOMP Service Area, 2016)



Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 21]

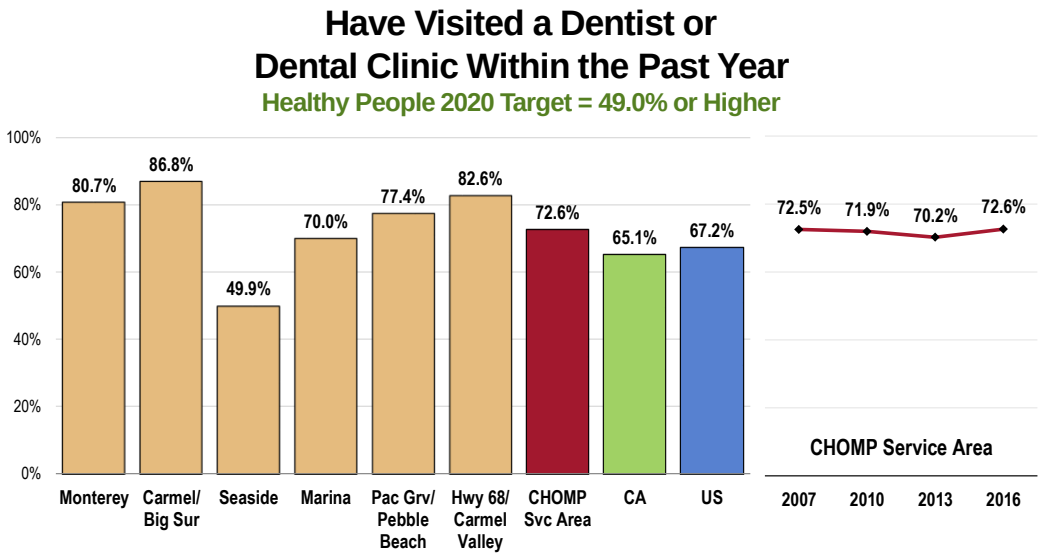
Notes:
- Asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Dental Care

Adults

A total of 72.6% of CHOMP Service Area adults have visited a dentist or dental clinic (for any reason) in the past year.

- More favorable than statewide and national findings.
- Satisfies the Healthy People 2020 target (49% or higher).
- Notably less favorable in Seaside.
- TREND: Statistically unchanged since 2007.



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 20]
- 2015 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): 2014 California data.

Notes:
- Asked of all respondents.

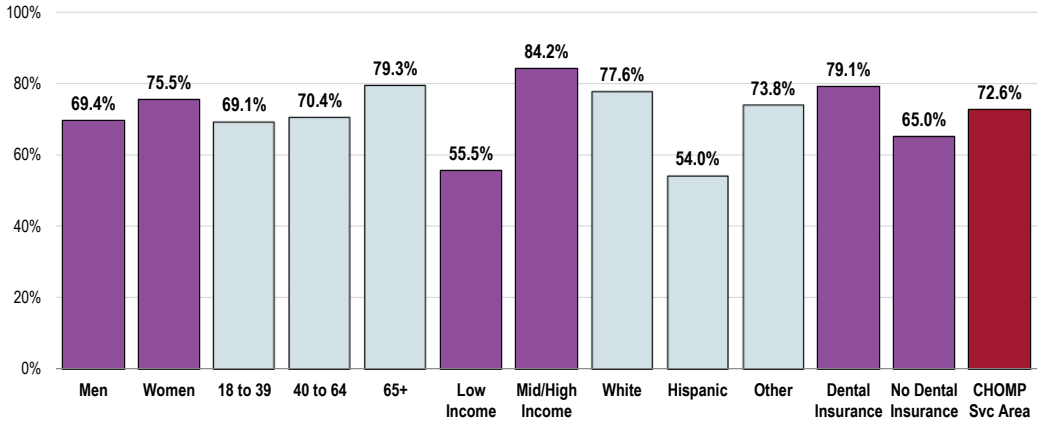
Note the following:

- Women and seniors (65+) are more likely than men or younger adults to report recent dental care.
- Persons living in the lower income categories as well as Hispanics report much lower utilization of oral health services than their demographic counterparts.
- As might be expected, persons with dental insurance report higher utilization of oral health services than those without dental coverage.

Have Visited a Dentist or Dental Clinic Within the Past Year

(CHOMP Service Area, 2016)

Healthy People 2020 Target = 49.0% or Higher



Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 20]
- 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. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Children

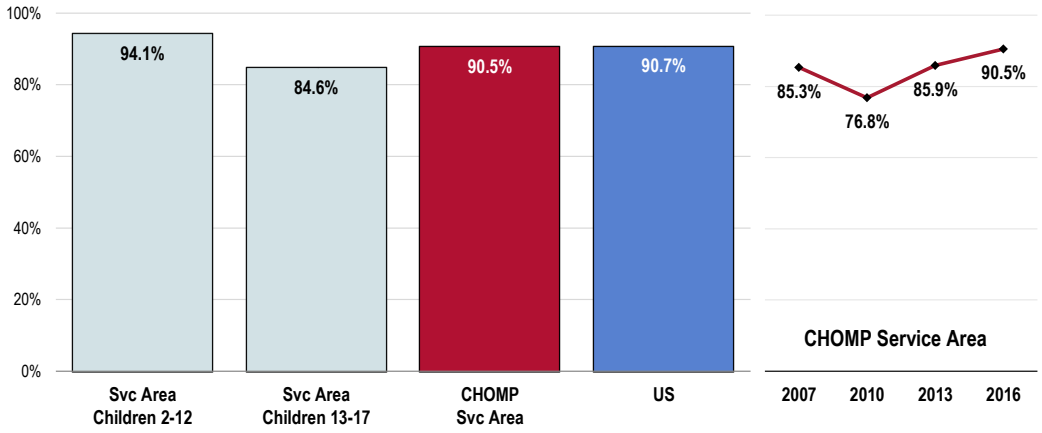
A total of 90.5% of parents report that their child (age 2 to 17) has been to a dentist or dental clinic within the past year.

- Nearly identical to national findings.
- Satisfies the Healthy People 2020 target (49% or higher).
- TREND: Marks a statistically significant increase in children's dental care since 2010 (similar to the 2007 finding).
- Regular dental care is notably lower among teenagers.

Child Has Visited a Dentist or Dental Clinic Within the Past Year

(Among Parents of Children Age 2-17)

Healthy People 2020 Target = 49.0% or Higher



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 141]
- 2015 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]

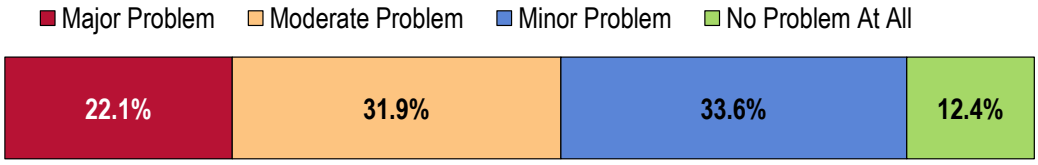
Notes:
- Asked of all respondents with children age 2 through 17.

Key Informant Input: Oral Health

Key informants taking part in an online survey more often characterized *Oral Health* as a "minor problem" than a "moderate problem" in the community.

Perceptions of Oral Health as a Problem in the Community

(Key Informants, 2016)



Sources:
- PRC Online Key Informant Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

Top Concerns

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

Affordable Care/Services

> *Expensive. Very little is covered by insurance. – Community/Business Leader*
>
> *Since Medicare does not have a dental program, I see a lot of seniors with dental problems. It is also the biggest expense that my non-profit helps fix. – Community/Business Leader*
>
> *There is limited access to dental care due to lack of coverage. There is limited education in schools on oral health. Diet plays a role in oral health and many times, young children are provided with sugar sweetened beverages, juice, candy, and other food. – Public Health Representative*
>
> *It is not a high priority and due to lack of insurance dental care becomes secondary. – Community/Business Leader*

Lack of adequate dental insurance options. Too many patients needing treatment for under and un-insured. No dental coverage for seniors. – Other Health Provider

Dental care for Medi-Cal is limited. No dental insurance covers repair to teeth from years of neglect; it is seen as cosmetic but hinders employment and social interactions. Even insurance coverage is inadequate for anything other than basic maintenance. – Social Services Provider

Oral and dental care are not covered by Medi-Cal. Many private insurance plans have a high co-pay, so a large number of patients that I see do not see a dentist at all. – Public Health Representative

Poor reimbursement from government programs has impacted access to services. – Public Health Representative

Cost. – Community/Business Leader

Lack of dental insurance. – Public Health Representative

Unfortunately dentists are expensive and do not accept most insurances. – Physician

A lot of the residents do not have dental insurance because they don't qualify or because they are uninsurable. Even the ones with insurance do not have the coverage needed. – Social Services Provider

See that people of all ages have difficulty accessing affordable dental care. Often times by the time they go to the dentist, the work they need is so expensive. – Public Health Representative

Much of Monterey County suffers from poverty. Low cost/free dental care is hard to find. – Social Services Provider

Incidence/Prevalence

Patient with diabetes often have problem with poor dentation and gum disease. This drives patient to depend mostly on carbohydrates as meat and vegetables are harder to chew. – Other Health Provider

Simple observation and anecdotal reports. – Community/Business Leader

Access to Care/Services

Accessibility and affordability. Education in schools. – Social Services Provider

Nutrition

Poor nutrition and oral health care along with lack of preventative dental care. – Community/Business Leader

Vision Care

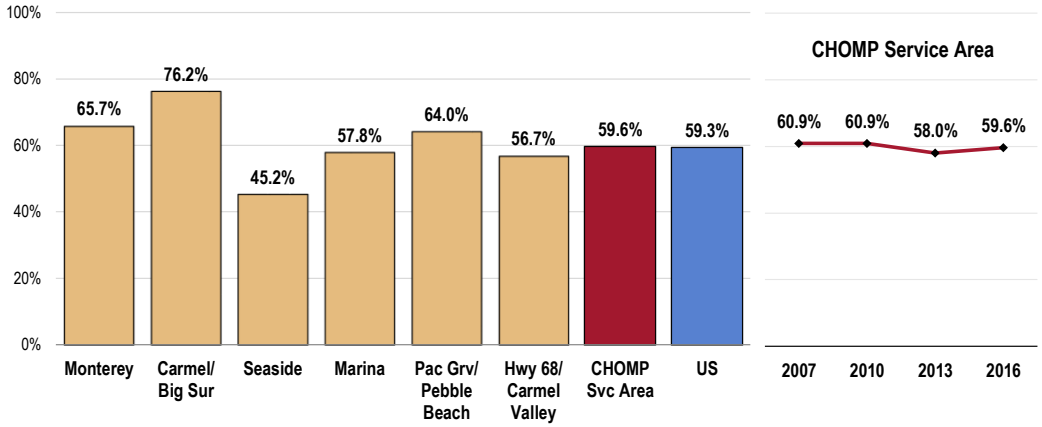
RELATED ISSUE:

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

Nearly three-fifths (59.6%) of CHOMP Service Area residents had an eye exam in the past two years during which their pupils were dilated.

- Similar to national findings.
- Much lower in Seaside.
- TREND: Has not varied significantly 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 19]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

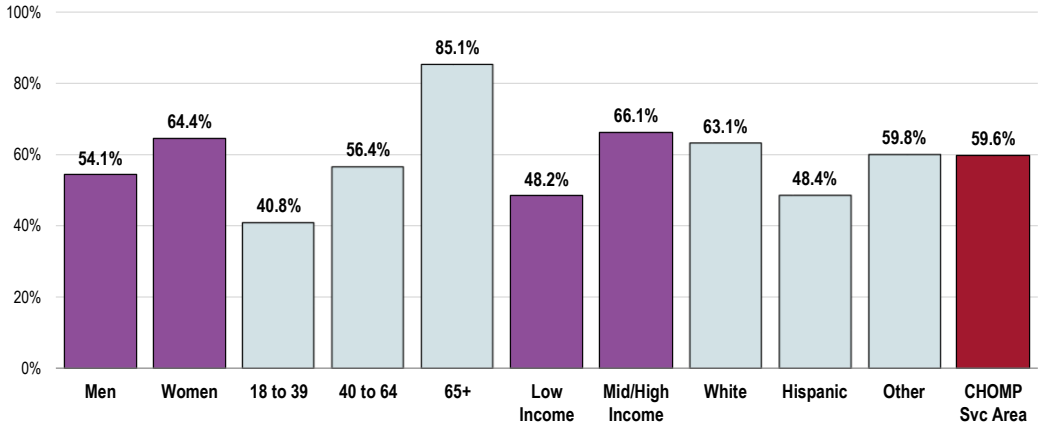
Notes:
- Asked of all respondents.

Recent vision care in CHOMP Service Area is more often reported among:

- Women.
- Residents with higher incomes.
- Whites.
- 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, 2016)



Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 19]

Notes:
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Health Education & Outreach

Professional Research Consultants, Inc.

Healthcare Information Sources

Participation in Health Promotion Events

About Educational & Community-Based Programs

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.

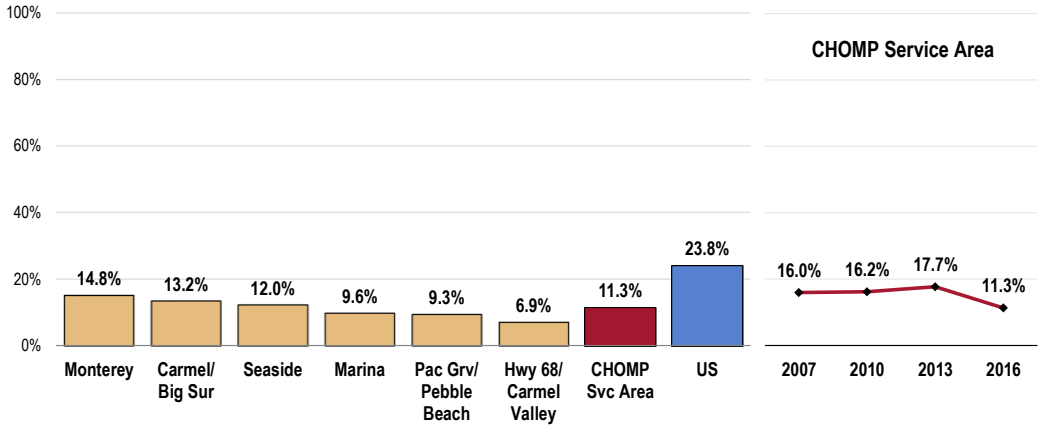
Educational and community-based programs encourage and enhance health and wellness by educating communities on topics such as: chronic diseases; injury and violence prevention; mental illness/behavioral health; unintended pregnancy; oral health; tobacco use; substance abuse; nutrition; and obesity prevention.

- Healthy People 2020 (www.healthypeople.gov)

A total of 11.3% 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.

- Less than half of the national prevalence.
- Lowest in Highway 68/Carmel Valley.
- TREND: Has decreased significantly in the past three years.

Participated in a Health Promotion Activity in the Past Year



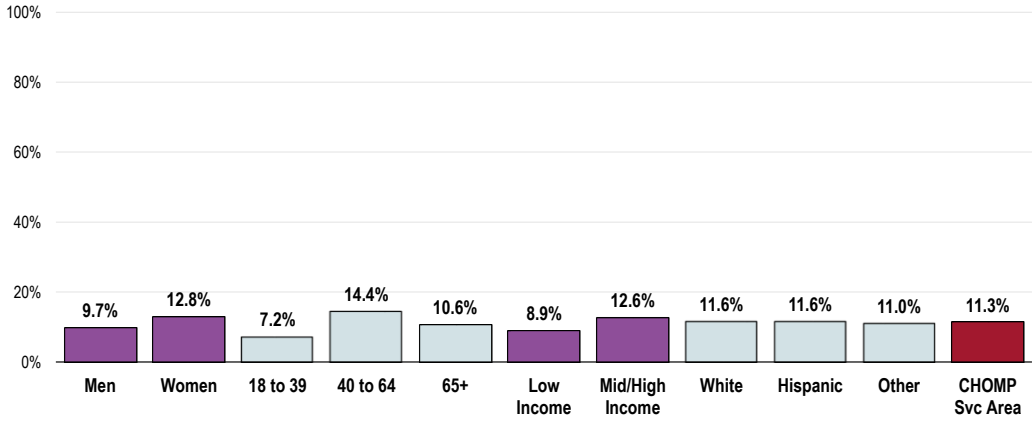
Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Items 306]
- 2013 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

- Note that adults age 40 to 64 more often report participation in health promotion activities.

Participated in a Health Promotion Activity in the Past Year

(CHOMP Service Area, 2016)



Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 306]

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).
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Local Resources

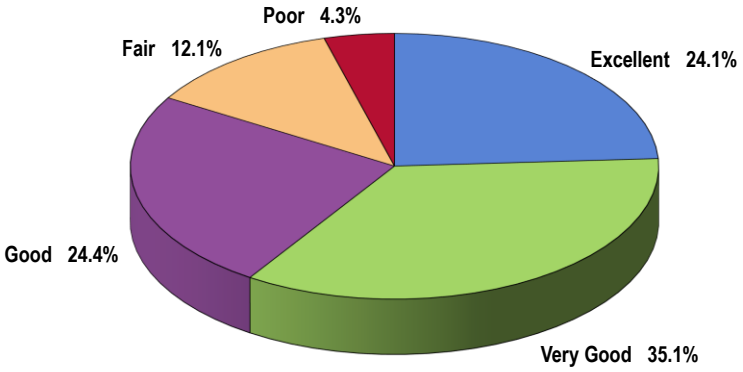
Professional Research Consultants, Inc.

Perceptions of Local Healthcare Services

Over one-half of CHOMP Service Area adults (59.2%) rates the overall healthcare services available in their community as "excellent" or "very good."

- Another 24.4% gave "good" ratings.

Rating of Overall Healthcare Services Available in the Community
(CHOMP Service Area, 2016)

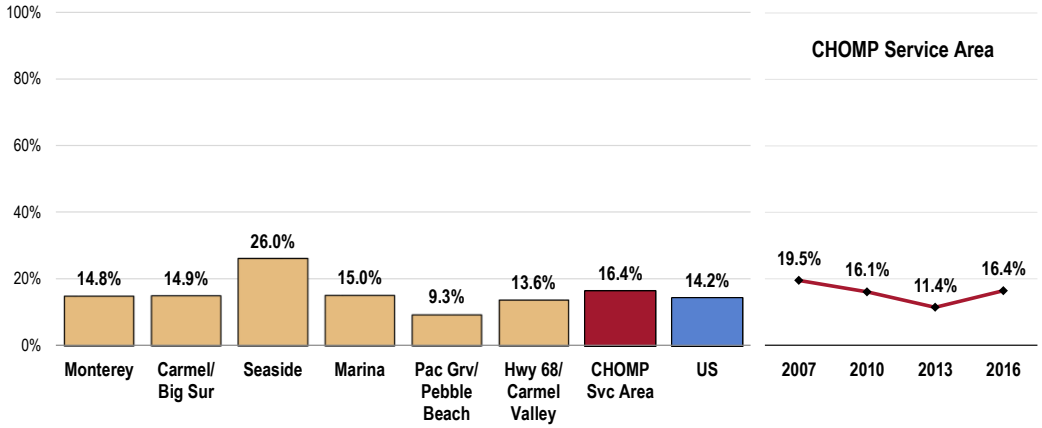


Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 6]
Notes: • Asked of all respondents.

However, 16.4% of residents characterize local healthcare services as "fair" or "poor."

- Comparable to that reported nationally.
- Considerably less favorable in Seaside.
- TREND: "Fair/poor" ratings have increased significantly since 2013, but are similar to 2007 and 2010 survey findings.

Perceive Local Healthcare Services as "Fair/Poor"



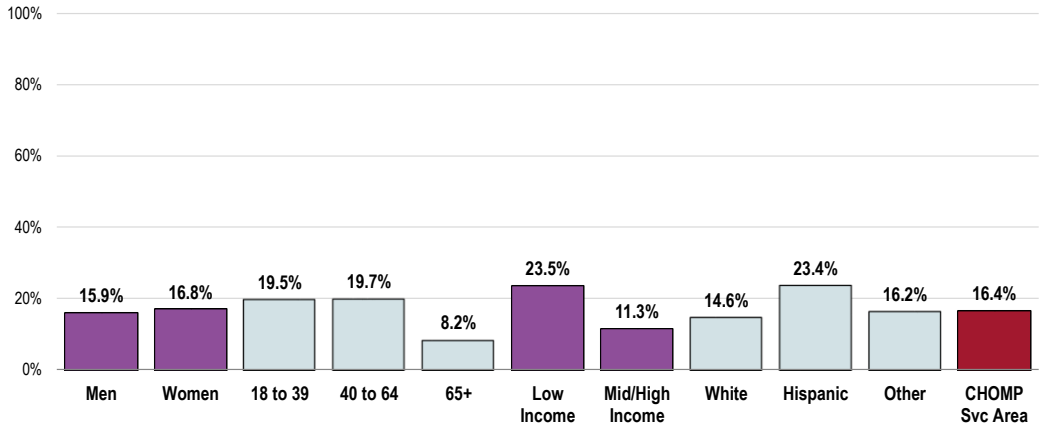
Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 6]
● 2015 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all respondents.

The following residents are more critical of local healthcare services:

- Adults under age 65.
- Residents with lower incomes.
- Hispanics.

Perceive Local Healthcare Services as "Fair/Poor"

(CHOMP Service Area, 2016)



Sources: ● 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 6]
Notes: ● Asked of all respondents.
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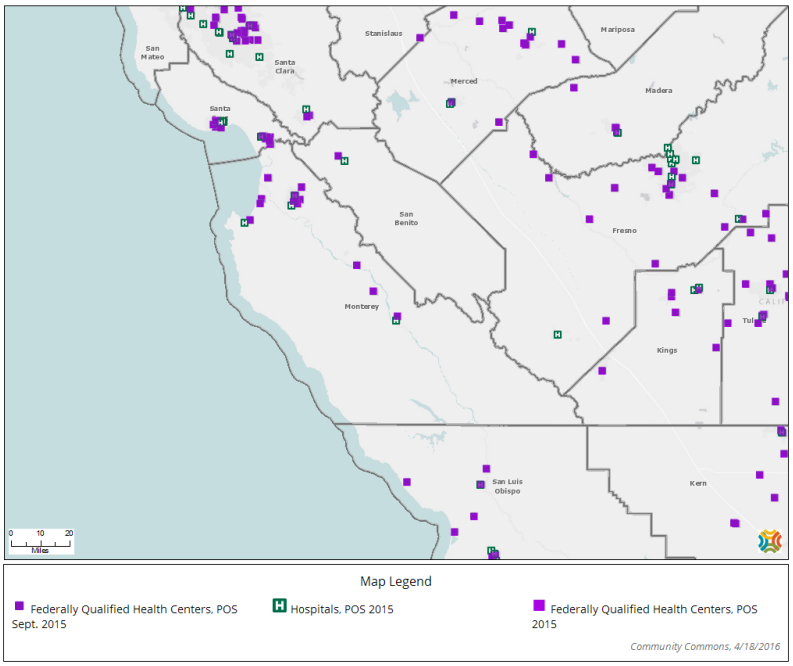
● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Healthcare Resources & Facilities

Hospitals & Federally Qualified Health Centers (FQHCs)

The following map details the hospitals and Federally Qualified Health Centers (FQHCs) within Monterey County as of September 2015.

Hospitals and Federally Qualified Health Centers, POS Sept. 2015



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 in the course of conducting this Community Health Needs Assessment.

Access to Healthcare Services

- *After School Programs*
- *Alisal Health Center*
- *Alliance*
- *Behavioral Health Providers*
- *Catholic Charities*
- *Central California Alliance for Health*
- *Central Coast Center*
- *Clinica de Salud Del Valle*
- *Community Centers*
- *Community Health Innovations - CHI*
- *Community Hospital of the Monterey Peninsula*
- *Community Human Services*
- *County Clinics*
- *County Mental Health*
- *DIRECT*
- *Doctor's Offices*
- *Doctors on Duty*
- *Door to Hope*
- *Employers*
- *Family Resource Center*
- *Farmer's Markets*
- *Federally Qualified Health Centers*
- *Government Subsidies and Incentives*
- *Health Department*
- *Hospitals*
- *Interim, Inc.*
- *Josephine Kernes Memorial Pool*
- *Mee Memorial Hospital and Clinics*
- *mHealth*
- *Mobile Dental Services Van*
- *Montage Health*
- *Monterey Bay IPA*
- *Monterey County Behavioral Health*
- *Monterey County Free Libraries*
- *Monterey County Health Department*
- *Monterey County Medical Society*
- *Monterey County Social Services*
- *Monterey-Salinas Transit (MST)*
- *NAMI*
- *Natividad Clinics*
- *Natividad Medical Center*
- *Natividad's Indigenous Interpreting Program*
- *Peninsula Primary Care*
- *Pilot Project Approved by Board of Supervisors*
- *Planned Parenthood*
- *PREP Monterey*
- *Provider Retention*
- *Public Health*
- *RotaCare*
- *Rural Health Clinics*
- *Salinas Valley Memorial Hospital*
- *Salud Para La Gente*
- *Salvation Army*
- *Seaside Health Clinic*
- *Soledad Medical Group*
- *Sun Street Centers*
- *Transportation ITN*
- *University of California at San Francisco*
- *Urgent Care*
- *Veterans Administration*
- *Visiting Nurses Association*
- *Walk-In Clinics*

Arthritis, Osteoporosis & Chronic Back Conditions

- *Arthritis Center Monterey County*
- *Arthritis Foundation*
- *Chiropractic Care*
- *Community Centers*
- *Community Hospital of the Monterey Peninsula*
- *Doctor's Offices*
- *Exercise Programs for the Elderly*
- *Free Clinics*
- *Josephine Kernes Memorial Pool*

- *Kyphoplasty*
- *Laurel Internal Medicine Clinic*
- *Mental Health Providers*
- *MRI*
- *Nutrition Services*
- *Physical Therapists*
- *Salinas Valley Memorial Hospital*
- *Spine Surgeons and Interventional Radiologists*

Cancer

- *American Cancer Society*
- *Central Coast Alliance*
- *Community Alliance for Safety and Peace*
- *Community Hospital*
- *Community Hospital of the Monterey Peninsula*
- *Doctor's Offices*
- *Every Woman Counts*
- *Free Clinics*
- *Hospice*
- *Hospitals*
- *Media*
- *Medical Outreach*
- *Monterey County Health Clinic*
- *Monterey County Health Department*
- *Monterey Sports Center*
- *Natividad Medical Center*
- *Online Resources*
- *Pacific Cancer Center*
- *Relay for Life*
- *Religious Organizations*
- *Salinas Valley Memorial Hospital*
- *Salvation Army*
- *Stanford*
- *University of California at San Francisco*
- *Visiting Nurses Association*

Chronic Kidney Disease

- *Central Coast Alliance*
- *Community Hospital of the Monterey Peninsula*
- *County Clinics*
- *Dialysis*
- *Doctor's Offices*
- *La Clinica de Valle*
- *Medical Outreach*
- *Natividad Clinics*
- *Nephrology*
- *Salinas Valley Memorial Hospital*
- *YWCA*

Dementias, Including Alzheimer's Disease

- *Adult Day Care*
- *Alliance on Aging*
- *Alzheimer's Association*
- *Alzheimer's Care Center*
- *Alzheimer's Society*
- *Alzheimer's Support Groups*
- *Area Agency on Aging*
- *Assisted Living Facilities*
- *Carmelo Park*
- *Central Coast Alliance*
- *Churches*
- *Community Associations*
- *Community Hospital*
- *Community Hospital of the Monterey Peninsula*
- *Del Mar Caregiver Resource Center*
- *Department of Social Services*
- *Doctor's Offices*
- *Health Care Organizations*
- *HICAP*
- *Home Health Care*
- *Hospice*
- *Hospitals*
- *Legal Services for Seniors*
- *Local Society for Dementia*
- *Meals on Wheels*
- *Medical Outreach*
- *Monterey County Health Clinic*
- *Monterey County IHSS*
- *Monterey County Social Services*
- *Nursing Homes*
- *Oldemeyer Center for Seniors*
- *Online Resources*
- *Peninsula Primary Care*
- *Salinas Valley Memorial Hospital*
- *Sally Griffith Senior Center*
- *Seaside Health Clinic*
- *Senior Affordable Living Facility*
- *Senior Center*
- *Senior Referral Services*
- *Stanford*
- *Sunrise House*
- *Victorian Home Care*
- *Visiting Nurses Association*
- *Wellness Center*

Diabetes

- *Alliance*
- *Alliance on Aging*
- *American Diabetes Association*
- *American Heart Association*
- *Bir Sur Health Center*
- *Clinica de Salud Del Valle*
- *Community Associations*
- *Community Health Innovations - CHI*
- *Community Hospital of the Monterey Peninsula*
- *Community Outreach*
- *Community Support Services*
- *Diabetes Care Center*
- *Diabetic Care*
- *Doctor's Offices*
- *Farmer's Markets*
- *First 5*
- *Health Department*
- *Hospitals*
- *Insurance Company*
- *Josephine Kernes Memorial Pool*
- *La Clinica de Valle*
- *Library*
- *Monterey County Health Clinic*
- *Monterey County Health Department*
- *Monterey County Social Services*
- *Monterey County Staff*
- *National Diabetes Prevention Program*
- *Natividad Medical Center*
- *Nutrition Services*
- *Oldemeyer Center for Seniors*
- *Online Resources*
- *Pajaro Valley Community Health Trust*
- *RotaCare*
- *Salinas Valley Memorial Hospital*
- *Seaside Health Clinic*
- *Sports Center*
- *Stanford*
- *Watsonville Hospital Diabetes Center*
- *Weigh of Life*
- *Weight Watchers*
- *YMCA*

Family Planning

- *Community Hospital of the Monterey Peninsula*
- *Community Outreach*
- *Doctor's Offices*
- *Employers*
- *Harmony At Home*
- *Monterey County Health Department*
- *Natividad Medical Center*
- *Planned Parenthood*
- *Postpone Pregnancy*
- *Salinas Valley Memorial Hospital*
- *Teen Success*
- *YWCA*

Hearing & Vision

- *Blind and Visually Impaired Center*
- *Carmel Hearing Center*
- *Doctor's Offices*
- *Natividad Medical Center*
- *Vantage Eye Care*

Heart Disease & Stroke

- *American Heart Association*
- *Community Groups*
- *Community Hospital*
- *Community Hospital of the Monterey Peninsula*
- *Doctor's Offices*
- *Employers*
- *Home Health Care*
- *Hospitals*
- *Josephine Kernes Memorial Pool*
- *Mayo Clinic*
- *Monterey Sports Center*
- *Natividad Medical Center*
- *Online Resources*
- *Peninsula Primary Care*
- *RT/PHNs Health Department*
- *Salinas Valley Memorial Hospital*
- *Seaside Health Clinic*
- *Stanford*
- *Visiting Nurses Association*

HIV/AIDS

- *Central Coast HIV/AIDS Services*
- *Churches*
- *College of Health Human Services and Public Policy*
- *Community Hospital of the Monterey Peninsula*
- *Community Outreach*
- *Doctor's Offices*
- *Monterey County Health Department*
- *NAACP HIV/AIDS Committee*

Natividad Medical Center
Outpatient Immunology Services (OPIS)
Salinas Valley Memorial Hospital
Salud Para La Gente

Immunization & Infectious Diseases

Community Hospital of the Monterey Peninsula
County Health
Doctor's Offices
Employers
Hospitals
Monterey County Health Department
Peninsula Primary Care
Pharmacies
Salinas Valley Memorial Hospital
Seaside Health Clinic
Urgent Care
Visiting Nurses Association

Infant & Child Health

Clinics de Salud
Community Groups
Community Hospital of the Monterey Peninsula
Doctor's Offices
Early Start
Easter Seals of Central California
First 5
Free Clinics
Friends and Family
Head Start
Hospitals
Josephine Kernes Memorial Pool
Library
MCSTART
Monterey County Health Department
Monterey County Office of Education
Monterey County Social Services
Natividad Medical Center
Online Resources
Salinas Adult School
Salinas Valley Memorial Hospital
San Andreas Regional Center
Seaside Health Clinic
Soup Kitchens
Special Kids Crusade
Stanford
WIC

Injury & Violence

After School Programs
Anti-Drug, Violence and Alcohol Programs
Boys and Girls Clubs
Breadbox
Breakthrough for Men
Community Alliance for Safety and Peace
Community Groups
Community Hospital
Community Human Services
Community Organizations
Counter-Gang Agencies
Crisis Prevention Center
DARE Program
Employers
Five Cities for Peace
Gang Intervention Programs
Governing for Racial Equity
Harmony At Home
Health Department
Hospitals
Media
Monterey County Free Libraries
Monterey County Gang Violence Prevention Group
Monterey County Health Department
Monterey County Rape Crisis Center
Monterey County Sheriff's Department
Monterey County Social Services
Monterey Sports Center
Natividad Medical Center
Natividad Trauma Center
Partners for Peace
Police Department
Probation Department
Rancho Cielo
Safe Routes to School
Salinas Fire Department
Salinas Police Department
Salinas Valley Memorial Hospital
Salvation Army
Second Chance Youth Program
Silver Star Program
STRYVE
Sun Street Centers
Victim/Witness Services
YWCA

Mental Health

- *2-1-1*
- *Alliance*
- *Alliance on Aging*
- *Beacon House*
- *Behavioral Health Providers*
- *BreakFree for Women*
- *Breakthrough for Men*
- *Catholic Charities*
- *Central California Alliance for Health*
- *Central Coast Center*
- *Churches*
- *Citizenship Project*
- *Community Alliance for Safety and Peace*
- *Community Groups*
- *Community Hospital of the Monterey Peninsula*
- *Community Human Services*
- *County Clinics*
- *Doctor's Offices*
- *Employers*
- *Harmony At Home*
- *Health Department*
- *Hospitals*
- *Interim, Inc.*
- *Medi-Cal*
- *Mental Health Providers*
- *Mobile Crisis Unit*
- *Monterey County Behavioral Health*
- *Monterey County Health Department*
- *Monterey County Mental Health Services*
- *Multidisciplinary Teams*
- *NAMI*
- *Natividad Medical Center*
- *No Wrong Door Access for Mental Health*
- *Non-Profits and NGOs*
- *OMNI/Interium Services*
- *Prevention and Early Recovery in Psychosis*
- *Salinas Valley Memorial Hospital*
- *School System*
- *Social Workers*
- *Sun Street Centers*
- *Sunrise House*
- *The Village Project*
- *Veterans in Transition*
- *Veterans Support Services*
- *YMCA*
- *YWCA*

Nutrition, Physical Activity & Weight

- *American Heart Association*
- *Big Sur Grange*
- *Big Sur Health Center*
- *Boys and Girls Clubs*
- *Building Healthy Communities*
- *Community Centers*
- *Community Groups*
- *Community Hospital of the Monterey Peninsula*
- *Diabetic Care*
- *Doctor's Offices*
- *Employers*
- *Fitness Centers/Gyms*
- *Food Bank*
- *Fresh Produce*
- *Hospitals*
- *In-Shape*
- *Josephine Kernes Memorial Pool*
- *Just Run*
- *Meals on Wheels*
- *Media*
- *Monterey County Free Libraries*
- *Monterey County Health Department*
- *Monterey Sports Center*
- *Natividad Medical Center*
- *Nutrition Services*
- *Oldemeyer Center for Seniors*
- *Online Resources*
- *Parks and Recreation*
- *Peninsula Wellness Centers*
- *PHN/MCHD*
- *Restaurants*
- *RotaCare*
- *Salinas Valley Memorial Hospital*
- *School System*
- *Soccer Leagues*
- *Summer Camps*
- *Summer Softball League*
- *Weigh of Life*
- *Weight Watchers*
- *WIC*
- *YMCA*
- *YWCA*

Oral Health

- *Children's Oral Health Program*
- *Clinica de Salud Del Valle*

- *Community Groups*
- *Denti-Cal*
- *Dentist's Offices*
- *Dientes*
- *Doctor's Offices*
- *Employers*
- *First 5*
- *Hands to Help Seniors*
- *La Clinica de Valle*
- *Monterey County Health Department*
- *RotaCare*
- *Rotary Club*
- *Salud Para La Gente*

Respiratory Diseases

- *American Lung Association*
- *Breathe California Central Coast*
- *Community Groups*
- *Community Hospital of the Monterey Peninsula*
- *Employers*
- *Free Clinics*
- *Monterey County Health Department*
- *Natividad Medical Center*
- *PHN/Health Department*
- *Salinas Valley Memorial Hospital*

Sexually Transmitted Diseases

- *Community Groups*
- *County Clinics*
- *CSVS*
- *Friends and Family*
- *La Clinica de Valle*
- *Monterey County Health Department*
- *Natividad Medical Center*
- *Planned Parenthood*
- *Salinas Valley Memorial Hospital*
- *School System*

Substance Abuse

- *AA/NA*
- *Alliance*
- *Beacon House*
- *BreakFree for Women*
- *Breakthrough for Men*
- *CASP*
- *Clint Eastwood Rehabilitation Program*
- *Community Based Outpatient Programs*
- *Community Health Services*
- *Community Hospital of the Monterey Peninsula*
- *Community Human Services*
- *County Mental Health*
- *Doctor's Offices*
- *Door to Hope*
- *Friends and Family*
- *Genesis House*
- *Health Department*
- *Hospitals*
- *Interim, Inc.*
- *MCSTART*
- *Mental Health Providers*
- *Monterey County Behavioral Health*
- *Monterey County Health Clinic*
- *Monterey County Health Department*
- *Monterey County Substance Abuse*
- *Natividad Medical Center*
- *Police Department*
- *Recovery Centers*
- *Red Cross*
- *Residential Treatment*
- *Salinas Valley Memorial Hospital*
- *Salvation Army*
- *School System*
- *Sun Street Centers*
- *Sunrise House*
- *The Bridge*
- *Turning Point*

Tobacco Use

- *1-800-NO-BUTTS*
- *American Cancer Society*
- *Breathe California Central Coast*
- *Community Hospital of the Monterey Peninsula*
- *Hospitals*
- *Media*
- *Monterey County Health Department*
- *Private Consultants*
- *Salinas Valley Memorial Hospital*
- *State of California*
- *Tobacco.org*

Appendix

Professional Research Consultants, Inc.

Evaluation of Past Activities

Community Hospital's current community needs assessment implementation plan was reviewed during 2014 and again in 2015 for progress in each of our top five health priority areas, against the baseline measures established in 2014. Baseline outcomes measures have been refined since then where appropriate. We have been able to sustain and enhance our efforts in most areas described in our plan.

Our initiatives include insurance products, physician recruitment programs, grant funding for community organizations, classes and community events, a nutritional program in Monterey County schools, working with employers, financial assistance and other forms of charity care, supporting those with chronic diseases and mental health concerns, and a congestive heart failure disease management program, just to name a few.

The following is a review of the results of each of the five priority areas of our 2103 plan:

Priority Area 1: Access to Health Services
Goal: Improve access to healthcare services and insurance coverage for individuals and families.

- Number of primary care physician/nurse visits provided in part as a result of grant funding was increased. 46,003 primary care visits were provided in 2014 and 47,724 in 2015 as a result of $75,000 grants each year to Monterey County Department of Health's primary care clinics in Marina and Seaside, improving access to primary care for the underserved.
- Dollar value and number of grants provided to support access to primary care for underserved populations remained the same. Two grants totaling $135,000 each year were provided to directly impact underserved populations.
- Number of new physicians hired in primary care and other demonstrated-shortage specialties was increased. Five new physicians were hired in primary care and other demonstrated-shortage specialties in 2014 and 10 physicians in 2015, for a total of 15 new physicians.
- Number of enrollees in the Aspire Medicare Advantage Plan was increased. Enrollment in the Aspire Medicare Advantage Plan doubled from 2014 to 2015. 783 were enrolled in 2014 and another 790 in 2015, for a total of 1573 enrollees.
- Number of enrollees in Cal-PERS exclusive provider insurance plan was increased. There were 564 enrollees in our Cal-PERS exclusive provider insurance plan in 2014. Enrollment dramatically increased to 1,841 enrollees in 2015.

Priority Area 2: Education and Community Based Programs
Goal: Enhance health literacy by providing health education, health screenings, and preventive services.

- Number of participants in hospital-sponsored health fairs declined. 4,324 individuals participated in hospital-sponsored health fairs in 2014 and 3,020 in 2015. This decrease is associated with the hospital discontinuing its participation in the Big Sur Half Marathon Expo in 2015 because prior participants were not engaged in the educational opportunity.
- Number of preventive screenings provided declined slightly. 1,836 preventive screenings were provided in 2014 and 1,756 in 2015; the decrease is associated with lower attendance at free health fairs, which may itself be a result of more individuals having health insurance.
- There was a modest increase in the number of classes, support groups, prevention programs, and lectures offered, from 124 in 2014 to 133 in 2015.
- There was also a modest increase in the number of overall participants in the classes, support groups, prevention programs, and lectures offered, from 24,131 in 2014 to 25,959 in 2015.

- The number of Living Well Workshops (Chronic Disease Self Management Program) increased from three in 2014 to six in 2015. There were 27 participants in 2014 and 33 participants in 2015.
- Number of employers engaged in the Working Well Initiative decreased from 99 in 2014 to 80 in 2015, but the number of employee participants in employer-based Working Well programs increased slightly. There were 13,125 employee participants in employer-based Working Well programs during 2014 and 13,691 participants in 2015.

Priority Area 3: Nutrition, Physical Activity and Weight
Goal: Provide programs and services focused on prevention and disease management with an emphasis on nutrition education, physical activity, and weight management.

- Number of school sites participating in the Kids Eat Right program increased from 12 schools to 14. There was a modest increase in the number of students that participated in the Kids Eat Right program, from 1,430 students in 2014 to 1,558 students in 2015. Pre- and post-tests were used instead of evaluations, and these demonstrated 68.6 percent change in knowledge in 2014 and 93.6 percent change in 2015.
- Number of enrollees in the Diabetes Prevention Program decreased slightly. In 2014 there were 16 enrollees (9 completed the 16-week sessions and 8 completed the entire program), while in 2015 7 enrollees completed the program. Enrollee weight loss in 2014 was 3.5 percent, and in 2015 weight loss was 1.9 percent.
- Number of residents served by grant-supported meal programs increased. Grant funding of $7,500 was provided in 2014 and 2015 to support healthy meals. Boys and Girls Clubs of Monterey County received $2,500 each year for their Healthy Lifestyles Initiative, and Meals on Wheels of the Monterey Peninsula received $5,000 each year for Save Our Breakfast. Boys and Girls Clubs of Monterey County served 773 residents in 2014 and 960 residents in 2015. Number of meals served by grant-supported meal programs remained almost the same. Meals on Wheels served 750 meals in 2014 and 749 meals in 2015.

Priority Area 4: Mental Health and Mental Disorders
Goal: Provide access to general mental health services and education related to ADD/ADHD and depression.

- Dollar value of mental healthcare provided through the financial assistance program decreased slightly.
  $1.58 million in mental healthcare was provided through the financial assistance program in 2014 and $1.13 million was provided in 2015, due in large part to the greater numbers of residents with health insurance.
- No psychiatrists were hired in 2014, and one new psychiatrist was hired in 2015.
- Number of mental health patients benefitting from the financial assistance program decreased slightly.
  258 mental health patients benefited from the financial assistance program in 2014 and 244 benefited in 2015.
- Despite three ADD/ADHD class offerings in 2014 and two in 2015, all were cancelled due to lack of enrollment.
- Number of classes and number of participants in classes on depression and anxiety decreased.
  Five classes on depression and anxiety were held in 2014 and three in 2015. There were 160 participants in 2014 and 26 participants in 2015.

Priority Area 5: Heart Disease and Stroke

Goal: Provide programs and services focused on increasing detection of hypertension and improving chronic disease management.

- Number of residents receiving blood pressure screening decreased.
  502 adults received blood pressure screening at hospital events in 2014 and 346 in 2015. This number was impacted by lower attendance at health fairs overall, which may be due to the significant increase in residents with health insurance.
- Number of participants enrolled in Life Connections program increased from 424 participants to 451.
- Number of added employers/health plans offering the Life Connections program also increased.
  One employer and one health plan (with 36 employers) added the Life Connections program in 2014; two additional employers and one health plan added the program in 2015.
- Number of physicians referring participants and the number of participants enrolled in the congestive heart failure disease management program increased.
  Six physicians referred participants to the congestive heart disease management program in 2014 and 12 in 2015. Six participants enrolled in and completed the congestive heart disease management program in 2014 and 11 in 2015. There was also improvement in functional capacity and quality of life measures (as measured by the program):
  - Average metabolic equivalent level change: 72.2 percent (ranged from -33 percent to 200 percent).
  - Average quality of life score improvement: 12.71 percent (ranged from -5 percent to 27 percent).