2025 Community Health Needs Assessment

Marian Regional Medical Center
Arroyo Grande Community Hospital

Adopted May 2025

Dignity Health.
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Executive Summary

The purpose of this community health needs assessment (CHNA) is to identify and prioritize significant health needs in the community served by Marian Regional Medical Center and Arroyo Grande Community Hospital ("the Hospital"). The priorities identified in this report help to guide the Hospital's community health improvement programs and community benefit activities, as well as its collaborative efforts with other organizations that share a mission to improve health. This CHNA report meets the requirements of the Patient Protection and Affordable Care Act, which mandates that not-for-profit hospitals conduct a CHNA at least once every three years.

Marian Regional Medical Center ("the Hospital") is located at 1400 East Church Street in Santa Maria, California, and has been serving the community since its founding in 1940. The Hospital also operates a second facility 17 miles to the north under the same hospital license, Arroyo Grande Community Hospital. Arroyo Grande Community Hospital is located at 345 South Halcyon Road in Arroyo Grande, San Luis Obispo County, California. The Hospital is a member of Dignity Health, which is part of CommonSpirit Health.

The Hospital community includes the following zip codes: 93420 (Arroyo Grande), 93433 (Grover Beach), 93434 (Guadalupe), 93444 (Nipomo), 93445 (Oceano), 93449 (Pismo Beach), 93454 and 93458 (Santa Maria), and 93455 (Santa Maria and Orcutt).

The community is home to 234,668 residents, with over half (56%) of the residents identifying themselves as Hispanic or Latino(a) origin and approximately one-third (36%) consider themselves White alone, not Hispanic or Latino(a). The remaining community members either identify as Asian (4%), two or more races (3%), or members of the Black community (1%).

The Hospital serves the City of Santa Maria, home to approximately 110,000 residents, of which nearly 80% of the cities' population identifies themselves as Hispanic or Latino(a). Comparing Santa Maria to all U.S. cities with populations over 100,000, it has the 8th highest proportion of Hispanic or Latino(a) residents.

In addition to the residents mentioned above and typically not captured in U.S. Census data, the community is home to a Mexican Indigenous population originally from the Mexican states of Oaxaca and Guerrero drawn to work in the area. These individuals are often monolingual in their native pre-Hispanic indigenous languages of Mixtec or Zapotec. It is estimated 25,000 indigenous migrants live and work in Santa Barbara County, with Santa Maria housing the majority.

The community is unique due to its location on the Central Coast, with vast unincorporated areas, striking natural beauty, and thriving communities. Behind the striking natural beauty are geographically isolated communities that may host one of the 540 individuals experiencing homelessness in the area. Underrepresented individuals can be found residing in poverty, working in the shadows of the agriculture, tourism, or retail industries.

The Hospital's commitment to engaging with the community, assessing priority needs, and helping to address them with community partners, is in keeping with its mission. As CommonSpirit Health, we make the healing presence of God known in our world by improving the health of the people we serve, especially those who are vulnerable, while we advance social justice for all.

The 2025 CHNA data collection process included a compilation of primary and secondary data sources, comprising community organization focus groups, key informant interviews, public health statistics, and U.S. Census data. Primary qualitative data was obtained through the facilitation of focus groups with a total of 117 participants and key informant interviews with community stakeholders. Focus groups were held during the summer of 2024, and included targeted members of vulnerable populations, including LGBTQ+, Black or African American, those with limited English proficiency, unhoused, veterans, youth, and seniors. This mixed-methods approach validates data by cross-verifying from multiple sources, providing a broader perspective of the community and population health needs. This information was corroborated with secondary quantitative data obtained from datasets maintained by governmental and nongovernmental organizations at the local, state, and national levels.

The 2025 CHNA preparation team thoughtfully determined the significant community health needs during collaborative discussions and presentations with senior leadership. Qualitative data and anecdotal stories all pointed to the identified community health needs. The same concerns and needs consistently emerged and were reiterated throughout many focus group meetings and key informant interviews. The following criteria were also utilized to evaluate the prioritization of community needs, including:

- Size or scale of the problem (how many impacted);
- Severity of the problem;
- Disparity and equity;
- Known effective interventions;
- Resource feasibility and sustainability; and,
- Community support.

The data collected and results presented in this CHNA were obtained prior to the November 2024 federal election. As shared during one focus group,

"A healthy community is one that is free from stigma and shame, where any individual can seek and receive the care they need." *– Focus group participant*

The following significant community health needs were determined for this 2025 CHNA report:

Priority 1: Culturally sensitive and accepting healthcare trusted by the community.

Priority 2: Readily available healthcare and navigation assistance in patients' spoken language.

Priority 3: Unmet vital conditions, including transportation, finances, housing (including the unhoused population), education, the environment, and childcare.

Priority 4: Access to improved behavioral health, including substance use disorder treatment, and navigation of services with a special emphasis on the unhoused population.

The communities' struggles to access healthcare go beyond statistics regarding health insurance, the number of physicians/clinics in the community, or the time since a person's last doctor visit. The barriers facing the community lie in how to navigate the healthcare system, getting to the appointment, receiving care in their spoken language, and being welcomed through the door. Focus groups were held with similar vulnerable populations across Dignity Health California Region's Central Coast Hospitals, and their shared stories and struggles were commonly reported across the area. Throughout the focus group sessions, it became apparent repeatedly that certain community members avoid seeking healthcare due to either a lived experience or a shared experience. While this CHNA identifies the communities' challenges, it is a thriving and resilient community that will unify and collaborate to address the needs.

While potential resources are available to address the identified needs of the community, these needs are too significant for any single organization. Making a substantial and upstream impact will require the collaborative efforts of community organizations, local government, local business leaders, and other institutions. The needs identified in this CHNA will be address in a Community Health Implementation Strategy that will be published in November 2025.

The 2025 CHNA report was completed as a collaborative effort between Patty Herrera, MA, Director of Community Health, Dignity Health California Region Central Coast Hospitals, and Amanda Gettig, MPH, Ganey Science, San Francisco, CA.

This CHNA report was adopted by the Marian Regional Medical Center Community Board in May 2025. The report is widely available to the public on the hospital's website, and a paper copy is available for inspection upon request at the Hospital's Community Education Office. Written comments on this report can be submitted to the hospital Manager of Community Health at 1400 E. Church Street, Santa Maria, CA 93454 or you may email CHNA-CCSAN@commonspirit.org.

I. Community Definition

Marian Regional Medical Center ("the Hospital") is located at 1400 East Church Street in Santa Maria, Santa Barbara County, California. The Hospital also operates a second facility 17 miles to the north under the same hospital license, Arroyo Grande Community Hospital. Arroyo Grande Community Hospital is located at 345 South Halcyon Road in Arroyo Grande, San Luis Obispo County, California. The Hospital is a member of Dignity Health, which is part of CommonSpirit Health.

The Hospital serves approximately 234,000 individuals from the urban and rural areas of northern Santa Barbara County and southern San Luis Obispo County, California. The community served by the Hospital primarily resides within the incorporated areas of Orcutt, Santa Maria, Guadalupe, Nipomo, Arroyo Grande, Grover Beach, Oceano, and Pismo Beach. The community served by the Hospital includes the following zip codes:

Santa Barbara County	San Luis Obispo County
93434 (Guadalupe)	93420 (Arroyo Grande)
93454 (Santa Maria)	93433 (Grover Beach)
93455 (Santa Maria and Orcutt)	93444 (Nipomo)
93458 (Santa Maria)	93445 (Oceano)
	93449 (Pismo Beach).

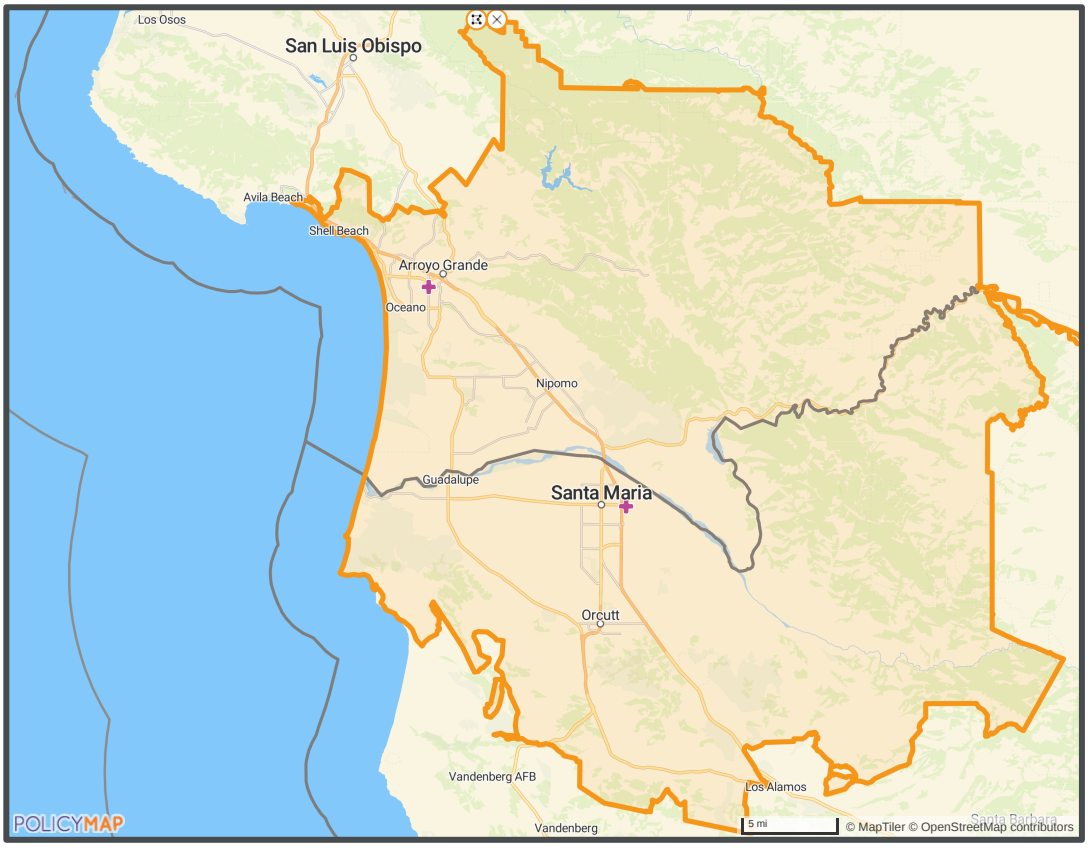
The community served by the Hospital is uniquely situated along the central coast of California in the Santa Maria Valley, which originates at the Pacific Ocean and narrows inland as it is bounded by the Casmalia Hills, Solomon Hills, and the Los Padres National Forest. This geographic area was originally part of the Chumash territory, whose ancestors call themselves "the first people."[1] The Coastal Band of the Chumash Nation is a sovereign nation of Coastal Chumash Indigenous Peoples, whose ancestors lived in what is now known as San Luis Obispo, Santa Barbara, Ventura, and other Counties within central and southern California for over 10,000 years.[2] After the Spanish exploration in 1769 and colonization, the central coast of California became part of Mexico and Spanish was the dominant language.[3] Following independence from Mexico in 1847, San Luis Obispo and Santa Barbara Counties were established in 1850 as two of the original 27 counties in

[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] The city was named Santa Maria in 1885 and by the end of the 19th century, the Santa Maria River Valley had become one of the most productive agricultural areas in the state. The City of Santa Maria is the largest city by population in Santa Barbara County with 109,707 residents at the time of the 2020 U.S. Census. Agriculture remains a key component of the economy for the city and the entire community.[5]

The Hospital's community does not exclude any low-income or underserved populations and includes all members of the community. The community served by the Hospital aligns with the residence location for more than 75% of all inpatient discharges. Marian Regional Medical Center and Arroyo Grande Community Hospital are the only acute care hospitals serving the community. They are supported by the San Luis Obispo County Public Health Department and Santa Barbara County Public Health Departments. The community served by the Hospital is geographically depicted in Figure 1.

Figure 1. Communities Served by the 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.

According to the American Community Survey (2019-2023, 5-year Estimates), the overall community served by both facilities of the Hospital is home to 234,668 residents. The community is ethnically diverse with over half (56%) of the residents identifying as Hispanic or Latino(a) origin, and approximately one-third (36%) consider themselves White alone, not Hispanic or Latino(a). The remaining community members either identify as Asian (4%), two or more races (3%), or members of the Black community (1%). Nearly half (113,771) of the community served by the Hospital are members of Medi-Cal.

The Hospital serves the City of Santa Maria which has approximately 110,000 residents, of which 79.3% of the population identify themselves as Hispanic or Latino(a). Comparing Santa Maria to all U.S. cities with populations over 100,000, it has the 8th highest proportion of Hispanic or Latino(a) residents.

The Hospital supports two distinct communities: approximately two-thirds of the community reside in Santa Barbara County (153,637 individuals) and commonly utilizes Marian Regional Medical Center, and one-third of the community resides in southern San Luis Obispo County (81,031 individuals), and frequents Arroyo Grande Community Hospital.

Northern Santa Barbara County

Approximately 70% of the northern Santa Barbara County community consider themselves of Hispanic or Latino(a) origin, with a much lesser 23% identifying as White alone, not Hispanic or Latino(a). The remaining community members either identify as Asian (4%), two or more races (2%), or members of the Black community (1%).

Approximately one in seven (14.3%) live below the federal poverty level, which increases to 28.2% in Guadalupe (93434) and 17.9% in Santa Maria (93458). In the City of Santa Maria only 62.8% of the population 25 years and older have attained a high school degree or equivalent. Over half (57%) of the community members residing in northern Santa Barbara County speak a language other than English, and one in four (26.2%) speak English less than very well. Overall, the youth and young adult population residing in the community is robust and accounts for approximately 40% of the population with a median age of 32.3. According to CenCal, over half (61.5%) of the community are members of CenCal with 87,951 CenCal members residing in the City of Santa Maria.

Southern San Luis Obispo County

The community served by the Hospital that resides in southern San Luis Obispo County is the inverse of the Santa Barbara County community. Overall, 61.4% of community members identify as White alone, not Hispanic or Latino(a) and a lesser 29.4% identify as Hispanic or Latino(a). The remaining 9% primarily identify as Asian alone (2.8%) or two or more races (4.6%), with approximately 1% identifying themselves as members of the Black community.

Approximately 8.6% of the southern San Luis Obispo County community live below the federal poverty level, which is less than the rate for the entire county (12.8%) and for the state (12.0%). Over 42% of community members living in southern San Luis Obispo County have public health insurance coverage, with one in four covered by CenCal, and about 5% have no health insurance coverage.[6] The southern San Luis Obispo County community has a median age of 45.5, with over a third (38%) being 55 and older. Table 1 provides U.S. Census population characteristics for the community.

Table 1. Hospital Community Served Demographics[7]

U.S. Census Data	Southern San Luis Obispo County	Northern Santa Barbara County	Hospital Community Served
Total population	81,031	153,637	234,668
Median age (years)	45.5	32.3	37.0
Percent Hispanic or Latino(a)	29.4%	70.1%	56.0%
Percent White alone, not Hispanic or Latino(a)	61.4%	22.3%	35.8%
Average median household income	$100,674	$88,770	$93,843
Percent of families live in poverty (below 100% federal poverty level)	6.2%	9.9%	8.4%
Unemployment rate	3.3%	6.5%	5.3%
Percent with less than a high school diploma, 25 years and over	9.9%	30.2%	22.1%
Percent, age 5 and older who speak English less than "very well"	7.2%	26.2%	19.5%
Percent without health insurance	5.4%	13.2%	10.5%
No. of Medi-Cal/CenCal Members[8]	19,157	94,614	113,771

Further evaluation regarding demographic indicators including economics and education is provided in Section III Assessment Data and Findings, below. Additional community population details can be found in Appendix A.

[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.

Communities of Concern

The 2024 Santa Barbara County Point in Time (PIT) Count[9] overall found a 12% increase in the number of individuals experiencing homelessness from 2023 in the County. On the night of the count, there were 424 persons experiencing homelessness in Santa Maria, an 11% increase from the prior year, and 116 individuals in the North County unincorporated areas. More than a third of the people experiencing homelessness on the night of the count were over the age of 55.

The 2024 San Luis Obispo PIT Count documented the following number of individuals experiencing unsheltered homelessness in the following communities: 88 individuals at the Santa Maria Riverbed; 73 individuals in Grover Beach; 60 individuals in Arroyo Grande; 28 in Nipomo and 21 in Pismo Beach.

In addition to the residents captured by the formalized data sources above, the Mexican Indigenous population residing in Santa Barbara and San Luis Obispo Counties originate from the Mixteca Region of Mexico, which includes the states of Oaxaca, Guerrero, Michoacán, and Puebla. These individuals are often monolingual in their native pre-Hispanic Indigenous language of Mixtec or Zapotec. The Mixteco Indígena Community Organizing Project (MICOP) estimates that there are 25,000 indigenous migrants that live and work in Santa Barbara County,[10] with Santa Maria housing the majority of farmworkers in the County.[11] These individuals often work in labor-intensive agricultural sectors such as row crops (strawberries and raspberries) and cut flowers. Mixtecs perform an increasing amount of physical labor, which makes farming profitable and fresh fruits and vegetables available to the public.

Medically Underserved Areas/Populations and Health Professional Shortage Areas

The U.S. Health Resources and Services Administration (HRSA) has identified Medically Underserved Areas/Populations (MUA/P) and Health Professional Shortage Areas (HPSA) within the community. HRSA estimates the community has a health professional shortage for primary care, mental health, and dental providers, as well as medically underserved communities in Guadalupe and Arroyo Grande. These designations have been provided in Table 2.

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[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.

Table 2. MUA/P and HPSA as Identified by HRSA in the Community[12]

Discipline	ID Number	HPSA or Service Area Name	Designation Type	Designation Date
Primary Care	00301	Guadalupe Service Area	Medically Underserved Area	12/22/1992
Primary Care	00395	Arroyo Grande Service Area	Medically Underserved Area	05/11/1994
Primary Care	1062140915	ME-MSSA 180.1/ Orcutt/Santa Maria	Medicaid Eligible Population HPSA	07/08/2020
Mental Health	7063481715	MSSA 171/172 – Arroyo Grande/San Luis Obispo	High Needs Geographic HPSA	03/07/2022
Mental Health	7062778515	MSSAs 178.1/178.2/179/180.2 – Solvang/Lompoc/Guadalupe	Geographic HPSA	11/08/2021
Mental Health	7062407340	LI/MFW-MSSA 180.1/Santa Maria	Low Income Migrant Farmworker Population HPSA	12/04/2015
Dental Health	6062701245	LI/MSSA 172 – San Luis Obispo	Low Income Population HPSA	11/17/2022

[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. Assessment Process and Methods

The 2025 Community Health Needs Assessment (CHNA) was completed through a compilation of primary qualitative and secondary quantitative data sources. Broad interests of the community were solicited and taken into account through primary data sources including focus groups, key informant interviews, and input from the San Luis Obispo County and Santa Barbara Public Health Departments. This information was corroborated with secondary quantitative data obtained from datasets maintained by governmental and nongovernmental organizations at the local, state, and national levels. This mixed-methods approach allowed for the cross-referencing of data to validate information and provide a broader perspective of community health needs. Each data source and the process utilized for collection and assessment are described in the following subsections.

Focus Groups, Vulnerable Populations

In collaboration with Dignity Health California Region Central Coast Hospitals (French Hospital Medical Center), a comprehensive focus group program was developed and completed in 2024. The goal was to take into account members of the medically underserved, low-income, and minority populations in the community, including vulnerable populations.

To maintain consistency with the State of California Community Benefit Reporting Requirements, the definition of vulnerable populations from Assembly Bill (AB) 1204 was utilized. Focus groups included members of vulnerable populations, including LGBTQ+, Black or African American, those with limited English proficiency, unhoused, veterans, youth, and seniors.[13]

Overall, 17 focus groups were facilitated by the Dignity Health California Region Central Coast Hospitals Team between June 5 and July 25, 2024, either virtually or in-person, to 117 participants. Focus groups were conducted in English, Spanish and Mixteco, to participants from teenagers through seniors, and 14 focus groups were specific to the community. The focus group participants were organized based upon demographics and whether they were individuals or community-based organizations. Each focus group participant received a $30 gift card as a token of appreciation for their time. Table 3 provides summary characteristics about the participants in each focus group.

Specific details regarding the focus group methodology and analysis are provided in Appendix B and summaries of each focus group are provided in Appendix C. Focus group results are provided in Section III. Assessment Data and Findings and Appendix B.

[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.

Table 3. Hospital Focus Groups

Individuals	Community Providers
Veterans	Unhoused Service Providers
Seniors at Mussell Senior Center	Underserved Youth Providers
Youth Santa Maria	Mixteco Interpreters
Mixteco Mothers (Herencia Indígena)	Promotores San Luis Obispo and Santa Barbara Counties
Spanish Speaking Mothers	Veteran Service Providers
Mixteco Speaking Farmworkers (California Farmworker Foundation)	
LGBTQ+	
Black Community (NAACP)	

Healthcare Providers Key Informant Interviews

Key informant interviews were conducted with invited Dignity Health California Region Central Coast Hospitals providers who serve the community, including the medically underserved, low-income, and minority populations. These key informant interviews were also facilitated by the CHNA preparation team, which asked a similar set of questions to those posed in the community focus groups. Key informant interviews were held with the Dignity Health Maternal Health Team, Dignity Health Medical Safe Haven Clinic, Dignity Cancer Center, and the Dignity Health Care Transitions Team. Summaries of these interviews can be found in Appendix D, and their input has been included throughout the report.

County Public Health Departments

The Santa Barbara County Public Health Department is an active participant in a collaborative with other hospitals in southern Santa Barbara County and CenCal. The Hospital has been in communication with the Santa Barbara County Public Health Department about their participation in the collaborative and the preparation of this 2025 CHNA since 2023, and the purpose of the collaborative is the preparation of a county-wide needs assessment. Unfortunately, the timeline and definition of community served evaluated as part of the Santa Barbara County Health Collaborative does not align with this CHNA. However, the Hospital remains an active participant in the Santa Barbara County Health Collaborative attending regular meetings and as a member of the secondary data workgroup.

Also, an initial meeting was held between Dignity Health and the San Luis Obispo County Public Health Department (SLOPHD) on July 8, 2024, regarding the CHNA process Dignity Health was initiating for its 2025 CHNA report. Talks of future collaboration and alignment were discussed, as well as SLOPHD's willingness to support Dignity Health through this process and their

excitement for the focus group results. A follow-up meeting was held on October 28, 2024, to share the preliminary results of the focus groups and gather any feedback they may have. SLOPHD was complimentary of Dignity Health's ability to reach the most vulnerable population and agreed with the preliminary results. SLOPHD expressed their desire to approach the implementation strategy collaboratively. Following the adoption of this CHNA, additional meetings will be scheduled with SLOPHD.

Written Comments from Previous CHNA

The Hospital invited written comments on the most recent CHNA Report and Implementation Strategy both in the documents and on the Hospital web site, where they are widely available to the public. No written comments have been received at the time of this CHNA report development.

Secondary Data Sources

The CHNA encompasses a multitude of secondary data indicators that help illustrate the community's health. Secondary data from local, county, state, and national sources were reviewed and include data points about demographics, mortality, morbidity, social determinants of health, health behaviors, clinical care, health outcomes, and physical environment. Secondary county, state, or national level data sources provide a comparison to community-level qualitative data. This CHNA report utilized the following secondary data sources, among others:

Centers for Disease Control and Prevention (CDC), Social Vulnerability Index	County of San Luis Obispo
CDC Behavioral Risk Factor Surveillance System	U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion
U.S. Census	Education Data Partnership
CenCal Health	SLO Health Counts
California Department of Education	California Department of Justice
California Department of Public Health	California Health Kids Survey
California Energy Commission	

All secondary data sources were thoroughly evaluated, and every effort was made to use the best available data at the time of report publication. While there are always data limitations, the assembled data, information, and completed analyses comprehensively identify and describe significant community health needs.

CHNA Report Preparers

This CHNA report and the preceding data collection process were completed as a collaborative effort between Patty Herrera, MA, Director of Community Health, Dignity Health California Region Central Coast Hospitals, and Ganey Science, San Francisco, CA. Patty has been a champion of community health since 1991 and has been responsible for the community health survey data collection process and compilation since 2016. The Ganey Science Team was led by Amanda Gettig, MPH, who has been preparing the Hospital CHNA reports since 2016 and began her career in public health in 2013 with Dignity Health, St. John's Regional Medical Center, Oxnard, CA.

III. Assessment Data and Findings

The data assessment for this CHNA Report consists of a systematic review of primary and secondary data sources. The results of the focus groups are summarized below and will be presented and included within each subsection, as appropriate. The data assessment compares the community against state and national levels, as well as the U.S. Department of Health and Human Services' Healthy People 2030 (HP 2030) benchmarks, when available. Data were analyzed for health and social inequities, health indicators, health behaviors, and health conditions. The analysis specifically notes population segments that are particularly vulnerable or experiencing disproportionate unmet health needs or poor outcomes.

Focus Group Results

During the summer of 2024, 14 focus groups were conducted with community members who had limited English proficiency, were an ethnic or racial minority, veterans, unhoused, seniors, youth, or identified as LGBTQ+. These individuals were provided a safe space to share their lived experiences with the facilitators, allowing for an in-depth understanding of their community's needs. The data collected during the focus groups does not take into account the apprehension felt by many community members that began in November 2024. Table 4 below provides the top themes identified during the focus groups by vulnerable population.

Table 4. Top Themes by Vulnerable Population

Limited English Proficiency	LGBTQ+	Unhoused & Veterans
Access to care barriers: - Language - Cultural competence - Service access: negative experience - Cultural humility - Insurance - Communication issues - Stigma Access to basic needs Community building Navigation	Access to care barriers: - Stigma - Cultural competence - Diversity - Communication issues - Service access: negative experience Behavioral health Cultural humility, feeling dismissed	Behavioral health, including trauma Desire for advocacy & empowerment Substance Use Disorder Community building Access to Basic Needs Navigation

Black Community	Seniors	Youth
Access to care barriers: - Cultural competence - Trust Community building Inequality/Invisible Stigma Behavioral Health	Access to care barriers: - Insurance - Long wait time - Communication issues - Geographical barriers Access to basic needs Behavioral health Community building	Access to care barriers: - Cultural competence - Hours - Cultural humility - Language Values Behavioral health Access to basic needs Community building

Specific details regarding the focus group data analyses are provided in Appendix B and Tables B-2 to B-7 in Appendix B provide responses for each focus group question by vulnerable population. The following Figure 2 represents a word cloud from all of the focus groups, with larger words representing those mentioned more frequently.

Figure 2. Focus Group Word Cloud

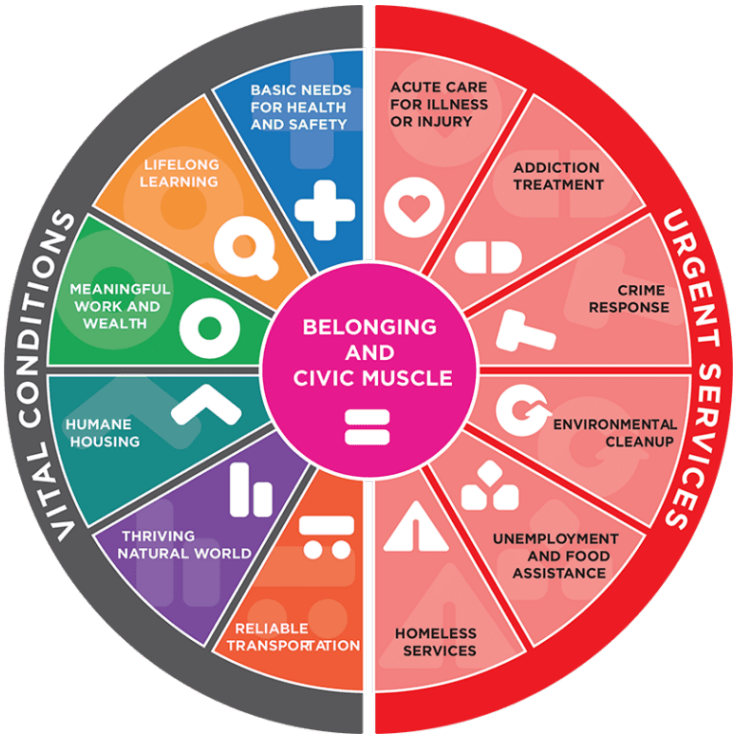
Vital Conditions Framework

One of the National Health Initiatives developed by the U.S. Office of Disease Prevention and Health Promotion is the Federal Plan for Equitable Long-Term Recovery and Resilience for Social, Behavioral, and Community Health (ELTRR) Plan. The Plan is organized around the Vital Conditions for Health and Well-Being structure. The overarching goal of the Plan states:

"All people and places THRIVING – no exceptions."

The strengths-based Vital Conditions for Health and Well-Being Framework provides an actionable, asset-based approach that is key to improving social determinants of health and addressing inequities. The Vital Conditions framework has roots in the community and is centered on the elements of "belonging and civic muscle." Civic engagement capacity and local, self-driven solutions are critical to addressing local needs.[14] Figure 3 further illustrates the relationship between vital conditions and urgent services.

Figure 3. Vital Conditions and Urgent Services[15]



[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.

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

Through the six urgent services developed alongside the vital conditions, communities can organize action to promote health equity and respond to crises that threaten health and well-being. The six urgent services are: acute care for illness or injury, addiction treatment, crime response, environmental cleanup, unemployment and food assistance, and homeless services. Urgent services are necessary and lifesaving, but they alone cannot produce human flourishing.

Social Determinants of Health

According to the U.S. Centers for Disease Control and Prevention, the Social Determinants of Health (SDOH) are the nonmedical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live and age and the forces and systems impacting daily life. The five key SDOH factors include:

- Economic stability,
- Education access and quality,
- Healthcare access and quality,
- Neighborhood and built environment, and
- Social and community context.

Figure 4. Social Determinants of Health

The SDOH are one of three priority areas for HP 2030, along with health equity and health literacy. During the focus groups, access to basic needs, which includes finances, transportation and housing were identified as a top need by the unhoused and veterans, seniors, youth, and the limited English proficiency community. A graphic depicting the SDOH is provided in the adjacent Figure 4.[16]

Economic Stability | Meaningful Work and Wealth

Income influences all aspects of an individual's life, including the ability to secure housing, food, transportation, health care, and childcare. Income also impacts an individual's ability to maintain good physical and mental health.

HP 2030 Goal: Reduce the proportion of people living in poverty.
Target: 8.0%

[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.

According to the U.S. Census, American Community Survey (2019-2023, 5-Year Estimates), 1 in 8 people or 12.0% of California residents live in poverty. These individuals are less likely to have access to health care, healthy food, stable housing, and opportunities for physical activity. In Santa Barbara County, 13.8% of all residents live below the poverty level, and in San Luis Obispo County this number improves slightly to 12.8%. The unemployment rate in the community is 5.31% which is slightly better than the California rate of 6.4%.

In the community, poverty rates range from a low of 5.3% in Nipomo (93444) to a high of 28.2% in Guadalupe. Poverty rates exceed the state poverty rate of 12.0% in Grover Beach (12.7%), Oceano (17.1%), Santa Maria - 93454 (13.9%), and Santa Maria – 93458 (17.9%). According to the 2025 Poverty Guidelines, as published by the U.S. Department of Health and Human Services, households with income below $15,650 for a one person household and $32,150 for a four person household are considered in poverty.[17]

In 2023, the gross domestic product for Santa Barbara County was $38.5 billion[18] and in San Luis Obispo County it was $22.8 billion.[19] In California, between 2018-2020 the majority of strawberry production occurred in the Salinas-Watsonville and Santa Maria areas. According to the U.S. Census, the agriculture, forestry, fishing and hunting industry employs 29.1% of civilians over the age of 16 years.[20]

In Santa Barbara County, according to the 2023 Crop and Livestock Report 2023, the gross production value of agriculture in the county was $1.8 billion, of which strawberries

Photo provided by Santa Maria Times.

[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.

accounted for $775 million.[21] Harvesting fresh strawberries is labor intensive, given that strawberries are mostly hand-picked, and the field is harvested more than 30 to 50 times during a season.[22] Despite the intensive labor required for specialty crops like strawberries, farmworkers are paid far less than comparable positions which are similarly physically demanding and hazardous. Agricultural laborers have historically been among the lowest paid occupations in the United States and are made up of the most marginalized individuals. Racial discrimination, labor exclusions, and immigration policy have limited the economic opportunities for farmworkers and impeded progress in their working conditions and quality of life. Table 5 below provides a comparison between farmworker income and other occupations.[23]

Table 5. Farmworker Income Comparison

	Mean Hourly Wage	Annual Wage 1 Adult	Annual Wage 2 Adults and 2 Children
MIT Living Wage Calculator	$32.11 / $36.53	$44,175	$129,954
United Way Real Cost Measure	$22.21 / $26.83	$46,198	$111,602
Santa Barbara County Median Income	$46.14	$48,013	$95,977
Santa Barbara Farmworkers	$17.42	$36,244	$72,488
Nonfarm (ex. Heavy truck driver)	$26.76	$55,672	-
Construction Laborers	$25.04	$52,104	-

The yearly farmworker income assumes work all year-round, but many workers earn their income during the summer and use those earnings to get by until the next harvesting season.

Mixteco interpreters shared in a focus group that low wages impact the health and access to care of the farmworker patients they serve. They also shared that their paychecks can vary because they are paid by the number of boxes they fill in a day instead of an hourly rate.

"We have been allowed to survive, but never allowed to truly live,"

said the teenage son of a farmworker. "*We are not objects imported from Mexico. We are humans that are worth fighting for."* He shared that his mother had broken her back to feed others' children, "*Now I'm asking you to feed us."*[24] Between 2019-2020, many farmworkers earned an annual

[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. 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.

income below $30,000. Farmworkers' wages have not increased with the rising costs of living in California's Central Coast and many farmworkers are unable to afford housing in the same area in which they work. As a result, farmworker families are forced to live in cramped apartment units or garage units. See more on housing in the farmworker community in the Humane Housing section below.[25]

Income often provides access to resources that promote good health, such as good schools, health care, healthy food, and safe neighborhoods. United Ways of California estimates 31% of households in San Luis Obispo County and 42% of households in Santa Barbara County struggle to meet their basic needs.[26]

According to the California Department of Education, 53.4% of students enrolled in San Luis Obispo County schools and 67.1% of students enrolled in Santa Barbara County Schools were eligible for free/reduced-price meals during the 2023-24 school year.[27][28] Specifically, 74.6% of students enrolled in Santa Maria Joint Union were eligible for free or reduced meals, 89.8% in Santa Maria-Bonita, and 90.4% of students enrolled in Guadalupe Union Elementary.[29] In Santa Maria and Arroyo Grande (93433, 93434, 93458, and 93445), over 90% of families that receive Food Stamp/SNAP benefits are working families.[30]

Income often provides access to resources that promote good health, such as good schools, health care, healthy food, and safe neighborhoods. United Ways of California estimates 31% of households in San Luis Obispo County and 42% of households in Santa Barbara County struggle to meet their basic needs.[31]

[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*

Humane Housing

Housing is the largest expense for most Americans, and so housing affordability is a significant factor in financial wellbeing.[32] Housing stability, quality, safety, and affordability all affect health outcomes. An individual's housing situation has serious implications – either positive or negative – on almost every other aspect of life, especially among children. Access to humane housing can determine who thrives and who struggles to survive.

HP 2030 Goal: Reduce the proportion of families that spend more than 30% of income on housing.

According to U.S. Department of Housing and Urban Development, a household is considered cost-burdened when it spends more than 30% of its income on rent and utilities. Severe overpaying occurs when households pay 50% or more of their gross income for housing.[33] In the community, the median household income is approximately $94,000, which means they should only spend approximately $28,000 on housing costs.[34]

The cost of rent has grown by 45% in Santa Barbara County and 36% in San Luis Obispo County since 2020.[35] According to the United Ways of California, 41% of all households in Santa Barbara County and 39% of households in San Luis Obispo County spend more than 30% of their income on housing.[36]

The California Department of Housing and Community Development identifies farmworkers as having special housing needs due to their limited income and the unstable nature of their employment.[37] Farmworkers are some of the lowest-paid workers in the U.S. and many have to share housing in order to afford it and other basic needs. According to the National Agricultural Workers Survey, 30% of farmworker households live in overcrowded housing (defined by the Census as having a ratio of more than one person per room).[38] The 2023 Farmworker Health report found that 25% of surveyed farmworkers reported sleeping in a room with three or more people.[39]

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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
[38] CAUSE & MICOP.
[39] CAUSE & MICOP.

A 2022 Farmworker Health Study published by UC Merced Community and Labor Center, found that more than a third (37%) of farmworkers reported bad-tasting water at home, which indicates poor water quality and possible health risks.[40] Other substandard housing issues reported include difficulty keeping their home cool (39%) or warm (36%), rotting wood (16%), mold (14%), water leaks (12%), cockroaches (24%), and rodents (17%).

Reliable Transportation

Reliable, safe, and accessible transportation is one of the seven vital conditions because access to transportation is a major driver of health and wellbeing. Individuals living in poverty, with functional limitations, and those who are under- or uninsured have a higher health care–related transportation burden. Across thirteen focus groups representing medically vulnerable populations, access to transportation was identified as a health need in all but one group.[41] Transportation was also identified as a primary community health need in key informant interviews with the maternal health care team and cancer center staff (Appendix D).

A youth service provider shared in a focus group that many of their community members do not know how to drive, so they will walk long distances to their medical appointments which takes time away from working and can be physically demanding if they are ill or recently gave birth.

Mixteco community members shared that access to transportation is a barrier to care for them because many do not have cars and do not know how to use public transportation or how to ask for medical transportation services. Lack of transportation was raised as a barrier to health and wellbeing in all of the focus groups with participants that speak Mixteco (Appendix C).

Participants in the senior focus group also shared that many of them do not have transportation and rely heavily on medical clinics that visit their housing development.

Education Access and Quality | Lifelong Learning

HP 2030 Goal: Increase educational opportunities and help children and adolescents do well in school.

Education has been described as the most important modifiable social determinant of health.[42] According to the U.S. Office of Disease Prevention and Health Promotion, people with higher levels of education are

[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.
[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

more likely to be healthier and live longer. Children from low-income families, children with disabilities, and children who are bullied or experience another form of social discrimination are more likely to struggle with math and reading. They are also less likely to graduate from high school or go to college.[43]

According to the U.S. Census, 78% of the community aged 25 and over are high school graduates. Specifically, educational attainment for the community was distributed as follows:

- 22% had less than a high school diploma or equivalent;
- 20% had high school graduate as their highest level of school completed;
- 31% had some college or an associate degree as their highest level of school completed;
- 17% had a bachelor's degree as their highest degree; and
- 9% had completed an advanced degree such as a master's degree, professional degree or doctoral degree.

The educational disparity increases as each zip code within the community is examined. Only half of the population (49.9%), over the age of 25, residing in Santa Maria (93458) completed high school. A similarly low high school completion rate of 57.4% can be found in 93434 (Guadalupe) and 73.9% in Santa Maria (93454).

The educational disparity increases in each zip code as a community member's ethnicity is taken into account. Overall, bachelor's degree attainment or higher by members of the Hispanic or Latino(a) community are approximately half or less than their White alone, not Hispanic or Latino counterparts. Specific details are provided on the following Table 6.

[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.

Table 6. Educational Attainment by Ethnicity for San Luis Obispo and Santa Barbara Counties[44]

U.S. Census Data		White alone, not Hispanic or Latino, 25 years and over		Hispanic or Latino(a) Origin, 25 years and over	
		High school graduate or higher	Bachelor's degree or higher	High school graduate or higher	Bachelor's degree or higher
SB County	Santa Maria (93454)	95.5%	30.1%	62.5%	10.4%
	Santa Maria/ Orcutt (93455)	96.1%	33.4%	75.6%	20.5%
	Santa Maria (93458)	85.4%	25.3%	42.0%	5.3%
	Guadalupe (93434)	87.0%	32.6%	50.8%	7.8%
SLO County	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%
	Oceano (93445)	87.4%	20.5%	62.3%	13.3%
	Pismo Beach (93449)	98.1%	51.0%	91.6%	42.3%

Limited English proficiency creates additional hurdles to accessing health care services and understanding health information. Focus group participants from the Hispanic/Latino(a) and Mixteco communities described feeling discriminated against after being turned away by health care providers due to language barriers. Participants cited language barriers and a lack of translators as significant challenges to health. There are 81 different variants of Mixteco, most of which are so different that communicating with those who speak a different variant or with a Mixteco interpreter from a different region is difficult if not impossible.[45]

Neighborhood and Built Environment | Thriving Natural World

A thriving natural world is a community that has sustainable natural resources and freedom from climate impacts. This includes clean air, water, and soil. While local industry is a source of employment and feeds the local economy, it may at times affect the physical environment, potentially exacerbating or increasing the risk factors for chronic disease.

HP 2030 Goal: Reduce the amount of toxic pollutants released into the environment.

[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.

While local industry is a source of employment and feeds the local economy, it at times may impact the physical environment, potentially exacerbating or increasing the risk factors for chronic disease. The California Department of Pesticide Regulation reported that over 6 million pounds of pesticide were used in 2022 to treat over 2.4 million acres in Santa Barbara County.[46] The county was ranked 11th of all California counties for total pounds of pesticide applied.[47] Specifically, 3.6 million pounds of pesticides were used to treat strawberries alone in the County with dozens of different chemicals applied. The community does include some agricultural lands in San Luis Obispo County, but a much lesser acreage as compared to the agricultural lands surrounding Guadalupe, Santa Maria, and Orcutt.

According to a presentation to Santa Barbara County Public Health Department, local reports and evidence-based studies find that farmworkers who are pregnant have higher health risks associated with their pregnancy due to working conditions and pesticide exposures. Studies show a relationship between pesticide exposure during pregnancy and low birthweight.[48]

Aside from the millions of pounds of pesticides that are used to insure the production of quality agricultural products, the air quality in the Santa Maria Valley is impacted by other industries and dust. The Air Quality Index, or AQI, is a standard value that was developed by the EPA so the public understands whether air pollution levels are healthy or unhealthy. AQI levels range from "good" to "hazardous." In 2023, the majority of days (232 or 63.6%) in Santa Barbara County were good, the remainder of the days (133 or 36.4%) were moderate, and no days were unhealthy for sensitive groups or higher.[49] A moderate air quality means that there is moderate health concern for individuals who are unusually sensitive to air pollution.

In addition, there is one U.S. Environmental Protection Agency Superfund Site in Santa Barbara County. The Casmalia Resources Superfund Site is an inactive, 252-acre commercial hazardous

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[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.

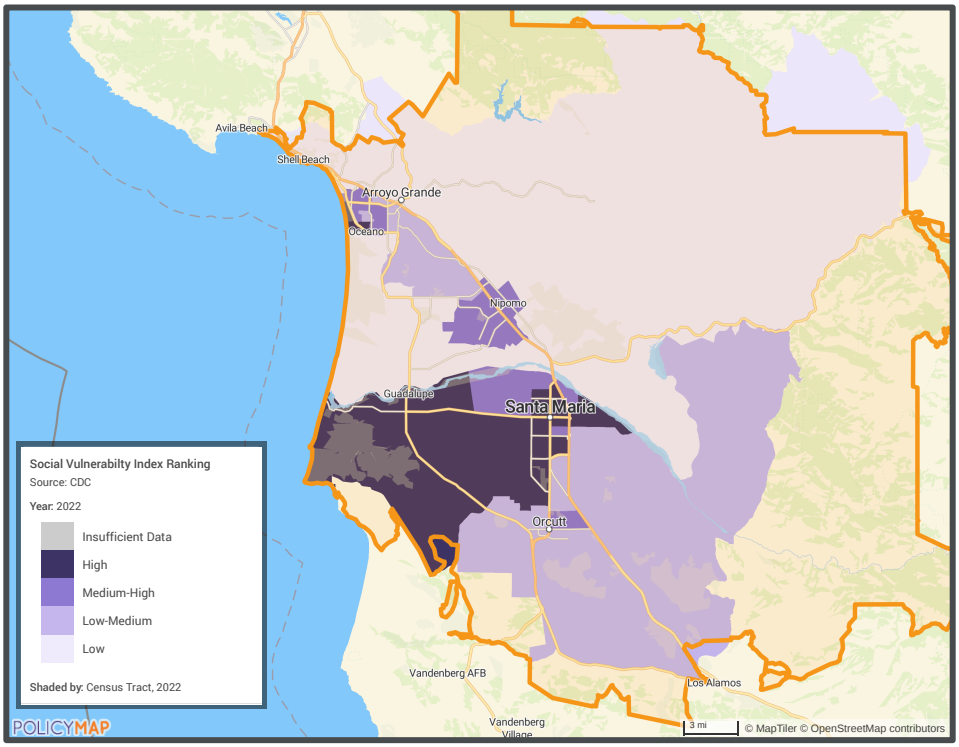
[49] Santa Barbara County. (October 2024). *2023 Annual Air Quality Report. https://www.ourair.org/wp-content/uploads/2024-10bd-g1.pdf.* Accessed March 31, 2025.

waste treatment, storage and disposal facility in northern Santa Barbara County, southwest of Santa Maria.[50]

Social Vulnerability Index (SVI)

The Social Vulnerability Index (SVI) is a tool, developed by the CDC, that evaluates a community's capacity to prepare for, respond to, and recover from incidents that can cause human suffering and financial loss. The SVI examines indicators related to socioeconomic status, household composition and disability, minority status and language, and housing type and transportation. Scores are structured so that lower values represent lesser vulnerability, while higher values denote greater vulnerability. Overall, Santa Barbara County has a High SVI ranking, with San Luis Obispo County having a slightly better Medium-High SVI ranking. However, examined at the census tract level, High SVI areas can be found within Guadalupe (93434), Santa Maria (93455, 93458), and Oceano (93445). The darkest purple areas shown in Figure 5 represent the highest SVI census tract areas with medium purple representing the medium-high areas.

Figure 5. Social Vulnerability Index



[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.

Climate and Health

In alignment with Dignity Health's commitment to environmental stewardship and its Climate Action Plan, this needs assessment incorporates climate and health indicators. The physical environment in which an individual lives, learns, works, and plays is vital to their health. Access to the outdoors, clean water, healthy soils for agriculture, clean air, and park and recreation facilities all impact an individual's wellness. This section summarizes the local climate, the potential impacts of climate change on the environment and public health in the service area, and discusses potential ways to manage the effects of climate impacts on health.

Local Climate

Both Santa Barbara and San Luis Obispo Counties fall within the Central Coast Region, which is notable for its extensive natural ecosystems, many of which will be impacted by climate change. Hardwood forests, scrublands, and herbaceous grasslands comprise most of its land cover.[51] There is a strong demand for development in rural areas and agriculture is being developed on lands formerly supporting grazing or natural vegetation.

The community can be described as having a temperate Mediterranean climate with mild, wet winters and warm, dry summers. Arroyo Grande has an average high temperature of 72°F, low of 42°F and receives 16.0 inches of rain annually. [52] Similarly, in Santa Maria, the average high temperature is 68°F and the average low temperature is 51°F, and there is an average of 17 inches of rain annually.[53]

Climate Change in the Central Coast Region

California's Fourth Climate Change Assessment provides data showing a warming trend. Since 1986, California's annual temperature increases over most of the state have exceeded 1°F, with some areas exceeding 2°F.[54] The Climate Change and Health Profile Report projected changes in

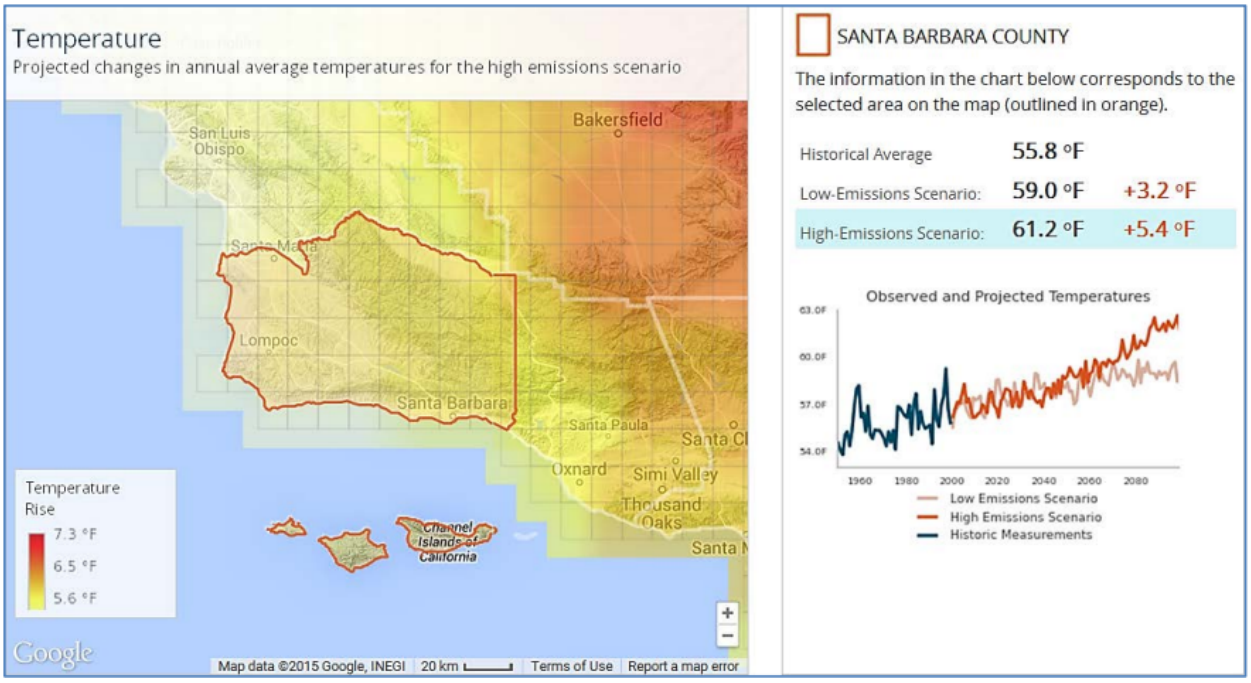
[51] California Energy Commission. (2018). *California's Fourth Climate Change Assessment Central Coast Region Report*. https://www.energy.ca.gov/sites/default/files/2019-11/Reg_Report-SUM-CCCA4-2018-006_CentralCoast_ADA.pdf. Accessed on October 23, 2024.
[52] County of San Luis Obispo. (2019). *San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

annual average temperature in a high carbon emissions scenario for San Luis Obispo and Santa Barbara Counties in the year 2099, as shown in Figure 6 on the next page.[55]

The Central Coast Region Report states the community is a very vulnerable agricultural region under climate change. Agricultural production is highly sensitive to climate change including the amounts, forms, and distribution of precipitation, changes in temperatures, and increased frequency and intensity of climate extremes.

Climate projections show an increase in extreme dry events. While only modest changes in mean precipitation are projected, when combined with increasing temperatures, the management of the Central Coast's already stressed water supplies will be challenging. Irrigated agriculture produces most of the harvested crops and a decrease in water availability could potentially reduce crop areas and yields. Additionally, as a consequence of more extreme droughts, lower stream flow and groundwater levels will harm crops by increasing the risk of wildfires when soil surfaces dry out. These impacts can affect food security.

Figure 6. Projected Temperature Change in Hospital Community by 2099 During High Emissions



The recently observed and projected acceleration of sea level rise is particularly significant to coastal communities. The style, frequency and magnitude of future El Niño events, combined with sea level rise, will be a key driver of coastal vulnerability in the coming decades. Narrowing and/or

[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.

loss of future beaches, and the ecosystems supported by those beaches, will primarily result from accelerating sea level rise combined with a lack of ample sediment in the system, which together will continue to drive the landward erosion of beaches, effectively submerging them between the rising ocean and the backing cliffs and/or urban hardscape.

Climate Change and Human Health

The impacts of climate change on human health are described by the National Institute of Environmental Health Sciences, which references global health organizations stating that the effects of climate change worsen many existing illnesses and diseases by increasing exposure to increased temperatures, introducing new pests and pathogens to an area, and affecting air and water quality.[56] The Fifth National Climate Assessment prepared by the U.S. Global Change Research Program states, "*It is an established fact that climate change is harming physical, mental, spiritual, and community health and well-being through the increasing frequency and intensity of extreme events, increasing cases of infectious and vector-borne diseases, and declines in food and water quality and security."* Certain populations are at higher risk for climate change health impacts, including children, the elderly, low-income populations, and persons with underlying health conditions.

According to data mapping by The New York Times, the highest climate risk in Santa Barbara and San Luis Obispo Counties is associated with water stress. The same data map lists sea level rise and wildfires as medium risks. High risk of water stress presents a clear risk to human health from drinking water shortages and reduced irrigation water for food supply.[57]

Managing Climate Impacts on Health

There are steps that can be taken to help manage and mitigate the negative impacts of climate on health in the service area. The Climate Change and Health Profile Reports for San Luis Obispo and Santa Barbara Counties have listed several public health strategies and near-term and short-term action steps for adapting to climate change. The goal of these strategies is to minimize the negative health impacts of climate change.

Wildfire and drought mitigation measures will help manage the predicted climate risk and water stress in the services area. Wildfire mitigation measures can consist of projects at the homeowner and community level and can consist of fuel management by reducing flammable vegetation, thinning tree canopies, and removing dead wood and debris. Land-use planning, development of

[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.
[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.

regulations, building codes, and homeowner education are also important components of wildfire mitigation.

Drought mitigation measures can consist of planning, water conservation measures, improved water storage, water recycling, and xeriscaping (drought landscaping). Funding may be available for natural hazard mitigation projects through the Federal Emergency Management Agency and other sources. Mitigation of extreme heat can be performed through strategic planning, including the establishment of extreme heat warning systems and the maintenance of cooling centers throughout the community.

Social and Community Context

The social and community context in which people live and work includes the relationships between neighbors and their social and civic connections. Social and community context can be evaluated through the following indicators:

- Discrimination;
- Incarceration and crime;
- Social cohesion and social connectedness; and,
- Community capacity.

The community is home to a number of churches, schools, gyms, parks, senior centers, and farmer's markets that can be used by the community and that foster community engagement. An example of the multitude of community organizations supporting the community are provided in Section V. Resources Potentially Available to Address Needs of this CHNA. According to the voting records, 52% of registered voters in San Luis Obispo County and 42% of registered voters in Santa Barbara County cast ballots in the March 2024 presidential primary election.[58]

The violent crime rate is the measurement of homicide, forcible rape, robbery and aggravated assault that occur in a community compared to the total population. Overall, Santa Maria's crime rate trend has fallen significantly since 2022. In 2023, the number of violent crimes, burglary, theft, and arson reduced 28% from 2022 levels in the City of Santa Maria. During the first four months of 2024 crime was down 30% as compared to the same time period one year earlier.

[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.

According to City of Santa Maria Police 2023 Annual Report, there were six homicides, 63 rapes, 428 aggravated assaults, and 751 motor vehicle thefts.[59]

According to the California Health Information Survey (CHIS) 2021-2022, half (51.2% or 22,000) of the teens that responded to the survey from Santa Barbara County have worried about being shot by a firearm. According to the CHIS` 2022-2023, in Santa Barbara County 30.2% of white individuals ages 19-30 have been stopped by the police at least once in the past three years, and 51.6% of Hispanic/Latino(a) individuals between the ages of 19-30 have been stopped at least once in the past three years.[60]

Human Trafficking and Domestic Violence

California has been identified by the FBI as one of the nation's top four destination states for trafficked persons, and San Luis Obispo and Santa Barbara Counties serve as a natural corridor for human trafficking activities between Los Angeles, The Central Valley, and San Francisco. Human trafficking is a form of modern day slavery where people profit from the control and exploitation of others [61] The Trafficking Victims Act of 2000 and its reauthorizations recognize and define two primary forms of human trafficking, sex trafficking and labor trafficking. Sex trafficking is recruiting, harboring, transporting, providing, obtaining, patronizing, or soliciting a person for commercial sex act, using force, fraud or coercion or in which the person induced to perform the act is not yet 18 years old. Labor trafficking is recruiting, harboring, transporting, providing, or obtaining a person for labor or services through force, fraud, or coercion for involuntary servitude, peonage, debt bondage, or slavery. Labor trafficking can occur in any industry including domestic work, agriculture, construction, forestry, professional services, science, technology, manufacturing, health, beauty, and landscaping.

According to the California Office of the Attorney General Open Justice data portal, in 2023 there were 35 domestic violence-related calls for assistance in Arroyo Grande and 536 in Santa Maria. The incidence of domestic violence related calls are often underreported due to fear. [62]

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[59] City of Santa Maria Police. (2024). *2023 Annual Report*. https://www.cityofsantamaria.org/home/showpublisheddocument/32047/638452225393600000. Accessed on March 23, 2025.
[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.

As shared during the unhoused service provider focus group about a female foster youth living in the Riverbed that was recently placed into a shelter,

"She had been in foster care forever, she timed out and then she was in the riverbed, being trafficked and running a lot of the drugs in the area…she goes, 'Why are you here?' I said, 'I want to help you.' She said, 'but why? I have always felt invisible my entire life.' For the first time in a very long time, someone told her that she matters." — *Unhoused Community Service Provider*

Health Care Access and Quality

Access to comprehensive, quality healthcare services is critical for achieving health equity and for increasing the quality of a healthy life for everyone. Inadequate health insurance coverage is one of the most significant barriers to healthcare access, and the unequal distribution of coverage contributes to health disparities.

HP 2030 Goal: Increase access to comprehensive, high-quality health care services.

For many community members, the opportunity to access healthcare, education, and employment requires relying on institutions that historically have not been a safe space for minority communities, immigrants, the LGBTQ+ community, women, and survivors of abuse. The community's ability to access healthcare was assessed through focus group discussions and key informant interviews supplemented with secondary data sources to validate information contributed for this report. As shared during the Black community focus group,

"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…" *– Focus group participant*

As previously mentioned, the community focus group participants' top needs across all focus groups were consistently access to care, access to care barriers, cultural competence of healthcare providers, and access to services.

As shared by the Farmworkers from Santa Maria focus group, as translated from Mixteco,

"Sometimes they know we don't have insurance and we are indigenous. Then it becomes discrimination. They pay less attention, the provider attends to those who have papers and who have social security than us. They are more important to them." *– Focus group participant*

Participant responses identified access to healthcare (including primary care and behavioral health) as an overarching challenge affecting community health, particularly among the youth population. As shared during the senior focus group,

"The doctors give you 15 minutes per visit, but you waited three months." – *Focus group participant*

The communities' struggles to access healthcare go beyond statistics regarding health insurance, the number of physicians/clinics in the community, or the last time you visited a doctor. The barriers facing the community lie in navigating the healthcare system, getting to the appointment, having care in their spoken language, and being welcomed through the door. Focus group participants shared that there are a lot of options when making a phone call to connect, and it is hard to get a hold of someone. Focus groups were held with similar vulnerable populations across the Dignity Health California Region's Central Coast Hospitals, and their shared stories and struggles were consistent across the region.

Chronic Conditions

Chronic diseases, including heart disease and cancer, are the leading cause of death in the United States, in California, and in San Luis Obispo and Santa Barbara Counties. According to the CDC, chronic diseases are defined as heart disease, stroke, cancer, diabetes, obesity, arthritis, Alzheimer's disease, epilepsy, and tooth decay. Chronic conditions also encompass mental health conditions, including depression and anxiety. Disparities emerge from policies and structural racism that separate the allocation of resources and opportunities.

Heart Disease and Stroke

Heart disease is the leading cause of death in the United States. According to the American Heart Association, cardiovascular disease can refer to a number of different conditions including coronary artery disease, heart attack, stroke, heart failure, arrhythmia, and heart valve problems. Heart disease risk factors include high blood pressure, high cholesterol, diabetes, obesity, an individual's lifestyle, age, and family history. These indicators are presented on Table 7 based on data from the California Health Information Survey (CHIS), 2023[63].

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

Table 7. Prevalence of Heart Disease and Stroke Indicators

CHIS Questions	San Luis Obispo County	Santa Barbara County	CA
Ever diagnosed with heart disease, adults age 50+	18.7%	11.5%	12.6%
Told have high cholesterol by health professional in the past year, adults age 20+	25.5%	20.9%	20.5%
High blood pressure, adults age 20+	32.4%	33.7%	28.1%
Adults (20+) with high blood pressure, taking medicine	80.7%	62.9%	80.0%

Cancer

HP 2030 Goal: Reduce new cases of cancer and cancer-related illness, disability, and death.

Cancer is a genetic disease that is caused by changes to genes that control the way cells function, especially how they grow and replicate. While some of the factors are inherited at birth, others are influenced by lifestyle and environmental factors. Cancer disparities are thought to reflect the relationship of socioeconomic factors, culture, diet, stress, the environment, and genetics. The poor and medically underserved are less likely to have recommended cancer screening tests than those who are medically well served. They are also more likely to be diagnosed with late-stage cancer that may have been treated more effectively if diagnosed earlier.

According to the California Cancer Registry, from 2017 to 2021 there were 8,979 cases of cancer in San Luis Obispo County and 11,479 cases of cancer in Santa Barbara County. The California Cancer Registry determined the crude rate of cancer for each county and then adjusted it for age, so that an "apples to apples" comparison could be made between the 58 counties in California. These rates were ranked from highest to lowest, with San Luis Obispo County having the fourth highest rate of cancer and Santa Barbara County having the fifth highest rate of cancer. The most common cancer sites with age adjusted rates for the Counties and state are provided on the following Table 8. [64]

[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.

Table 8. Age-Adjusted Cancer Incidence Rates (2017-2021)

Site	San Luis Obispo County		Santa Barbara County		California
	Total Cases	Age Adjusted Rate*	Total Cases	Age Adjusted Rate*	Age Adjusted Rate*
All Sites	8,979	456.3	11,479	453.1	398.3
Lung	818	38.6	921	34.6	36.8
Prostate, Males	1,319	124.7	1,887	150.0	99.0
Colorectal	610	32.0	808	32.7	33.5
Breast, Females	1,375	147.1	1,806	145.9	124.1
Melanoma of the Skin	1,054	55.2	675	26.8	22.8
* All rates are calculated per 100,000 people. Rates are age adjusted to the 2000 US Standard Population.					

Preventive cancer screening rates exceed the state rate (58.7%) in both Counties for colorectal cancer (San Luis Obispo County 66.1%; Santa Barbara County 60.5%) but fall below the state rate of 73.0% for mammograms (San Luis Obispo County 70.2%, Santa Barbara County 69.9%).[65]

Social and Emotional Wellness

Social and emotional wellness includes our emotional, psychological, and social wellbeing. Social and emotional wellness is essential to a person's overall wellbeing.

Chronic health conditions and traumatic experiences can also be tied to historical trauma. Individuals from marginalized communities that have been subjected to long term mistreatment and abuse often have a higher disease burden and greater health disparities. Community members and medical providers expressed during focus groups the desire and need for more efforts to competently address underlying trauma, life experiences, and stressors that influence health and wellbeing.

In 2022-2023, 19.5% of adults and teens in Santa Barbara County and 11.3% of adults and teens in San Luis Obispo County replied that they likely have had serious psychological distress during the past year. About one in five adults and teens in Santa Barbara County replied they likely had serious psychological distress in the past year.[66]

According to the California Healthy Kids Survey (CHKS) most recent data (2021-2023), 15-18% of 9th and 11th grade students in the community considered suicide. However, a high of approximately half of all 9th and 11th grade transgender or not straight-gay/lesbian/bisexual students in San Luis Obispo County reported considering suicide, as compared to a lesser 37% in

[65] University of California, San Francisco. California Health Maps website.
[66] UCLA. AskCHIS Dashboard. https://healthpolicy.ucla.edu/our-work/askchis/askchis-dashboard#!/results

Santa Barbara County.[67] Of the students surveyed, both female students and LGBTQ+ students were more likely to report sad or hopeless feelings. Research indicates that LGBTQ+ individuals face health disparities linked to societal stigma, discrimination, and denial of their civil and human rights.[68] Discrimination against LGBTQ+ persons has been associated with high rates of psychiatric disorders, substance use disorders, and suicide.

Trauma and toxic stress experienced in childhood have long lasting effects into adulthood. Adverse Childhood Experiences (ACEs) are all types of abuse, neglect, and other experiences in children's lives that may have the potential to cause traumatic stress or negatively affect children's feelings of safety and stability.[69] Children whose families are medically vulnerable or of low socioeconomic status are more likely to have ACEs. Medi-Cal has been screening its members for ACEs. Medi-Cal members ages 0-20 with an ACE Score of 4 or more ranges from a high of 13.7% in San Luis Obispo County to 6.5% in Santa Barbara.[70] Individuals with an ACE Score of 4 or more are 12 times more likely to have attempted suicide, 7 times more likely to be an alcoholic, and 10 times more likely to have injected street drugs. Addiction and suicide are the two health issues that most highly correlate with high ACE scores.[71] As shared during the veteran service providers' focus group,

"Most of the folks we are dealing with have, for one reason or another, lost trust by virtue of experience or trauma…there isn't a sense of belonging." – *Veteran service provider*

These experiences can increase the risks of injury, sexually transmitted infections, teen pregnancy, and involvement in sex trafficking. Foster youth often have high rates of ACEs and lack a steady support system, which makes them vulnerable to substance use and behavioral health disorders, sex trafficking, and housing instability.

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[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

[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.

Health Behaviors

Healthy behaviors can help reduce an individual's risk of developing chronic conditions and improve mental wellness. These healthy behaviors include maintaining a healthy weight, avoiding tobacco, limiting the amount of alcohol consumed, and physical fitness.

Childhood Obesity

According to the World Health Organization, obesity is a chronic, complex condition characterized by excessive fat deposits that can impair health. Obesity can lead to increased risk of type 2 diabetes and heart disease, it can affect bone health and reproduction, and it increases the risk of certain cancers.

Approximately 1 in 5 children and adolescents in the U.S. have obesity. Obesity affects some groups more than others, including adolescents, Hispanic/Latino(a) and non-Hispanic/Latino(a) Black children, and children in families with lower incomes.[72] The CenCal Health 2024 Population Needs Assessment found that of the pediatric CenCal Health members who were overweight or obese, 84% identified as Hispanic/Latino(a), whereas only 63% of the total member population identifies as Hispanic/Latino(a).[73] From 2020 to 2023, 46.2% of teens in San Luis Obispo County were considered obese, whereas only 18.1% of teens across the State of California were obese.[74]

Substance Use

Substance use is a high-risk behavior that can lead to immediate or long-term health problems, and ultimately impacts individuals, families, and communities. According to the California Department of Public Health, San Luis Obispo County has an opioid-related overdose age-adjusted rate of 30.02 per 100,000 residents. This rate makes San Luis Obispo County ranked 18th highest compared to all California counties (State rate = 20.81).[75] Santa Barbara County's rate is below the state rate at 16.3 per 100,000 residents with an increase in overdose death rates in Q4 2024. Additional information can be found in the Santa Barbara and San Luis Obispo Counties Overdose Snapshot Reports are available in Appendix E.

According to CHKS most recent data (2021-2023) reported that 24% of San Luis Obispo 11th grade students and a lesser 14% of Santa Barbara County 11th grade students reported using alcohol

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[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.

or drugs in the past 30 days. Smoking is the leading cause of preventable and premature death in the United States. Tobacco use or smoking in any form (including e-cigarettes) is unsafe and causes cumulative, irreversible harm. According to the CHKS, tobacco use by 11th grade students ranges from a high of 11% in San Luis Obispo County to 5% in Santa Barbara County.[76]

Mortality

According to the CDC Wonder database, cancer and heart disease were the two leading causes of death in Santa Barbara and San Luis Obispo Counties between 2018-2023. In California and Santa Barbara County, the leading cause of death is heart disease, followed by cancer, but in San Luis Obispo County it is cancer. The cause of death crude rate per 100,000 in Santa Barbara County are slightly higher than the state rates, but generally align. The cause of death rate per 100,000 in San Luis Obispo County exceeds the California rate, which could be attributed to the aging population that currently calls San Luis Obispo County home. Table 9 provides the leading cause of death in and the respective crude rate for Santa Barbara County, San Luis Obispo County, and California.

Table 9. Top 5 Underlying Cause of Death 2018-2023[77]

Cause of Death (2018-2023)	Crude Rate Per 100,000		
	Santa Barbara County	San Luis Obispo County	California
Cancer	155.6	195.4	152.6
Heart Disease	169.3	170.4	164.4
Strokes	52.7	93.0	45.0
Unintentional Injuries	51.4	53.6	47.1
Chronic lower respiratory diseases	29.0	44.0	31.9
COVID-19	29.3	31.8	41.7
Alzheimer disease	49.8	43.0	43.5

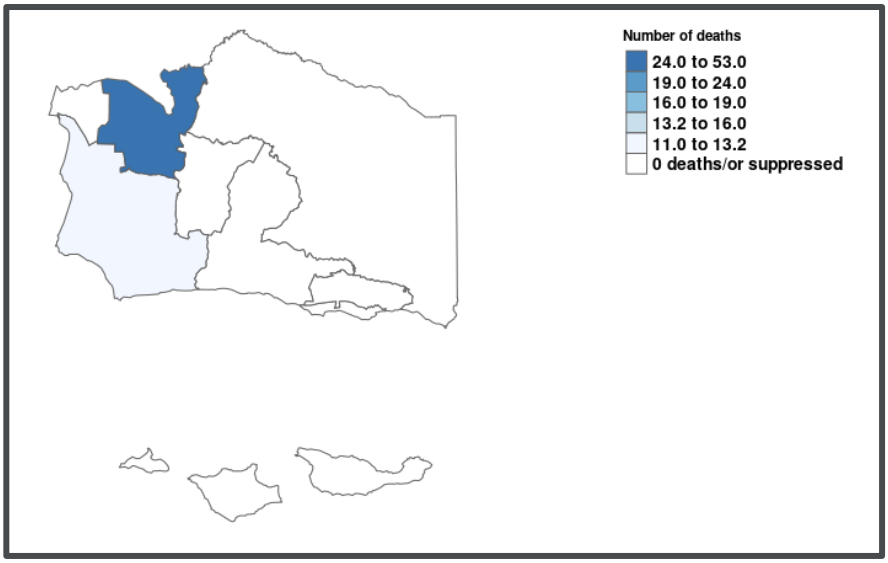
Anecdotally, in January 2025 there were 242 births at Marian Regional Medical Center, of which, 57 were to Mixteco speaking women or 23.5%. The Mixteco births resulted in 2 fetal deaths, and 55 live births, while the non-Mixteco mothers had 184 live births and one fetal death.

[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.

Figure 7 depicts the disparity between neonatal deaths as compared to other communities in Santa Barbara County as provided by the California Department of Public Health.[78]

Figure 7. Number of Deaths from Neonatal Conditions in 2019-2023 in Santa Barbara County and Statewide



[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. Prioritized Description of Significant Community Health Needs

The significant community health needs were thoughtfully determined during a Dignity Health California Region Central Coast Hospitals Leadership Meeting on February 6, 2025, and a collaborative discussion with the CHNA preparation team on March 4, 2025. Quantitative data, as well as qualitative data and anecdotal stories, all pointed to the priorities detailed in this section. The same concerns and needs consistently emerged and were reiterated through many focus group meetings and key informant interviews. The following criteria were also utilized to evaluate the prioritization of community needs, including:

- Size or scale of the problem (how many impacted);
- Severity of the problem;
- Disparity and equity;
- Known effective interventions;
- Resource feasibility and sustainability; and
- Community support.

The significant community health needs identified for the local community served by the Hospital extend far beyond health and healthcare. Social factors, including education, employment status, income level, gender, and ethnicity, all contribute to health inequities.

Health inequities are systematic differences in the health status of different population groups. These inequities have significant social and economic costs both to individuals and societies. Health inequities can be best addressed by setting a goal to attain health equity in the community. Health equity is the state in which everyone has a fair and just opportunity to attain their highest level of health.

Attaining health equity in the community will require addressing the most significant disparities and helping the pockets of the community that are facing a constant struggle with everyday life. The following paragraphs present a prioritized list of the significant health needs identified through the CHNA primary and secondary data. The needs identified during this CHNA process have also been substantiated through the Pathways to Excellence survey to nurses seeking their input on the greatest health needs in the community. Finally, although a safe space was provided to the focus group participants, the focus group results would have been impacted if the focus groups occurred after January 2025.

Priority 1: Culturally sensitive and accepting health care trusted by the community.

According to research, the rates of disease and death are elevated for historically marginalized racial groups including, Black, Native American, and Native Hawaiian and Other Pacific Islanders, who tend to have earlier onset of illness, more aggressive progression of disease, and poorer survival.[79] Yet, during the focus groups it became apparent that accessing healthcare (walking through the door) is very difficult for many community members. Healthcare providers must recognize each patient as an expert on their own background and experiences.

For many community members, the opportunity to access healthcare requires relying on institutions that historically have not been a safe space for minority communities, immigrants, the LGBTQ+ community, women, and survivors of abuse. The community's ability to access healthcare was assessed through focus group discussions and key informant interviews supplemented with secondary data sources to validate information contributed for this report.

The LGBTQ+ community fears and avoids accessing healthcare due to stigma and the experience as a member of the LGBTQ+ community. Non-profit healthcare organizations are available and open to all community members, including those with different religious, ethnic, cultural, or spoken language.

As shared by members of the Black community,

"Most times people do not see the person, they see the color of my skin. If you don't see 'me,' you don't see my needs."

"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…"— *Focus group participant*

Priority 2: Readily available health care and navigation assistance in patients' spoken language.

Time and time again throughout the focus group sessions it became apparent that certain community members avoid seeking healthcare due to either a lived experience or shared experience. As one Mixteco mothers focus group participant shared (translated from Mixteco),

[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.

"I think you don't have to speak the language to see someone's actions…you can tell by their face, like, you know, they sigh, or they look at you (in) a weird way. You know, you can feel that….And within our community, they share with each other…word spreads…and if that reaches the community, you know…a trust kind of is no longer there." *— Focus group participant*

The Mixteco and Spanish speaking community identified language barriers and difficulty navigating the healthcare system in every focus group. The Mexican Indigenous community residing within the community is estimated up to 25,000 community members and approximately 20% of the community speaks English less than "very well."

Aside from the Mixteco and Spanish speaking communities mentioned above, difficulties navigating the complex healthcare system were also discussed by seniors, Black, unhoused and veteran community members. As one nurse said in the Pathways to Excellence survey,

"Patients get lost in the system. I get lost in the system." *— Nurse*

Priority 3: Unmet vital conditions, including transportation, finances, housing (including the unhoused population), education, the environment, and childcare.

The Vital Conditions framework has roots in the community and is centered on the elements of "belonging and civic muscle." Civic engagement capacity and local, self-driven solutions are critical to addressing local needs.

Unmet vital conditions, or access to basic needs, have been substantiated through multitudes of secondary data, the nurses survey, and focus groups. Access to basic needs was mentioned in 13 of the 17 focus groups, with finances and transportation being the greatest struggles. Educational desires for the community were mentioned during the youth, Mixteco, and Spanish-speaking Promotores focus groups. The community has nearly 28,000 individuals living below poverty and 32,931 residents without a high school degree.

Priority 4: Access to improved behavioral health, including substance use disorder treatment, and navigation of services with a special emphasis on the unhoused population.

Behavioral health was consistently identified as a need facing the community during the focus groups. Community members and medical providers expressed during focus groups the desire and need for more efforts to competently address underlying trauma, life experiences, and stressors that influence health and well-being. As shared during the veteran service providers focus group,

“The guy who fentanyl overdosed the day after he wanted to get into rehab, and there’s no rehab because we don’t have the resources. His life could have been saved if he could have walked into an establishment right then and there, got services, got counseling, got a bed, because he was ready the day before. You know, we’re losing folks. We need more social workers, absolutely, and if we could get a veteran peer support hired on at the hospital, that would be amazing.” *— Veteran Service Provider*

V. Resources Potentially Available to Address Needs

While potential resources are available to address the community's needs, these needs are too significant for any single organization. Making a substantial and upstream impact will require the collaborative efforts of community organizations, local government, local business leaders, and institutions. The community is home to a wealth of organizations, businesses, and non-profits that could contribute to this effort.

The resources potentially available to address the identified significant health needs include the following organizations, facilities, and programs:

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

Oceano Boys and Girls Club

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. Impact of Actions Taken Since the Preceding CHNA

The 2022 CHNA Report identified the following health needs:

1. Educational attainment;
2. Access to primary healthcare, behavioral healthcare, and oral healthcare; and,
3. Health promotion and prevention.

The Hospital's Implementation Strategy associated with the 2022 CHNA reported that the Hospital intended to address all three prioritized health needs. The following activities were undertaken to address these selected significant health needs since the completion of the 2022 CHNA.

Educational Attainment

- Funded Community Health Improvement Projects, whose goal is to encourage higher education, adult literacy, and medical literacy.
- The physician mentoring program provided local high school and college students with the opportunity to participate in a rotation that introduces them to the many multidisciplinary facets of medicine.
- The health professions' education program provided a clinical setting for undergraduate training and internships for dietary professionals, technicians, physical therapists, social workers, and pharmacists. Nursing students conduct their clinical rounding at the hospital. The Hospital provides local community colleges with financial support to further address community-wide workforce issues, such as school-based programs for healthcare careers.
- Provided bilingual bicultural interpreter services to hospital departments for non-English speaking patients. Also provided Mixteco speaking individuals' advocacy and navigation services for social and basic needs.

Access to Primary, Behavioral, and Dental Healthcare

- Funded Community Health Improvement Projects, whose goal is to encourage higher education, adult literacy, and medical literacy.
- In collaboration with the Marian Regional Medical Center Family Residency program, the Street Medicine Program provided basic health and needs assessments to unsheltered individuals in the community.

- The Chronic Disease Self-Management Program and the Diabetes Education and Empowerment Program are offered to community members.

- Behavioral Wellness Support Groups provided mental health support to families impacted by perinatal mood and anxiety disorder (PMAD).

- The Behavioral Wellness Center provided a safe haven for those individuals experiencing a mental health crisis.

- The Medical Safe Haven Clinic for Human Trafficking provides a safe space where medical providers can offer a full spectrum of health services for victims and survivors of human trafficking.

- The Cancer Prevention and Screening Program supported patients' psychosocial and emotional needs using the Distress Screening Tool. It also provided financial support to medically underserved patients for transportation and genetic counseling.

- Dedicated social workers assisted patients presenting with substance use disorder to connect with appropriate resources. A naloxone distribution program was also part of the program.

Health Promotion and Prevention

- The Cancer Prevention and Screening Program supported patients' psychosocial and emotional needs using the Distress Screening Tool. Financial support was provided to medically underserved patients for transportation and genetic counseling.

- Conducted Behavioral Wellness Support Groups, which provided mental health support to families impacted by PMAD. Community support groups were also offered to community members who have been affected by cancer, stroke, chronic illnesses, and grief.

- A Diabetes Prevention and Self-Management Program in English and Spanish was offered to the community. The program was accompanied by an after-hours clinic that allowed participants access to a registered dietician and a nurse specialized in diabetes management.

- Culturally appropriate education was provided to Indigenous women during pregnancy.

- Provided bilingual, bicultural interpreter services to Hospital departments for non-English speaking patients. Also provided Mixteco speaking individuals' advocacy and navigation services for social and basic needs.

- Provided the Chronic Disease Prevention and Self-Management Program and the Diabetes Education and Empowerment Program to community members.

Community Health Improvement Grants

One crucial way the Hospital helps to address community health needs is by awarding financial grants to non-profit organizations working together to improve health status and quality of life. Grant funds are used to deliver services and strengthen service systems, to improve the health and well-being of vulnerable and underserved populations related to CHNA priorities. Table 10 depicts the organizations the Hospital has supported to help address community health needs over the past several years.

Table 10. Hospital Community Grant Recipients

Lead Grant Recipient	Project Name	2023	2024	2025
Good Samaritan	Santa Maria Stabilization Center	$100,000	$50,000	
Family Service Agency of Santa Barbara County	Senior and Caregiver Support	$68,172		
Los Osos Cares, Inc.	Basic Needs and Resources for Vulnerable & Seniors	$40,000		
SLO Noor Foundation	Dental Care Access and Service Expansion for Uninsured and Underinsured	$19,701		
Future Leaders of America (FLA)	Youth Leadership and Education Project	$25,000		
Community Action Partnership of San Luis Obispo County, Inc	5 Cities Connection for People Experiencing Homelessness	$50,000		
805 Street Outreach	805 Street Outreach		$50,000	
Community Environmental Council	Minimizing community health impacts from air pollution, pesticide exposure and extreme heat Guadalupe and the Santa Maria Valley		$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	Comprehensive Healthcare for Survivors of Sexual Assault and Intimate Partner Violence in Rural San Luis Obispo County		$50,000	
One Community Action	Mental Health Youth Project: Mi VIDA and POR VIDA!		$50,000	$78,000
Santa Barbara Foodbank	Food Prescription Program		$50,000	
The Cecilia Fund	Oral Health Program for Cancer Patients		$50,000	$78,000

Lead Grant Recipient	Project Name	2023	2024	2025
The Salvation Army	Street Outreach Program: SLO County		$50,000	
Five Cities Meals on Wheels	Food Insecurity Among Homebound Seniors			$78,000
Hearts Aligned Inc.	Comprehensive Services Critically Ill Children			$78,000
One Cool Earth	School Garden Nutrition Program			$78,000
	Total:	$302,873	$424,496*	$468,000*

*In FY24 and FY25, the Hospital made grant awards in conjunction with French Hospital Medical Center

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

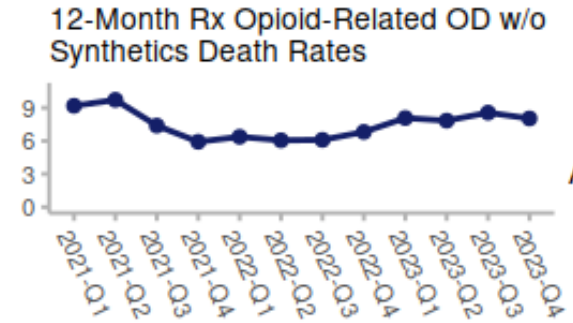
Santa Barbara County & San Luis Obispo County Overdose Snapshot Report

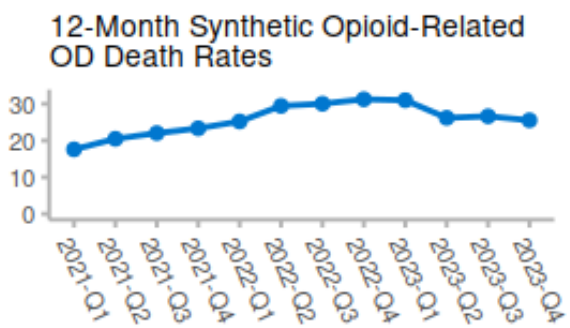
Overdose Prevention Initiative

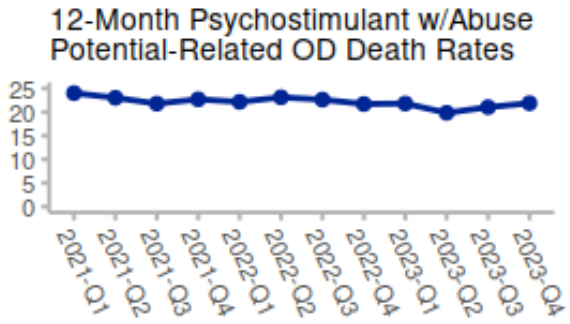
San Luis Obispo County Overdose Snapshot: 2021-Q1 through 2023-Q4

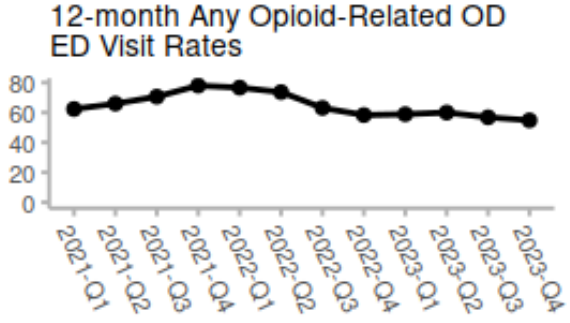
Report downloaded 03-24-2025

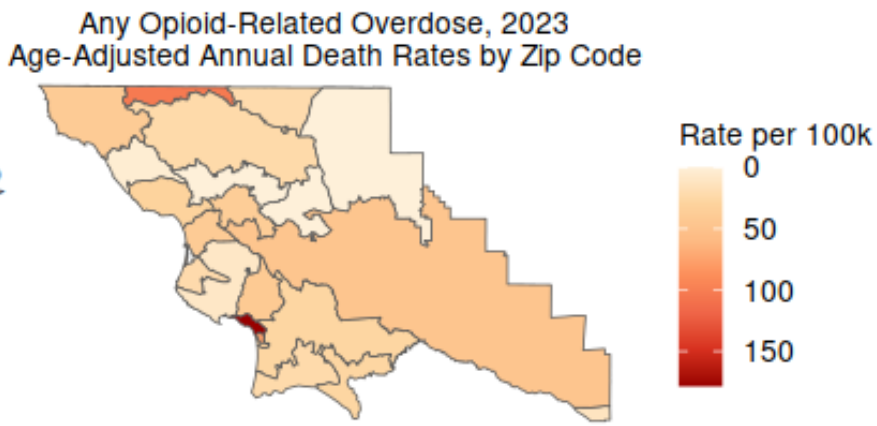
San Luis Obispo experienced 78 opioid-related overdose deaths in 2023, the most recent full year of data available. The annual age-adjusted mortality rate for 2023 was 30.02 per 100k residents, an decrease of 11.5% from 2022. The following charts present 12-month age-adjusted rates for selected overdose 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.

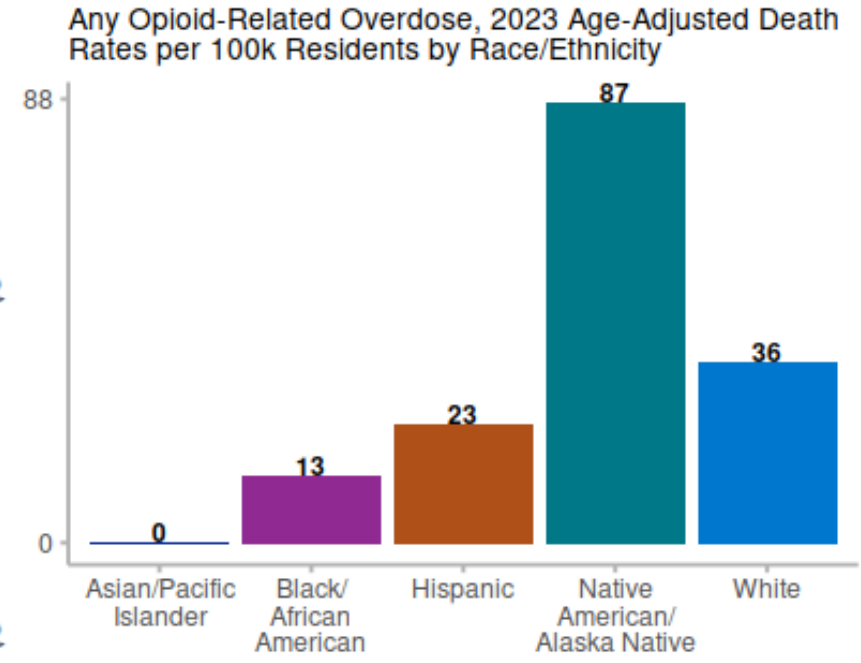








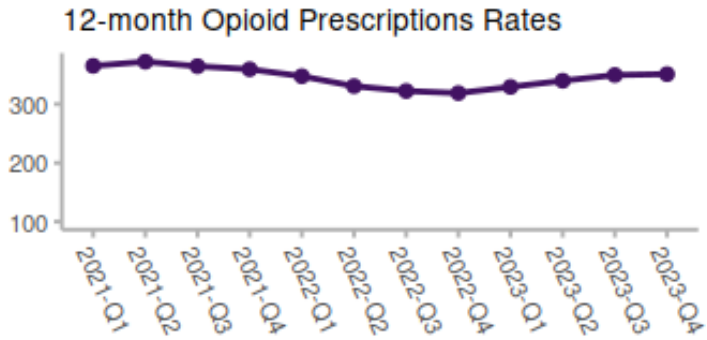


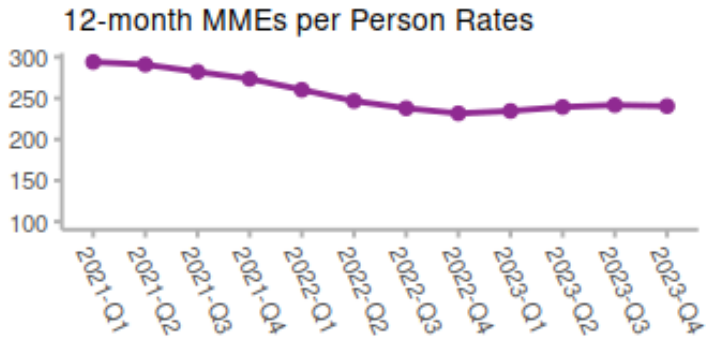


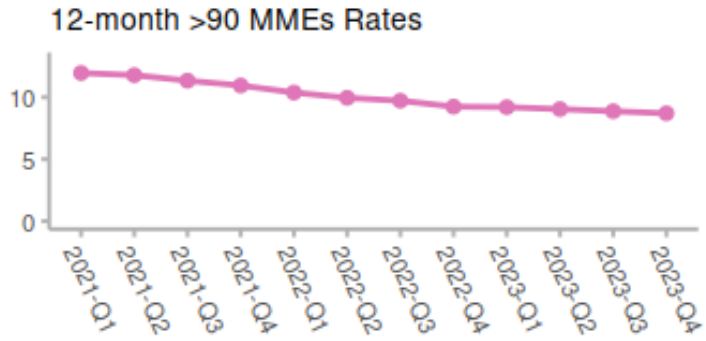
Footnotes:
12-month rates are based on moving averages; OD = Overdose
Produced by the California Overdose Surveillance Dashboard: https://skylab.cdph.ca.gov/ODdash

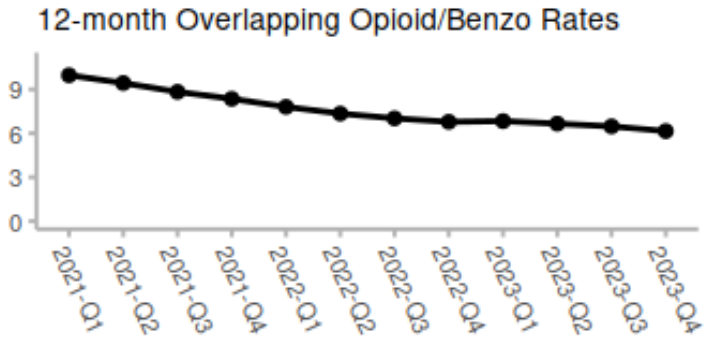
Prescribing

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.



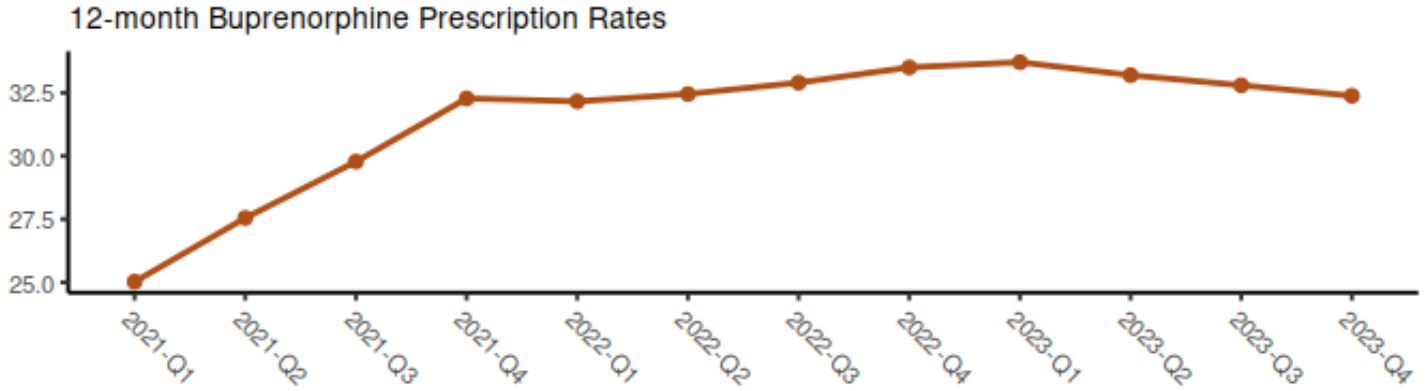






Treatment

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.



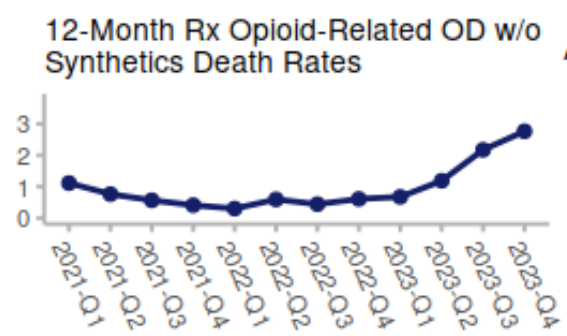
Footnotes:
12-month rates are based on moving averages; OD = Overdose
Produced by the California Overdose Surveillance Dashboard: https://skylab.cdph.ca.gov/ODdash

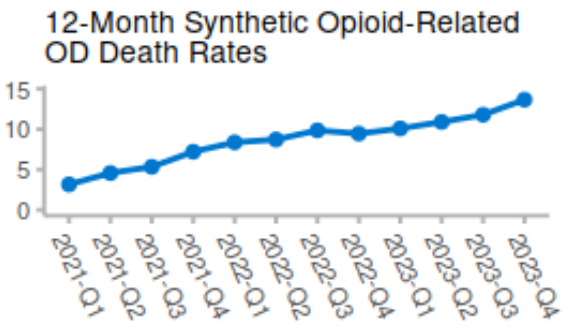
Overdose Prevention Initiative

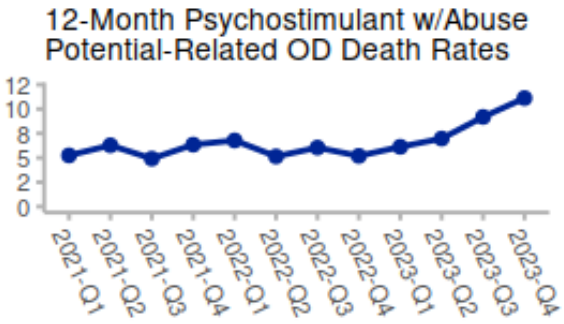
Santa Barbara County Overdose Snapshot: 2021-Q1 through 2023-Q4

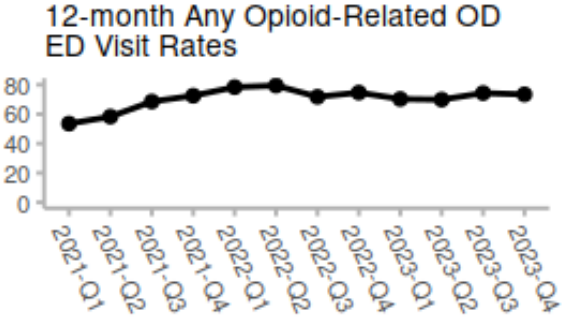
Report downloaded 04-09-2025

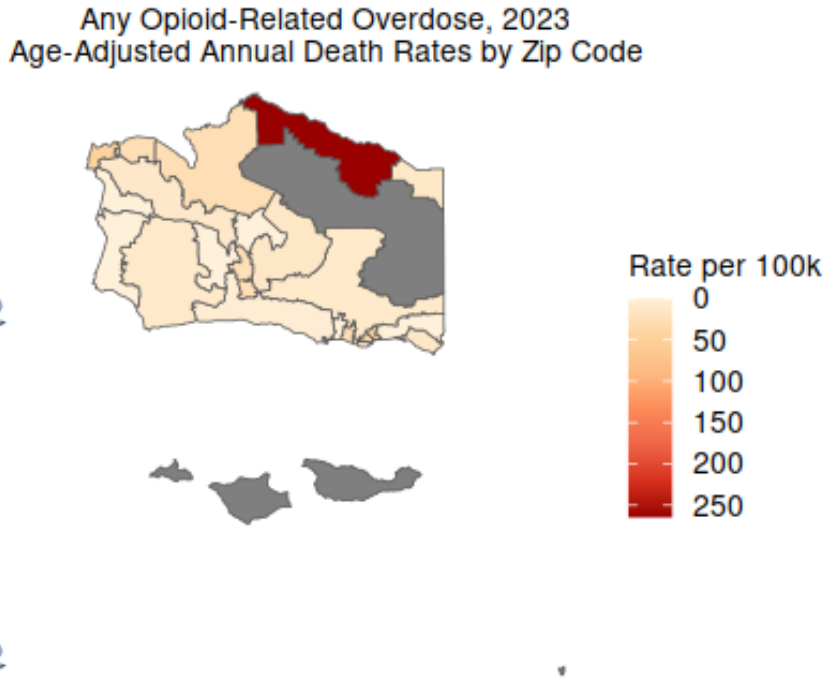
Santa Barbara experienced 64 opioid-related overdose deaths in 2023, the most recent full year of data available. The annual age-adjusted mortality rate for 2023 was 16.26 per 100k residents, an increase of 54.83% from 2022. The following charts present 12-month age-adjusted rates for selected overdose 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.

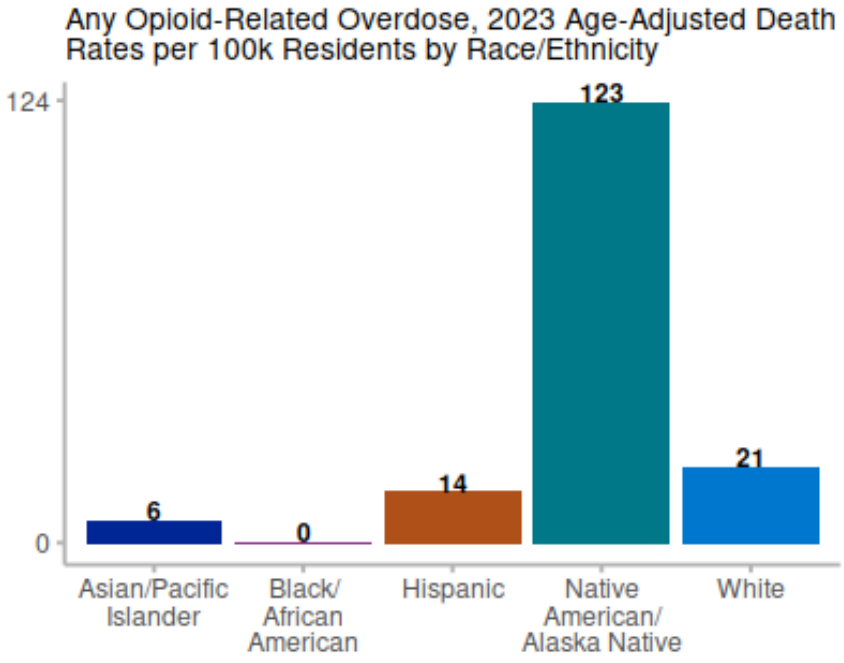








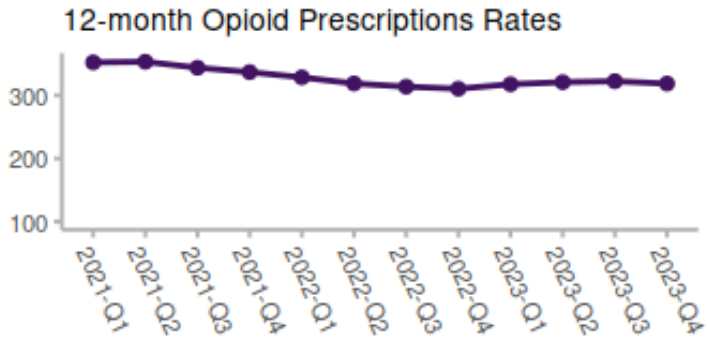


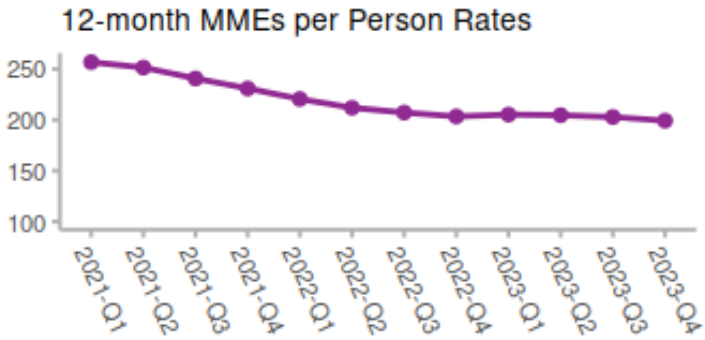


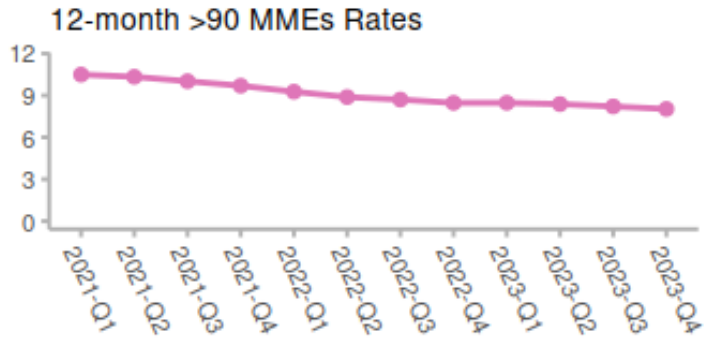
Footnotes:
12-month rates are based on moving averages; OD = Overdose
Produced by the California Overdose Surveillance Dashboard: https://skylab.cdph.ca.gov/ODdash

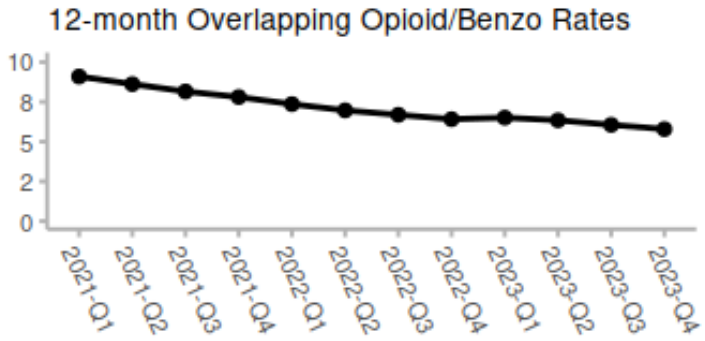
Prescribing

There were 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.



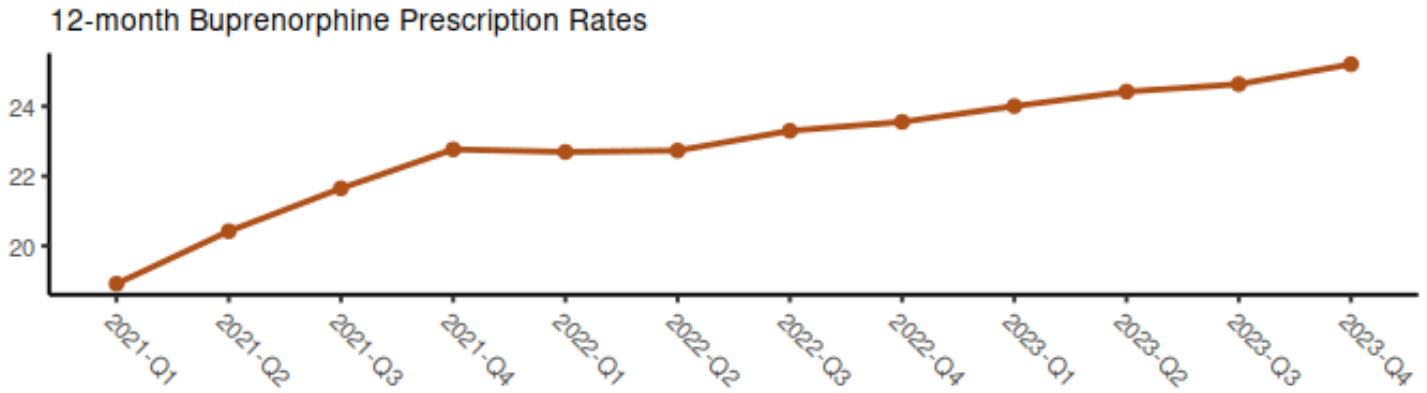






Treatment

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.



Footnotes:
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