Evaluación de Necesidades de la Salud Comunitaria 2025

Centro Médico Regional Marian
Hospital Comunitario de Arroyo Grande

Adoptado en mayo de 2025

Dignity Health.
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Resumen ejecutivo

El propósito de esta Evaluación de Necesidades de la Salud Comunitaria (ENSC) es identificar y priorizar las necesidades de salud importantes en la comunidad atendida por el Centro Médico Regional Marian y el Hospital Comunitario de Arroyo Grande («el Hospital»). Las prioridades identificadas en este informe ayudan a guiar los programas de mejora de la salud comunitaria y las actividades de beneficio comunitario del Hospital, así como sus esfuerzos de colaboración con otras organizaciones que comparten la misión de mejorar la salud. Esta ENSC cumple con los requisitos de la Ley de Protección al Paciente y Cuidado de Salud Asequible, la cual exige que los hospitales sin fines de lucro realicen una Evaluación de Necesidades de la Salud Comunitaria por lo menos una vez cada tres años.

El Centro Médico Regional Marian («el Hospital») está ubicado en 1400 East Church Street en Santa María, California, y ha estado sirviendo a la comunidad desde su fundación en 1940. El Hospital también opera un segundo centro a 17 millas al norte con la misma licencia hospitalaria, el Hospital Comunitario de Arroyo Grande. El Hospital Comunitario de Arroyo Grande está ubicado en 345 South Halcyon Road en Arroyo Grande, Condado de San Luis Obispo, California. El Hospital es miembro de Dignity Health, que forma parte de CommonSpirit Health.

La comunidad hospitalaria incluye los siguientes códigos postales: 93420 (Arroyo Grande), 93433 (Grover Beach), 93434 (Guadalupe), 93444 (Nipomo), 93445 (Océano), 93449 (Pismo Beach), 93454 y 93458 (Santa María) y 93455 (Santa María y Orcutt).

La comunidad alberga a 234,668 residentes, y más de la mitad (56%) de los residentes se identifican como de origen hispano o latino (a) y aproximadamente un tercio (36%) se consideran solamente blancos, no hispanos o latinos (as). El resto de los miembros de la comunidad se identifican como asiáticos (4%), de dos o más razas (3%), o miembros de la comunidad negra (1%)

El Hospital presta servicios a la ciudad de Santa María, donde viven aproximadamente 110,000 residentes, de los cuales casi el 80% de la población de las ciudades se identifica como hispana o latina(o). Si comparamos Santa María con todas las ciudades estadounidenses con poblaciones de más de 100,000 habitantes, tiene la octava proporción más alta de residentes hispanos o latinos (as).

Además de los residentes mencionados anteriormente y que, por lo general, no figuran en los datos del Censo de los EE. UU., la comunidad alberga a una población indígena mexicana originaria de los estados mexicanos de Oaxaca y Guerrero atraída por el trabajo en la zona. Estas personas suelen ser monolingües en sus lenguas indígenas prehispánicas nativas, el mixteco o el zapoteco. Se estima que 25,000 migrantes indígenas viven y trabajan en el Condado de Santa Bárbara, y Santa María alberga a la mayoría.

Esta comunidad es única debido a su ubicación en la Costa Central, con amplias zonas no incorporadas, una belleza natural sorprendente y comunidades prósperas. Detrás de esta belleza natural impresionante hay comunidades geográficamente aisladas que contienen a más de 540 personas sin vivienda en la zona. Se pueden encontrar personas subrepresentadas que viven en la pobreza y trabajan en la sombra de las industrias de la agricultura, el turismo o el comercio minorista.

El compromiso del Hospital de involucrar a la comunidad, evaluar las necesidades prioritarias y ayudar a abordarlas con colaboradores comunitarios está en acorde con su misión. Siendo CommonSpirit Health, damos a conocer la presencia sanadora de Dios en nuestro mundo al mejorar la salud de las personas a las que servimos, especialmente las que son vulnerables, mientras promovemos la justicia social para todos.

El proceso de recopilación de datos para esta ENSC de 2025 incluyó una compilación de fuentes primarias y secundarias de datos, que comprendía de grupos focales de organizaciones comunitarias, entrevistas con informantes clave, estadísticas de salud pública y datos del Censo de los EE.UU. Los datos cualitativos primarios se obtuvieron mediante la facilitación de grupos focales con un total de 117 participantes y entrevistas con informantes clave con las partes interesadas de la comunidad. Los grupos focales se realizaron el verano de 2024 e incluyeron a miembros clave de poblaciones vulnerables como personas de la comunidad LGBTQ+, negras o afroamericanas, personas con un dominio limitado del inglés, personas sin vivienda, veteranos, jóvenes, y personas de la tercera edad. Esta metodología mixta valida los datos mediante la verificación a través de múltiples fuentes, así brindando una perspectiva más amplia de las necesidades de salud de la comunidad y la población. Esta información se corroboró con datos cuantitativos secundarios obtenidos de conjuntos de datos mantenidos por organizaciones gubernamentales y no gubernamentales a nivel local, estatal y nacional.

El equipo de preparación de la ENSC de 2025 determinó cuidadosamente las importantes necesidades de salud comunitaria durante discusiones y presentaciones colaborativas con los dirigentes superiores. Todos los datos cualitativos y anécdotas apuntaban hacia las necesidades de salud comunitarias ya identificadas. Las mismas inquietudes y necesidades surgieron constantemente y se reiteraron en varios grupos focales y entrevistas con informantes clave. También se utilizaron los siguientes criterios para evaluar la priorización de las necesidades comunitarias:

- el tamaño o escala del problema (cuántas personas se vieron afectadas);
- la gravedad del problema;
- la desigualdad y equidad;
- intervenciones eficaces ya conocidas;
- la viabilidad y sustentabilidad de recursos; y

- el apoyo comunitario.

Los datos recopilados y los resultados presentados en esta Evaluación se obtuvieron antes de las elecciones presidenciales de noviembre de 2024. Como se comentó en un grupo de discusión,

«Una comunidad saludable es aquella que está libre de estigma y vergüenza, en la que cualquier persona puede buscar y recibir la atención que necesita».
— Participante del grupo de enfoque

Para este informe de la evaluación de 2025 se determinaron las siguientes importantes necesidades de la salud comunitaria:

Prioridad 1: Una atención médica culturalmente sensible y receptiva que tiene la confianza de la comunidad.

Prioridad 2: Asistencia médica y de navegación fácilmente disponible en el idioma que hablan los pacientes.

Prioridad 3: Condiciones de vida insatisfechas, como el transporte, las finanzas, la vivienda (incluida la población sin vivienda), la educación, el medioambiente y el cuidado de los niños.

Prioridad 4: Acceso a una mejor salud conductual, incluyendo el tratamiento de los trastornos por consumo de sustancias y la navegación de los servicios con un énfasis especial en la población sin vivienda.

Las dificultades de las comunidades para acceder a la atención médica van más allá de las estadísticas sobre el seguro médico, la cantidad de médicos o clínicas en la comunidad o el tiempo transcurrido desde la última visita al médico de una persona. Las barreras que enfrenta la comunidad se presentan en cómo navegar por el sistema de salud, llegar a la cita, recibir atención en su idioma y ser bien recibidos en la puerta de entrada. Se realizaron grupos focales con poblaciones similares en los hospitales de la región de la costa central de Dignity Health California, y sus historias y dificultades compartidas aparecieron con frecuencia en toda la zona. A lo largo de las sesiones de los grupos focales, se hizo evidente en repetidas ocasiones que ciertos miembros de la comunidad evitan buscar atención médica ya sea debido a una experiencia vivida o compartida. Si bien esta evaluación identifica los desafíos de la comunidad, no deja de ser una comunidad próspera y resiliente que se unirá y colaborará para satisfacer sus necesidades.

Si bien hay recursos potenciales disponibles para abordar las necesidades identificadas de la comunidad, estas necesidades son demasiado significantes para una sola organización. Lograr un impacto sustancial y ascendente requerirá los esfuerzos de colaboración de las organizaciones comunitarias, el gobierno local, los líderes empresariales locales y otras instituciones. Las

necesidades identificadas en esta evaluación se abordarán en una Estrategia de Implementación de Salud Comunitaria que se publicará en noviembre de 2025.

El informe de esta Evaluación de Necesidades de la Salud Comunitaria 2025 se realizó como una colaboración entre Patty Herrera, Maestría en Humanidades, Directora de Salud Comunitaria de los hospitales de la región de la costa central de Dignity Health California y Amanda Gettig, (Maestría en Salud Pública), Ganey Science, San Francisco, CA.

El informe la evaluación fue adoptado por la Junta Comunitaria del Centro Médico Regional Marian en mayo de 2025. El informe está a amplia disposición del público en el sitio web del hospital, y se puede solicitar una copia impresa en la Oficina de Educación Comunitaria del Hospital. Comentarios por escrito sobre este informe pueden enviarse al Gestor de Salud Comunitaria del hospital ubicado/a en 1400 Johnson Avenue, San Luis Obispo, CA 93454, o puede enviar un correo electrónico a CHNA-CCSAN@commonspirit.org.

I. Definición de comunidad

El Centro Médico Regional Marian («el Hospital») está ubicado en 1400 East Church Street en Santa María, Condado de Santa Bárbara, California. El Hospital también opera un segundo centro a 17 millas al norte con la misma licencia hospitalaria, el Hospital Comunitario de Arroyo Grande. El Hospital Comunitario de Arroyo Grande está ubicado en 345 South Halcyon Road en Arroyo Grande, Condado de San Luis Obispo, California. El Hospital es miembro de Dignity Health, que forma parte de CommonSpirit Health.

El Hospital atiende a aproximadamente 234,000 personas de las áreas urbanas y rurales del norte del condado de Santa Bárbara y el sur del condado de San Luis Obispo, California. La comunidad que es atendida por el Hospital reside principalmente en las áreas incorporadas de Orcutt, Santa María, Guadalupe, Nipomo, Arroyo Grande, Grover Beach, Océano y Pismo Beach. La comunidad atendida por el Hospital incluye los siguientes códigos postales:

Condado de Santa Bárbara	Condado de San Luis Obispo
93434 (Guadalupe)	93420 (Arroyo Grande)
93454 (Santa María)	93433 (Grover Beach)
93455 (Santa María y Orcutt)	93444 (Nipomo)
93458 (Santa María)	93445 (Océano)
	93449 (Pismo Beach).

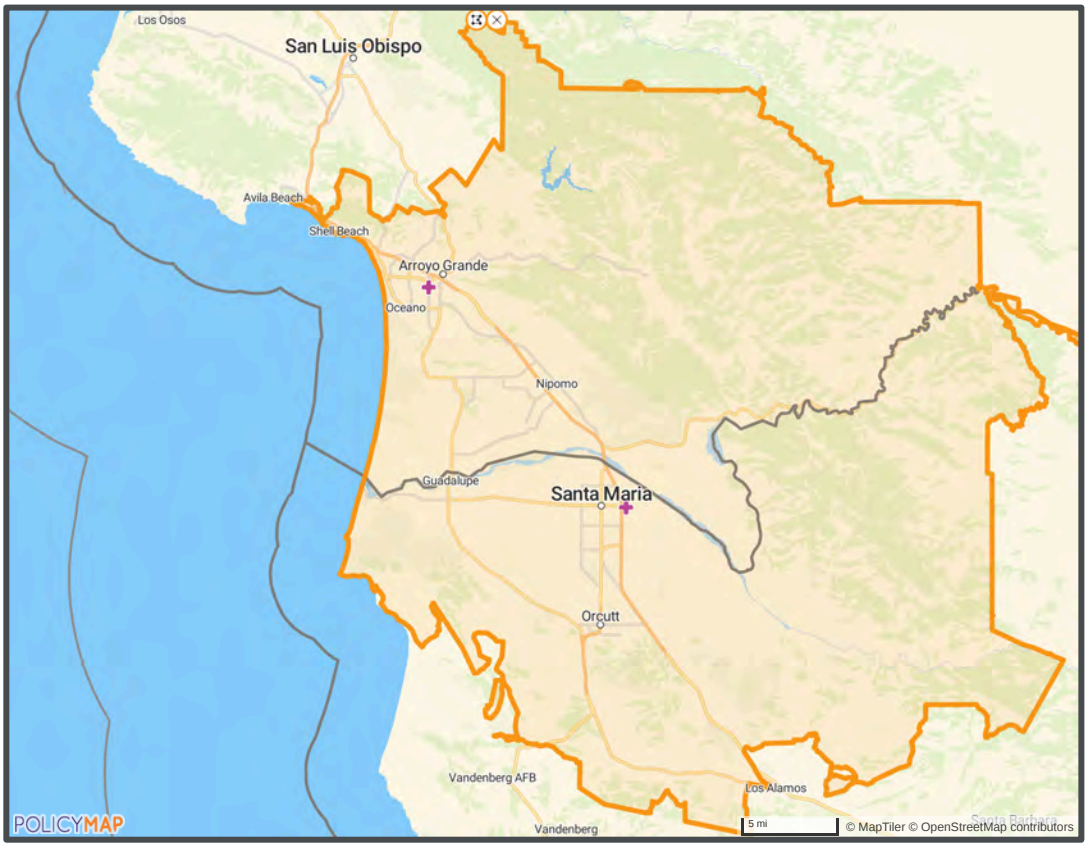
La comunidad que es atendida por el Hospital tiene una ubicación única a lo largo de la costa central de California, en el valle de Santa María, que se empieza en el Océano Pacífico y se estrecha tierra adentro, ya que limita con las colinas de Casmalia, Solomon y el Bosque Nacional Los Padres. Esta área geográfica originalmente formaba parte del territorio de los chumash, cuyos antepasados se autodenominan «los pueblos originarios».[1] La Banda Costera de la Nación Chumash es una nación soberana de pueblos indígenas chumash costeros, cuyos antepasados vivieron en lo que ahora se conoce como San Luis Obispo, Santa Bárbara, Ventura y otros condados del centro y sur de California durante más de 10,000 años.[2] Tras la exploración española en 1769 y la colonización, la costa central de California pasó a formar parte de México y el español fue el idioma dominante.[3] Tras la independencia de México en 1847, los Condados de San Luis Obispo y Santa Bárbara se establecieron en 1850 como dos de los 27 condados originales de

[1] Santa Ynez Band of Chumash Indians, Federally Recognized Tribe Since 1901. (n.d.) *Our History.* https://chumash.gov/chumash-history. Accessed April 2, 2025.
[2] Coastal Band of the Chumash Nation. https://cbcntribe.square.site/home. Accessed April 1, 2025.
[3] Santa Margarita Historical Society. *"Native Americans." Santa Margarita Historical Society*, n.d. https://santamargaritahistoricalsociety.org/first-settlers. Accessed February 18, 2025.

California.[4] La ciudad recibió el nombre de Santa María en 1885 y, a fines del siglo XIX, el valle del río Santa María se había convertido en una de las áreas agrícolas más productivas del estado. La ciudad de Santa María es la ciudad más grande por población en el Condado de Santa Bárbara, con 109,707 residentes cuando se hizo el Censo de los EE.UU. en 2020. La agricultura sigue siendo un componente clave de la economía de la ciudad y de toda la comunidad.[5]

La comunidad del Centro Médico del Hospital French no excluye a ninguna población de bajos recursos o subatendida e incluye a todos los miembros de la comunidad. La comunidad atendida por el Hospital coincide con el lugar de residencia para más del 75% de todas las dadas de altas de pacientes hospitalizados. El Centro Médico Regional Marian y el Hospital Comunitario de Arroyo Grande son los únicos hospitales de cuidados intensivos que atienden a la comunidad. Cuentan con el apoyo del Departamento de Salud Pública del Condado de San Luis Obispo y los Departamentos de Salud Pública del Condado de Santa Bárbara. La comunidad atendida por el Hospital se representa geográficamente en la Figura 1.

Figura 1. Comunidades atendidas por el Hospital



[4] California State Association of Counties. (n.d.) *The Creation of Our 58 Counties.* https://www.counties.org/general-information/creation-our-58-counties. Accessed April 1, 2025.
[5] *A Brief History of Santa Maria.* https://web.archive.org/web/20121105113623/http:/www.ci.santa-maria.ca.us/history.html . Accessed April 1, 2025.

Según la Encuesta sobre la Comunidad Estadounidense (2019-2023, estimaciones a 5 años), la comunidad en general atendida por ambos centros del Hospital alberga a 234,668 residentes. La comunidad es étnicamente diversa: más de la mitad (56%) de los residentes se identifican de origen hispano o latino(a), y aproximadamente un tercio (36%) se consideran solamente blancos, no hispanos o latinos(as). El resto de los miembros de la comunidad se identifican como asiáticos (4%), de dos o más razas (3%), o miembros de la comunidad negra (1%) Casi la mitad (113,771) de la comunidad atendida por el Hospital son miembros de Medi-Cal.

El Hospital presta servicios a la ciudad de Santa María, que tiene aproximadamente 110,000 residentes, de los cuales el 79.3% de la población se identifica como hispana o latina(o). Si comparamos Santa María con todas las ciudades estadounidenses con poblaciones de más de 100,000 habitantes, tiene la octava proporción más alta de residentes hispanos o latinos (as).

El Hospital apoya a dos comunidades distintas: aproximadamente dos tercios de la comunidad residen en el Condado de Santa Bárbara (153,637 personas) y suelen utilizar el Centro Médico Regional Marian, y un tercio de la comunidad reside en el sur del Condado de San Luis Obispo (81,031 personas) y frecuenta el Hospital Comunitario de Arroyo Grande.

Norte del Condado de Santa Bárbara

Aproximadamente el 70% de la comunidad del norte del Condado de Santa Bárbara se considera de origen hispano o latino (a), y un 23% mucho menos se identifica como solamente blanco, no como hispano o latino (a). El resto de los miembros de la comunidad se identifican como asiáticos (4%), de dos o más razas (2%), o miembros de la comunidad negra (1%)

Aproximadamente, uno de cada siete (14.3%) vive por debajo del nivel federal de pobreza, que aumenta al 28.2% en Guadalupe (93434) y al 17.9% en Santa María (93458). En la ciudad de Santa María, solo el 62.8% de la población de 25 años de edad o más se han graduado de la escuela secundaria o su equivalente. Más de la mitad (57%) de los miembros de la comunidad que residen en el norte del Condado de Santa Bárbara hablan un idioma que no es el inglés, y uno de cada cuatro (26.2%) habla inglés menos fluido. En general, la población de jóvenes y adultos jóvenes que reside en la comunidad es significante y representa aproximadamente el 40% de la población con una edad promedio de 32.3 años. Según CenCal, más de la mitad (61.5%) de la comunidad son miembros de CenCal y 87,951 miembros de CenCal residen en la ciudad de Santa María.

Sur del Condado de San Luis Obispo

La comunidad atendida por el Hospital que reside en el sur del Condado de San Luis Obispo es la inversa de la comunidad del Condado de Santa Bárbara. En general, el 61.4% de los miembros de la comunidad se identifican solo como blancos, no como hispanos o latinos (as) y un 29.4% menos se identifica como hispano o latino (a). El 9% restante se identifica principalmente como asiático

solo (2.8%) o de dos o más razas (4.6%), y aproximadamente el 1% se identifica como miembro de la comunidad negra.

Aproximadamente el 8.6% de la comunidad del sur del Condado de San Luis Obispo vive por debajo del nivel federal de pobreza, que es inferior a la tasa de todo el Condado (12.8%) y del estado (12.0%). Más del 42% de los miembros de la comunidad que viven en el sur del Condado de San Luis Obispo tienen cobertura de seguro médico público, uno de cada cuatro está cubierto por CenCal y alrededor del 5% no tiene cobertura de seguro médico.[6] La comunidad del sur del Condado de San Luis Obispo tiene una edad promedio de 45.5 años, y más de un tercio (38%) tiene 55 años o más. La Tabla 1 muestra las características de la población de la comunidad según el Censo de los EE. UU.

Tabla 1. Demográfica de la comunidad atendida por el Hospital[7]

Datos del Censo de EE. UU.	Condado de San Luis Obispo	Norte del Condado de Santa Bárbara	Comunidad atendida por el Hospital
Población total	81,031	153,637	234,668
Edad promedio (años)	45.5	32.3	37.0
Porcentaje de hispanos o latinos/as	29.4%	70.1%	56.0%
Porcentaje de solo blancos, no hispanos o latinos/as	61.4%	22.3%	35.8%
Ingresos familiares promedios	$100,674	$88,770	$93,843
Porcentaje de familias que viven en la pobreza (por debajo del 100% del nivel federal de pobreza)	6.2%	9.9%	8.4%
Tasa de desempleo	3.3%	6.5%	5.3%
Porcentaje con menos de un diploma de escuela secundaria, 25 años de edad o más	9.9%	30.2%	22.1%
Porcentaje de personas de 5 años de edad o más que hablan inglés menos «fluido»	7.2%	26.2%	19.5%
Porcentaje sin seguro médico	5.4%	13.2%	10.5%
Número de miembros de Medi-Cal/CenCal[8]	19,157	94,614	113,771

[6] U.S. Census Bureau. "DP05: ACS Demographic and Housing Estimates."*American Community Survey 5-Year Data (2019-2023),* U.S. Department of Commerce, 2023, https://data.census.gov/table/ACSDP5Y2023.DP05?q=ZCTA5%2093402. Accessed December 23, 2024.

[7] U.S. Census Bureau, U.S. Department of Commerce. "ACS Demographic and Housing Estimates." American Community Survey, ACS 5-Year Estimates Data Profiles, 2023.

[8] CenCal Health. (2025). Member Demographics, 2024 Calendar Year. https://www.cencalhealth.org/wp-content/uploads/2025/03/CenCal-Health-Member-Demographics-Report-December-2024-2.pdf. Accessed March 22, 2025.

En la Sección III de Datos y Hallazgos de la Evaluación que sigue a continuación, se proporciona una evaluación adicional de los indicadores demográficos, incluidos los económicos y educativos. Se pueden encontrar detalles adicionales sobre la población de la comunidad en el Apéndice A.

Comunidades preocupantes

El Recuento de un Punto en el Tiempo 2024 (PIT, por sus siglas en inglés)[9] del Condado de Santa Bárbara halló un aumento general del 12% en el número de personas sin vivienda en el Condado desde 2023. En la noche del recuento, hubo 424 personas sin vivienda en Santa María, un aumento del 11% del año anterior y 116 individuos en las áreas no incorporadas del norte del Condado. Más de un tercio de las personas sin vivienda que se hallaron la noche del conteo eran mayores de 55 años

El Recuento de un Punto en el Tiempo de 2024 documentó la cantidad de personas sin vivienda y sin refugio en las siguientes comunidades del Centro Médico del Hospital French: 88 individuos en el lecho del rio de Santa María; 73 individuos en Grover Beach; 60 individuos en Arroyo Grande; 28 en Nipomo y 21 en Pismo Beach.

Además de los residentes contados por las fuentes de datos formales anteriormente, la población indígena mexicana que reside en los Condados de Santa Bárbara y San Luis Obispo es originaria de la Región Mixteca de México, que incluye los estados de Oaxaca, Guerrero, Michoacán y Puebla. Estas personas suelen ser monolingües en su lengua indígena prehispánica nativa, el mixteco o el zapoteco. El Proyecto de Organización Comunitaria Mixteco Indígena (MICOP) calcula que hay 25,000 migrantes indígenas que viven y trabajan en el Condado de Santa Bárbara,[10] y que Santa María alberga a la mayoría de los campesinos del Condado.[11] Estos individuos a menudo trabajan en sectores agrícolas con una intensa mano de obra como recogiendo cosechas (fresas y frambuesas) y cortando flores. Los mixtecos realizan mano de obra física que va en aumento, lo que hace que la agricultura sea rentable y que haya frutas y verduras frescas a disposición del público.

Áreas/poblaciones médicamente subatendidas y Áreas con escasez de profesionales de la salud

La Administración de Recursos y Servicios Sanitarios de EE.UU. (HRSA, por sus siglas en inglés) ha identificado en la comunidad Áreas/poblaciones médicamente subatendidas (MUA/P, por sus

[9] Santa Barbara County: Point In Time Count. 2024. https://santabarbaraca.gov/sites/default/files/2024-06/Point%20In%20Time%20Count%202024%20Report.pdf Accessed March 2025.
[10] MICOP. *Who Are We?* https://mixteco.org/ Accessed on March 27, 2025.
[11] Central Coast Alliance United for a Sustainable Economy, Mixteco/Indígena Community Organizing Project. (April 1, 2024). Harvesting Dignity The Case for a Living Wage for Farmworkers. https://mixteco.aflip.in/a6a5e8fb26.html#page/1. Accessed on March 27, 2025.

siglas en inglés) y Áreas de escasez de profesionales de la salud (HPSA, por sus siglas en inglés) HRSA estima que la comunidad tiene una escasez de profesionales de la salud para la atención primaria, la salud mental y dentistas, al igual que las comunidades médicamente subatendidas en Guadalupe y Arroyo Grande Estas designaciones se pueden apreciar en la Tabla 2.

Tabla 2. Áreas/poblaciones médicamente subatendidas y Áreas de escasez de profesionales de la salud identificados por HRSA en la comunidad[12]

Disciplina	Número de identificación	Nombre de áreas con escasez de profesionales de la salud o área de servicio	Tipo de designación	Fecha de designación
Atención primaria	00301	Área de servicio en Guadalupe	Área médicamente desatendida	22/12/1992
Atención primaria	00395	Área de servicio en Arroyo Grande	Área médicamente desatendida	11/05/1994
Atención primaria	1062140915	ME-MSSA 180.1/ Orcutt/Santa María	Población elegible para Medicaid (área de escasez de profesionales de la salud)	08/07/2020
Salud mental	7063481715	MSSA 171/172 — Arroyo Grande/San Luis Obispo	Geográfica de alta necesidad (área de escasez de profesionales de la salud)	07/03/2022
Salud mental	7062778515	MSSAs 178.1/178.2/179/180.2 – Solvang/Lompoc/Guadalupe	Geográfica (Área de escasez de profesionales de la salud)	08/11/2021
Salud mental	7062407340	LI/MFW-MSSA 180.1/Santa María	Población de campesinos migrantes de bajos recursos (Área de escasez de profesionales de la salud)	04/12/2015
Salud dental	6062701245	LI/MSSA 172 — San Luis Obispo	Poblaciones en áreas de escasez de profesionales de la salud de bajos recursos	17/11/2022

[12] U.S. Department of Health and Human Services, Health Resources and Services Administration. (2025). *HRSA Data Warehouse, Find Shortage Areas*. https://data.hrsa.gov/tools/shortage-area. Accessed March 9, 2025.

II. Proceso y métodos de evaluación

La Evaluación de Necesidades de la Salud Comunitaria (ENSC) de 2025 se completó mediante una recopilación de fuentes de datos cualitativos primarios y cuantitativos secundarios. Se solicitaron y tuvieron en cuenta los intereses generales de la comunidad a través de fuentes de datos primarias, incluyendo grupos focales, entrevistas con informantes clave y aportes del Departamento de Salud Pública del Condado de San Luis Obispo. Esta información se corroboró con datos cuantitativos secundarios obtenidos de conjuntos de datos mantenidos por organizaciones gubernamentales y no gubernamentales a nivel local, estatal y nacional. Este enfoque de métodos mixtos permitió la referencia cruzada de los datos para validar la información y proporcionar una perspectiva más amplia de las necesidades de salud comunitaria. Cada fuente de datos y el proceso utilizado para la recopilación y evaluación se describen en las siguientes subsecciones.

Grupos focales, poblaciones vulnerables

En colaboración con los hospitales regionales de la costa central de Dignity Health California (Centro Médico del Hospital French), se desarrolló y completó un programa integral de grupos focales en 2024. El objetivo era tener en cuenta a los miembros de las poblaciones minoritarias, de bajos recursos y médicamente desatendidas de la comunidad, incluidas las poblaciones vulnerables.

Para mantener la coherencia con los requisitos de notificación de beneficios comunitarios del estado de California, se utilizó la definición de poblaciones vulnerables del proyecto de ley de la Asamblea (AB) 1204. Los grupos focales incluyeron a miembros de poblaciones vulnerables, como personas LGBTQ+, negras o afroamericanas, personas con un dominio limitado del inglés, personas sin vivienda, veteranos, jóvenes y adultos mayores.[13]

En total, el equipo de hospitales regionales de la costa central de Dignity Health California facilitó 17 grupos focales entre el 5 de junio y el 25 de julio de 2024, de forma virtual o presencial, para 117 participantes. Los grupos focales se realizaron en inglés, español y mixteco, para participantes adolescentes hasta adultos mayores, y 14 grupos focales fueron específicos para la comunidad del Centro Médico del Hospital French. Los participantes del grupo de enfoque se organizaron en función de la demografía y de si eran individuos u organizaciones comunitarias. Cada participante del grupo de enfoque recibió una tarjeta de regalo de $30 como muestra de agradecimiento por su tiempo. La Tabla 3 proporciona un resumen de las características de los participantes en cada grupo de enfoque.

[13] State of California, Legislative Counsel Bureau. "Assembly Bill No. 1204 , Chapter 751," 2021, https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220AB1204. Accessed March 1, 2025.

Los detalles específicos sobre la metodología y el análisis de los grupos focales se proporcionan en el Apéndice B y los resúmenes de cada grupo de enfoque se proporcionan en el Apéndice C. Los resultados de los grupos focales se proporcionan en la sección III. Datos y hallazgos de la evaluación y Apéndice B.

Tabla 3. Grupos focales del Hospital

Individuos	Proveedores comunitarios
Veteranos Adultos mayores en Centro Mussell del Adultos Mayores Jóvenes de Santa María Madres mixteco-hablantes (Herencia Indígena) Madres hispanohablantes campesinos mixteco-hablantes (Fundación de Campesinos de California) LGBTQ+ Comunidad negra (NAACP)	Proveedores de servicios para personas sin vivienda Proveedores para jóvenes desatendidos Intérpretes de mixteco Promotoras de los Condados de San Luis Obispo y Santa Bárbara Proveedores de servicios para veteranos

Entrevistas con informantes clave de proveedores de atención médica

Se realizaron entrevistas con informantes clave con proveedores invitados de los hospitales regionales de la costa central de Dignity Health California que prestan servicios a la comunidad, incluidas las poblaciones minoritarias, de bajos recursos y médicamente desatendidas. Estas entrevistas con informantes clave también fueron facilitadas por el equipo de preparación de la evaluación, en la cual se hicieron una serie de preguntas similares a las planteadas en los grupos focales comunitarios. Se realizaron entrevistas con informantes clave con el equipo de salud materna de Dignity Health, la clínica Dignity Health Medical Safe Haven, el Centro de Cancer Dignity y el equipo de transición de atención de Dignity Health. Los resúmenes de estas entrevistas se encuentran en el Apéndice D, y sus aportaciones se han incluido en todo el informe.

Departamentos de Salud Pública del Condado

El Departamento de Salud Pública del Condado de Santa Bárbara participa activamente en una colaboración con otros hospitales del sur del Condado de Santa Bárbara y CenCal. El Hospital ha estado en comunicación con el Departamento de Salud Pública del Condado de Santa Bárbara sobre su participación en la colaboración y la preparación de esta evaluación en 2025 desde 2023, y el propósito de la colaboración es la preparación de una evaluación de las necesidades en todo el Condado. Desafortunadamente, el cronograma y la definición de servicio comunitario

evaluados como parte de la Colaboración de Salud del Condado de Santa Bárbara no se alinean con esta ENSC. Sin embargo, el Hospital sigue participando activamente en la Colaboración de Salud del Condado de Santa Bárbara, asistiendo a reuniones periódicas y como miembro del grupo de trabajo sobre datos secundarios.

El 8 de julio de 2024 se celebró una reunión inicial entre Dignity Health y el Departamento de Salud Pública del Condado de San Luis Obispo (SLOPHD, por sus siglas en inglés) en relación con el proceso de la ENSC que Dignity Health estaba iniciando para el 2025. Se tuvieron conversaciones sobre la colaboración y la alineación futuras, así como la voluntad de SLOPHD de apoyar a Dignity Health durante este proceso y su entusiasmo por los resultados de los grupos focales. El 28 de octubre de 2024 se llevó a cabo una reunión de seguimiento para compartir los resultados preliminares de los grupos focales y recopilar cualquier comentario del departamento de salud. SLOPHD asistió a Dignity Health para llegar a la población más vulnerable y estuvo de acuerdo con los resultados preliminares. SLOPHD expresó su deseo de abordar la estrategia de implementación de manera colaborativa. Tras la adopción de esta ENSC, se programarán reuniones adicionales con SLOPHD.

Comentarios escritos de la ENSC anterior

El Hospital solicitó comentarios por escrito sobre el informe y la estrategia de implementación más recientes de la ENSC, tanto en los documentos como en el sitio web del Hospital, donde están ampliamente disponibles para el público. No se recibió ningún comentario por escrito en el momento de la elaboración de este informe de la ENSC.

Fuentes de datos secundarias

La ENSC abarca una multitud de indicadores de datos secundarios que ayudan a ilustrar la salud de la comunidad. Se revisaron los datos secundarios de fuentes locales, del condado, estatales y nacionales e incluyen puntos de datos sobre la demografía, la mortalidad, la morbilidad, los determinantes sociales de la salud, las conductas de salud, la atención clínica, los resultados de salud y el entorno físico. Las fuentes de datos secundarias a nivel de condado, estado o país proporcionan una comparación con los datos cualitativos a nivel comunitario. Este informe de la ENSC utilizó las siguientes fuentes de datos secundarios, entre otras:

- Centros para el Control y la Prevención de Enfermedades (CDC, por sus siglas en inglés), Índice de vulnerabilidad social
- Sistema de vigilancia de los factores de riesgo conductuales del CDC
- Censo de los EE. UU.
- CenCal Health
- Departamento de Educación de California
- Departamento de Salud Pública de California
- Comisión de Energía de California
- Condado de San Luis Obispo
- Departamento de Salud y Servicios Humanos de los Estados Unidos, Oficina de Prevención de Enfermedades y Promoción de la Salud
- Asociación de datos educativos
- SLO Health Counts
- Departamento de Justicia de California
- Encuesta de la Salud de Niños

Todas las fuentes de datos secundarias se evaluaron minuciosamente y se hizo todo lo posible para utilizar los mejores datos disponibles en el momento de la publicación del informe. Si bien siempre hay limitaciones de datos, los datos recopilados, la información y los análisis completados identifican y describen de manera exhaustiva las necesidades significantes de salud de la comunidad.

Preparadores de informes de la Evaluación de Necesidades de la Salud Comunitaria (ENSC)

Este informe de la ENSC y el proceso de recopilación de datos anterior se completaron como un esfuerzo de colaboración entre Patty Herrera, Maestría en Humanidades, Directora de salud comunitaria de los hospitales de la costa central de la región de California de Dignity Health, y Ganey Science, de San Francisco, CA. Patty ha sido una defensora de la salud comunitaria desde 1991 y ha sido responsable del proceso de recopilación y compilación de datos de las encuestas de salud comunitaria desde 2016. El equipo científico de Ganey fue dirigido por Amanda Gettig, Maestría en Salud Pública, quien ha estado preparando los informes sobre la ENSC del Centro Médico del Hospital French desde 2016 y comenzó su carrera en la salud pública en 2013 en Dignity Health, del Centro Médico Regional St. John de Oxnard, California.

III. Datos y hallazgos de la Evaluación

La evaluación de datos para este informe de la ENSC consiste en una revisión sistemática de las fuentes de datos primarias y secundarias. Los resultados de los grupos focales se resumen a continuación y se presentarán e incluirán en cada subsección, según corresponda. La evaluación de datos compara a la comunidad con los niveles estatales y nacionales, así como con los puntos de referencia *Healthy People 2030* (HP 2030) del Departamento de Salud y Servicios Humanos de los EE. UU., cuando están disponibles. Se analizaron los datos para determinar las desigualdades sociales, los indicadores de salud, los comportamientos ante la salud y las condiciones de salud. El análisis señala específicamente los segmentos de población que son particularmente vulnerables o que experimentan necesidades de salud desproporcionadamente insatisfechas o resultados deficientes.

Resultados de los grupos focales

Durante el verano de 2024, se realizaron 14 grupos de enfoque con miembros de la comunidad que tenían un dominio limitado del inglés, pertenecían a una minoría étnica o racial, veteranos, personas sin vivienda, adultos mayores, jóvenes o personas que se identificaron como LGBTQ+. A estas personas se les proporcionó un espacio seguro para compartir sus experiencias con los facilitadores, lo que les permitió comprender en profundidad las necesidades de su comunidad. Los datos recopilados durante los grupos focales no tienen en cuenta la aprensión que sentían muchos miembros de la comunidad que comenzó en noviembre de 2024. La Tabla 4 que figura a continuación muestra los temas principales identificados durante los grupos focales por población vulnerable.

Tabla 4. Temas principales de la población vulnerable

Dominio limitado del inglés	LGBTQ+	Veteranos y personas sin vivienda
Barreras de acceso a la atención: - Idioma - Competencia cultural - Acceso al servicio: experiencia negativa - Humildad cultural - Seguro médico - Problemas de comunicación - Estigma Acceso a las necesidades básicas Solidaridad comunitaria Navegación	Barreras de acceso a la atención: - Estigma - Competencia cultural - Diversidad - Problemas de comunicación - Acceso al servicio: experiencia negativa Salud conductual Humildad cultural, sentirse ignorado	Salud conductual, incluido el trauma Deseo por más abogacía y empoderamiento Trastorno por consumo de sustancias Solidaridad comunitaria Acceso a las necesidades básicas Navegación

La comunidad negra	Adultos mayores	Jóvenes
Barreras de acceso a la atención: - Competencia cultural - Confianza Solidaridad comunitaria Desigualdad/Invisibilidad Estigma Salud conductual	Barreras de acceso a la atención: - Seguro médico - Largo tiempo de espera - Problemas de comunicación - Barreras geográficas Acceso a las necesidades básicas Salud conductual Solidaridad comunitaria	Barreras de acceso a la atención: - Competencia cultural - Horarios - Humildad cultural - Idioma Valores Salud conductual Acceso a las necesidades básicas Solidaridad comunitaria

Los detalles específicos sobre los análisis de datos de los grupos de enfoque se proporcionan en el Apéndice B y las Tablas B-2 a B-7 del Apéndice B proporcionan respuestas para cada pregunta del grupo de enfoque de la población vulnerable. La siguiente Figura 2 representa una nube de palabras de todos los grupos focales, y las palabras más grandes representan las que se mencionaron con más frecuencia.

Figura 2. Nube de palabras para grupos focales

Marco de condiciones vitales

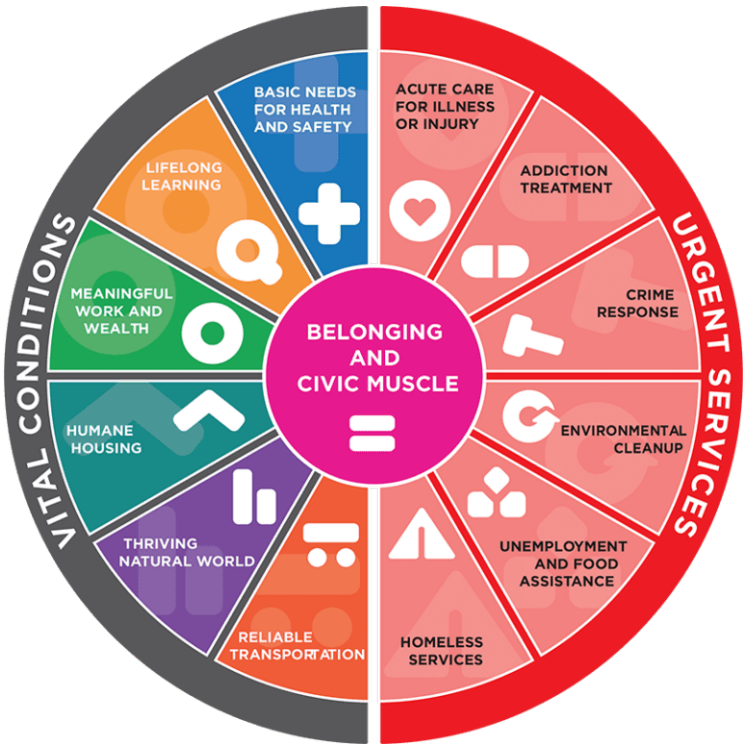
Una de las iniciativas nacionales de salud desarrolladas por la Oficina de Prevención de Enfermedades y Promoción de la Salud de los EE. UU. es el Plan Federal para la Recuperación Equitativa y la Resiliencia a Largo Plazo para la Salud Social, Conductual y Comunitaria (ELTRR, por sus siglas en inglés). El Plan se organiza en torno a la estructura de Condiciones vitales para la salud y el bienestar. El objetivo general del Plan establece:

«Todas las personas y lugares PROSPERAN, sin excepciones».

El marco de Condiciones vitales para la salud y el bienestar, con un enfoque especial en las fortalezas, proporciona un enfoque práctico y basado en los buenos aportes la cual es clave para mejorar los determinantes sociales de la salud y abordar las desigualdades. El marco de Condiciones vitales tiene sus raíces en la comunidad y se centra en los elementos de «pertenencia y fuerza cívica». La capacidad de participación cívica y las soluciones locales y autónomas son fundamentales para abordar las necesidades locales.[14] La Figura 3 ilustra además la relación entre las condiciones vitales y los servicios de urgencia.

[14] Office of Disease Prevention and Health Promotion. (January 20, 2022). Federal Plan for Equitable Long-Term Recovery and Resilience for Social, Behavioral, and Community Health. https://origin.health.gov/sites/default/files/2022-04/ELTRR-Report_220127a_ColorCorrected_2.pdf. Accessed March 15, 2025.

Figura 3. Condiciones vitales y servicios de urgencia[15]



A través de los seis servicios de urgencia desarrollados junto con las condiciones vitales, las comunidades pueden organizar acciones para promover la equidad de salud y responder a las crisis que amenazan la salud y el bienestar. Los seis servicios de urgencia son: cuidados intensivos para enfermedades o lesiones, tratamiento de adicciones, respuesta a la delincuencia, limpieza ambiental, asistencia alimentaria y de desempleo y servicios para personas sin vivienda. Los servicios de urgencia son necesarios y salvan vidas, pero por sí solos no pueden producir el florecimiento humano.

Determinantes sociales de la salud

Según los Centros para el Control y la Prevención de Enfermedades de los EE. UU., los Determinantes sociales de la salud (DSS) son los factores no médicos que influyen en los resultados de salud. Son las condiciones en las que las personas nacen, crecen, trabajan, viven y

[15] The Rippel Foundation. (2025). What is a Well-Being Portfolio? https://rippel.org/vital-conditions/. Accessed March 9, 2025.

envejecen, y las fuerzas y los sistemas que influyen en la vida diaria. Los cinco factores clave de los DSS incluyen:

- La estabilidad económica,
- Acceso y calidad de la educación,
- Acceso y calidad de la atención médica,
- Barrio y entorno construido, y
- Contexto social y comunitario.

Figura 4. Determinantes sociales de la salud

Los DSS son una de las tres áreas prioritarias de HP 2030, junto con la equidad en salud y la alfabetización en salud. Durante los grupos focales, las personas sin vivienda y los veteranos, los adultos mayores, los jóvenes y la comunidad con dominio limitado del inglés identificaron como una de las principales necesidades el acceso a las necesidades básicas, que incluyen la situación financiera, el transporte y la vivienda. En la Figura 4 adjunta se proporciona una gráfica que representa los DSS.[16]

Estabilidad económica | Trabajo significativo y riqueza

Los ingresos influyen en todos los aspectos de la vida de una persona, incluida la capacidad para garantizar la vivienda, la alimentación, el transporte, la atención médica y el cuidado de los niños. Los ingresos también afectan la capacidad de una persona para mantener una buena salud física y mental.

Objetivo de HP 2030: Reducir la proporción de personas que viven en la pobreza.

Según la Encuesta sobre la Comunidad Estadounidense del Censo de los EE. UU. (2019-2023, estimaciones a 5 años), 1 de cada 8 personas o el 12.0% de los residentes de California viven en la pobreza. Estas personas tienen menos probabilidades de tener acceso a atención médica, alimentos saludables, viviendas estables y oportunidades para realizar actividad física. En el Condado de Santa Bárbara, el 13.8% de todos los residentes viven por debajo del nivel de pobreza, y en el Condado de San Luis Obispo, este número mejora ligeramente hasta el 12.8%. La tasa de desempleo en la comunidad es del 5.31%, un poco mejor que la tasa de California del 6.4%.

En la comunidad, las tasas de pobreza oscilan entre un mínimo del 5.3% en Nipomo (93444) y un

[16]U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Healthy People 2030. https://odphp.health.gov/healthypeople/objectives-and-data/social-determinants-health. Accessed on March 17, 2025.

máximo del 28.2% en Guadalupe. Las tasas de pobreza superan la tasa de pobreza estatal del 12.0% en Grover Beach (12.7%), Océano (17.1%), Santa María: 93454 (13.9%) y Santa María: 93458 (17.9%). Según las Pautas de Pobreza de 2025, publicadas por el Departamento de Salud y Servicios Humanos de los EE. UU., los hogares con ingresos inferiores a $15,650 para un hogar de una persona y $32,150 para un hogar de cuatro personas se consideran en situación de pobreza.[17]

En 2023, el producto interno bruto del Condado de Santa Bárbara fue de $38,500 mil millones[18] y en el Condado de San Luis Obispo fue de $22,800 mil millones.[19] En California, entre 2018 y 2020, la mayor parte de la producción de fresas se produjo en las áreas de Salinas-Watsonville y Santa María. Según el Censo de los EE. UU., la industria agrícola, forestal, pesquera y de caza emplea al 29.1% de los civiles mayores de 16 años.[20]

Foto proporcionada por el periódico Santa María Times.

En el Condado de Santa Bárbara, según el Informe sobre cosechas y ganadería de 2023, el valor bruto de la producción agrícola en el Condado fue de $1,800 millones, de los cuales las fresas representaron $775 mil millones.[21] La cosecha de fresas frescas requiere mucha mano de obra, dado que las fresas se cosechan principalmente a mano y el campo se cosecha más de 30 a 50 veces durante una temporada.[22] A pesar de la mano de obra intensiva requerida

[17] U.S. Department of Health and Human Services. "Poverty Guidelines." Office of the Assistant Secretary for Planning and Evaluation, 2025, https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines. Accessed March 18, 2025.
[18] U.S. Bureau of Economic Analysis. "Total Gross Domestic Product for Santa Maria-Santa Barbara, CA (MSA) [NGMP42200], retrieved from FRED, Federal Reserve Bank of St. Louis." https://fred.stlouisfed.org/series/NGMP42200. Accessed April 1, 2025.
[19] County of San Luis Obispo, Administrative Office. SLO County Key Economic Indicators. https://www.slocounty.ca.gov/departments/administrative-office/administrative-and-budget-services/services-3f2773cec1c7378bd010760903e2368e/about-the-county-s-economic-strategy/slo-county-key-economic-indicators. Accessed on March 18, 2025.
[20] U.S. Census Bureau, U.S. Department of Commerce. "Selected Economic Characteristics." American Community Survey, ACS 1-Year Estimates Data Profiles, Table DP03, 2023, https://data.census.gov/table/ACSDP1Y2023.DP03?q=santa+maria,+ca+employment. Accessed on April 7, 2025.
[21] County of Santa Barbara (2023). "Crop & Livestock Report." https://content.civicplus.com/api/assets/149b2f9a-e302-46a1-8f54-2ffd1a47d2c9. Accessed April 1, 2025.
[22] Photo originally published in the Santa Maria Times, "Farmers, farmworkers face off over proposed $26 minimum wage." Taken by Len Wood, Staff. December 10, 2024.

para los cultivos especiales, como las fresas, a los campesinos se les paga mucho menos que en puestos comparables, que son igualmente exigentes en lo físico y lo riesgoso. Los campesinos han estado históricamente entre las ocupaciones peor pagadas de los Estados Unidos y están compuestos por las personas más marginadas. La discriminación racial, las exclusiones laborales y la política de inmigración han limitado las oportunidades económicas para los campesinos e impedido el progreso en sus condiciones de trabajo y calidad de vida. La Tabla 5 que figura a continuación proporciona una comparación entre los ingresos de los campesinos y otras ocupaciones.[23]

Tabla 5. Comparación de ingresos de campesinos

	Salario promedio por hora	Salario anual 1 adulto	Salario anual 2 adultos y 2 niños
Calculadora de salario digno del MIT	$32.11 / $36.53	$44,175	$129,954
Medida de costos reales de United Way	$22.21 / $26.83	$46,198	$111,602
Ingresos promedios del Condado de Santa Bárbara	$46.14	$48,013	$95,977
Campesinos de Santa Bárbara	$17.42	$36,244	$72,488
No agrícola (p. ej. conductor de camión pesado)	$26.76	$55,672	-
Obreros de la construcción	$25,04	$52,104	-

El ingreso anual de los campesinos supone trabajar durante todo el año, pero muchos trabajadores obtienen sus ingresos durante el verano y utilizan esos ingresos para sobrevivir hasta la próxima temporada de cosecha.

Los intérpretes mixtecos compartieron en un grupo de enfoque que los bajos salarios afectan la salud y el acceso a la atención de los pacientes campesinos a los que atienden. También compartieron que sus cheques de pago pueden variar porque se les paga según la cantidad de casillas que llenan en un día en lugar de una tarifa por hora.

«Se nos ha permitido sobrevivir, pero nunca se nos ha permitido vivir de verdad»

dijo el hijo adolescente de un campesino. *«No somos objetos importados de México. Somos seres humanos por los que vale la pena luchar».* Compartió que su madre se había quebrado la espalda para alimentar a los hijos de otros: *«Ahora te pido que nos des de comer».*[24] Entre 2019 y 2020,

https://santamariatimes.com/news/local/farmers-farmworkers-face-off-over-proposed-26-minimum-wage/article_0510ab38-b286-11ef-bc74-4735ff078c9c.html

[23] CAUSE & MICOP. *Harvesting Dignity: The Case for a Living Wage for Farmworkers.* https://mixteco.aflip.in/a6a5e8fb26.html#page/1

[24] Santa Barbara Independent. *I'm Asking You to Feed Us.* November 13, 2024.

muchos campesinos obtuvieron un ingreso anual inferior a $30,000. Los salarios de los campesinos no han aumentado con el aumento del costo de vida en la costa central de California y muchos campesinos no pueden pagar una vivienda en la misma área en la que trabajan. Como resultado, las familias de campesinos se ven obligadas a vivir en apartamentos o garajes estrechos. Vea más información sobre la vivienda en la comunidad de campesinos en la sección de Vivienda Humana que aparece a continuación.[25]

Los ingresos a menudo brindan acceso a recursos que promueven la buena salud, como buenas escuelas, atención médica, alimentos saludables y vecindarios seguros. United Ways of California estima que el 31% de los hogares del Condado de San Luis Obispo y el 42% de los hogares del Condado de Santa Bárbara luchan por satisfacer sus necesidades básicas.[26]

Según el Departamento de Educación de California, el 53.4% de los estudiantes matriculados en las escuelas del Condado de San Luis Obispo y el 67.1% de los estudiantes matriculados en las escuelas del Condado de Santa Bárbara calificaron para recibir comidas gratis/a precio reducido durante el año escolar 2023-24.[27][28] Específicamente, el 74.6% de los estudiantes matriculados en Santa María Joint Union reunían los requisitos para recibir comidas gratis o a precio reducido, el 89.8% en Santa María-Bonita y el 90.4% de los estudiantes matriculados en la escuela primaria Guadalupe Union.[29] En Santa María y Arroyo Grande (93433, 93434, 93458 y 93445), más del 90% de las familias que reciben beneficios de estampillas de alimentos/SNAP son familias trabajadoras.[30]

Los ingresos a menudo brindan acceso a recursos que promueven la buena salud, como buenas escuelas, atención médica, alimentos saludables y vecindarios seguros. United Ways of California estima que el 31% de los hogares del Condado de San Luis Obispo y el 42% de los hogares del Condado de Santa Bárbara luchan por satisfacer sus necesidades básicas.[31]

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[25] CAUSE & MICOP.

[26] United Ways of California. *Santa Barbara County: The Real Cost Measure in California 2023.* *https://unitedwaysca.org/wp-content/uploads/2023/05/santa_barbara_county.pdf*

[27] Ed Data Education Data Partnership, Fiscal, Demographic, and Performance Data on California's K-12 Schools. *San Luis Obispo County.* https://www.ed-data.org/county/san-luis-obispo/. Accessed on March 15, 2025.

[28] Ed Data. Santa Barbara County: County Summary. https://www.ed-data.org/county/santa-barbara/ Accessed on March 27, 2025.

[29]California Department of Education. 2025. *Selected County Level Data – Santa Barbara for the year 2023-24.* https://dq.cde.ca.gov/dataquest/Cbeds2.asp?FreeLunch=on&cChoice=CoProf2&cYear=2023-24&TheCounty=42%2CSANTA%5EBARBARA&cLevel=County&cTopic=FRPM&myTimeFrame=S&submit1=Submit. Accessed April 8, 2025.

[30] PolicyMap. (n.d.). Percent of population that received Food Stamps in July 2019 [Map based on data from Census SAIPE: Data downloaded from https://www.census.gov/programs-surveys/saipe/data.html, March 2022]. Retrieved April 9, 2025, from http://www.policymap.com

[31] United Ways of California. *Santa Barbara County: The Real Cost Measure in California 2023.* *https://unitedwaysca.org/wp-content/uploads/2023/05/santa_barbara_county.pdf*

Vivienda humanitaria

> Objetivo de HP 2030: Reducir la proporción de familias que gastan más del 30% de sus ingresos en vivienda.

La vivienda es el mayor gasto para la mayoría de los estadounidenses, por lo que la asequibilidad de la vivienda es un factor importante en el bienestar financiero.[32] La estabilidad, la calidad, la seguridad y la asequibilidad de la vivienda afectan los resultados de salud. La situación de vivienda de una persona tiene graves implicaciones, ya sean positivas o negativas, en casi todos los demás aspectos de la vida, especialmente entre los niños. El acceso a una vivienda humanitaria puede determinar quién prospera y quién lucha por sobrevivir.

Según el Departamento de Vivienda y Desarrollo Urbano de los EE. UU., se considera que un hogar está agobiado por los costos cuando gasta más del 30% de sus ingresos en alquileres y servicios públicos. Los sobrepagos graves se producen cuando los hogares pagan el 50% o más de sus ingresos brutos por la vivienda.[33] En la comunidad, el ingreso familiar promedio es de aproximadamente $94,000, lo que significa que solo deben gastar aproximadamente $28,000 en gastos de vivienda.[34]

El costo del alquiler ha aumentado un 45% en el Condado de Santa Bárbara y un 36% en el Condado de San Luis Obispo desde el año 2020.[35] Según United Ways of California, el 41% de todos los hogares del Condado de Santa Bárbara y el 39% de los hogares del Condado de San Luis Obispo gastan más del 30% de sus ingresos en vivienda.[36]

El Departamento de Vivienda y Desarrollo Comunitario de California identifica a los campesinos teniendo necesidades especiales de vivienda debido a sus ingresos limitados y a la naturaleza inestable de su empleo.[37] Los campesinos son algunos de los trabajadores peor pagados de los EE.UU. y muchos tienen que compartir la vivienda para poder pagarla y cubrir otras necesidades básicas. Según la Encuesta Nacional de Campesinos, el 30% de los hogares de campesinos viven en viviendas superpobladas (definidas por el censo como una proporción de más de una persona

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[32] Community Commons. https://www.communitycommons.org/collections/Humane-Housing-as-a-Vital-Condition

[33] United States Census Bureau. *Nearly Half of Renter Households are Cost-Burdened, Proportions Differ by Race.* September 12, 2024, https://www.census.gov/newsroom/press-releases/2024/renter-households-cost-burdened-race.html#:~:text=Households%20are%20considered%20cost%2Dburdened,are%20considered%20severely%20cost%2Dburdened. Accessed January 15, 2025.

[34] U.S. Census Data. 2019-2023.

[35] Bentz, A. *California Housing Affordability Tracker (4th Quarter 2024).* https://lao.ca.gov/LAOEconTax/Article/Detail/793

[36] United Ways of California. https://unitedwaysca.org/wp-content/uploads/2023/05/san_luis_obispo_county.pdf

[37] City of Santa Maria. *6th Cycle Housing Element 2023-2031.* https://www.cityofsantamaria.org/home/showpublisheddocument/31983/638351161124600000

por habitación).[38] El informe sobre la salud de los campesinos de 2023 encontró que el 25% de los campesinos encuestados informaron haber dormido en una habitación con tres o más personas.[39]

Un estudio sobre la salud de los campesinos de 2022 publicado por el Centro Comunitario y Laboral de la Universidad de California en Merced descubrió que más de un tercio (37%) de los campesinos informaron que el agua tenía mal sabor en el hogar, lo que indica una mala calidad del agua y posibles riesgos para la salud.[40] Otros problemas de vivienda deficientes reportados incluyen la dificultad para mantener la casa fresca (39%) o cálida (36%), la madera podrida (16%), el moho (14%), las fugas de agua (12%), las cucarachas (24%) y los roedores (17%).

Transporte confiable

El transporte confiable, seguro y accesible es una de las siete condiciones vitales porque el acceso al transporte es uno de los principales impulsores de la salud y el bienestar. Las personas que viven en la pobreza, con limitaciones funcionales y las que tienen un seguro insuficiente o no tienen seguro alguno tienen una mayor carga de transporte relacionada con la atención médica. En once grupos focales que representan a poblaciones médicamente vulnerables, el acceso al transporte se identificó como una necesidad de salud en todos los grupos excepto en uno.[41] El transporte también se identificó como una necesidad primaria de salud comunitaria en entrevistas con informantes clave con el equipo de atención médica materna y el personal del centro oncológico (Apéndice D).

Un proveedor de servicios para jóvenes compartió en un grupo de enfoque que muchos de los miembros de su comunidad no saben conducir, por lo que caminan largas distancias hasta sus citas médicas, lo que les quita tiempo del trabajo y puede resultar físicamente exigente si están enfermas o han dado a luz recientemente.

Los miembros de la comunidad mixteca compartieron que el acceso al transporte es una barrera para su atención médica porque muchos no tienen automóviles y no saben cómo usar el transporte público o cómo solicitar los servicios de transporte médico. La falta de transporte se presentó como una barrera para la salud y el bienestar en todos los grupos de enfoque con participantes que hablaban español y mixteco (Apéndice C).

[38] CAUSE & MICOP.
[39] CAUSE & MICOP.
[40] City of Santa Maria. *6th Cycle Housing Element 2023-2031.*
[41] Ufere, Nneka N, Lago-Hernandez, Carlos, et al. January 2024. *Health care–related transportation insecurity is associated with adverse health outcomes among adults with chronic liver disease.* Hepatology Communications. https://journals.lww.com/hepcomm/fulltext/2024/01010/health_care_related_transportation_insecurity_is.20.aspx. Accessed on March 21, 2025.

Los participantes del grupo de enfoque para adultos mayores también compartieron que muchos de ellos no tienen transporte y dependen en gran medida de las clínicas médicas que visitan su complejo de viviendas.

Acceso y calidad de la educación | Aprendizaje de por vida

La educación ha sido descrita como el determinante social modificable más importante de la salud. [42] Según la Oficina de Prevención de Enfermedades y Promoción de la Salud de los EE. UU., las personas con niveles más altos de educación tienen más probabilidades de estar más sanas y vivir más tiempo. Los niños de familias de bajos ingresos, los niños con discapacidades y los niños que son acosados o sufren otra forma de discriminación social tienen más probabilidades de tener dificultades con las matemáticas y la lectura. También tienen menos probabilidades de graduarse de la escuela secundaria o ir a la universidad. [43]

Objetivo de HP 2030: Aumentar las oportunidades educativas y ayudar a los niños y adolescentes a tener un buen desempeño en la escuela.

Según el Censo de los EE. UU., el 78% de la comunidad de 25 años de edad o más se ha graduado de la escuela secundaria. Concretamente, el nivel educativo de la comunidad se distribuyó de la siguiente manera:

- El 22% tenía menos de un diploma de escuela secundaria o equivalente;
- El 20% se había graduado de la escuela secundaria cuando había completado su nivel más alto de estudios;
- El 31% tenía algún título universitario o asociado cuando había completado su nivel más alto de estudios;
- El 17% tenía una licenciatura como su título más alto; y
- El 9% había completado un título avanzado, como una maestría, un título profesional o un doctorado.

La disparidad educativa aumenta a medida que se examina cada código postal dentro de la comunidad. Solo la mitad de la población (49.9%), mayor de 25 años, residente en Santa María (93458) terminó la escuela secundaria. Una tasa de finalización de la escuela secundaria

[42] Rural Health Information Hub, 2022. Improving Education to Address Social Determinants of Health. Retrieved from: https://www.ruralhealthinfo.org/toolkits/sdoh/2/education/index

[43] U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion, 2025. *HP 2030, Education Access and Quality.* Retrieved from: https://health.gov/healthypeople/objectives-and-data/browse-objectives/education-access-and-quality. Accessed April 1, 2025.

igualmente baja, del 57.4%, se encuentra en 93434 (Guadalupe) y del 73.9% en Santa María (93454).

La desigualdad educativa aumenta en cada código postal a medida que se toma en cuenta el origen étnico de un miembro de la comunidad. En general, los miembros de la comunidad hispana o latina obtienen una licenciatura o un título superior aproximadamente la mitad o menos que los de sus compañeros blancos solamente, no hispanos o latinos. Los detalles específicos se proporcionan en la siguiente Tabla 6.

Tabla 6. Nivel educativo por etnia en los Condados de San Luis Obispo y Santa Bárbara[44]

Datos del censo de EE. UU.		Solo blancos, no hispanos ni latinos, de 25 años de edad o más		De origen hispano o latino (a), 25 años de edad o más	
		Graduado de escuela secundaria o superior	Licenciatura o superior	Graduado de escuela secundaria o superior	Licenciatura o superior
Condado de SB	Santa Maria (93454)	95.5%	30.1%	62.5%	10.4%
	Santa María/Orcutt (93455)	96.1%	33.4%	75.6%	20.5%
	Santa María (93458)	85.4%	25.3%	42.0%	5.3%
	Guadalupe (93434)	87.0%	32.6%	50.8%	7.8%
Condado de SLO	Nipomo (93444)	97.4%	44.2%	68.3%	17.1%
	Arroyo Grande (93420)	96.2%	45.1%	88.1%	32.9%
	Grover Beach (93433)	93.1%	30.9%	63.4%	15.3%
	Océano (93445)	87.4%	20.5%	62.3%	13.3%
	Pismo Beach (93449)	98.1%	51.0%	91.6%	42.3%

El dominio limitado del inglés crea obstáculos adicionales para acceder a los servicios de atención médica y comprender la información de salud. Los participantes de los grupos focales de las comunidades hispana/latina y mixteca describieron que se sentían discriminados después de que los proveedores de atención médica los rechazaran debido a las barreras lingüísticas. Los participantes mencionaron las barreras lingüísticas y la falta de traductores como desafíos importantes para la salud. Hay 81 variantes diferentes del mixteco, la mayoría de las cuales son tan diferentes que comunicarse con quienes hablan una variante diferente o con un intérprete de mixteco de una región diferente es difícil, si no imposible.[45]

[44] U.S. Census Bureau, U.S. Department of Commerce. (2023). *American Community Survey, ACS 5-Year Estimates Subject Tables, Table S1501, Educational Attainment*. https://data.census.gov/table/ACSST5Y2023.S1501?q=S1501:+Educational+Attainment&g=860XX00US93401,93402,93405,93407,93409,93410,93422,93424,93428,93442,93446,93465&moe=false. Accessed on March 17, 2025.

[45] SLO Health Counts. (n.d.). *Demographics.* https://www.slohealthcounts.org/demographics. Accessed March 23, 2025.

Barrio y entorno construido | Mundo natural próspero

Un mundo natural próspero es una comunidad que tiene recursos naturales sustentables y está libre de los impactos climáticos. Esto incluye un aire, agua y suelo limpios. Si bien la industria local es una fuente de empleo y alimenta la economía local, en ocasiones puede afectar al entorno físico, lo que podría agravar o aumentar los factores de riesgo de enfermedades crónicas.

Objetivo de HP 2030: Reducir la cantidad de contaminantes tóxicos liberados al medio ambiente.

Si bien la industria local es una fuente de empleo y alimenta la economía local, en ocasiones puede afectar al entorno físico, lo que podría agravar o aumentar los factores de riesgo de enfermedades crónicas. El Departamento de Regulación de Pesticidas de California informó que en 2022 se usaron más de 6 millones de libras de pesticidas para tratar más de 2.4 millones de acres en el Condado de Santa Bárbara.[46] El condado ocupó el puesto 11 de todos los condados de California en cuanto al total de libras de pesticidas aplicados.[47] Específicamente, solo en el condado se usaron 3.6 millones de libras de pesticidas para tratar las fresas y se aplicaron docenas de productos químicos diferentes. La comunidad incluye algunas tierras agrícolas en el Condado de San Luis Obispo, pero una superficie mucho menor en comparación con las tierras agrícolas que rodean Guadalupe, Santa María y Orcutt.

Según una presentación ante el Departamento de Salud Pública del Condado de Santa Bárbara, los informes locales y los estudios basados en evidencia revelan que las trabajadoras agrícolas que están embarazadas tienen mayores riesgos de salud asociados con su embarazo debido a las condiciones laborales y la exposición a pesticidas. Los estudios muestran una conexión entre la exposición a pesticidas durante el embarazo y el bajo peso al nacer.[48]

Además de los millones de libras de pesticidas que se utilizan para asegurar la producción de productos agrícolas de calidad, la calidad del aire en el Valle de Santa María se ve afectada por otras industrias y el polvo. El índice de calidad del aire, o AQI, es un valor estándar desarrollado por la EPA para que el público comprenda si los niveles de contaminación del aire son saludables o no. Los niveles de AQI van de «buenos» a «peligrosos». En 2023, la mayoría de los días (232 o

[46] State of California, California Department of Pesticide Regulation. (2025). *Total Pounds, Applications, and Acres Treated by County: 2022*. https://www.cdpr.ca.gov/wp-content/uploads/2024/12/2022_county_total_pounds_applied_agricultural_applications_and_acres_treated.pdf. Accessed March 31, 2025.

[47] State of California, California Department of Pesticide Regulation. (2025). *Counties Ranked by Pounds of Chemicals: 2021 and 2022 Comparison*. https://www.cdpr.ca.gov/wp-content/uploads/2024/12/2022_counties_ranked_by_pounds_applied_2021_and_2022_comparison.pdf. Accessed March 31, 2025.

[48] Griffith, C., Smith, M., Hyunh, A., Hyland, C. (October 17, 2024). *Clinical Guidelines for Supporting Farmworkers During Pregnancy and Postpartum.* In conjunction with Santa Barbara County Public Health Department.

el 63.6%) en el Condado de Santa Bárbara fueron buenos, el resto de los días (133 o el 36.4%) fueron moderados y ningún día fue insalubre para los grupos sensibles o más.[49] Una calidad del aire moderada significa que existe un problema de salud moderado para las personas que son inusualmente sensibles a la contaminación del aire.

Además, hay un sitio Superfondo de la Agencia de Protección Ambiental de los EE. UU. en el Condado de Santa Bárbara. El sitio Superfondo de Casmalia Resources es una instalación inactiva de 252 acres de tratamiento, almacenamiento y eliminación de residuos peligrosos comerciales en el norte del Condado de Santa Bárbara, al suroeste de Santa María.[50]

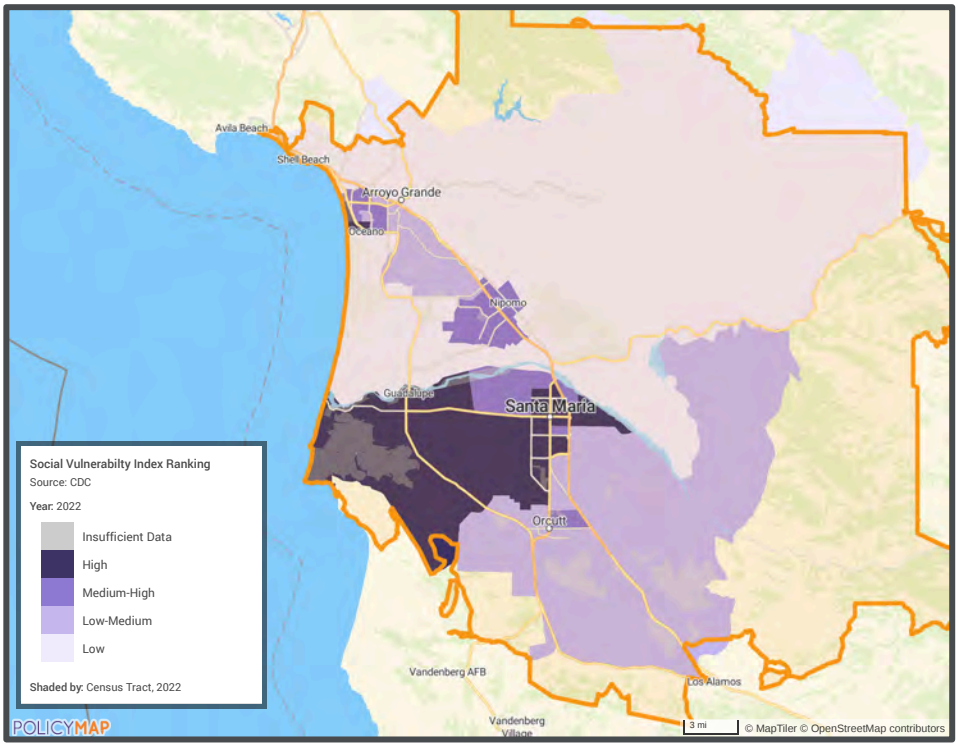
Índice de vulnerabilidad social (IVS)

El Índice de vulnerabilidad social (IVS) es una herramienta, desarrollada por el CDC, que evalúa la capacidad de una comunidad para prepararse, responder y recuperarse de los incidentes que pueden causar sufrimiento humano y pérdidas financieras. El IVS examina los indicadores relacionados con el nivel socioeconómico, la composición y la discapacidad del hogar, el estado y el idioma de las minorías, y el tipo de vivienda y el transporte. Las puntuaciones están estructuradas de manera que los valores más bajos representan una menor vulnerabilidad, mientras que los valores más altos indican una mayor vulnerabilidad. En general, el Condado de Santa Bárbara tiene una clasificación de IVS alta, y el Condado de San Luis Obispo tiene una clasificación de IVS medio-alta, ligeramente mejor. Sin embargo, examinadas a nivel de distrito censal, las áreas de alto IVS se encuentran en Guadalupe (93434), Santa María (93455, 93458) y Océano (93445). Las áreas moradas más oscuras que se muestran en la Figura 5 representan las áreas más altas del distrito censal del IVS, y el púrpura medio representa las áreas medio-altas.

[49] Santa Barbara County. (October 2024). *2023 Annual Air Quality Report.* *https://www.ourair.org/wp-content/uploads/2024-10bd-g1.pdf.* Accessed March 31, 2025.

[50] Environmental Protection Agency. Casmalia Resources, Casmalia CA. https://cumulis.epa.gov/supercpad/SiteProfiles/index.cfm?fuseaction=second.Cleanup&id=0901257#bkground Accessed March 26, 2025.

Figura 5. Índice de vulnerabilidad social



Clima y salud

En consonancia con el compromiso de Dignity Health con la administración ambiental y su Plan de Acción Climática, esta Evaluación de necesidades incorpora indicadores climáticos y de salud. El entorno físico en el que una persona vive, aprende, trabaja y recrea es vital para su salud. El acceso al aire libre, el agua limpia, los suelos de cultivo sanos para la agricultura, el aire limpio y las instalaciones de parques y recreación afectan el bienestar de una persona. Esta sección resume el clima local, los posibles impactos del cambio climático en el medioambiente y la salud pública en el área de servicio, y analiza las posibles formas de gestionar los efectos de los impactos climáticos en la salud.

Clima local

Los condados de Santa Bárbara y San Luis Obispo se encuentran dentro de la región de la costa central, que se caracteriza por sus extensos ecosistemas naturales, muchos de los cuales se verán afectados por el cambio climático. Los bosques frondosos, matorrales y pastizales herbáceos comprenden la mayor parte de su cobertura terrestre.[51] Hay una fuerte demanda de desarrollo en

[51]California Energy Commission. (2018). *California's Fourth Climate Change Assessment Central Coast Region Report*. https://www.energy.ca.gov/sites/default/files/2019-11/Reg_Report-SUM-CCCA4-2018-006_CentralCoast_ADA.pdf. Accessed on October 23, 2024.

las zonas rurales, y la agricultura se está desarrollando en tierras que anteriormente albergaban pastos o vegetación natural.

La comunidad puede describirse con clima mediterráneo templado con inviernos suaves y húmedos y veranos cálidos y secos. Arroyo Grande tiene una temperatura alta promedio de 72 °F, una baja de 42 °F y recibe 16 pulgadas de lluvia al año. [52] Del mismo modo, en Santa María, la temperatura alta promedio es de 68 °F y la temperatura baja promedio es de 51 °F, y hay un promedio de 17 pulgadas de lluvia al año.[53]

Cambio climático en la región de la costa central

La Cuarta Evaluación del Cambio Climático de California proporciona datos que muestran una tendencia al calentamiento. Desde 1986, los aumentos anuales de temperatura de California en la mayor parte del estado han superado 1 °F, y algunas áreas superan los 2 °F.[54] El Informe sobre el cambio climático y el perfil de salud proyectó cambios en la temperatura promedio anual en un escenario de altas emisiones de carbono para los Condados de San Luis Obispo y Santa Bárbara en el año 2099, como se muestra en la Figura 6 de la página siguiente.[55]

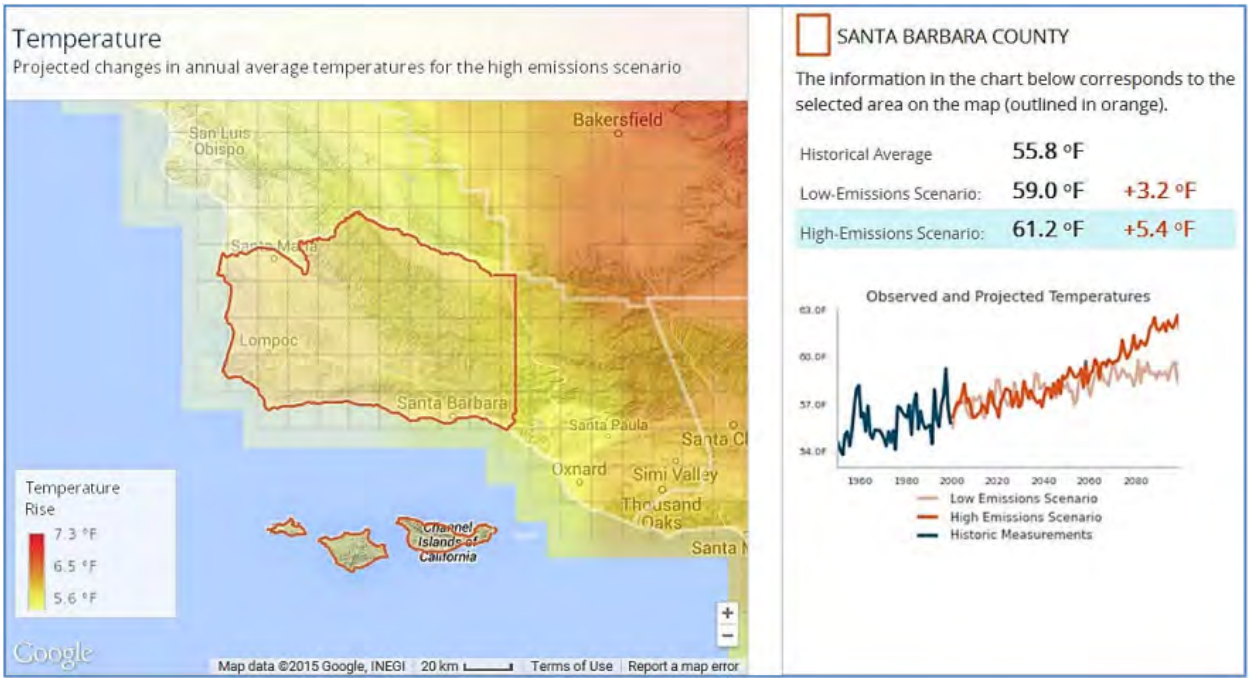
El informe de la región de la costa central afirma que la comunidad es una región agrícola muy vulnerable al cambio climático. La producción agrícola es muy sensible al cambio climático, incluidas las cantidades, formas y distribución de las precipitaciones, los cambios de temperatura y el aumento de la frecuencia e intensidad de los fenómenos climáticos extremos.

Las previsiones climáticas muestran un aumento de los fenómenos secos extremos. Aunque sólo se prevén cambios modestos en las precipitaciones medias, si se combinan con el aumento de las temperaturas, la gestión de las reservas de agua de la costa central, ya sometidas a presión, será todo un reto. La agricultura de regadío produce la mayor parte de los cultivos cosechados, y una disminución de la disponibilidad de agua podría reducir potencialmente las superficies de cultivo y los rendimientos. Además, como consecuencia de sequías más extremas, la disminución del caudal de los arroyos y del nivel de las aguas subterráneas perjudicará a los cultivos al aumentar

[52] County of San Luis Obispo. (2019). *San Luis Obispo Local Hazard Mitigation Plan*. https://www.slocounty.ca.gov/departments/planning-building/forms-documents/plans-and-elements/elements/local-hazard-mitigation-plan/san-luis-obispo-county-annexes-municipalities-a-g. Accessed on October 23, 2024.
[53] Climate Data. 2025. *Santa Maria Climate.* https://en.climate-data.org/north-america/united-states-of-america/california/santa-maria-1488/. Accessed February 14, 2025.
[54] California Energy Commission. (2018) *California's Fourth Climate Change Assessment Statewide Summary Report*. https://www.energy.ca.gov/sites/default/files/2019-11/Statewide_Reports-SUM-CCCA4-2018-013_Statewide_Summary_Report_ADA.pdf. Accessed on October 23, 2024.
[55] California Department of Public Health; U.C. Davis. (February 2017). *Climate Change and Health Profile Report, San Luis Obispo County*. https://www.cdph.ca.gov/Programs/OHE/CDPH%20Document%20Library/CHPRs/CHPR079SanLuisObispo_County7-17-17.pdf. Accessed October 23, 2024.

el riesgo de incendios forestales cuando se sequen las superficies del suelo. Estos impactos pueden afectar a la seguridad alimentaria.

Figura 6. Cambio de temperatura proyectado en la comunidad hospitalaria para 2099 durante las altas emisiones



La aceleración de la subida del nivel del mar observada y prevista recientemente es especialmente significativa para las comunidades costeras. El estilo, la frecuencia y la magnitud de los futuros fenómenos de El Niño, combinados con la subida del nivel del mar, serán un factor clave de la vulnerabilidad costera en las próximas décadas. El estrechamiento o la pérdida de las playas futuras y de los ecosistemas que sustentan esas playas se derivarán principalmente de la aceleración del aumento del nivel del mar combinada con la falta de sedimentos abundantes en el sistema, lo que, en conjunto, seguirá impulsando la erosión de las playas hacia tierra, sumergiéndolas de manera efectiva entre el aumento del océano y los acantilados secundarios y/o el paisaje urbano duro.

El cambio climático y la salud humana

Las repercusiones del cambio climático en la salud humana las describe el Instituto Nacional de Ciencias de la Salud Medioambiental, que hace referencia a organizaciones internacionales de salud que afirman que los efectos del cambio climático empeoran muchas enfermedades y dolencias existentes al aumentar la exposición a temperaturas más elevadas, introducir nuevas plagas y agentes patógenos en una zona y afectar a la calidad del aire y el agua. [56] La Quinta

[56]National Institute of Environmental Health Sciences. (n.d). *Climate Change and Human Health.* https://www.niehs.nih.gov/research/programs/climatechange. Accessed October 23, 2024.

Evaluación Nacional del Clima preparada por los EE. UU. El Programa de Investigación del Cambio Global afirma: *«Es un hecho establecido que el cambio climático está dañando la salud y el bienestar físico, mental, espiritual y comunitario a través de la creciente frecuencia e intensidad de los eventos extremos, el aumento de los casos de enfermedades infecciosas y transmitidas por vectores y la disminución de la calidad y seguridad de los alimentos y el agua».* Ciertas poblaciones corren un mayor riesgo de sufrir los efectos del cambio climático sobre la salud, como los niños, los adultos mayores, las personas con bajos ingresos y las personas con problemas de salud subyacentes.

Según el mapeo de datos de The New York Times, el mayor riesgo climático en los Condados de Santa Bárbara y San Luis Obispo está asociado con el estrés hídrico. El mismo mapa de datos enumera la subida del nivel del mar y los incendios forestales como riesgos medios. El alto riesgo de estrés hídrico supone un riesgo claro para la salud humana por la escasez de agua potable y la reducción del agua de riego para el suministro de alimentos.[57]

Gestionar los efectos del cambio climático en la salud

Hay medidas que pueden adoptarse para ayudar a gestionar y mitigar los efectos negativos del clima sobre la salud en la región. Los informes sobre el cambio climático y el perfil de salud de los Condados de San Luis Obispo y Santa Bárbara han enumerado varias estrategias de salud pública y medidas de acción a medio y corto plazo para adaptarse al cambio climático. El objetivo de estas estrategias es minimizar los efectos negativos del cambio climático sobre la salud.

Las medidas de mitigación de incendios forestales y sequías ayudarán a gestionar el riesgo climático y el estrés hídrico previstos en la zona de servicios. Las medidas de mitigación de incendios forestales pueden consistir en proyectos a nivel de propietarios de viviendas y comunidades y pueden consistir en la gestión del combustible mediante la reducción de la vegetación inflamable, el aclareo de las copas de los árboles y la eliminación de madera muerta y escombros. La planificación del uso del suelo, el desarrollo de regulaciones, los códigos de construcción y la educación de los propietarios son también componentes importantes de la mitigación de los incendios forestales.

Las medidas de mitigación de la sequía pueden consistir en planificación, medidas de conservación del agua, mejora del almacenamiento de agua, reciclaje de agua y xerojardinería (paisajismo para sequías). Puede haber financiación disponible para proyectos de mitigación de peligros naturales a través de la Agencia Federal de Gestión de Emergencias y otras fuentes. La mitigación del calor extremo puede llevarse a cabo mediante la planificación estratégica, incluido el establecimiento de sistemas de alerta de calor extremo y el mantenimiento de centros de enfriamiento en toda la comunidad.

[57] S. Thompson and Y. Serkez. (September 18, 2020). *Every Place Has Its Own Climate Risk. What Is It Where You Live?* New York Times.

Contexto social y comunitario.

El contexto social y comunitario en el que viven y trabajan las personas incluye las relaciones entre vecinos y sus vínculos sociales y cívicos. El contexto social y comunitario puede evaluarse mediante los siguientes indicadores:

- Discriminación;
- Encarcelamiento y delincuencia;
- Cohesión social y conexión social,
- Capacidad comunitaria.

La comunidad tiene varias iglesias, escuelas, gimnasios, parques, centros para adultos mayores y mercados agrícolas que pueden ser utilizados por la comunidad y que fomentan la participación comunitaria. En la Sección V. Recursos potencialmente disponibles para abordar las necesidades de esta ENSC, se ofrece un ejemplo de la multitud de organizaciones comunitarias que apoyan a la comunidad. Según los registros de votación, el 52% de los votantes registrados en el Condado de San Luis Obispo y el 42% de los votantes registrados en el Condado de Santa Bárbara votaron en las elecciones primarias presidenciales de marzo de 2024.[58]

La tasa de delitos violentos es la medida del número de homicidios, violaciones forzadas, robos y agresiones con agravantes que se producen en una comunidad en comparación con la población total. En general, la tendencia de la tasa de criminalidad de Santa María ha disminuido significativamente desde 2022. En 2023, la cantidad de delitos violentos, robos e incendios provocados se redujo un 28% con respecto a los niveles de 2022 en la ciudad de Santa María. Durante los primeros cuatro meses de 2024, la delincuencia se redujo un 30% en comparación con el mismo período del año anterior. Según el Informe Anual 2023 de la Policía de la Ciudad de Santa María, hubo seis homicidios, 63 violaciones, 428 asaltos agravados y 751 robos de vehículos motorizados.[59]

Según la Encuesta de información de salud de California (CHIS) 2021-2022, la mitad (el 51,2% o 22,000) de los adolescentes del Condado de Santa Bárbara que respondieron a la encuesta están preocupados de recibir un disparo con un arma de fuego. Según el CHIS, en el Condado de Santa Bárbara el 30.2% de las personas blancas de 19 a 30 años han sido detenidas por la policía al menos

[58] March 5, 2024, Presidential Primary Election Voter Participation Statistics by County. https://elections.cdn.sos.ca.gov/sov/2024-primary/sov/03-voter-participation-stats-by-county.pdf. Accessed on March 23, 2025.
[59] City of Santa Maria Police. (2024). *2023 Annual Report*. https://www.cityofsantamaria.org/home/showpublisheddocument/32047/638452225393600000. Accessed on March 23, 2025.

una vez en los últimos tres años, y el 51.6% de las personas hispanas o latinas (a) de entre 19 y 30 años han sido detenidas al menos una vez en los últimos tres años.[60]

La trata de personas y la violencia doméstica

El FBI ha identificado a California como uno de los cuatro principales estados de destino del país para las personas víctimas de trata humana, y los Condados de San Luis Obispo y Santa Bárbara sirven como un corredor natural para las actividades de trata de personas entre Los Ángeles, el Valle Central y San Francisco. La trata de personas es una forma de esclavitud moderna en la que las personas se benefician del control y la explotación de otras personas.[61] La Ley de Víctimas de la Trata de 2000 y sus re-autorizaciones reconocen y definen dos formas principales de trata de personas, la trata sexual y la trata laboral. La trata sexual consiste en reclutar, albergar, transportar, proporcionar, obtener, patrocinar o solicitar a una persona para un acto sexual comercial, mediante el uso de la fuerza, el fraude o la coacción, o en el que la persona inducida a realizar el acto aún no tiene 18 años. La trata laboral incluye el reclutamiento, captura, transporte, prestación u obtención de una persona a cambio de mano de obra o servicios mediante fuerza, fraude o coacción con fines de servidumbre involuntaria, peonaje, servidumbre por deudas o esclavitud. La trata laboral puede ocurrir en cualquier industria, incluyendo el trabajo doméstico, la agricultura, la construcción, la silvicultura, los servicios profesionales, la ciencia, la tecnología, la fabricación, la salud, la belleza y el paisajismo.

Según el portal de datos Open Justice de la Oficina del Fiscal General de California, en 2023 hubo 35 llamadas de asistencia relacionadas con la violencia doméstica en Arroyo Grande y 536 en Santa María. La incidencia de las llamadas relacionadas con la violencia doméstica a menudo no se denuncia debido al miedo. [62]

Como se informó durante el grupo de discusión para proveedores de servicios sin vivienda sobre una joven adoptiva que vivía en el lecho del río y que recientemente fue alojada en un refugio,

«Llevaba mucho tiempo en hogares de acogida, se le agotó el tiempo de espera y luego estaba en el lecho del río, siendo víctima de tráfico y vendiendo muchas de las drogas en la zona... y dice: '¿Por qué estás aquí?' Le dije: «Quiero ayudarte». Ella dijo: «¿Pero por qué? Siempre me he sentido invisible durante toda mi vida». Por primera vez en mucho tiempo, alguien le dijo que es importante». — *Proveedor de servicios comunitarios sin vivienda*

[60] UCLA Center for Health Policy Research. (2025). *California Health Interview Survey Ask CHIS Dashboard.* https://healthpolicy.ucla.edu/user/login?destination=/our-work/askchis/askchis-dashboard. Accessed on March 15, 2025.
[61] County of San Luis Obispo. (2025). *District Attorney, Human Trafficking.* https://www.slocounty.ca.gov/departments/district-attorney/victim-witness-assistance-center/human-trafficking. Accessed March 23, 2025.
[62] California Department of Justice, Office of the Attorney General. (2025). *OpenJustice, Crimes & Clearances.* https://openjustice.doj.ca.gov/exploration/crime-statistics/crimes-clearances. Accessed on March 23, 2025.

Acceso y calidad de la atención médica

El acceso a servicios médicos completos y de calidad es fundamental para lograr la equidad de salud y aumentar la calidad de una vida sana para toda persona. La cobertura inadecuada del seguro médico es uno de los obstáculos más importantes para acceder a la atención médica, y la distribución desigual de la cobertura contribuye a las desigualdades sanitarias.

Para muchos miembros de la comunidad, la oportunidad de acceder a la atención médica, la educación y el empleo exige depender de instituciones que históricamente no han sido un espacio seguro para las comunidades minoritarias, los inmigrantes, la comunidad LGBTQ+, las mujeres y los sobrevivientes del abuso. La capacidad de la comunidad para acceder a la atención médica se evaluó mediante grupos de discusión y entrevistas a informantes clave, complementados con fuentes de datos secundarias para validar la información aportada para este informe. Como se compartió durante el grupo de enfoque sobre la comunidad negra,

«¿Valoras lo que digo o lo descartas porque tienes tanta educación que no estás dispuesto a escucharme? Creo que simplemente no nos ven...» - *Participante de un grupo de enfoque*

Como se ha mencionado anteriormente, las principales necesidades de los participantes en los grupos de discusión del Centro Médico del Hospital French en todos los grupos de discusión fueron sistemáticamente el acceso a la atención médica, los obstáculos para el acceso a la atención médica, la competencia cultural de los proveedores de atención médica y el acceso a los servicios.

Como lo compartió el grupo de enfoque de Campesinos de Santa María, traducido del idioma mixteco,

«A veces saben que no tenemos seguro y que somos indígenas. Entonces se convierte en discriminación. Prestan menos atención, el proveedor atiende a quienes tienen papeles y que tienen un número social que a nosotros. Son más importantes para ellos». — *Participante del grupo de enfoque*

Las respuestas de los participantes identificaron el acceso a la atención sanitaria (incluida la atención primaria y la salud conductual) como un reto global que afecta a la salud de la comunidad, especialmente entre la población joven. Como se comentó en un grupo de discusión,

«Los médicos te dan 15 minutos por visita, pero has esperado tres meses». — *Participante en un grupo de enfoque*

Las dificultades de las comunidades para acceder a la atención médica van más allá de las estadísticas sobre el seguro médico, la cantidad de médicos o clínicas en la comunidad o el tiempo

transcurrido desde la última visita al médico de una persona. Las barreras que enfrenta la comunidad se presentan en cómo navegar por el sistema de salud, llegar a la cita, recibir atención en su idioma y ser bien recibidos en la puerta de entrada. Los participantes en los grupos focales compartieron que hay muchas opciones a la hora de hacer una llamada telefónica para conectarse, y que es difícil ponerse en contacto con alguien. Se realizaron grupos focales con poblaciones similares en los hospitales de la región de la costa central de Dignity Health California, y sus historias y dificultades compartidas aparecieron con frecuencia en toda la región.

Condiciones crónicas

Las enfermedades crónicas, incluidas las cardiopatías y el cáncer, son la causa de muerte principal en Estados Unidos, en California y en el Condado de San Luis Obispo. Según el CDC, se consideran enfermedades crónicas las cardiopatías, los infartos, el cáncer, la diabetes, la obesidad, la artritis, la enfermedad de Alzheimer, la epilepsia y las caries dentales. Las enfermedades crónicas también incluyen las enfermedades mentales, como la depresión y la ansiedad. Las disparidades surgen de las políticas y el racismo estructural que separan la asignación de recursos y oportunidades.

Cardiopatías y derrame cerebral

La enfermedad cardíaca es la principal causa de muerte en los Estados Unidos. Según la Asociación Estadounidense del Corazón, la enfermedad cardiovascular puede referirse a una serie de afecciones diferentes, como la enfermedad de las arterias coronarias, los ataques cardíacos, los derrames cerebrovasculares, la insuficiencia cardíaca, la arritmia y los problemas de las válvulas cardíacas. Los factores de riesgo de las cardiopatías son la hipertensión, el colesterol alto, la diabetes, la obesidad, el estilo de vida, la edad y el historial familiar. Estos indicadores se presentan en la Tabla 7 según los datos de la Encuesta de Información de Salud de California (CHIS, por sus siglas en inglés) de 2023.[63]

Tabla 7. Indicadores de prevalencia de cardiopatías y derrames cerebrales

Preguntas de la encuesta de salud de California	Condado de San Luis Obispo	Condado de Santa Bárbara	CA
Le han diagnosticado alguna vez una cardiopatía	18.7%	11.5%	12.6%
Un profesional de la salud les dijo que tenían el colesterol alto en el último año, adultos mayores de 20 años	25.5%	20.9%	20.5%
Hipertensión arterial, adultos mayores de 20 años	32.4%	33.7%	28.1%
Adultos (mayores de 20 años) con presión arterial alta que estén tomando medicamentos	80.7%	62.9%	80.0%

[63] UCLA. *California Health Information Survey, AskCHIS Dashboard.*

Cáncer

> Objetivo de HP 2030: Reducir los casos nuevos de cáncer y las enfermedades, discapacidades y muertes relacionadas con el cáncer.

El cáncer es una enfermedad genética causada por cambios en los genes que controlan el funcionamiento de las células, especialmente la forma en que crecen y se replican. Mientras que algunos de los factores se heredan de nacimiento, otros están influidos por el estilo de vida y los factores ambientales. Se cree que las disparidades en el cáncer reflejan la conexión de los factores socioeconómicos, la cultura, la dieta, el estrés, el medioambiente y la genética. Los pobres y los que carecen de servicios médicos suficientes tienen menos probabilidades de someterse a las pruebas de detección del cáncer recomendadas que los que están medicamente bien atendidos. También tienen más probabilidades de que se les diagnostique un cáncer en fase avanzada que podría haberse tratado con mayor eficacia si se hubiera diagnosticado antes.

Según el Registro de Cáncer de California, de 2017 a 2021 hubo 8,979 casos de cáncer en el Condado de San Luis Obispo y 11,479 casos de cáncer en el Condado de Santa Bárbara. El Registro de Cáncer de California determinó la tasa bruta de cáncer en cada condado y luego la ajustó según la edad, de modo que se pudiera hacer una comparación «manzana con manzana» entre los 58 condados de California. Estas tasas se clasificaron de mayor a menor: el Condado de San Luis Obispo tiene la cuarta tasa más alta de cáncer y el Condado de Santa Bárbara tiene la quinta tasa más alta de cáncer. En la Tabla 8 se presentan los tipos de cáncer más comunes con tasas ajustadas por edad para el condado y el estado.[64]

Tabla 8. Tasas de incidencia de cáncer ajustadas por edad (2017-2021)

Lugar	Condado de San Luis Obispo		Condado de Santa Bárbara		California
	Total de casos	Tasa ajustada por edad*	Total de casos	Tasa ajustada por edad*	Tasa ajustada por edad*
Todos los lugares	8,979	456.3	11,479	453.1	398.3
Pulmones	818	38.6	921	34.6	36.8
Próstata, hombres	1,319	124.7	1,887	150.0	99.0
Colorectal	610	32.0	808	32.7	33.5
Mama, mujeres	1,375	147.1	1,806	145.9	124.1
Melanoma de la piel	1,054	55.2	675	26.8	22.8
* Todas las tasas se calculan por cada 100,000 personas. Las tasas están ajustadas por edad a la población estándar estadounidense de 2000.					

[64] University of California, San Francisco. California Health Maps website. https://www.californiahealthmaps.org/?areatype=county&address=35.53890%2C-120.80429&sex=Both&site=Kidney&race=&year=05yr&overlays=counties&choropleth=AAIR. Accessed March 24, 2025.

Las tasas de detección preventiva del cáncer superan la tasa estatal (58.7%) en ambos condados (el 66.1% del Condado de San Luis Obispo; el 60.5% del Condado de Santa Bárbara), pero están por debajo de la tasa estatal del 73.0% de mamografías (el 70.2% del Condado de San Luis Obispo y el 69.9% del Condado de Santa Bárbara).[65]

Bienestar social y emocional.

El bienestar social y emocional incluye nuestro bienestar emocional, psicológico y social. El bienestar social y emocional es esencial para el bienestar general de una persona.

Las enfermedades crónicas y las experiencias traumáticas también pueden estar vinculadas a traumas históricos. Las personas de comunidades marginadas que han sufrido malos tratos y abusos durante mucho tiempo suelen tener una mayor carga de morbilidad y desigualdades de salud más significativas. Los miembros de la comunidad y los proveedores médicos expresaron durante los grupos focales el deseo y la necesidad de esforzarse más para abordar de forma competente los traumas subyacentes, las experiencias de vida y los factores de estrés que influyen en la salud y el bienestar.

En 2022, el 19.5% de los adultos y adolescentes del Condado de Santa Bárbara y el 11.3% de los adultos y adolescentes del Condado de San Luis Obispo respondieron que probablemente habían tenido problemas psicológicos graves durante el último año. Aproximadamente uno de cada cinco adultos y adolescentes del Condado de Santa Bárbara respondió que probablemente había tenido problemas psicológicos graves en el último año.[66]

Según los datos más recientes de la Encuesta de Niños Saludables de California (*California Healthy Kids Survey, CHKS*) (2021-2023), entre el 15 y el 18% de los estudiantes de noveno y undécimo grado de la comunidad consideraron el suicidio. Sin embargo, aproximadamente la mitad de todos los estudiantes transgénero o no heterosexuales gay/lesbianas/bisexuales de noveno y undécimo grados del Condado de San Luis Obispo informaron haber considerado el suicidio, en comparación con un 37% menos en el Condado de Santa Bárbara.[67] De los estudiantes encuestados, tanto las mujeres como los estudiantes LGBTQ+ eran más propensos a manifestar sentimientos de tristeza o desesperanza. Las investigaciones indican que las personas LGBTQ+ se enfrentan a desigualdades de salud relacionadas con la estigmatización social, la discriminación y la negación de sus derechos civiles y humanos.[68] La discriminación de las personas LGBTQ+

[65] University of California, San Francisco. California Health Maps website.
[66] UCLA. AskCHIS Dashboard. https://healthpolicy.ucla.edu/our-work/askchis/askchis-dashboard#!/results
[67] CalSCHLS. (2025). *California Healthy Kids Survey (CHKS), Public Dashboards: Key Indicators: Secondary.* https://calschls.org/reports-data/public-dashboards/f882f1e2-dfc0-4448-b90b-f49cef6e6d3f/. Accessed March 21, 2025.
[68] Bostwick, W. B., Boyd, C. J., Hughes, T. L., West, B. T., & McCabe, S. E. (2014). Discrimination and mental health among lesbian, gay, and bisexual adults in the United States. *The American journal of orthopsychiatry*, *84*(1), 35–45. https://doi.org/10.1037/h0098851

se ha asociado a altas tasas de trastornos psiquiátricos, trastornos por consumo de sustancias y suicidio.

Los traumas y el estrés tóxico sufridos en la infancia tienen efectos duraderos en la edad adulta. Las Experiencias Infantiles Adversas (EIA) son todo tipo de abusos, negligencias y otras experiencias en la vida de los niños que pueden tener el potencial de causar estrés traumático o afectar negativamente a los sentimientos de seguridad y estabilidad de los niños. [69] Los niños cuyas familias son vulnerables desde el punto de vista médico o de bajo nivel socioeconómico tienen más probabilidades de sufrir EIA. Medi-Cal ha estado evaluando a sus miembros en busca de EIA. Los miembros de Medi-Cal de 0 a 20 años con un puntaje EIA de 4 o más oscilan entre un máximo del 13.7% en el Condado de San Luis Obispo y el 6.5% en Santa Bárbara.[70] Los individuos con una puntuación EIA de 4 o más tienen 12 veces más probabilidades de haber intentado suicidarse, 7 veces más probabilidades de ser alcohólicos y 10 veces más probabilidades de haberse inyectado drogas callejeras. La adicción y el suicidio son los dos problemas de salud que más se correlacionan con puntuaciones EIA elevadas.[71] Como se comentó en el grupo de enfoque de proveedores de servicios para veteranos,

«La mayoría de la gente con la que tratamos ha perdido, por una razón u otra, la confianza en virtud de la experiencia o el trauma... no hay un sentimiento de pertenencia». - *Proveedor de servicios para veteranos*

Estas experiencias pueden aumentar el riesgo de lesiones, infecciones de transmisión sexual, embarazo adolescente y participación en la trata con fines sexuales. Los jóvenes en hogares de acogida suelen tener un alto índice de EIA y carecen de un sistema de apoyo estable, lo que los hace vulnerables al consumo de sustancias y a los trastornos de salud conductual, a la trata sexual y a la inestabilidad de la vivienda.

Conductas de salud

Los comportamientos saludables pueden ayudar a reducir el riesgo de desarrollar enfermedades crónicas y mejorar el bienestar mental. Estas conductas saludables incluyen mantener un peso saludable, evitar el tabaco, limitar la cantidad de alcohol que se consume y mantenerse en forma física.

[69] Centers for Disease Control and Prevention. About Adverse Childhood Experiences. https://www.cdc.gov/aces/about/index.html
[70] Aces aware. (n.d.) *"Medi-Cal Members Ages 0-20 Screened with an ACE Score of 4 or More."* https://data.acesaware.org/medi-cal-aces-children/. Accessed March 31, 2025.
[71] Pinetree Institute Learning Center. *The ACE Study*. https://pinetreeinstitute.org/aces/#:~:text=The%20%E2%80%9CACE%20Score%E2%80%9D&text=Individuals%20with%20ACE%20scores%20of,20%E2%80%90year%20shortening%20of%20lifespan. Accessed March 23, 2025.

Obesidad infantil

Según la Organización Mundial de la Salud, la obesidad es una enfermedad crónica y compleja caracterizada por depósitos excesivos de grasa que pueden perjudicar la salud. La obesidad puede aumentar el riesgo de diabetes de tipo 2 y de cardiopatías, puede afectar a la salud ósea y a la reproducción, y aumenta el riesgo de padecer ciertos tipos de cáncer.

Aproximadamente 1 de cada 5 niños y adolescentes estadounidenses padece obesidad. La obesidad afecta a algunos grupos más que a otros, como los adolescentes, los niños hispanos/latinos y negros no hispanos/latinos, y los niños de familias con menos recursos.[72] La Evaluación de Necesidades de la Población de CenCal Health 2024 descubrió que de los miembros pediátricos de CenCal Health que tenían sobrepeso o eran obesos, el 84% se identificaba como hispano/latino(a), mientras que sólo el 63% de la población total de miembros se identificaba como hispano/latino(a).[73] De 2020 a 2023, el 46.2% de los adolescentes en el Condado de San Luis Obispo se consideraron obesos, mientras que solo el 18.1% de los adolescentes en todo el estado de California eran obesos.[74]

Consumo de sustancias

El consumo de sustancias es un comportamiento de alto riesgo que puede provocar problemas de salud inmediatos o a largo plazo y que, en última instancia, repercute en las personas, las familias y las comunidades. Según el Departamento de Salud Pública de California, el Condado de San Luis Obispo tiene una tasa ajustada por edad de sobredosis relacionadas con opioides de 30.02 por cada 100,000 residentes. Esta tasa coloca al Condado de San Luis Obispo en el puesto 18 más alto en comparación con todos los condados de California (tasa estatal = 20.81).[75] La tasa del Condado de Santa Bárbara está por debajo de la tasa estatal, de 16.3 por cada 100,000 residentes, con un aumento en las tasas de mortalidad por sobredosis en el cuarto trimestre de 2024. Puede encontrar información adicional en los informes instantáneos de sobredosis de los Condados de Santa Bárbara y San Luis Obispo que están disponibles en el Apéndice E.

Según los datos más recientes del CHKS (2021-2023), el 24% de los estudiantes de undécimo grado de San Luis Obispo y un 14% menos de los estudiantes de undécimo grado del Condado de Santa Bárbara informaron haber consumido alcohol o drogas en los últimos 30 días. El consumo de tabaco es la principal causa de muerte prevenible y prematura en Estados Unidos. El consumo de tabaco o fumar en cualquier forma (incluidos los cigarrillos electrónicos) no es seguro y causa

[72] Centers for Disease Control and Prevention. Childhood Obesity Facts. https://www.cdc.gov/obesity/childhood-obesity-facts/childhood-obesity-facts.html
[73] CenCal Health. Pediatric Overweight & Obesity. https://www.cencalhealth.org/health-wellness/pediatric-overweight-obesity/
[74] CHIS. https://healthpolicy.ucla.edu/our-work/askchis/askchis-dashboard#!/results
[75] California Department of Public Health. (2025). *California Overdose Surveillance Dashboard.* https://skylab.cdph.ca.gov/ODdash/?tab=CTY. Accessed March 21, 2025.

daños acumulativos e irreversibles. Según el CHKS, el consumo de tabaco entre los estudiantes de undécimo grado oscila entre un máximo del 11% en el Condado de San Luis Obispo y el 5% en el Condado de Santa Bárbara.[76]

Mortalidad

Según la base de datos Wonder del CDC, el cáncer y las enfermedades cardíacas fueron las dos principales causas de muerte en los Condados de Santa Bárbara y San Luis Obispo entre 2018 y 2023. En California y el Condado de Santa Bárbara, la principal causa de muerte son las enfermedades cardíacas, seguidas del cáncer, pero en el Condado de San Luis Obispo es el cáncer. La tasa bruta de causas de muerte por cada 100,000 habitantes en el Condado de Santa Bárbara es ligeramente superior a las tasas estatales, pero en general coinciden. La tasa de causas de muerte por cada 100,000 habitantes en el Condado de San Luis Obispo supera la tasa de California, lo que podría atribuirse al envejecimiento de la población que actualmente llama hogar al Condado de San Luis Obispo. La Tabla 9 muestra la principal causa de muerte y la tasa bruta respectiva para el Condado de Santa Bárbara, el Condado de San Luis Obispo y California.

Tabla 9. Las 5 principales causas subyacentes de muerte 2018-2023[77]

Causa de muerte (2018-2023)	Tasa bruta por cada 100,000		
	Condado de Santa Bárbara Condado	Condado de San Luis Obispo	California
Cáncer	155.6	195.4	152.6
Cardiopatía	169.3	170.4	164.4
Derrames cerebrales	52.7	93.0	45.0
Lesiones no intencionales	51.4	53.6	47.1
Enfermedades crónicas de las vías respiratorias inferiores	29.0	44.0	31.9
COVID-19	29.3	31.8	41.7
Enfermedad de Alzheimer	49.8	43.0	43.5

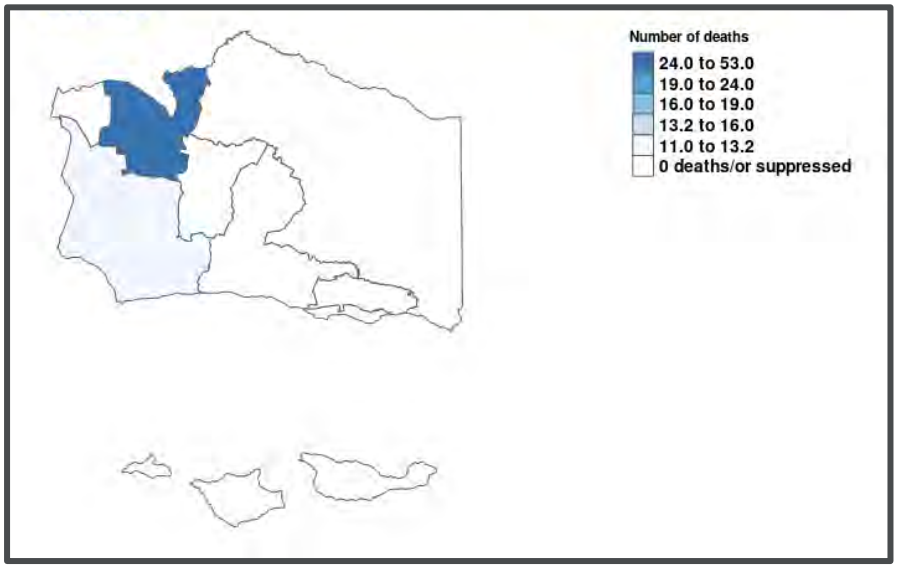
Como anécdota, en enero de 2025 hubo 242 nacimientos en el Centro Médico Regional Marian, de los cuales 57 fueron de mujeres de habla mixteca, es decir, el 23.5%. Los partos por madres mixtecas resultaron en 2 muertes fetales y 55 nacidos vivos, mientras que las madres no mixtecas tuvieron 184 nacidos vivos y una muerte fetal.

[76] CalSCHLS. (2025). *California Healthy Kids Survey (CHKS), Public Dashboards: Key Indicators: Secondary.* https://calschls.org/reports-data/public-dashboards/f882f1e2-dfc0-4448-b90b-f49cef6e6d3f/. Accessed March 21, 2025.

[77] Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Mortality 2018-2023 on CDC WONDER Online Database, released in 2024. Data are from the Multiple Cause of Death Files, 2018-2023, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. http://wonder.cdc.gov/ucd-icd10-expanded.html. Accessed on March 24, 2025.

La Figura 7 muestra la desigualdad entre las muertes neonatales en comparación con otras comunidades del Condado de Santa Bárbara, según lo establecido por el Departamento de Salud Pública de California.[78]

Figura 7. Número de muertes por afecciones neonatales en 2019-2023 en el Condado de Santa Bárbara y en todo el estado



[78] California Department of Public Health. (2025). *California Community Burden of Disease and Cost Engine (CCB).* https://skylab.cdph.ca.gov/communityBurden/?tab=rankbycause. Accessed on March 24, 2025.

IV. Descripción priorizada de las necesidades importantes de salud de la comunidad

Las necesidades importantes de salud de la comunidad se determinaron cuidadosamente durante una reunión de liderazgo de los hospitales de la costa central de la región de Dignity Health California el 6 de febrero de 2025, y en una diálogo colaborativo con el equipo de preparación de la ENSC el 4 de marzo de 2025. Los datos cuantitativos, así como los datos cualitativos y las historias anecdóticas, apuntaban a las prioridades detalladas en esta sección. Las mismas inquietudes y necesidades surgieron constantemente y se reiteraron en varios grupos focales y entrevistas con informantes clave. También se utilizaron los siguientes criterios para evaluar la priorización de las necesidades comunitarias:

- el tamaño o escala del problema (cuántas personas se vieron afectadas);
- la gravedad del problema;
- la desigualdad y equidad;
- intervenciones eficaces ya conocidas;
- la viabilidad y sustentabilidad de recursos; y
- el apoyo comunitario.

Las importantes necesidades de salud comunitaria identificadas para la comunidad local atendida por el Hospital van mucho más allá de la salud y la atención médica. Los factores sociales, como la educación, la situación laboral, el nivel de ingresos, el género y el origen étnico, contribuyen a las desigualdades de salud.

Las desigualdades de salud son diferencias sistemáticas en el estado de salud de los diferentes grupos de la población. Estas desigualdades tienen importantes costos sociales y económicos tanto para las personas como para las sociedades. La mejor manera de abordar las desigualdades en salud es establecer una meta para lograr la equidad de salud en la comunidad. La equidad en salud es el estado en el que todos tienen una oportunidad justa y equitativa de alcanzar su nivel más alto de salud.

Lograr la equidad de salud en la comunidad requerirá abordar las desigualdades más importantes y ayudar a los sectores de la comunidad que enfrentan una lucha constante con la vida cotidiana. Los siguientes párrafos presentan una lista priorizada de las necesidades de salud importantes identificadas a través de los datos primarios y secundarios de la ENSC. Las necesidades identificadas durante este proceso de la ENSC también se han corroborado mediante la encuesta *Pathways to Excellence* dirigida a las enfermeras que buscan su opinión sobre las necesidades de salud más importantes de la comunidad. Por último, aunque se proporcionó un espacio seguro

para los participantes del grupo de enfoque, los resultados del grupo de enfoque se habrían visto afectados si se hubieran realizado después de enero de 2025.

Prioridad 1: Una atención médica culturalmente sensible y receptiva que tiene la confianza de la comunidad.

Según las investigaciones, las tasas de enfermedad y la muerte son elevadas en los grupos raciales históricamente marginados, incluidos la gente negra, Nativo Americana y personas Nativas de Hawái y otras islas del Pacífico, que tienden a tener una aparición más temprana de la enfermedad, una progresión más agresiva de la enfermedad y una supervivencia más deficiente.[79] Sin embargo, durante los grupos focales se hizo evidente que acceder a la atención médica (entrar por la puerta) es muy difícil para muchos miembros de la comunidad. Los proveedores de atención médica deben reconocer a cada paciente como experto en función de sus propios antecedentes y experiencias.

Para muchos miembros de la comunidad, la oportunidad de acceder a la atención médica requiere depender de instituciones que históricamente no han sido un espacio seguro para las comunidades minoritarias, los inmigrantes, la comunidad LGBTQ+, las mujeres y los sobrevivientes de abuso. La capacidad de la comunidad para acceder a la atención médica se evaluó mediante grupos de discusión y entrevistas a informantes clave, complementados con fuentes de datos secundarias para validar la información aportada para este informe.

La comunidad LGBTQ+ teme y evita acceder a la atención médica debido al estigma y la experiencia como miembro de la comunidad LGBTQ+. Las organizaciones de atención médica sin fines de lucro están disponibles y abiertas a todos los miembros de la comunidad, incluidos aquellos con diferentes idiomas religiosos, étnicos, culturales o hablados.

Como compartieron los miembros de la comunidad negra,

«La mayoría de las veces las personas no ven a la persona, ven el color de mi piel. Si no me ves, no ves mis necesidades».

«¿Valoras lo que digo o lo descartas porque tienes tanta educación que no estás dispuesto a escucharme? Creo que simplemente no nos ven...» - *Participante de un grupo de enfoque*

[79] Williams, D.R., Lawrence, J.A., et al. (2019). *Annual Review of Public Health.* "Racism and Health: Evidence and Needed Research." https://www.annualreviews.org/docserver/fulltext/publhealth/40/1/annurev-publhealth-040218-043750.pdf?expires=1743522729&id=id&accname=guest&checksum=11B829653EC3F1C6B5E4527BEC810511. Accessed March 1, 2025.

Prioridad 2: Asistencia médica y de navegación fácilmente disponible en el idioma que hablan los pacientes.

A lo largo de las sesiones de los grupos focales, se hizo evidente en repetidas ocasiones que ciertos miembros de la comunidad evitan buscar atención médica ya sea debido a una experiencia vivida o compartida. Como compartió una participante del grupo de enfoque de madres mixtecas (traducido del mixteco):

«Creo que no tienes que hablar el idioma para ver las acciones de alguien... puedes darte cuenta por su rostro, ya sabes, suspira o te mira (de) una manera extraña. Y dentro de nuestra comunidad, comparten entre sí... se corre la voz... y si eso llega a la comunidad, ya sabes... ya no existe una confianza ahí». *— Participante del grupo de enfoque*

La comunidad mixteca e hispanohablante identificó las barreras lingüísticas y la dificultad para navegar el sistema de salud en todos los grupos focales. Se estiman hasta 25,000 personas de la comunidad mexicana indígena que forma parte de la comunidad y aproximadamente 20% de ellos habla un ingles menos «fluido».

Además de las comunidades mixtecas e hispanohablantes mencionadas anteriormente, los miembros de la comunidad de adultos mayores, negra, sin vivienda y veteranos también comentaron las dificultades para navegar por el complejo sistema de salud. Como dijo una enfermera en la encuesta *Pathways to Excellence*:

«Los pacientes se pierden en el sistema. Yo me pierdo en el sistema». *— Enfermera*

Prioridad 3: Condiciones de vida insatisfechas, como el transporte, las finanzas, la vivienda (incluida la población sin vivienda), la educación, el medioambiente y el cuidado de los niños.

El marco de Condiciones vitales tiene sus raíces en la comunidad y se centra en los elementos de «pertenencia y fuerza cívica». La capacidad de participación cívica y las soluciones locales y autónomas son fundamentales para abordar las necesidades locales.

Las condiciones vitales insatisfechas o el acceso a las necesidades básicas se han corroborado a través de multitud de datos secundarios, la encuesta de enfermeras y los grupos focales. El acceso a las necesidades básicas se mencionó en 13 de los 17 grupos focales, siendo las finanzas y el transporte las mayores dificultades. Los deseos educativos para ellos se mencionaron durante los grupos focales de jóvenes, mixtecos, y los grupos de Promotores hispanohablantes. La comunidad

tiene casi 28,000 personas que viven por debajo de la pobreza y 32,931 residentes sin un título de escuela secundaria.

Prioridad 4: Acceso a una mejor salud conductual, incluyendo el tratamiento de los trastornos por consumo de sustancias y la navegación de los servicios con un énfasis especial en la población sin vivienda.

La salud conductual se identificó constantemente como una necesidad a la que se enfrentaba la comunidad durante los grupos focales. Los miembros de la comunidad y los proveedores médicos expresaron durante los grupos focales el deseo y la necesidad de realizar más esfuerzos para abordar de forma competente los traumas subyacentes, las experiencias de vida y los factores de estrés que influyen en la salud y el bienestar. Como se comentó en el grupo de enfoque de proveedores de servicios para veteranos,

«El tipo que sufrió una sobredosis de fentanilo al día siguiente quería entrar en rehabilitación, y no hay rehabilitación porque no tenemos los recursos. Se le podría haber salvado la vida si hubiera podido entrar en un establecimiento en ese mismo momento, recibir servicios, recibir terapia, conseguir una cama, porque estaba listo el día anterior. Ya sabes, estamos perdiendo gente. Necesitamos más trabajadores sociales, por supuesto, y si pudiéramos contratar a un veterano para el apoyo entre pares en el hospital, sería increíble». — *Proveedor de servicios para veteranos*

V. Recursos potencialmente disponibles para abordar las necesidades

Si bien hay recursos potenciales disponibles para abordar las necesidades de la comunidad, estas necesidades son demasiado grandes para una sola organización. Lograr un impacto sustancial y ascendente requerirá los esfuerzos de colaboración de las organizaciones comunitarias, el gobierno local, los líderes empresariales locales y otras instituciones. La comunidad alberga una gran cantidad de organizaciones, empresas y organizaciones sin fines de lucro que podrían contribuir a este esfuerzo.

Los recursos potencialmente disponibles para abordar las importantes necesidades de salud identificadas incluyen las siguientes organizaciones, centros y programas:

5 Cities Homeless Coalition

Alan Hancock Community College

American Post 534

Boys and Girls Club, Oceano

Boys and Girls Club, Santa Maria

Cal Poly

California Farmworkers Foundation

Community Action Partnership of SLO County

CenCal Health

Center for Family Strengthening

City Net

City of Santa Maria

County of Santa Barbara

County of San Luis Obispo

Cuesta College

Family Service Agency

First 5

Future Leaders of America Inc.

Good Samaritan Shelter

Herencia Indígena

Little House by the Park (Guadalupe Family Resource Center)

Mission Hope Center

Mixteco/Indígena Community Organizing Project (MICOP)

Oasis Senior Center

One Community Action

Pacific Pride

Rescue Mission

San Luis Obispo County and Santa Barbara County Promotores Collaborative

Santa Barbara Foundation

Santa Maria Valley YMCA

Santa Maria Valley Youth and Family Center

United Way

University of California, Santa Barbara

VI. Impacto de las medidas adoptadas desde la anterior ENSC

El informe de la ENSC de 2022 identificó las siguientes necesidades de salud:

1. Logro educativo;
2. Acceso a la atención médica primaria, la salud conductual y la atención bucal; y
3. Promoción y prevención de la salud.

La estrategia de implementación del Hospital French asociada a la ENSC de 2022 informó que el hospital tenía la intención de abordar las tres necesidades de salud prioritarias. Se llevaron a cabo las siguientes actividades para abordar estas importantes necesidades de salud seleccionadas desde la finalización de la ENSC de 2022.

Logro educativo;

- Financió proyectos comunitarios de mejora de la salud, cuyo objetivo es fomentar la educación superior, la alfabetización de adultos y la alfabetización médica.
- El Programa de Tutoría Médica brindó a los estudiantes de secundaria y universidades locales la oportunidad de participar en una rotación que los introdujo en las muchas facetas multidisciplinarias de la medicina.
- El Programa de Educación para Profesionales de la Salud proporcionó un entorno clínico para la formación de pregrado y pasantías para profesionales de la alimentación, técnicos, fisioterapeutas, trabajadores sociales y farmacéuticos. Los estudiantes de enfermería realizan su ronda clínica en el hospital. El Hospital brinda a las universidades comunitarias locales apoyo financiero para abordar aún más los problemas de la fuerza laboral en toda la comunidad, como los programas escolares para carreras de atención médica.
- Proporcionó servicios de interpretación bicultural bilingüe a los departamentos de los hospitales para pacientes que no hablaban inglés. También se proporcionaron servicios de defensa y navegación para personas de habla mixteca para necesidades sociales y básicas.

Acceso a la atención médica primaria, conductual y dental

- Financió proyectos comunitarios de mejora de la salud, cuyo objetivo es fomentar la educación superior, la alfabetización de adultos y la alfabetización médica.
- En colaboración con el Programa de Residencia Familiar del Centro Médico Regional Marian, el Programa de Medicina Callejera proporcionó evaluaciones básicas de salud y

necesidades a personas desprotegidas de la comunidad del Centro Médico del Hospital French.

- El Programa de Autocontrol de Enfermedades Crónicas y el Programa de Educación y Empoderamiento de la Diabetes se ofrecen a los miembros de la comunidad.

- Los Grupos de Apoyo para el Bienestar Conductual brindaron apoyo de salud mental a las familias afectadas por el trastorno perinatal del estado de ánimo y la ansiedad (PMAD, por sus siglas en inglés).

- El Centro de Bienestar Conductual proporcionó un refugio seguro para las personas que experimentaban una crisis de salud mental.

- La Clínica Medical Safe Haven para la Trata de Personas ofrece un espacio seguro donde los proveedores médicos pueden ofrecer una gama completa de servicios de salud para las víctimas y sobrevivientes de la trata de personas.

- El Programa de Prevención y Detección del Cáncer apoyó las necesidades psicosociales y emocionales de los pacientes mediante la herramienta de detección de la angustia. También brindó apoyo financiero a pacientes médicamente subatendidos para el transporte y la terapia genética.

- Trabajadores sociales dedicados ayudaron a los pacientes que presentaban un trastorno por consumo de sustancias a conectarse con los recursos adecuados. También formaba parte del programa un programa de distribución de naloxona.

Promoción y prevención de la salud.

- El Programa de Prevención y Detección del Cáncer apoyó las necesidades psicosociales y emocionales de los pacientes mediante la herramienta de detección de la angustia. Se brindó apoyo financiero a pacientes con carencia de servicios médicos para el transporte y la terapia genética.

- Los grupos de apoyo para el bienestar conductual brindaron apoyo de salud mental a las familias afectadas por el trastorno perinatal del estado de ánimo y la ansiedad (PMAD). También se ofrecieron grupos de apoyo comunitario a los miembros de la comunidad que se han visto afectados por el cáncer, los derrames cerebrales, las enfermedades crónicas y el duelo.

- Se ofreció a la comunidad un Programa de Prevención y Autocontrol de la Diabetes en inglés y español. El programa estuvo acompañado de una clínica fuera del horario laboral que permitió a los participantes acceder a un nutriólogo con licencia y a una enfermera especializada en el control de la diabetes.

- Se impartió educación culturalmente apropiada a las mujeres indígenas durante el embarazo.

- Se proporcionaron servicios de interpretación bicultural bilingüe a los departamentos de los hospitales para pacientes que no hablaban inglés. También se proporcionaron servicios de defensa y navegación para personas de habla mixteca para necesidades sociales y básicas.

- Se proporcionó el Programa de Prevención y Autocontrol de Enfermedades Crónicas y el Programa de Educación y Empoderamiento de la Diabetes a los miembros de la comunidad.

Subvenciones para la mejora de la salud comunitaria

Una forma fundamental en que el Hospital ayuda a abordar las necesidades de salud de la comunidad es mediante la concesión de subvenciones financieras a organizaciones sin fines de lucro que trabajan juntas para mejorar el estado de salud y la calidad de vida. Los fondos de las subvenciones se utilizan para prestar servicios y fortalecer los sistemas de servicios, con el fin de mejorar la salud y el bienestar de las poblaciones vulnerables y desatendidas en relación con las prioridades de la ENSC. La Tabla 10 muestra las organizaciones que el Hospital ha apoyado para ayudar a abordar las necesidades de salud de la comunidad en los últimos años.

Tabla 10. Beneficiarios de subvenciones para la comunidad hospitalaria

Beneficiario principal de la subvención	Nombre del proyecto	2023	2024	2025
Good Samaritan	Santa Maria Stabilization Center	$100,000	$50,000	
Family Service Agency of Santa Barbara County	Apoyo para adultos mayores y cuidadores	$68,172		
Los Osos Cares, Inc.	Necesidades y recursos básicos para adultos mayores y personas vulnerables	$40,000		
SLO Noor Foundation	Acceso a la atención dental y expansión del servicio para personas sin seguro o con seguro insuficiente	$19,701		
Future Leaders of America Inc.	Proyecto de liderazgo y educación juvenil	$25,000		
Community Action Partnership of San Luis Obispo County, Inc	Conexión de 5 ciudades para las personas sin vivienda (*5 Cities Connection for People Experiencing Homelessness*)	$50,000		
805 Street Outreach	805 Street Outreach		$50,000	

Beneficiario principal de la subvención	Nombre del proyecto	2023	2024	2025
Community Environmental Council	Minimizar los impactos en la salud de la comunidad derivados de la contaminación del aire, la exposición a pesticidas y el calor extremo en Guadalupe y el valle de Santa María		$24,496	
Community Counseling Center	Grief Awareness Treatment and Education Project , GRATE		$50,000	
Good Samaritan	San Luis Obispo Sobering Center and Recuperative Care Housing Program		$50,000	$78,000
Lumina Alliance	Atención médica integral para sobrevivientes de agresión sexual y violencia de pareja íntima en la zona rural del Condado de San Luis Obispo		$50,000	
One Community Action	Proyecto de Salud Mental para Jóvenes: ¡Mi VIDA y POR VIDA!		$50,000	$78,000
Santa Barbara Foodbank	Programa de Prescripción de Alimentos		$50,000	
The Cecilia Fund	Programa de Salud Dental para Pacientes con Cáncer		$50,000	$78,000
The Salvation Army	El Programa de Alcance en las Calles: Condado de SLO		$50,000	
Five Cities Meals on Wheels	Inseguridad alimentaria en adultos mayores confinados en casa			$78,000
Hearts Aligned Inc.	Servicios integrales para niños gravemente enfermos			$78,000
One Cool Earth	Programa de Nutrición de Huertos Escolares			$78,000
	Total:	$302,873	$424,496*	$468,000*

*En los años fiscales de 2024 y 2025, el Hospital otorgó subvenciones en conjunto con el Centro Médico del Hospital French

Appendices

2025 CHNA
Marian Regional Medical Center & Arroyo Grande Community Hospital

Appendix A

U.S. Census Demographic Data

Table A-1. Hospital Community Served U.S. Census Data

U.S. Census Data	Arroyo Grande 93420	Grover Beach 93433	Nipomo 93444	Oceano 93445	Pismo Beach 93449	Arroyo Grande Community Hospital	San Luis Obispo County
Total Population (2019-2023)	32,016	12,684	21,495	6,812	8,024	81,031	281,486
Under 18 years	21.2%	20.1%	20.7%	21.3%	10.9%	11.5%	17.6%
65+	26.2%	17.7%	25.1%	26.2%	32.0%	14.8%	21.5%
Median age (years)	45.4	40.5	44.3	46.6	56	45.49	40.2
HISPANIC OR LATINO AND RACE							
Hispanic or Latino origin (of any race)	17.4%	37.9%	44.1%	43.6%	11.7%	29.4%	24.5%
White alone, not Hispanic or Latino	70.8%	55.1%	48.0%	50.7%	79.0%	61.4%	65.4%
Black or African American alone	0.7%	1.0%	1.2%	1.1%	0.9%	0.9%	1.1%
American Indian and Alaska Native alone	0.2%	0.1%	0.2%	0.0%	0.1%	0.1%	0.2%
Asian alone	3.3%	2.1%	3.1%	0.9%	3.1%	2.8%	3.4%
Native Hawaiian and Other Pacific Islander	0.0%	0.4%	0.3%	0.0%	2.1%	0.4%	0.2%
Some other race	0.4%	0.5%	0.3%	0.0%	0.5%	0.4%	0.6%
Two or more races	7.2%	2.8%	2.7%	3.8%	2.5%	4.6%	4.6%
LANGUAGE SPOKEN AT HOME AND ABILITY TO SPEAK ENGLISH							
Population 5 years and over	30,108	12,119	20,356	6,407	7,825	76,815	269,109
Speak language other than English	8.7%	28.1%	25.9%	29.5%	9.9%	18.2%	17.2%
Speak English "very well"	5.9%	14.9%	15.9%	15.7%	7.9%	92.8%	11.4%
Speak English less than "very well"	2.8%	13.2%	10.1%	13.8%	2.1%	7.2%	5.8%
EDUCATION ATTAINMENT							
Less than high school graduate	5.0%	16.9%	12.8%	21.1%	2.4%	9.9%	8.2%
High school graduate(includes equivalency)	17.9%	26.8%	19.3%	20.7%	14.1%	19.5%	18.2%
Some college or associates degree	33.4%	29.5%	33.6%	40.3%	33.4%	33.4%	34.4%
Bachelor's degree	28.3%	15.3%	20.1%	13.0%	29.3%	23.0%	24.3%
Graduate or professional degree	15.4%	11.6%	14.2%	4.9%	20.8%	14.2%	14.9%
Median income (dollars)	48,835	39,861	45,461	33,951	59,677	X	40,720
POVERTY STATUS IN THE PAST 12 MONTHS							
Below 100 percent of the poverty level	7.5%	12.7%	5.3%	17.1%	8.1%	8.6%	12.8%
100 to 149 percent of the poverty level	4.3%	8.0%	3.5%	7.1%	4.9%	5.0%	5.5%

Table A-1. Hospital Community Served U.S. Census Data

U.S. Census Data	Guadalupe	Santa Maria		Santa Maria & Orcutt	Marian Regional Medical Center	Santa Barbara County
	93434	93454	93458	93455		
Total Population (2019-2023)	8,451	41,710	59,126	44,350	153,637	443,975
Under 18 years	37.9%	29.9%	33.8%	23.5%	30.0%	22.4%
65+	8.0%	13.8%	8.4%	19.1%	12.9%	16.2%
Median age (years)	28.4	32.2	27.7	39.3	32.3	34.5
HISPANIC OR LATINO AND RACE						
Hispanic or Latino origin (of any race)	88.6%	73.4%	86.9%	41.1%	70.1%	47.6%
White alone, not Hispanic or Latino	7.5%	19.6%	7.9%	46.8%	22.3%	41.5%
Black or African American alone	0.0%	1.0%	0.5%	1.6%	0.9%	1.5%
American Indian and Alaska Native alone	0.0%	0.3%	0.1%	0.5%	0.2%	0.2%
Asian alone	2.7%	2.9%	4.0%	5.0%	3.9%	5.1%
Native Hawaiian and Other Pacific Islander	0.0%	0.0%	0.0%	0.1%	0.0%	0.1%
Some other race	0.0%	0.0%	0.0%	0.2%	0.1%	0.4%
Two or more races	1.2%	2.8%	0.6%	4.7%	2.4%	3.5%
LANGUAGE SPOKEN AT HOME AND ABILITY TO SPEAK ENGLISH						
Population 5 years and over	7,421	38,419	53,161	41,748	140,749	417,026
Speak language other than English	70.7%	56.9%	78.7%	27.1%	57.0%	40.0%
Speak English "very well"	38.0%	32.1%	38.4%	18.9%	73.8%	23.8%
Speak English less than "very well"	32.8%	24.8%	40.3%	8.2%	26.2%	16.2%
EDUCATION ATTAINMENT						
Less than high school graduate	42.7%	26.0%	50.1%	10.6%	30.2%	17.9%
High school graduate(includes equivalency)	19.7%	23.2%	20.8%	19.3%	20.9%	16.9%
Some college or associates degree	26.0%	32.9%	19.9%	38.5%	29.9%	29.4%
Bachelor's degree	7.5%	13.0%	7.2%	20.4%	13.1%	21.6%
Graduate or professional degree	4.2%	4.8%	2.0%	11.2%	5.9%	14.2%
Median income (dollars)	30,838	33,259	28,954	48,256	X	38,787
POVERTY STATUS IN THE PAST 12 MONTHS						
Below 100 percent of the poverty level	28.2%	13.9%	17.9%	7.2%	14.3%	13.8%
100 to 149 percent of the poverty level	10.1%	13.1%	15.6%	6.2%	11.9%	8.9%

Appendix B

Focus Groups, Vulnerable Population Methodology

Focus Group Script

The goal of the focus group program was to capture input at the community and individual level and hear the voices of the underserved, with the intent of better understanding the barriers they must overcome to access care. A focus group script was developed in collaboration with Dignity Health. Once the script was formalized, it was translated into Spanish and prepared to be delivered in Mixteco. The focus group script was also accompanied by an informed consent form that was approved by Dignity Health compliance. Following the finalization of the focus group script, all focus group facilitators attended a training and practice session in the Spring of 2024. An English copy of the final focus group script follows.

Focus Group Facilitation

[Note to facilitator: Running an effective focus group is a skill and requires planning. Please review prior to facilitating the focus group Tips for Facilitating Focus Groups attached.]

I am so happy you are here and I am very excited that you are willing to help us with our Community Health Needs Assessment. Thank you for coming – we appreciate your time. My name is [Insert Name] and I am a [Insert Position] that works for Marian Regional Medical Center.

You have been asked to come here today to share your thoughts about the health of the community and your own health. The information you share can be something you have seen or experienced and will be used for our Community Health Needs Assessment.

The hospital prepares a Community Health Needs Assessment every three years. Our hope is the information you share will help us better the overall community health in mind, body, and spirit. The last time we prepared a Community Health Needs Assessment, the greatest needs facing the community were:

- Educational attainment
- Access to primary health care, behavioral health care, and oral health; and
- Health promotion and prevention.

Only you will know that you were part of this group. Your name will remain confidential and anonymous.

This focus group will be audiotaped so that we can listen to you and focus on our discussion and summarize the discussion later. Although the discussion will be taped, your input will remain confidential. Once the audio is summarized, there will not be any information to link individuals back to statements made during the session and the recording will be deleted. If there are any

questions or discussions that you do not wish to answer or participate in, you do not have to answer. I am encouraging you to be as involved as possible.

If you are in-person say: "Before we start, each participant must complete a consent form to participate in the focus group. Please print your name and age at the top of the consent document and then sign your name at the end if you agree to participate. I will collect the consent forms before we begin."

If your focus group is virtual, say: "This focus group will be recorded and the recording will be used by our team to summarize our conversation. When I press the record button you will see an alert on your screen. If you press "yes" to agree to being recorded you are also providing your consent to participate in the focus group."

Before we begin I would like to go over a few basic ground rules for our discussion:

- Participation in this discussion is voluntary.
- There are no right or wrong answers.
- Please respect the opinions and experiences of others even if you disagree.
- If you feel uneasy about a topic you do not have to respond.
- Speak as openly as you feel comfortable.
- Help protect others' privacy by not discussing details outside the group.

If your focus group is virtual, say: "As a reminder you have pressed the ok button to give consent to be recorded and participate in the focus group. Thank you and now we are ready to begin."

Focus Group Questions

1. What do you think is impacting the health of your community the most?
    a. [Can you please explain more? Be curious and seek to fully understand. Follow-up based on the responses, how, where, when?]
2. Do you get care when you need it?
    a. How do you do it? Do you go to the clinic, natural healer, ER, family member?
    b. Why not?
    c. What have you heard from people that keeps you from going?

3. When you come into a doctor's office or hospital do you feel you belong?
    a. Why not?
4. [Trust] If you are given instructions by a healthcare provider do you follow the plan of care? Please explain.
5. In your opinion what does a healthy community in mind, body, and spirit look like to you? [Stress youth, elderly, young families]
6. In your opinion, what can we do to help you?

Optional Youth Questions for Specific Groups:

1. What do you view as the most important youth health need in our community?
2. What would you say is the most important thing that can be done to improve child health in our community?
3. What is the greatest barrier to child wellness in our community?

Conclusion

Thank you very much for participating. Once again, your input will be used to prepare our Community Health Needs Assessment. This report will be available in June of 2025.

Focus Group Facilitation

Overall, 17 different focus groups were facilitated with 117 participants across the Dignity Health California Central Coast communities by the Dignity Health team between June 5 to July 25, 2024 either virtually or in-person. Dignity Health conducted the outreach to community partners and staff to identify potential focus group participants. Focus groups were conducted in English, Spanish, or Mixteco, and focus group participants ranged in age from teens to seniors. Focus groups were held with vulnerable community members and individuals affiliated with a service provider or community-based organization that serves vulnerable populations. The vulnerable community members represented during the focus group process included the following: LGBTQ+, Black community, seniors, unhoused adults, youth, veterans, and individuals whose primary language is Spanish or Mixteco. Each focus group participant (excluding service providers and community-based organizations) received a $30 gift card as a token of appreciation. The following Table B-1 provides specific details related to each focus group.

Table B-1. Dignity Health California Central Coast Hospitals' Focus Group Details

Focus Group Target Population	Date	Language
Black community (NAACP)	7/25/2024	English
Farmworkers (male) from Paso Robles, CA	6/18/2024	Mixteco
Farmworkers (male) from Santa Maria, CA	6/19/2024	Mixteco
Herencia Indígena Mixteco interpreters (two sessions)	6/10/2024 & 7/1/2024	English and Spanish
Homeless service providers	6/18/2024	English
Members of LGBTQ+ Community	6/27/2024	English
Mixteco Mothers	6/7/2024	Mixteco
Mothers, including female farmworkers from Santa Maria, CA	6/11/2024	Spanish and Mixteco
Promotora's from Santa Barbara and San Luis Obispo Counties	7/17/2024	Spanish
Senior Center in Paso Robles, CA	6/11/2024	English
Seniors from Santa Maria, CA	6/10/2024	English
Veterans	6/5/2024	English
Veterans Service Providers	6/13/2024	English
Youth (teens) from Paso Robles, CA	6/11/2024	English
Youth (teens) from Santa Maria, CA	7/10/2024	English
Youth service providers	6/6/2024	English

Focus Group Qualitative Data Analysis

All focus groups were recorded by Dignity Health and shared with Ganey Science for analysis. Each recording was transcribed, and if needed, the non-English language recordings were translated. All transcriptions were reviewed for accuracy. Each focus group was listened to, and a summary was prepared for inclusion in the CHNA. The transcriptions and summaries were analyzed using qualitative analysis software, including Nvivo and ATLAS.ti. Using ATLAS.ti, the transcriptions and summaries were phrases that were coded and analyzed thematically. The frequency with which a topic was discussed across the focus groups was used to determine key themes and conclusions.

The following Tables B-2 to B-7 provides the highest frequency codes and a summary of responses for each focus group question by demographic. Certain questions are best analyzed by providing quotes, as shown in the tables. Summaries of each focus group are provided in Appendix C.

Table B-2. Q1. “What do you think is impacting the health of your community the most?” Responses by Demographic

Black Community	LGBTQ+	Limited English Proficiency	Seniors	Unhoused & Veterans	Youth
Language Barriers	Access to care: Communication Issues	Access to care, insurance	Access to care, insurance, geographical barriers	Access to care	Cultural Competency
Cultural Competency	Cultural Competency	Language Barriers	Behavioral Health, anxiety, stress, and loneliness	Behavioral Health, Trauma, Anxiety, stress, and loneliness	Behavioral Health
Behavioral Health	Stigma	Cultural Competency	Time constraints	Basic needs, finances	Access to care insurance
Social disparities	Values	Behavioral Health, Trauma	Housing	Substance use disorder	Finances
Stigma & Being Invisible		Transportation	Health literacy	Housing	Substance use disorder

Table B-3. Q2. “Do you get care when you need it? How do you do it? Why not?” Responses by Demographic

Black Community	LGBTQ+	Limited English Proficiency	Seniors	Unhoused & Veterans	Youth
No	No	80% said No, only in an emergency	Not always	Yes, but difficult	Yes
Why not? Service Access Issues – Negative Experience Cultural Competency Stigma Trust issues	Why not? Service Access Issues – Negative Experience Cultural Competency Access to care, communication issues Stigma	Why not? Service Access Issues – Negative Experience, Limited access Navigation Cultural Competency Language Barriers Insurance Finances Transportation	Why not? Navigation Insurance Language Barriers Finances Transportation	Why not? Navigation Insurance Community support	What stops you? Insurance Cultural Competency Language Barriers Finances Transportation

Table B-4. Q3. "When you come into a doctor's office or hospital do you feel you belong? Why not?"
Responses by Demographic

Black Community	LGBTQ+	Limited English Proficiency	Seniors	Unhoused & Veterans	Youth
Yes	No	At times	At times	Not usually	At times
	Why not? Negative Experience Stigma Communication issues Gender identity	Why not? Dismissive healthcare provider Cultural Competency Language Barriers Negative Experience Stigma Feel rushed Trust	Why not? Cultural humility Feel rushed	Why not? Dismissive healthcare provider Cultural Competency Stigma Trust Behavioral health, Trauma	Why not? Dismissive healthcare provider Cultural Competency Language Barriers Negative Experience Feel rushed Finances Transportation Behavioral health

Table B-5. Q4. "If you are given instructions by a healthcare provider do you follow the plan of care? Explain."
Responses by Demographic

Black Community	LGBTQ+	Limited English Proficiency	Seniors	Unhoused & Veterans	Youth
Sometimes	Sometimes	Sometimes	Sometimes. The seniors were dissatisfied with the care they receive.	Not applicable	Sometimes

Table B-6. Q5. “In your opinion what does a healthy community in mind, body, and spirit look like to you?” Responses by Demographic

Black Community	Ample resources for mind, body, and spirit that the community can access.
LGBTQ+	A healthy community is one that is free from stigma and shame. Where any individual can seek and receive the care they need.
Limited English Proficiency	The perfect community would have more interpreters that speak Mixteco and have more housing. Education opportunities for the Mixteco community so they become aware of the resources available. More support for the elderly and youth.
Seniors	A healthy community is one that is well connected and where community members are able to support each other.
Unhoused & Veterans	Affordable and accessible healthcare and livable wages. One that does not have stigma around people being unsheltered or having behavioral health needs. Changing stigma around the community.
Youth	A healthy community is one where children gather and play outside together, green spaces, and a clean environment. Also, one with more mental health services.

Table B-7. Q6. “In your opinion, what can we do to help you?” Responses by Demographic

Black Community	All participants advocated for health equity, where all people can be seen and treated equally within the hospitals, regardless of race and status.
LGBTQ+	Staff and healthcare professionals should take LGBT 101 and be educated on the different forms of gender expression and sexuality.
Limited English Proficiency	The hospital can have more in person interpreters and transportation options. Also navigators that speak Mixteco to help them fill out paperwork, understand billing, and apply for insurance. The hospital could improve the health of the community by having community health workers and promotoras do more outreach.
Seniors	The participants think more community events are needed to build engagement and more senior outreach programs.
Unhoused & Veterans	Make healthcare more affordable.
Youth	The participants believed they need more free/low-cost clinics to improve access to care. They also would like more education about life skills for their future such as financial, career, and college coaching.

Appendix C

Focus Group Summaries

LGBTQ+ Focus Group Summary
June 27, 2024

A focus group was facilitated virtually by with three participants representing the LGBTQ+ community from the Central Coast of California.

1. What is impacting the health of your community the most?

One of the main issues impacting the health of the LGBTQIA+ community is stigma and a lack of awareness of gender identity and sexuality. Multiple participants shared how their healthcare providers will assume they are cisgender or heterosexual and how that is not only invalidating and emotionally hurtful, it negatively impacts the care they receive because providers will not pursue the correct treatment plan.

Another participant agreed that the main issue is the lack of education on gender expression because their providers will assume their gender based on their legal name instead of the preferences they shared when checking in or that had been put in their chart.

2. Do you get healthcare when you need it?

All three participants agreed that they do not receive care when they need it.

One participant shared that mental healthcare is not accessible to them because the intersection of their identities requires a therapist with specialized training or lived experience and finding a therapist that fits their needs requires much more work than it would for a cisgender, heterosexual individual.

Another participant shared that many healthcare providers are not properly educated on what trans bodies look like. When they do receive care, they often have negative experiences with providers believing there is something wrong with their body when it actually is healthy.

3. When you do access care, where do you go?

The participants said that they often talk to friends and family about their health before accessing healthcare.

Another participant shared that when they are sick they have to go to the Emergency Department instead of their primary care provider because the primary care provider cannot see them for two to four weeks and they are too sick to wait that long.

Two of the participants shared how the intersection of being transgender or gender nonconforming and having a mental illness can negatively impact their care. They shared how the symptoms of their mental illness can be dismissed as part of being transgender or that their gender expression can be invalidated by the mental health diagnoses.

4. **When you come into a doctor's office or hospital, do you feel you belong? What is the experience like?**

All of the participants said that they do not feel welcome. One of the participants said that they do not feel welcome because healthcare providers assume they are heterosexual and they dislike always correcting the providers and explaining their situation.

Another participant shared that they often experience gender dysphoria in medical spaces because providers will not use their preferred name even after asking for it. They also said that providers do not ask about or use their preferred pronouns.

5. **If you are given instructions by a healthcare provider, do you follow the plan of care?**

One participant shared that they typically follow their healthcare provider's instructions, but that they have to check for medical interactions because their providers do not check before prescribing them new medications.

Another participant shared that their providers do not listen to their concerns and prescribe them medications they are not willing to take.

6. **What does a healthy community in mind, body, and spirit look like to you?**

A healthy community is one that is free from stigma and shame. Where any individual can seek and receive the care they need.

7. **What can Dignity Health do to help you?**

Staff and healthcare professionals should take LGBTQ+ 101 and be educated on the different forms of gender expression and sexuality.

Gentle curiosity would be another way that healthcare professionals can improve the experiences of LGBT patients. Asking questions in a kind and empathetic way instead of making transgender patients feel like a medical oddity. Changes to systems such as having pronouns on hospital wristbands and in charts and listing preferred/lived names above legal names would improve their community's experience in medical settings.

Recognize that trans patients are diverse and require myriad treatment plans.

Create accountability in the hospital, especially in the teaching hospital, so that healthcare professionals learn from their mistakes and do not pass on harmful practices.

8. **Can you describe the experiences of LGBTQ+ youth accessing healthcare?**

There needs to be improved sexual education that includes all kinds of relationships instead of just heterosexual sex.

Many queer youth cannot access queer, gender affirming care either because they cannot find it or because there are barriers such as parental permission. Many queer youths aren't able to express their true gender identity to their parents so that is a barrier to them receiving care. Many are out at school but not at home and are forced to live a double life.

The participants stressed the importance of believing individuals when they say what they are feeling and if they say they are in pain.

9. What can we do to improve the health of the youth?

The participants shared the value of medical confidentiality from parents for LGBTQ+ youth and the importance of minors being able to talk to their healthcare provider without the presence of a parent.

Another way to improve the health of LGBTQ+ youth is increasing healthcare providers' competency with and awareness of gender identity and expression.

Mixteco Farmworkers of Paso Robles Focus Group
June 18, 2024

A focus group was held with eight participants that spoke Mixteco. One of the focus group facilitators described their emotions as "silence, focus, loneliness, sadness, not very confident, confused, very thoughtful and very brave." They also shared, "I think there was a lot of similarity between the participants and me at that time. When I felt this way: confused, speechless, sad, thoughtful, in short I felt like I had fallen into a canyon slowly waiting for someone to come help me because I didn't know their language."

1. **What is impacting the health of the community or why are we not able to get care?**

One of the participants shared that because they do not speak Spanish or English there is no one who can help them at the clinic or doctor's office. When asked why they do not ask for an interpreter at the clinic or the hospital, the participant replied that they have not gone to either because they ask for a parent to be present.

Another participant answered that they do not access care because they do not qualify for MediCal. When asked if they have tried applying, they replied that there hadn't been anyone to help them in Paso Robles in the past, but now there are translators that can help.

Another barrier that prevents the participants from accessing care is the fear that the care or medications will be too expensive even after MediCal. When the interpreters asked if they had asked for help with the costs because they are unable to afford care, the participants shared that they didn't know where to ask for help or when they tried to call there was no way to communicate because they don't speak Spanish.

Access to transportation is also a barrier to care because many in the Mixteco community do not have cars and they do not know how to use public transportation or how to ask for transportation to their appointments at the clinic.

2. **Do you get care when you need it?**

The participants shared that they often do not access care because they are worried they will not be able to afford the costs after MediCal. If they are sick, they will buy over the counter medicine from the pharmacy or grocery store.

3. **When you come into a doctor's office or hospital do you feel you are welcome? Do they receive you kindly?**

The participants shared that they are sometimes welcomed when there are Mixteco interpreters, but when there are no interpreters they are treated differently because they don't speak Spanish well. They shared that the staff that check them in are the ones that treat them differently and that

they will make rude faces and speak unkindly. One participant shared that because the Mixteco community members work in the field, the healthcare staff think they smell bad and that "they give them a look of disgust" when they come in. Another participant shared that when they call to ask questions the staff on the phone say they have to wait until their appointment to ask questions or that they only speak English.

4. **If you are given instructions by a healthcare provider do you follow the plan of care? Please explain.**

The participants answered that they will take the medications that the provider prescribes them, but that they will stop taking the medication once they feel better because they don't like the medication and think it is too big. They also shared that the medications often do not taste good and will make them feel different. They said their community is used to taking natural remedies such as lemongrass or lemon tea.

Another participant shared that one time they followed the care plan and took the medication, but did not feel better so then they did not return to the hospital even though they were still sick.

5. **In your opinion what does a healthy community in mind, body, and spirit look like to you?**

The participants shared that they would be happy if they lived comfortably and were healthy. They said that a perfect community would have more interpreters that speak Mixteco that can help them. They also said that the community would be better if there were more housing.

6. **In your opinion, what can we do to help you?**

The participants shared that two main ways the hospital can help them is by having more interpreters and transportation options. They said that it is better to have interpreters in person that they can talk to and ask questions. The participants also shared that there is often paperwork that they do not understand how to fill out and that they need assistance with it.

One participant shared that they will try to access care, but because they are a minor the healthcare staff will ask for their parents which prevents them from receiving care.

Another participant asked for hospital staff and providers to just be patient and kind with members of the Mixteco community.

Mixteco Farmworkers of Santa Maria Focus Group
June 27, 2024

1. **What do you think is impacting the health of your community the most? What is the cause that we can't get care or that we are not well here?**

The participants shared that they often will not access care because they cannot afford it. They are unable to ask for help because there are many Mixteco people who do not speak Spanish. In the past the healthcare staff would not ask if they needed a Mixteco interpreter, but now they typically ask. One participant shared that the healthcare providers can tell from their appearance that they are indigenous and do not have papers, so they treat them differently.

2. **When you get sick or your family gets sick, does the hospital help you?**

One participant shared that if it is an urgent health problem, they will go to the Emergency Department and get treated. If they have the flu or get sick, they know what medicines to take. The other participants shared that sometimes the hospital will treat them and sometimes they don't. They often only are helped if there is a Mixteco interpreter present.

3. **When you go to a clinic or office, do they make you feel welcome?**

The participants shared that there are some hospital staff that are friendly and help them, but that there are some staff that say they don't speak Spanish so that they don't have to help them. The participants said that the hospital staff will tell them they have to wait for someone who speaks Spanish and that then they have to wait for a long time, but the participant doesn't "know if it's because they are short of staff who can help us in Spanish or just an excuse not to treat us."

Another participant shared that they think maybe there are not enough staff in Santa Maria because when they went to Arroyo Grande they didn't have to wait as long as they do in Santa Maria.

4. **If you are given instructions by a healthcare provider do you follow the plan of care? Please explain.**

The participants shared that if they are given a prescription or instructions by the doctor then they will follow them.

5. **In your opinion, how can your community here be perfect? If there was everything that you needed?**

The primary need that the participants voiced is more Mixteco interpreters so that there is an interpreter for each of the different variants of Mixteco. The participant said that there are a lot of Oaxaca and Guerrero communities and some people speak Zapotec so there is a need for interpreters that speak the different varieties because sometimes they go to the hospital and they do not understand their interpreter. Another participant shared that it can also be difficult to pick up their prescriptions at the pharmacy because of the language barrier.

6. In your opinion, what can we do to help you?

The participants shared that it would be helpful to have navigators to help them fill out paperwork, understand billing, and to apply for insurance and MediCal. They would need navigators that speak Mixteco or more interpreters to help them understand.

Mixteco Interpreters Focus Group #1
June 10, 2024

The focus group was facilitated participants that serve as Mixteco Interpreters.

1. **What do you think is impacting the health of the population you serve in your community the most?**

The factor that is impacting the health of the community the most is the language barrier. Many agencies and clinics do not offer services in different languages, not just Mixteco but other languages.

Another barrier is the lack of transportation. Some appointments are outside of the area, and it is difficult for community members to get to the appointment if they don't have transportation.

Lack of education and health literacy is another barrier to health. Many members of the community don't understand that educational resources are available. This also occurs in the medical setting, many times Mixteco community members do not know how to navigate in the medical setting.

There is also a lack of resources that negatively impacts the health of the community.

2. **Can you please share how the population you serve accesses care when it is needed? What are the barriers that keep them from accessing care?**

Health care is reserved only for emergencies and many only receive care when it is extremely urgent, since transportation and care are expensive. Family members reach out to other family members and seek natural remedies and do not go to the doctor unless necessary. Transportation and language barrier are additional reasons why they don't seek care.

In their towns they go to their local pharmacy, folk healer, or friend who is knowledgeable about medicinal plants and homemade remedies. Only if they are very sick/urgent do they go to the hospital. Often Mixteco community members don't have Medi-Cal and emergency Medi-Cal only covers some things.

Another participant shared that Mixteco community members will reach out to other family members that had similar symptoms for advice or a natural healer. They go to natural remedies and try not to go to the doctor unless it is absolutely necessary because they can't afford it, they lack transportation and the language barrier. The community uses the clinic and the community health center (CHC).

3. **Do you think community members in the population you serve feel like they belong when they enter the doctor's office or the hospital?**

They do not feel welcome due to the lack of awareness of all the paperwork involved. They do not understand why this is needed.

One participant shared that you don't have to speak the language to see someone's actions, you can tell by their face, if they sigh, or look at you a certain way, you can feel that. No one wants to go back to a place where they weren't treated fairly. The community shares information to one another, and word spreads. If words spread throughout the community about poor treatment the trust is lost.

The language barriers make it extremely hard to feel a sense of belonging because patients of the Mixteco community are often neglected. Without interpreters, this problem does not get any better since there isn't anyone to speak for the Mixteco community. They think twice before going back.

4. **From a patient's or community members perspective, are our facilities welcoming? Please explain.**

A participant shared that it depends on the staff, they have had some good experiences. They try to educate them and help them and give them information on how to get services outside of the hospital. Sometimes, even with the language barriers, doctors will try their best to be patient, but other doctors are dismissive. The connection between patients and doctors is better with an interpreter and leads to more trust. When asked if they have seen advertisements for Spanish/Mixteco interpreters in the clinics, the participants answered not in the clinics, but in the hospital they are recognized as being an interpreter. Mixteco is not a written language, so it is difficult to share that a Mixteco interpreter is available. They could show through pictures or a short 30-minute welcoming video in Mixteco.

5. **What can we do differently to help the population you serve increase access to healthcare?**

The participants shared that there is a need for more Mixteco interpreters that can speak a variety of variants. This will make them feel more comfortable.

They also need more interpreters for Mixteco so that when Mixteco community members are getting discharged, they can make sure they understand the instructions.

The hospital can also increase access to care by ensuring that physicians and nurses understand that maybe there are some traditions and cultural beliefs that do not align with what the physician is ordering.

The hospital can also increase access by assisting with transportation.

6. **In your opinion, what does the healthy community in mind, body, and spirit look like to you?**

Education opportunities for the Mixteco community so they become aware of the resources that are out there. They would tell the Mixteco community how they can get help and where they can get help.

A healthy community would have navigation of paperwork done by a person who is patient and empathetic.

Health professionals would do the proper follow up with the Mixteco community. For example, at the dentist the patients are told what they need but no one will follow up to set up the next appointment.

Participants also shared that a healthy community would have emergency financial resources. They shared that when their community goes to the hospital, gets admitted, and then they are discharged, it may take them weeks or months to recover before they can return to work. They often are not eligible for disability or Family Medical Leave Act and struggle financially. There is a need for more resources outside of the hospital and clinic that can help them financially when they have to take time off of work to recover.

7. If you were to help the population you serve have better health what would you do?

The participants share that they would provide more community resources, fundraisers, and education opportunities, especially educational classes in their language.

They would also show educational videos that are dubbed in multiple Mixteco variants in the waiting area of the hospital lobby and clinics.

They would increase the number of urgent care centers that are open after hours so that Mixteco community members do not have to use the ER.

They would also host a donation drive maybe once or twice a year for car seats, shoes, or other items Mixteco families might need. A donation closet that struggling Mixteco families could access would also improve their health and wellbeing by alleviating the costs of certain items.

Whenever Mixtec community members go to the hospital, they bring their whole family with them. Participants asked for a place for their children to stay while they receive care, since it is hard to keep them contained in a hospital.

8. What do you view as the most important youth health need in our community?

The participants shared that in Mexico the girls go to school and then after school they do housework and help their parents out. When they arrive here, they are not enrolled in school right away and they cannot leave the house by themselves, so they try to look for a job to help their parents.

Another health need of the youth the participants shared was lack of education.

The participants shared that the transition of moving to one place from another takes a toll mentally, but in their culture discussing mental health is taboo. They shared that the youth need

to know that it's ok to feel sad, but there is a lot that isn't discussed. This applies to both youth and adults. The cycle repeats itself.

Families lack empowerment and confidence to give to their children when they arrive. Everything is new and they feel that their dream to have everything for their families is very far to reach.

9. What would you say is the most important thing that could be done to improve youth health in the community?

The participants shared that the main factor that needs to be improved is the lack of attention to the children by the parents due to working.

The community also needs daycare for families when they have a medical appointment, because sometimes people have 4 or 5 kids. Many community members put their health aside because they don't have daycare. Some form of childcare during the appointments would be helpful. Sometimes it's hard to find childcare or they can't leave their child alone. Another participant shared that many parents do not seek health care services because they put the health needs of their children first. If the community health centers had childcare, then parents could go to the doctor without worrying about who will take care of their children.

There is also a need for specialty daycare centers for children with special needs, such as children with autism or special medical needs.

Youth health could also be improved with better access to transportation services. Parents encourage their older children to find work.

Mixteco parents also need to be educated about the laws on arranged marriages. Some families will marry their young daughter to an older man.

10. What is the greatest barrier to child wellness in the community?

The health clinics' current schedules are a barrier to child wellness because the Mixteco community has to work during the day. They need the clinics to be open in the evening or outside of normal work hours.

The health care clinics also need to be ready with interpreters when they schedule appointments with Mixteco speaking families before the Mixteco patients show up. Many show up and for some reason the interpreter is a no show, and they cancel the appointment. This is hard for the family because many miss an entire day of work.

Another barrier to child wellness is the need for resources for families that have lost a family member and for single parent homes. They need support and resources all around, maybe the hospital could form a foundation.

Mixteco Interpreters Focus Group #2
July 1, 2024

The focus group was facilitated virtually with participants that serve as Mixteco Interpreters.

1. **What do you think is impacting the health of the population of the community you serve the most?**

The primary issue impacting the health of the Mixteco community is access to care. Healthcare is inaccessible because of the language barrier and the lack of Mixteco interpreters. Low literacy rates also make it difficult for them to use educational resources to learn how to access care. They are also scared to ask questions that may expose what they don't know.

Another barrier that prevents members of the Mixteco community from accessing care is the lack of transportation. Many families have only one car, which makes it difficult to get to the hospital or to appointments. Although there are services that provide rides, many people in the Mixteco community don't know who to call or find that the services are unreliable and have long wait times.

In addition to this, lack of money and documents make it hard for the community to get representation and care when represented.

Their access to care is also impeded by their low wages. Also they comment that due to family situations that cause lack of productivity at work, sometimes they lose pay in their paychecks. Many work in the field and are paid by the number of boxes they can fill in a day not paid hourly wage.

2. **Can you please share how your community accesses care when they need it? How do they do it? Where do they go? What are some barriers?**

One of the main barriers to accessing care is that the patients do not trust the healthcare providers and often need to bring family with them. Difficulty communicating between patients and healthcare providers is also a barrier because they speak different languages.

3. **Do your community members feel like they belong when they enter the hospital or the doctors office? Do they feel welcome?**

The Mixteco community members do not feel welcome in the hospital and they do not trust the hospital staff. One interpreter shared how their family member went to the hospital after work and that the staff made a face and asked them why they smelled so much. The family member was offended and thought it obvious that they just came from work. This experience stayed with the family member and always goes home and changes before their appointments. Another interpreter shared that the Mixteco patients do not feel welcome because of the long wait times and the poor communication across the language barrier. One interpreter described how their patients could

hear the healthcare staff laughing and felt as though they were making fun of them. The interpreters describe how they build relationships and trust with the Mixteco patients in order to communicate their concerns to the healthcare providers, and they said the providers need to be more compassionate to build trust with patients.

4. **[Trust] Do you think your community, as in the interpreters, feels comfortable? Do the hospital staff feel comfortable? Do they feel love?**

The interpreters explained the difficulty of their role and how the healthcare providers can make them feel uncomfortable. They shared how once they start talking to a patient that speaks Mixtec, the patient will have many questions and will want to talk to the interpreter for a long time. The providers often become frustrated with how long it takes the interpreters to communicate what the patient has said or asked and will ask why it is taking so long or try to tell the interpreters what to say.

5. **In your opinion, what can we do to help you? If you had a solution, how could we change?**

Staff needs to be more sensitive and understand that the interpreter's way of interpreting in a situation is not quick and easy. They need to understand that the way they explain a procedure or an order there might not be a word in Mixteco so the interpreter needs to think and try to communicate in words and phrases that the patient will understand. The interpreters are aware that the nursing staff are very busy and want to finish quickly and attend to the next patient but this is not always easy to do. We need more communication and visual aids when educating our patients so that they are more well informed. We need more communication among all team members that are taking care of these patients.

Staff need to be more patient and not show that they are being impatient by their body language.

6. **In your opinion what does a healthy community in mind, body, and spirit look like to you?**

They want there to be more interpreters so that they could take more time with each patient.

They also said that a healthy community would have more support for the elderly and the youth. There should be educational resources that help young people with college.

Another interpreter also shared that they believed there should be more mental health awareness for the Mixtec community because community members are suffering from traumas, such as domestic violence or losing family members. They explained how it is taboo in their community to talk about depression and that there ought to be resources in their language so that "*they can know that it is okay to feel that way and that there is help out there*."

Mixteco-Speaking Mothers Focus Group
June 7, 2024

1. **What is your experience like when you go to the hospital or a clinic?**

One participant shared that when they try to access care they wonder whether or not they will receive help because sometimes it is full and they aren't let in.

Another participant shared that when she went to her provider she had to wait an hour or more to be seen even though she had an appointment. She said the healthcare providers would tell her everything was normal despite her not feeling well. She said she wanted them to tell her why she felt the way she did so she could understand. Another participant agreed that they have to wait a long time to be seen and then even longer for them to find an interpreter who speaks Mixteco. Another woman shared her experiences of the healthcare providers not understanding that she does not speak Spanish and getting frustrated with her not telling them what is wrong.

2. **Do you get care when you need it?**

One participant shared that when they go to a healthcare provider because they have a cold or a fever they are told that it's normal and they should just take Tylenol.

When asked where they will go if they or their family get sick, the participants answered that they go to the hospital. They then clarified that they will try to use natural remedies first if their children are sick and then go to the hospital as a last resort. Unless it is a serious injury or emergency, then they will go straight to the hospital.

A different participant said that they don't feel comfortable going back to the hospital because they aren't treated well there. Multiple participants said that the nurses are rude to them and that they are left waiting without being told what is going on.

3. **When you go to the hospital and the doctor or nurse tells you what to do and what not to do, do you listen and do what they tell you?**

One participant said that they will follow the care plan because they want their child to get better, but sometimes they don't get better and they return to home remedies. The participants also said it is sometimes difficult for them to understand what the healthcare providers are doing.

4. **What would a perfect healthcare setting look like? How would you improve things?**

The participants shared that they would like there to be interpreters that speak Mixteco in the office because many people in the Mixteco community do not speak Spanish. They also brought up that they need transportation services. Another participant said that there are enough interpreters at the hospital, but that there aren't enough healthcare providers. They feel like they are rushed and not able to ask any questions because the doctors are moving too fast.

5. What can the hospital and healthcare providers do to help your community?

The participants shared that they want the hospital to decrease the waiting times, to increase the availability of interpreters, and to improve communication between interpreters and patients because sometimes the interpreters speak a different variant of Mixteco and the patients still do not understand what is going on even with the Mixteco interpreter.

Spanish-Speaking Mothers Focus Group
June 11, 2024

A focus group was conducted with women that belong to a support group for mothers of children with severe respiratory illnesses.

1. What do you think is impacting the health of our community the most?

One participant shared that she believes poor eating habits and lack of exercise are impacting the community. Multiple participants share that the chemicals used in agriculture are affecting the health of the community.

Another participant shared that the community's health is impacted by the use of tobacco, cigarettes, alcohol, and marijuana.

Another participant answered that the combination of low wages and rising prices of rent and groceries has been a barrier to health for her family and her community. She shared that the financial instability causes stress and depression because they know that their wages are not enough to support their family.

2. Can you share how your community accesses care when they need it? Where do you go? What are the barriers?

Multiple participants shared that if there is an emergency they will go to the hospital or if there is not enough time then they will go to an emergency clinic. They also shared that they will make an appointment with their primary care providers. When asked if they always receive care when they need it, a participant shared that sometimes it is so busy they will ask her to wait a day or a few days.

3. What are the barriers to accessing care?

One participant shared that she often feels that healthcare providers dismiss her concerns and symptoms as being just the result of her chronic illness.

Another participant shared that there are not enough clinics in Santa Maria because when her husband was looking for a primary care provider they told her that the clinics are full and not accepting any more patients. They told him to go to Arroyo Grande to find a provider. Another participant shared a similar experience. She said when she called her son's pediatrician's office and they said there were no appointments available, but when she mentioned that her son's doctor was a specialist then there was an appointment available for them. Another participant shared that the clinics are dismissive of her son needing an appointment for his cold until they find out he has problems with his lungs and sees a specialist for them.

Another barrier that the participants shared is that they have to wait longer than English-speaking patients when they go to the Emergency Department because they need an interpreter.

The participants also shared that it is difficult for their children to access the specialty care they need because there are not enough specialists in Santa Maria and they have to travel long distances to see a specialist.

Two participants shared stories about their children not receiving quality care in Santa Maria. The first woman said that when she brought her son to have his blood drawn in Santa Maria, they tried many times but could not get a vein. But when they went to Madera, they were able to draw his blood. The other participant shared how her son was kept in the hospital overnight for observation with a saline drip, but the saline started to come out of his arm and caused his arm to swell. When she called for the nurses to tell them what was happening, they were rude to her. She felt they did more harm than help him.

4. When you go to the hospital or clinic, do you feel welcome?

The participants shared many different experiences in which they did not feel welcome or that they were treated differently by the hospital staff.

One of the participants shared her difficult experiences at the hospital. One time she had an accident and couldn't walk, but the nurse told her she had to get up and walk if she wanted to go home to her family. She was also treated unkindly by the nurses after she had given birth and her child was in the NICU. She said it felt like it was her own people who were discriminating against her.

Another participant shared that her son was having difficulty breathing so they had to give him a tracheotomy, but he wasn't improving so they air lifted him to the hospital in Madera. When he arrived in Madera, the nurses were upset and informed the participant that they could sue the hospital in Santa Maria for malpractice because they were administering oxygen to her son through his nose even though the tracheotomy meant he was not breathing through his nose. The participant reiterated that there is a need for specialists in Santa Maria because there are many ill children not receiving adequate care. She had another bad experience with her son not receiving good care in the NICU. She also shared that she thinks that the nurses are not there to help patients, but are there for the money. They don't trust the hospital and don't want to go back because she believes she won't receive quality care.

A different participant shared that she thinks the clinics' waiting rooms are welcoming and relaxing such that she often even feels sleepy while sitting there.

5. If your doctor gives you instructions, do you follow the care plan?

A participant shared that if the doctor tells them to take a certain amount of a medication then they will follow their advice because they know the doctors studied to learn what doses different patients need.

6. In your opinion what is a healthy community, in body, mind, and spirit?

A community that has many programs of support and that has different religious groups, parks, and games for children.

7. What can we do to support you? What should the hospital do to help you or the community?

The first way the hospital could improve the community's health that the participants shared is increasing the capacity of healthcare providers and bringing in more specialists.

The second way they shared that the hospital can improve their access to care is for the hospital staff to have better cultural competency and communication with their Spanish-speaking patients. The participants shared stories of the nurses becoming angry or rude when they tried to communicate with them or because they had brought their children with them to the hospital. Another participant also shared that there is a need for more interpreters.

8. What is the most important thing that can be done to improve the health of the youth in our community? What is the biggest barrier to child welfare in our community?

One participant shared that she believes the greatest barrier to youth health is the lack of specialists in their community because in order to access specialty care they have to travel long distances, such as to Los Angeles or Palo Alto.

Another participant shared that in their community it is the different cultural practices that are a barrier to youth care because many of the immigrant families will use homemade medicines instead of going to a healthcare provider.

National Association for the Advancement of Colored People (NAACP) Focus Group
July 25, 2024

The focus group was facilitated virtually with community members recruited by the NAACP.

1. **What do you think is impacting the health of your community the most right now?**

Community members identified the health concerns of blood pressure, hypertension, stress, depression and diabetes.

Racism. The Black population is so small, they are erased and if your numbers are not high enough you are not called upon. Most times people do not see the person, they see the color of their skin. If you don't see "me," you don't see my needs.

Cultural competency of healthcare providers. "Do you value what I am saying or is it dismissed because you have so much education you're not willing to listen to me? I think they just don't see us." A participant reported they can tell a medical provider they are having a problem but they don't see it as a problem for the Black person. One participant shared a concern about a medicine that has been known to affect black populations differently than others. The provider dismissed the concern and the participant felt unheard and disrespected.

2. **Why is it so hard for the Black community, the African American community, to access care when needed? What are the barriers?**

The community is paranoid and has mistrust. They don't go – they call someone and complain.

They feel accessing care comes with a lot of microaggressions and prejudice. Doctors can take generalizations from their perceived version of the black community and use it to indirectly attack the black patient. For example, one focus group member, who does not smoke marijuana, was pressured by the doctor since they believed them to be a smoker. The participants felt like their time in the hospital was being wasted by irrelevant questions that were based on prejudice and misinformation.

There is a lack of an effective, intentional outreach program to bring people into the healthcare system. They called for a concerted effort to advocate for the underserved community to take charge of their health and meet them on the street.

One participant pointed out there is no such thing as a monolithic black community. Folks are from different regions and different educational levels, and it's a mistake to reach out to the "Black community." Regardless of your educational level, it can be challenging to navigate through the healthcare system and many people will suffer in silence. There is a lack of providers and it takes a long time to get an appointment. Some folks have retired from good jobs with great benefits and

others working in the gig economy without benefits. "Reach people where they are at and take blinders off related to race/ethnicity."

3. **When you come into a doctor's office or hospital, even one of our facilities, do you think they feel welcome?**

Yes, one participant shared a good experience at Arroyo Grande Emergency Department. There is a difference between Marian Regional Medical Center and Arroyo Grande.

The Emergency Department waiting room exposes folks to situations they would rather not witness. One participant had a good experience at Marian ED. The ED at Marian is like the doctor's office and not used for emergencies. Perhaps have more places where people can go for non-emergencies.

4. **[Trust] If you are given instructions by a healthcare provider do you follow the plan of care? Please explain.**

Mixed answers. One member of the focus group recalled getting adequate care, but having to be transported to three different hospitals to receive it. One participant mentioned that a doctor told them to stop taking a medication that was helping them out, to which the participant did not listen and continued to get better taking the medication. One other participant mentioned that they were having an "adversarial relationship" with a doctor; they preferred taking natural remedies rather than the prescribed medication that did not work.

5. **In your opinion what does a healthy community in mind, body, and spirit look like to you?**

A community that has ample resources for mind, body, and spirit that the community is able to access. We need more resources so everyone can adequately access them. One participant mentioned having a "one stop shop," where their local community can get everything they need within close proximity of home, because a lot of needs are spread out and require hours of transportation.

Another participant mentioned that the community needs better education of health and service that are available to them to maintain optimal health.

White people have the highest rate of cancer yet black people die twice as often. It was suggested that Dignity Health work with different agencies and establish measures that advance health equity such as promoting early cancer detection/screening. The Black community also has a high infant mortality rate.

6. **In your opinion, what can we do to help you?**

All participants advocated for "health equity," where all people can be seen and treated equally within the hospitals, regardless of race and status. Some participants believe the Emergency

Department is too stressful, so a restructured, more affirming hospital would allow the burden of stress to be lifted from those receiving care.

The medical profession should do more to help the Black community and other communities - don't forget the Black community. As one participant said, "Dignity Health has a responsibility to do better and do more - we need someone to walk beside us and with us as we try to save our community from being extinct."

Promotoras Focus Group
July 17, 2024

This focus group was conducted with a group of promotoras (community health workers) that work with Spanish-speaking members of the community.

1. What do you think is impacting the health of your community the most?

The promotoras shared that the greatest factor impacting the health of their community is socioeconomic status. The cost of living in the area is greater than the families' income and the economic struggle affects the health of their children because of the increase of drug use, violence, and gang involvement. Because of the high cost of rent, many families will live together in the same house which creates environments of neglect and abuse. Many of the youth in the community have PTSD or have had traumatic experiences such as sexual abuse and there are not enough behavioral and mental health resources to care for them. Not only do youth struggle with mental health, but the mental health of parents is negatively impacted too by not being able to provide for their children.

The participants also shared that there is a lack of educational resources in the community for people who are no longer in school. There is a need for educational resources in the evening for people who work during the day.

2. Do you get care when you need it?

The promotoras shared that the community that they work with does not believe in preventive care and will not access care until they have serious symptoms. Most community members will go to urgent care when sick or the Emergency Department if it is urgent. There are many people in the community that use traditional medicine and home remedies or use over the counter medications from pharmacies. There are also Mexican stores and botanicas that offer unregulated treatments for pain and illness. The community members that rely on traditional remedies often do not know they can apply for Medi-Cal, so there is a need for educational outreach.

3. What are the barriers that prevent people from going to the doctor when they are sick?

The primary barrier that prevents community members from accessing care is the cost of care. Many of the community members will avoid accessing care until it is an emergency because they are unable to afford any medical bills. These community members also often do not have Medi-Cal and lack the education on what insurance is available to them or how to enroll.

4. When you come into a doctor's office or hospital do you feel welcome?

The promotoras shared that there is a cultural misunderstanding by some members of the Spanish-speaking community. The Spanish-speaking community members believe the hospital is doing

them a favor by providing care since they are not paying for their care directly. These patients feel uncomfortable speaking up when the care is poor or not working.

There are also patients that avoid accessing care because they are afraid of what illnesses or conditions they may have and so they feel better not knowing what might be wrong.

One participant shared that sometimes there are healthcare providers or staff that speak Spanish, but the kind of Spanish they have learned is different from the Spanish that the patients in the community speak. So this barrier of understanding and confusion contributes to the patients not feeling comfortable or welcome.

Another particpant shared that the doctors will sometimes only spend 15 minutes with a patient after they have waited for over 30 minutes in the waiting room and for a few weeks or even a month for the appointment. The community members do not feel welcome because the healthcare providers do not take the time to make a personal connection with their patients.

5. In your opinion, what can we do to help you?

The promotoras shared that the hospital could improve the health of the community by having the community health workers and promotoras do more outreach and host educational programs in the community about preventive care.

6. In your opinion, what does a healthy community look like in mind, body, and spirit?

One participant shared that she believes a healthy community begins by being healthy and stable at home so that she is able to care for herself and her children and then her neighbors. She said that we cannot help others if we are not well first. One participant said that a healthy community for her is one where there is balance in all areas of health including physical, emotional, and spiritual. That the needs of families and the economy are balanced. Another participant shared that a healthy community is one that has opportunity, resources, accessibility and education.

Another shared that a healthy community is one that is unified and prospers with peace. That a healthy community supports each other.

7. If you had the opportunity to help the population you serve improve their health, what would each of you do?

The promotoras answered that they would improve the health of their community through continued outreach and health education. They believe that the outreach programs have a great impact on the community but there is still a need for funding and for education about housing and health issues such as birth control and prenatal care. There are many children born in the farmworker communities that have health conditions because the women believe they have to keep working as long as possible.

Chet Dotter Seniors Focus Group
June 11, 2024

A focus group was conducted at the Chet Dotter Senior living community with eight participants. A Dignity Health community outreach staff member shared that the participants were interested and engaged from the beginning to the end of the focus group. He described the emotions of the participants as "excited to participate, focused, serious, thoughtful, worried, empathetic, despair, disappointment, sadness, depression, frustration, anger, loneliness, a little joy, [and] stress."

1. What is impacting the health of your community the most?

One participant shared that they believe there is a lack of socialization and community connection because people stay in their rooms/homes and that this leads to a deterioration of their mental and physical health. Another participant shared that they agreed that socialization is important for morale.

Multiple participants shared that it is difficult to make appointments and see healthcare providers in a timely manner. One participant shared an example of having to wait three months to get a dermatologist appointment. Another senior shared that if they are sick or have a problem it will take two or three weeks to be seen, unless they go to the Emergency Department. Another participant shared that they couldn't find the care they needed in the community and had to travel far enough away that they stayed the night there.

Another issue that affects the health of the community that the participants raised is housing. They shared that there are waitlists so long that people have to wait years to get into housing and that the paperwork to apply is confusing and difficult to fill out.

2. Do you get care when you need it?

The participants shared that they do not always get care when they need it because it is difficult for them to navigate the healthcare system. They shared how it can be difficult to get an appointment or for them to talk to someone on the phone. They explained that sometimes they are told to use their patient portal, but that it is difficult for them to navigate the portal or use a computer. One participant shared how they have difficulty understanding who takes their insurance and where they should go for specialty care.

3. When you are in a doctor's office, do you feel like you belong?

The participants shared how they often feel rushed along and that the doctors don't have enough time to listen to all of their questions. They also shared how the offices are packed with people.

One participant shared that they will have to wait in the waiting room for 40 minutes and then when they call them back to a room they wait for another 40 minutes only to talk to the doctor for

15 minutes and not get everything they needed. A different participant shared that they didn't have that experience at CHC (Community Health Centers) and that there is not a long wait time there.

4. **If you do go see your healthcare provider and they give you instructions, do you follow the plan of care?**

The participants shared that the healthcare providers they see do not have enough time to talk to them and give them good care plans. One participant shared that the doctors at Dignity Health are there to fulfill their educational requirements, so there is a high turnover and lack of stability.

Multiple participants shared their negative experiences and opinions of Marian hospital. One participant said that he felt worse after his stay at the hospital than when he had heart surgery at another hospital. Another participant said that they "never feel like [they are] going to come out alive" and that her husband came home from a three day stay in the hospital with "enormous" bed sores. Four participants agreed that they were afraid to go to MRMC.

They also shared that the paramedics are "terrific" and "prompt."

5. **What does a healthy community in mind, body, and spirit look like to you?**

The participants shared that they would like more geriatric care to accommodate their specific needs.

Another participant shared that the community outreach programs, such as vaccine clinics, are important. They shared how a provider at one of the outreach clinics had told them they needed to get their toe checked out at the hospital and if they hadn't received that advice they would have lost their foot. They shared that outreach to the senior living communities is important because many of them do not have transportation.

They also said they would like more group exercise classes and gym equipment. One participant shared that they thought the community could use meditation classes to help with their blood pressure.

6. **What can the hospital do to help you?**

The participants said that they think they need more community events to build engagement and connection amongst the seniors. They also said there is a need for an orientation for when someone moves into the community so that they know what resources are available.

Seniors of Santa Maria Focus Group
June 10, 2024

A focus group was held with six participants. Cesar Vega, a Dignity Health community outreach staff member, described the participants as "very alert, focused, and ready to participate" and the emotions of the participants as "excited to participate, focused, serious, clear in their communication, thoughtful, worried, empathy, comfortable, disappointment, a little bit of frustration, joy, alert, [and] caring."

1. **What do you think is impacting the health of your community the most?**

One participant shared that the cost of health insurance has the greatest impact on their community.

Another participant shared that when they try to make an appointment with their doctor's office the next available appointment is two or three months out and so by that time the problem is resolved or something worse has developed. They shared that this causes people to over use the Emergency Department and urgent care because that's the only way to get timely care. They said that the long wait times for appointments is "really detrimental and discouraging to people." Other participants agreed that the primary impediment to the community's health is clinician accessibility.

Another participant shared that when many older people go to the doctor's they don't understand what their health issue is or how to treat it, so when they go home they don't do anything differently.

2. **Do you get care when you need it? And if you do, where do you go?**

The participants shared that long wait times and poor access to transportation can deter them from accessing care, but that they usually do receive care from their providers or when they are sick they will go to an urgent care or the Emergency Department. The participants shared that one of the county's transportation programs will not cross county lines which can make it difficult to get to appointments that are farther away. Longer taxi or Uber rides can be cost prohibitive.

3. **When you come into a doctor's office or hospital do you feel you belong?**

The participants shared that the hospital staff are welcoming and that "every department was excellent". One participant shared that the administrative staff at the hospital is welcoming and easy to talk to, but that it is difficult for them to reach their doctor and talk to them.

4. **If you are given instructions by a healthcare provider do you follow the plan of care? Please explain.**

The participants shared that they follow their care plans with the support of their family members.

5. In your opinion what does a healthy community in mind, body, and spirit look like to you?

The participants shared that a healthy community is one that is well connected and where community members are able to support each other. They also shared that they as seniors find community at the senior center's activities such as art and exercise classes.

6. In your opinion, what can we do to help you?

The participants shared that a senior outreach program to check in on their health and well-being would benefit their community. One example a participant shared is how Meals on Wheels was beneficial for their father when he was living alone.

Veteran Service Providers Focus Group
June 13, 2024

A focus group was held with four veteran service providers.

1. What do you think is impacting the health of your community the most?

The main health need identified by the veteran service providers was access to care, especially behavioral health and substance use treatment.

The veterans in the hospital service area are a part of the Los Angeles Veterans Administration region, veterans have to travel to LA, which can take four and a half hours, to go to the hospital. There are two community based outpatient clinics (CBOCs) in the area, one in Santa Maria and one in San Luis Obispo, but many veterans don't know to go to them.

The service providers also described how the referral process for substance abuse treatment has a long wait time that is not realistic for someone suffering from addiction or mental health crisis. It takes an average of about a month for a veteran to get screened after their primary care provider puts in a referral to the "DOM" or the Mental Health Residential Rehabilitation Treatment Program (MH RRTP). A service provider said that substance abuse is the largest health concern they deal with. One of the programs will discharge the veterans before they have completed the treatment which causes more trauma and nine out of ten relapse. The VA's substance use program is dependent on the veterans moving down to Los Angeles which is not feasible for most veterans because LA is unfamiliar or they would lack needed support.

Housing is another health issue that veterans struggle with. Many of the unhoused elderly veterans need IHSS (in-home support services) or assisted living support, so sometimes they can't get them into housing because they need extra support that is not available even when the housing is available.

2. How does the population you serve access care when it is needed?

One participant shared that most veterans access care through their social worker at Dignity Health, but that many of the veterans don't know where to access care when they first come in. They shared that some of the veterans don't know if they qualify for VA health or where the San Luis and Santa Maria CBOCs are. Some of the veterans that the participant works with haven't seen a doctor in 10 to 20 years.

Another veteran service provider shared that they received an MHSA (Mental Health Services Act) grant and that they have been doing outreach events every other month. They see an average of 150 to 300 veterans at each event depending on the location.

Another service provider shared that they also do a lot of outreach, but that it takes time to build relationships with veterans because many of them have lost trust in caseworkers or the healthcare system.

There is also a population of veterans that do not qualify for VA health because of their discharge status. So there are programs for trying to upgrade their discharge status.

3. **Do you think that the community members that you serve feel like they belong when they walk into a doctor's office or hospital?**

One service provider said that the veterans they work with do not feel welcome when they are in a healthcare setting. When a person is using drugs or unhoused they are not treated well by healthcare providers because there are negative biases and stigmas. Many of the veterans feel embarrassed and are struggling with their mental health and their circumstances.

Another aspect of why they do not feel welcome is that hospitals are often triggers for veterans because hospitals, field aid stations, and medical settings remind them of mass casualty events and past traumas. So not only are they not feeling welcome because of how they are treated externally, but also internally they struggle with the healthcare environment.

A second service provider shared that they often will accompany veterans to the Dignity Health hospitals and that they meet with a social worker there that helps them navigate the system and receive care.

4. **What can we do differently to help the population you serve increase access to healthcare?**

One participant said that it would be helpful for the hospitals to keep brochures with information about their services so that veterans know what resources and support is available to them. They also shared the importance of working relationships with hospital staff because they will contact them when a veteran comes into the Emergency Department. Another resource that would be helpful is to have peer support on hand at the hospital for when a veteran arrives in crisis.

5. **In your opinion what does a healthy community in mind, body, and spirit look like to you?**

The participants shared that a healthy community is one where there is access to healthcare, including mental health treatment, for everyone. There would be an ease of access to resources without discrimination or scarcity. The dream for this service provider would be to have a mental health urgent care that would have immediate care and beds open for when someone needs to access it.

Another service provider stressed the importance of constant collaboration between service providers because organizations and programs have to act as a continuous chain to help their clients

or veterans move forward and that once the chain breaks people backslide back to where they started.

6. If you were to help make the population you serve have better health, what would you do? How would you make it happen?

One participant said that their dream to make care more accessible to veterans is to have one physical location where they can go to talk to someone and get help. The building would have office space for all of the different organizations that serve veterans to come together and work alongside each other.

Another way that the veteran population could be better served is by hiring more social workers and especially a veteran peer support specialist. Having someone who is well versed in veteran policy and with lived experience would help connect more veterans to services because many don't believe they qualify as a veteran.

Veterans Focus Group
June 5, 2024

A focus group was held with five veterans facilitated by a Dignity Health community outreach staff member who described some individuals of them as ready to participate and others a little quiet.

1. **What do you think is impacting the health of your community the most?**

One participant shared that mental health is the greatest health challenge for their community and that there isn't much support for alternative treatments. They found massage therapy and yoga to be helpful for them, but that isn't approved by their healthcare providers. Another participant agreed that the formal programs for mental health are only treating mental health with medication instead of offering a holistic approach.

Another challenge they face in accessing care is the difficulty of finding providers or therapists that can see them and are a good match for them. They shared that they have to only get online providers or travel far distances to see someone in person.

2. **Do you get care when you need it?**

One participant shared that the wait time to see someone at the VA is about six months, so they try to access care from other providers but that means they have to have another health insurance from what the military provides them. Another participant agreed that there is a long line at the VA to access care and that it can be months before veterans are able to start accessing mental healthcare.

They shared that the process to see a specialist is similarly lengthy because after waiting to see a primary care provider for a referral they have to wait a few months for an appointment with the specialist. They said there is a lot of bureaucracy and hoops to jump through in order to access care.

3. **When you come into a doctor's office or hospital do you feel welcome?**

One of the veterans said that they have private insurance so they are able to get good care, but they said that the other veterans that have unstable housing or struggle with their mental health will have a very difficult time accessing care. They compared accessing care at the VA to "trying to move an aircraft carrier on a dime - it's not gonna happen."

4. **In your opinion what does a healthy community in mind, body, and spirit look like to you?**

The participants said that a healthy community would have affordable and accessible healthcare and livable wages. They said many Americans cannot afford their healthcare and will receive bills

that cause them to go into debt. One participant shared how they had to take an ambulance to the hospital and that the bill was $10,000 and their insurance only covered $2,000.

5. In your opinion, what can we do to help you?

The participants said that they want the hospital to make care affordable for them. They cannot afford going to the hospital and they cannot afford their prescription medications.

They also wanted the Emergency Department to have shorter wait times because they said their family members would be sick but have to wait hours to be seen.

Paso Robles Youth Focus Group
June 11, 2024

A focus group was facilitated in Paso Robles with eight participants.

1. What do you think is impacting the health of your community the most?

The first concern the Paso Robles youth raised was the prevalence of drug use. They explained that vapes and marijuana are sold by students and promoted through social media through chances to win free vapes or discounts.

They also shared that the lack of sexual education was negatively impacting their community. They shared that many adolescents don't learn about safe sex or reproductive health in class because the students have to opt in and get a parent consent form signed. The only sexual education they received was a puberty lesson in fifth grade.

Another concern they raised was how the COVID-19 pandemic negatively impacted their community's mental and socioemotional health. They found the isolation of quarantine to be difficult and that the online schooling delayed their learning. The younger children are also lacking in social and emotional skills. They also attributed an increase in technology use and screen time to the COVID-19 pandemic. They described how their younger siblings will not eat without watching something on a screen. They also raised concerns about younger children being exposed to inappropriate or harmful content online.

2. Do you get care when you need it?

Most of the youths agreed that when there is an emergency or the care is necessary, they are able to access care. However they also agreed that many of their family members wait to get care because it is too expensive or they don't have enough time to go. Multiple participants shared that their parents have curable illnesses that go untreated because their health insurance doesn't cover it and they don't have time to recover from surgery.

Another barrier to care is transportation. One of the participants shared that many Latina women do not drive. Another participant said that many people don't have cars or their cars don't work.

3. When you come into a doctor's office or hospital do you feel you belong?

The youth participants said they often feel uncomfortable or embarrassed at the doctor's office because of the offensive or unempathetic ways the healthcare providers talk about obesity. One participant said she feels so anxious on the way to her appointments that she has stomach aches. She also shared that she didn't want her dad to have to be in her appointments and hear what the providers said about her weight.

They also shared how uncomfortable and stressful it can be to have to translate for the healthcare providers and their parents. Six of the participants agreed that they had translated for their parents at a healthcare visit.

4. **[Trust] If you are given instructions by a healthcare provider do you follow the plan of care? Please explain.**

Two participants shared that when they were younger they didn't pay much attention to the instructions they were given, but now that they're getting older they follow the instructions of the healthcare provider.

5. **In your opinion what does a healthy community in mind, body, and spirit look like to you?**

They imagined a healthy community as one where children gather and play together outside. They stressed the importance of social events and connections that aren't hindered by technology and screens. A healthy community would have green spaces and a clean environment. They also said that there needs to be more accessible public transportation so that they can attend the public events.

6. **In your opinion, what can we do to help you? What is the most important health need for youth?**

The youth participants believed that they needed more free/low-cost clinics to improve access to care. They also expressed interest in community activities for teenagers and that they be advertised well so that the students know about them.

The youths also wanted more education about life skills for their future such as financial, career, and college coaching. They shared how AVID was helping them learn how to prepare for college applications. One of the youth participants also shared that he thought there needed to be more education for parents so that they can help instill healthy habits in their children. Seven of the participants said they had to step in to help parent and take care of their younger siblings or cousins.

7. **What is the greatest barrier to child wellness in our community?**

They expressed concern that the greatest barrier to child wellness is poor socioemotional health. They shared how many of their peers or their siblings spend most of their time isolated and on the internet. They think there needs to be more healthy socialization for youths.

Another participant shared that sexual education would be important to improving health because most adolescents do not know much about reproductive health.

Another barrier they shared was the easy access to drugs and alcohol. The participants said there needs to be better education and awareness about the risks and harm of drug and alcohol use. They shared stories they had heard of other teens that drink with their parents or had unknowingly overdosed on fentanyl.

Youth of Santa Maria Focus Group
July 10, 2024

1. **What do you think is impacting the health of the youth in your community right now?**

The participants identified drug use, the high costs of healthcare, and mental health as the main factors impacting the health of their community. They also agreed that there is a lot of gun violence in Santa Maria.

2. **When you need care, how do you get it? Where do you go?**

The participants shared that they will talk to family and friends that they trust about their health and that they will go to the pediatrician.

3. **When you go to the doctor's office or the hospital, do you feel like you belong there? If you do, why? And if you don't, why?**

The participants shared that some of the nurses are nice and some are not.

4. **When you or a family member goes to a clinic or the doctor's office and they give you a plan of care, do you or the person you're with usually follow what the doctor tells them to do?**

The participants shared that they follow the plan of care because they want to get better. They also shared that sometimes they don't follow the plan if they forget to take the medication because they are too busy or stressed.

5. **When you do go to the doctor's office or hospital, do you feel like you belong?**

One participant shared that sometimes they don't feel comfortable because their providers talk over them when they are trying to share their concerns. They also shared that it made them not feel comfortable asking questions.

6. **What does a healthy community look like? In body, mind, and spirit?**

One participant shared that a healthy community would have more mental health resources because there aren't many therapists or psychiatrists in their area and they have to travel outside of the city to get help.

When asked if they had as much money as possible to achieve a healthy population, they answered that they would give out food to the community and have programs to support single parents, to help with housing, and for mental health. They also said they would like programs that supported creativity such as arts and crafts and music.

7. What can the hospital do to help?

One participant shared that it would be helpful if a healthcare provider could come to their house instead of them having to go into the clinic. Another participant shared that they would increase the staffing at the hospital because it is so busy when they go and the wait time to get admitted is too long.

Youth Service Providers Focus Group
June 6, 2024

The focus group was facilitated virtually with four participants representing youth service providers.

1. What do you think is impacting the health of your community the most?

"Time" – time to take off from work to take their children to a medical appointment.

"Cost of Living" – Everything is too expensive and everyone is worried about how much money things cost.

"Navigating and Accessing Resources" – The community has resources surrounding behavioral health, however the availability may be limited especially those who accept Medi-Cal.

"Cultural competency" – Providers are not always familiar on how to communicate with some patients. Such as, "Go to therapy" is not always culturally relevant or accepted. There is stigma surrounding therapy and many parents think something is wrong with them and they won't even consider it.

2. Please share how the population you serve accesses care and what are their barriers? How do they do it? Where do they go?

A lot of effort is often put forth to bring services to the youth. However, often once the program is set up and the services become operational, it is often not utilized by the community members that need it most. Youth often don't know a lot about their own ways of seeking help, they often think they need parental consent. Being a **trusted partner** means the community knows who you are, they feel welcome, their language is spoken and the services being provided are accessible to them. Many times trusted information is shared through word of mouth. Schools and communities are opportunities to strengthen partnerships. Also, many operational hours do not work for a lot of marginalized families - 9 to 5 hours are when parents work. Weekend hours need to be offered.

3. Do you feel our youth and families feel comfortable when they seek care in a doctor's office or hospital? What have you heard in your work with your youth?

If a person shares with the doctor what they do, their cultural traditions, often the practitioner shows worry on their face and shuts down. Instead of actively listening, sharing some inquisition and having cultural competency. If patients that are sharing their cultural traditions feel rejected or not respected they will not return. Also, many times patients feel dismissed and they often have gone through a lot to get to the appointment. At times providers reschedule after a patient has used gas, missed time from work, and lost wages. This leaves the patient feeling dismissed.

Also, we have heard that many kids go to doctors appointments with their parents to translate and wind up missing school.

4. **What can healthcare do differently to youth and families to better serve them? To become more welcoming and trustful?**

Healthcare providers can receive cultural competency training to better understand the daily struggles of the community. It seems that staff that don't go to the continuing education opportunities are the ones that need it the most. Many communities are very oral which takes time, but yet some providers don't have time for stories. How do you strike the balance because telling stories builds trust? When providers patiently listen, the stories may lead to a deeper understanding of where a patient is coming from and provide a better diagnosis. A cultural change is needed to better align the pressures of time, reimbursements, and documentation at the same time listen to the people that are in front of us and understand their stories.

5. **In your opinion what does a healthy community in mind, body, and spirit look like to you? [Stress youth, elderly, young families]**

Compassionate, community healthcare, where you are known and you know the providers. Acceptance of different health methods that are historically acceptable to the Mexican community.

6. **If you were to help the youth and the families that you serve (and your staff) have better health, what would you do and how would you make it happen?**

Transportation is a basic need and a lot of the community does not know how to drive. Many individuals walk very far to get to an appointment only to have it rescheduled after they arrive. Ideally, if you need transportation you can call a number and someone will come to pick you up. Again, having local trusted health centers that are part of the community where you have been going for a long time. One participant is also concerned about diabetes and cholesterol in the communities. She thinks about how everything in the US is consumerism and buying groceries for the week.

"Knowledge takes us to many place, action takes us to many more, and perseverance definitely takes us to the goal."

Homeless Service Providers Focus Group
June 18, 2024

A focus group was facilitated in services providers that work with unsheltered and unhoused clients.

1. **What do you think is impacting the health of the population you serve in our community the most?**

The primary need identified was severe mental health needs. There are the highest number of unsheltered people outside that the service providers have seen in their time working. Another participant identified that the greatest health need is housing and people living outdoors and being unsheltered. They shared that they have "seen a 32% increase in rental rates since covid which is making the process of actually getting people into housing even more difficult." As the prices of housing increase and the lack of housing increases, the people at the bottom of the pricing level are priced out and fall off the ladder. They shared that they are "seeing significant changes in disparity of housing based on income, particularly those of fixed income. So [they're] seeing elderly aging into homelessness, being displaced."

Another service provider described how there is a pattern of when someone who has been chronically unhoused gets into housing, then many severe health problems begin to appear once they are no longer just trying to survive being on the streets. They shared, "once you get them into a shelter or permanent housing it seems like they start to deteriorate almost."

Another service provider shared that at least half of the people they see are in active addiction and that they believe that the substance use disorders that go untreated and the mental health struggles that go along with it that are the predominant cause of chronic homelessness. They also identified the lack of government programming and housing for people with active addiction or substance use disorder and how that can prevent individuals from getting into housing.

One service provider shared that the combination of housing self-sufficiency, income, and health are like the three legs of a stool that are needed to help someone stabilize.

2. **Can you please share how the population you serve accesses care when they need it? How do they do it? Where do they go and what are the barriers keeping them from seeking care?**

There are many different ways for unhoused people to access care from free clinics, to the street medicine outreach program, to sheltered clients seeing health care providers in the office. One provider shared that one of the greatest barriers to unhoused clients getting care is the disorganization caused by mental health and substance use that prevents them from attending their appointments. Many unhoused people are also accessing care through the emergency room.

3. **Do you think community members and the population you serve feel like they belong when they enter a doctor's office or hospital or any place to receive care or services?**

Many of their clients who are unhoused do not have their basic needs met. They may not have showered in a while and they have a lot of shame and discomfort when visiting the doctor's office. This service provider shared how they build relationships with the healthcare staff and their clients and serve as the connection between the two to make their clients feel more comfortable.

The medical safe haven clinic also provides trauma informed care which serves women who have been trafficked.

Most of their clients have lost trust in others and service providers because of their experiences and trauma, and "until that trust is rebuilt or bridges are built, there isn't a sense of belonging." This service provider shared a story of a young woman that she offered services to who asked her why she was trying to help her. She said, "I have always felt invisible my entire life." After working with her and getting her into a shelter, "for the first time in a very long time, someone told her that she matters."

When people have been living outside for so long and feel invisible, it can be very jarring to go to the hospital or a doctor's office because the change of scenery is so extreme.

They also shared that much of their time is spent accompanying their clients to their medical appointments because it is so daunting and traumatizing for them. Unhoused clients are highly stigmatized by health care workers. They shared that the attitudes have improved over the past 10 years but the stigma still exists.

4. **From your patients' or community members' perspective, are our facilities welcoming?**

The service providers shared that having social workers in the hospitals makes a big difference in the experience of their clients because the social workers are able to deescalate situations or serve as a bridge between their clients and the health care staff. The addition of social workers to the hospitals has also improved the discharge process for many of their unhoused clients by decreasing patient dumping and connecting them to the appropriate resources instead.

5. **What can we do differently to help the population you serve increase access to healthcare?**

The service providers shared that they would increase the available resources by having more available appointments at the free primary care clinic or sending out the street medicine team multiple days a week instead of a couple days a month. Another provider agreed that they would increase investment in street medicine, mental health, and addiction services. When one of their clients is ready for detox and get sober, but then the waitlist is weeks to months long.

6. In your opinion, what does a healthy community in mind, body, and spirit look like to you?

One service provider answered, "the resources are sufficient that if one needs to access them, that they're available."

The service providers shared that they would see a healthy community as one that does not have stigma around people being unsheltered or having behavioral health needs. They shared, "Changing that stigma in our community, I think it's very important because these unsheltered folks are somebody. Somebody you know. They're moms, they're dads, they're kids."

7. If you were to help the population you serve have better health, what would you do and how would you make it happen?

The first need they would address is to serve mental health and severe substance use. It is very difficult for the service providers to help their clients if they are continuously struggling with substances and they "can't make a lot of life changing decisions if [their client] is talking to someone that you and I do not see. So I think for me, the severe mental health and substance abuse that is still overpowering [and] taking a lot of our unsheltered by storm" needs to be addressed.

They also shared that in an ideal world there would be one system with all of their clients' information. One kind of collaborative platform that the different agencies could use for case management and communication.

Another service provider shared the importance of collaboration and communication across different agencies to ensure that services aren't being duplicated and that they are serving the population differently to meet as many needs as possible.

Appendix D

Healthcare Providers Key Informant Interviews

Mission Hope Cancer Center and Hearst Cancer Resource Center

Attendees: Amanda Gettig, Patty Herrera, Cynthia Maldonado, Julie Neiggeman, and Ramie Castilleja

The health needs identified by the Dignity Health Mission Hope Cancer Center and Hearst Cancer Resource Center are access to basic needs, access to primary and specialty care, and navigation of healthcare systems and insurance.

The basic needs that the patients served by the cancer centers do not have access to are affordable housing, food security, and transportation. The Mission Hope Cancer Center reported that many of their patients struggle with affording housing and food. They have partnered with the local food bank to give out food to patients and they have a grant program to help patients pay their housing or utility bills. They also have a social worker that finds grants to help support patients because their one time grants are not a sustainable way to help patients afford increasing costs of living. Both cancer centers have transportation programs in place because many of their patients do not have access to transportation or are not able to drive. The Mission Hope Cancer Center has three different cars that they can use to give patients rides. The Cancer Care collaborative has a partnership with Ride On Transportation where they pay a discounted rate for their patients. Transportation has become a growing issue as patients have to travel further for treatment centers that take their insurance.

The second need identified by the cancer center employees is access to care. The representatives shared that it is difficult for patients to get appointments with primary care providers and to get screenings and scans. Patients that don't have insurance or do not qualify for CenCal have the most difficulty getting appointments. The Cancer Care Center will have patients that have received a cancer diagnosis but have to wait a month for a scan to determine and begin their treatment. Mission Hope Cancer Center reported that when the free colonoscopy colon cancer screening program moved from an outpatient facility to Marian Hospital, it became more difficult for patients to get screened, and the number of screenings dropped and the number of cases of Stage III and IV cancer rose.

The possible actions to be taken by the hospital to help the community identified by the cancer centers are health education outreach and increased support for social workers in navigation roles. The cancer centers shared that there needs to be a greater awareness in the community about cancer screenings. There is a stigma surrounding colonoscopies, especially in Black and Latino men, that needs to be reduced through education and community outreach. Once patients have symptoms and come in concerned for their health, they are already at Stage III or IV which is not curable. Social workers play a large role in getting patients enrolled in health insurance or disability.

Dignity Health Maternal Health Team

Amanda Gettig and Patty Herrera conducted a key informant interview with the Dignity Health California Central Coast Hospitals maternal health team to identify the health needs and barriers to care for vulnerable populations in the community. The primary barrier to care identified was the language barrier between the hospital's clinicians and staff and their patients. This language barrier prevents Mixteco women from receiving adequate prenatal care.

Over 60% of the patients cared for in the maternal health department speak Mixteco, but many Mixteco patients will request an interpreter that speaks Spanish out of fear that they will be treated differently for being Mixteco or that their Mixteco interpreter will speak a different variant of the language than them. So much of the clinician's time and energy is spent trying to overcome the language barrier and establish communication with their patients that it is difficult to get to the specifics of actually treating the patient. The maternal health team's social worker explained that because the health clinics in the community triage their appointments the Mixteco women are unable to communicate their situation and are given the lowest priority. Once the social worker is involved and communicating for the Mixteco patient, they are able to be seen in the next few days instead of a few weeks.

The other health need identified by the maternal health team is health education. Farmworkers have increased health risks for themselves and for their children because of their exposure to pesticides. It has been shown that exposure to pesticides from the very beginning of pregnancy can cause low birth weights, preterm birth, and neurological conditions. There is a need for education about the health risks, but also for education on the rights of workers and the resources available to them such as short term disability. Many women continue working while pregnant because they are dependent on the income and cannot afford to stop working.

Transportation was also identified as a health need because many women have to walk to their appointments. They cannot afford to pay for a ride and their family members are working. Women who have just had cesarean sections will walk to their child's well visit which can prevent them from healing properly.

The majority of the maternal health team's patients face significant barriers to care including language barriers, a lack of education, and poor access to transportation.

Marian Regional Medical Center Medical Safe Haven Clinic

Medical Safe Haven is a Dignity Health clinic that offers trauma-informed family medicine care for victims and survivors of human trafficking. The clinic at the Marian Regional Medical Center has been going for three years and served 59 patients with approximately 20 to 30 visits a month. Their trauma-informed approach to care includes longer first appointment times to establish relationships with patients and a navigator who communicates with patients between appointments and will sit in on appointments to help them feel more comfortable and advocate for themselves. They also maintain a schedule that allows them to see a patient within a day or two because the timing of resources and support is critical to the health and success of their patients.

The patients at Medical Safe Haven are female and their ages range from 18 to women in their 50s and 60s. Most of their patients are bilingual but some of them only speak Spanish. Many of the patients have histories of child abuse and were in the foster care system or they were groomed by their boyfriends for sexual trafficking. Many become addicted to drugs while being trafficked. Most patients are in temporary housing or shelters, but some are unhoused and couchsurf. Some patients have children, but they are typically in foster care because they were in active addiction and being trafficked when they gave birth. The clinic is equipped to take on patients' children as patients because they are secondary victims of human trafficking. Medical Safe Haven aims to meet the complex combination of physical, mental, and spiritual health needs that the victims and survivors of human trafficking have. The clinic does not see many cases of labor trafficking, but it is more difficult to identify such cases.

Medical Safe Haven is looking to expand their program by building relationships with law enforcement and other community partner organizations. Knowledge of the clinic spreads by word of mouth because they want to be discreet so that patients that are currently being trafficked are able to receive care. They will also soon be adding a tattoo removal program at the clinic. They have received a grant to fund the tattoo removals and a laser removal machine will be donated. Many victims and survivors of trafficking are branded by their trafficker with tattoos that are traumatic because they are in visible places such as the face, neck or chest.

Medical Safe Haven could better serve their patients if there was greater awareness of human trafficking and more mental and behavioral health resources. The Medical Safe Haven team shared that the American public holds many misconceptions about human trafficking and that educational outreach would help individuals avoid and identify trafficking better. They also shared that not all hospital staff are trained in trauma-informed care and that it would improve patient care and provider burnout to include more trauma-informed care practices. The patients at Medical Safe Haven need outpatient behavioral healthcare that is more specialized than what the family medicine clinic can offer and because their patients are so vulnerable they don't have the ability to wait to see a psychiatrist for the time that the current system demands.

Dignity Health Care Transitions Team

The Dignity Health California Central Coast Hospitals Care Transitions Team works collaboratively across Dignity Health California Central Coast hospitals. They have an intra-hospital capitation agreement with MediCal to care for 130,000 lives and a second similar agreement with Medicare. The team consists of social workers and healthcare providers that do case management and outreach to the patients.

One of the primary health needs identified by the Population Health staff is the lack of health literacy in the community. They believe that patients have difficulty accessing primary care not because there is a shortage of primary care providers but because they do not know how to access them. They shared that many patients are also frustrated with their experiences, such as long wait times for appointments, because they have misinformed expectations about being able to access care on demand. Patients also do not understand the difference between going to their primary care provider, an urgent care, or the Emergency Department.

The population health staff also emphasized the importance of the promotoras and community health workers in patients navigating the healthcare system and receiving care.

The other health needs in the community identified by the Population Health staff were outpatient alcohol and drug use treatment centers, assisted living facilities for older adults, and outpatient behavioral health resources.

They also identified the farmworkers as a vulnerable population with specific health needs. Many of the farmworkers are malnourished and have low blood pressure. There was a population of mothers that had tuberculosis that needed help navigating care because they did not speak English.

Appendix E

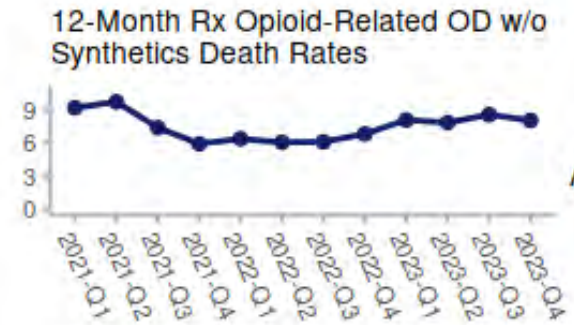
Santa Barbara County & San Luis Obispo County Overdose Snapshot Report

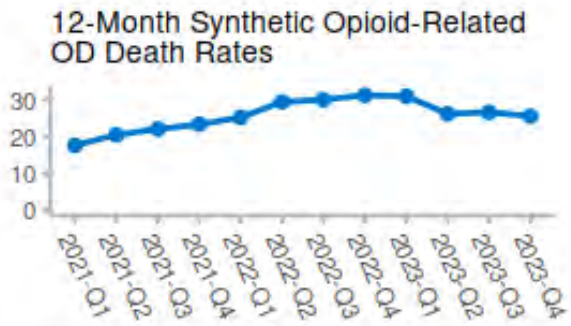
Overdose Prevention Initiative

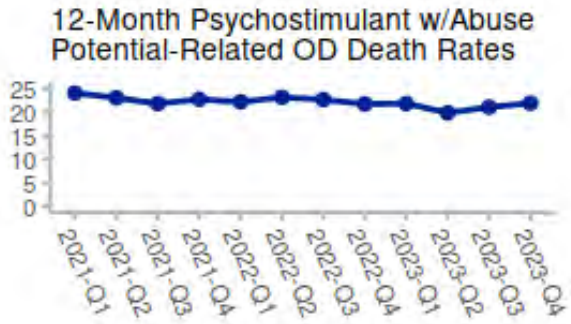
San Luis Obispo County Overdose Snapshot: 2021-Q1 through 2023-Q4

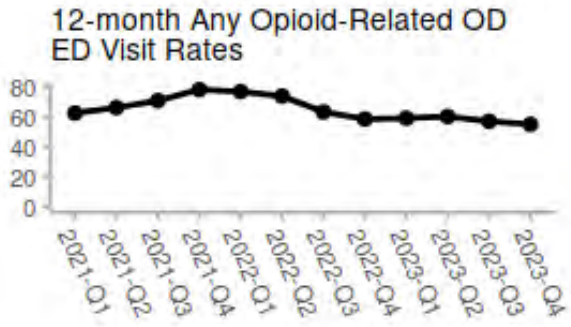
Report downloaded 03-24-2025

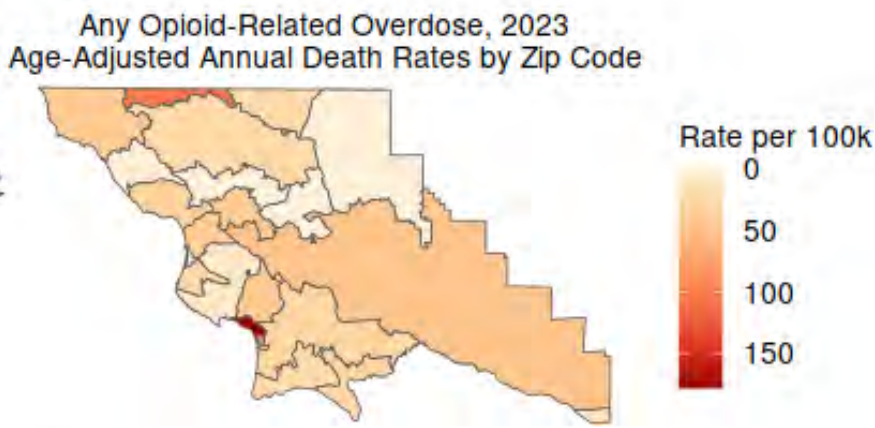
San Luis Obispo experienced 78 opioid-related overdose deaths in 2023, the most recent full year of data available. The annual age-adjusted mortality rate for 2023 was 30.02 per 100k residents, an decrease of 11.5% from 2022. The following charts present 12-month age-adjusted rates for selected overdose indicators (visit the CA Overdose Surveillance Dashboard **Data Definitions** page for indicator details). The map displays the annual age-adjusted rates for Any Opioid-Related overdose deaths by zip code. Synthetic opioid overdose deaths may be largely related to fentanyl.

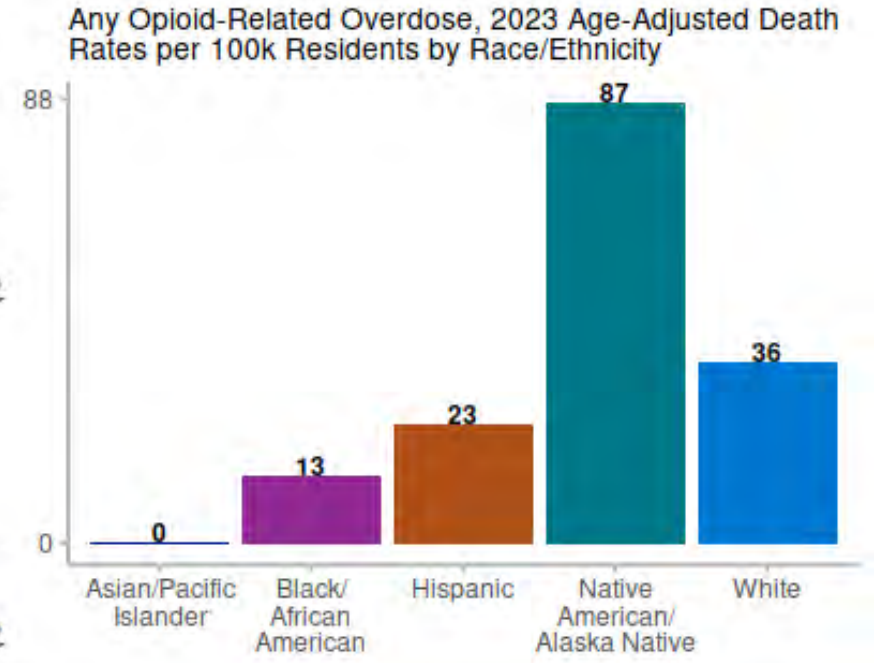








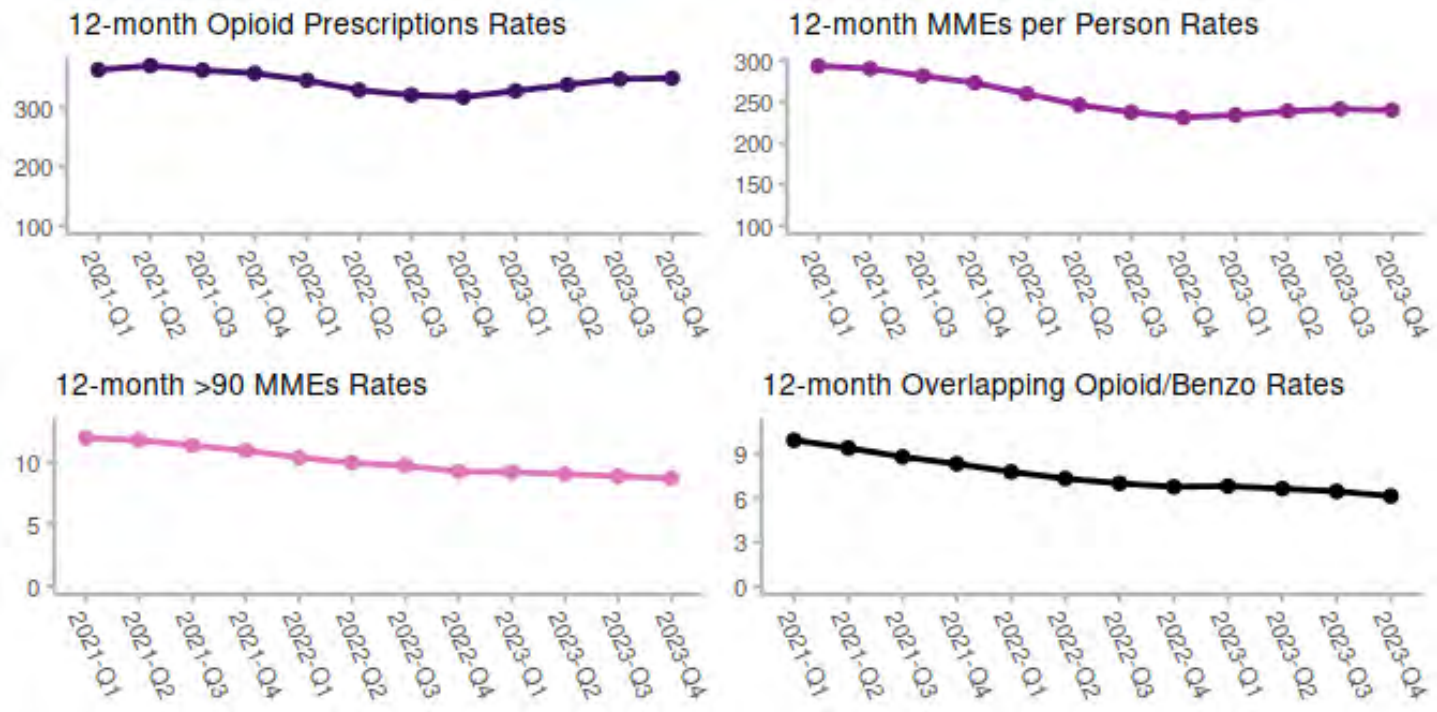




Footnotes:
12-month rates are based on moving averages; OD = Overdose
Produced by the California Overdose Surveillance Dashboard: https://skylab.cdph.ca.gov/ODdash

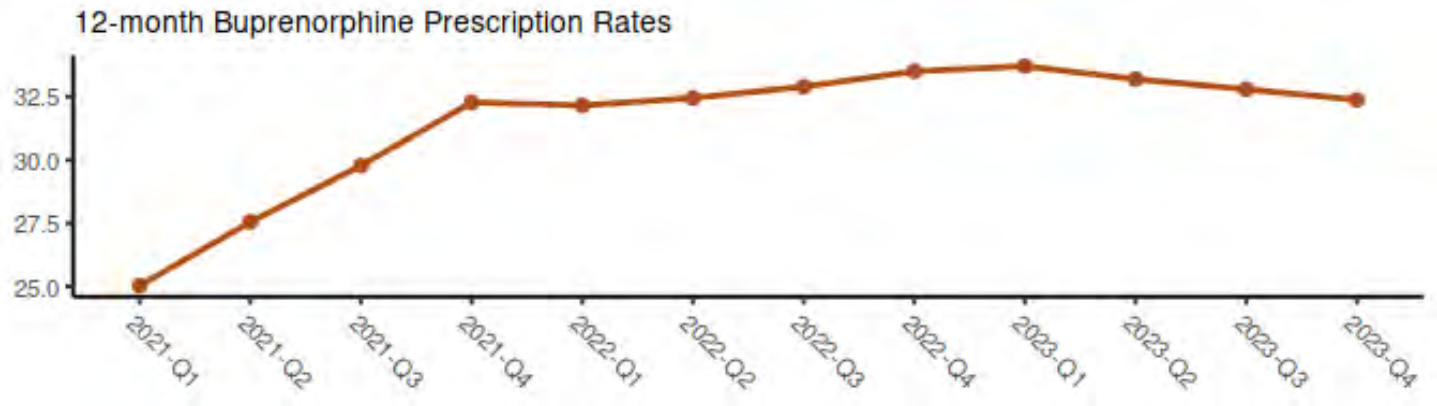
Prescribing

There were 128,825 prescriptions for opioids in San Luis Obispo in 2023. The annual age-adjusted opioid prescribing rate for 2023 was 351.1 per 1,000 residents. This represents a 10% increase in prescribing from 2022. The following charts present 12-month moving averages for age-adjusted opioid prescribing rates, MMEs (morphine milligram equivalents) per person, high dosage (i.e. greater than 90 Daily MMEs in the quarter), and opioid/benzodiazepine overlap age-adjusted rate from 2021 to 2023.



Treatment

Buprenorphine prescriptions in the county are used to gauge the expansion of medications for opioid use disorder (MOUD). The annual age-adjusted buprenorphine prescribing rate for 2023 was 32.38 per 1,000 residents. This represents a 3% decrease in buprenorphine prescribing from 2022.



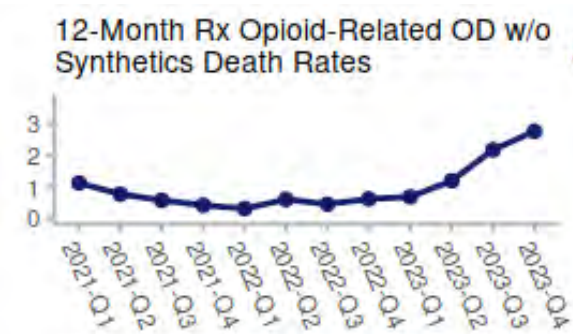
Footnotes:
12-month rates are based on moving averages; OD = Overdose
Produced by the California Overdose Surveillance Dashboard: https://skylab.cdph.ca.gov/ODdash

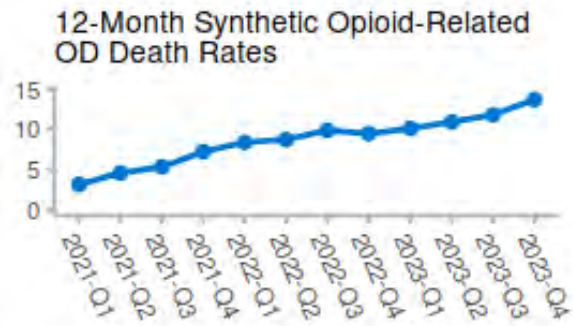
Overdose Prevention Initiative

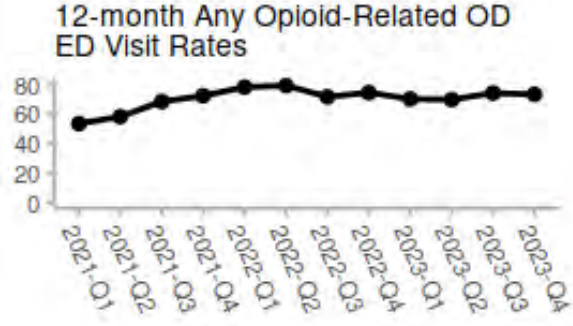
Santa Barbara County Overdose Snapshot: 2021-Q1 through 2023-Q4

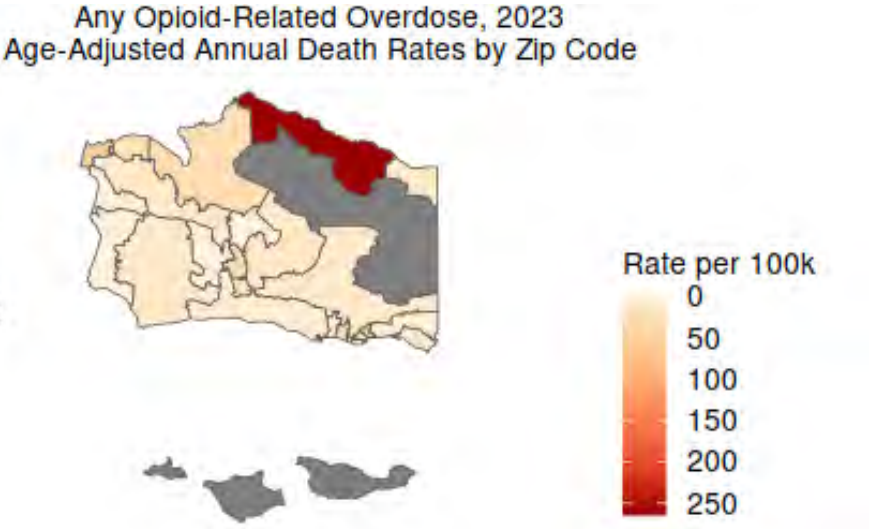
Report downloaded 04-09-2025

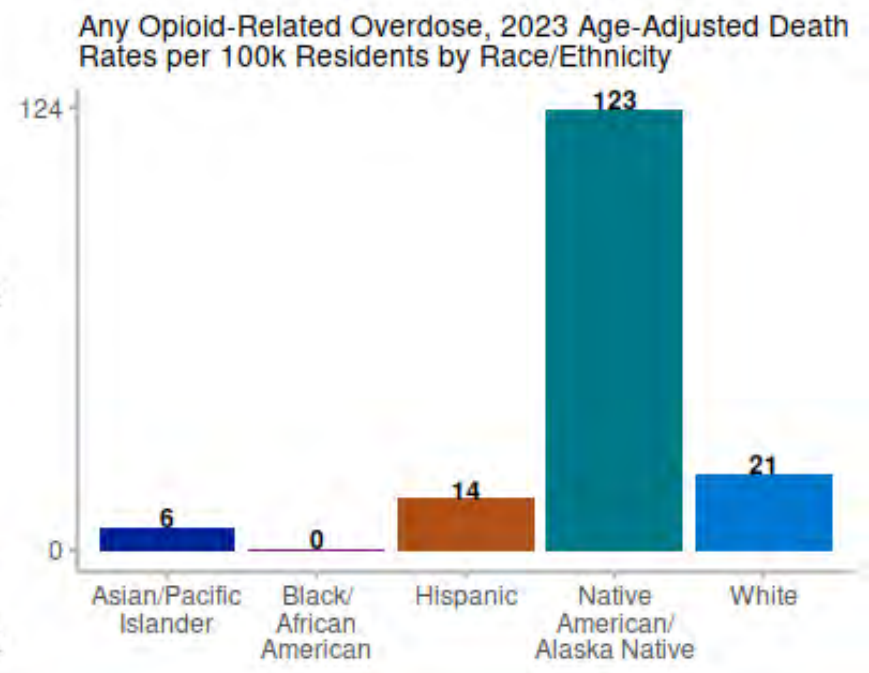
Santa Barbara experienced 64 opioid-related overdose deaths in 2023, the most recent full year of data available. The annual age-adjusted mortality rate for 2023 was 16.26 per 100k residents, an increase of 54.83% from 2022. The following charts present 12-month age-adjusted rates for selected overdose indicators (visit the CA Overdose Surveillance Dashboard **Data Definitions** page for indicator details). The map displays the annual age-adjusted rates for Any Opioid-Related overdose deaths by zip code. Synthetic opioid overdose deaths may be largely related to fentanyl.











Footnotes:
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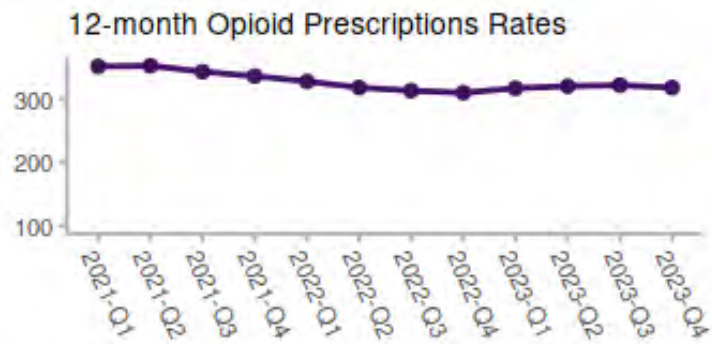
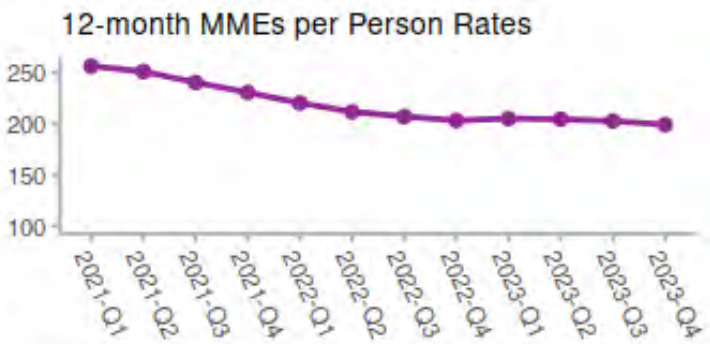
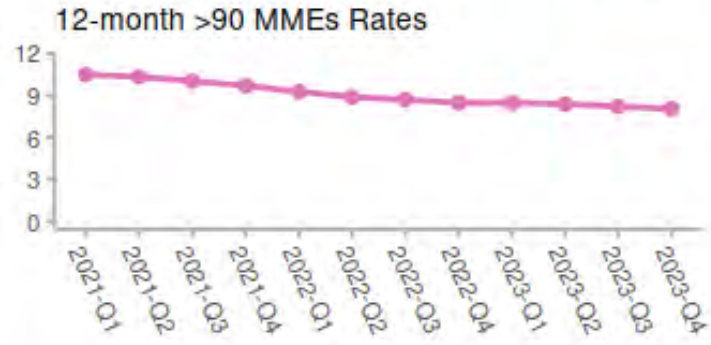
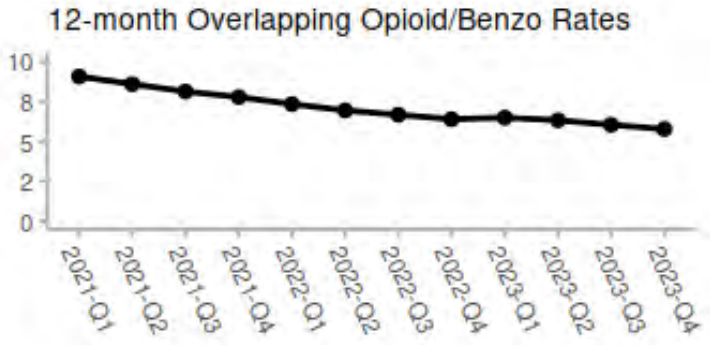
Prescribing

There were 160,971 prescriptions for opioids in Santa Barbara in 2023. The annual age-adjusted opioid prescribing rate for 2023 was 318.64 per 1,000 residents. This represents a 3% increase in prescribing from 2022. The following charts present 12-month moving averages for age-adjusted opioid prescribing rates, MMEs (morphine milligram equivalents) per person, high dosage (i.e. greater than 90 Daily MMEs in the quarter), and opioid/benzodiazepine overlap age-adjusted rate from 2021 to 2023.



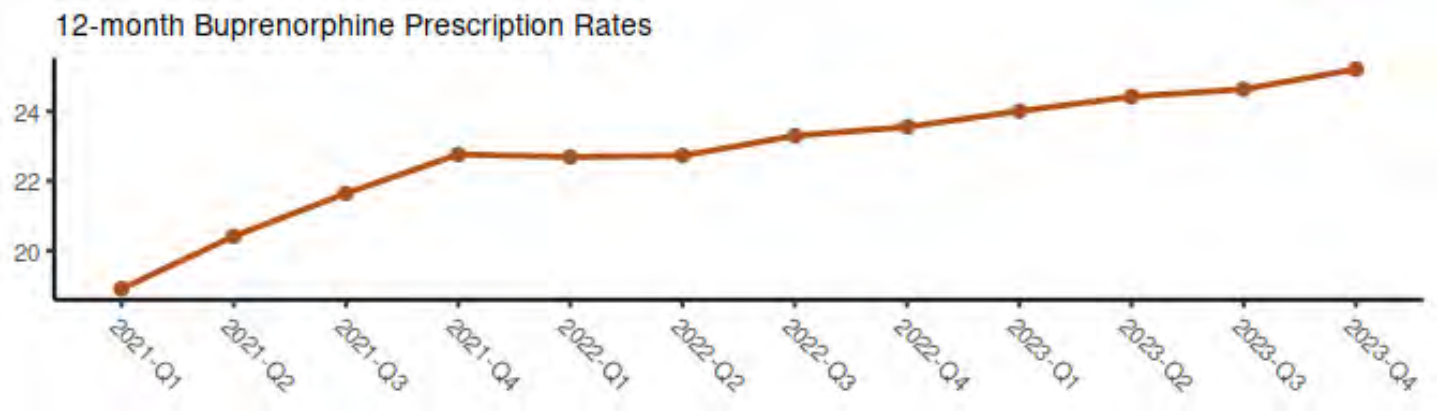






Treatment

Buprenorphine prescriptions in the county are used to gauge the expansion of medications for opioid use disorder (MOUD). The annual age-adjusted buprenorphine prescribing rate for 2023 was 25.21 per 1,000 residents. This represents a 7% increase in buprenorphine prescribing from 2022.



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