2022

Community Health Needs Assessment

Marian Regional Medical Center &

Arroyo Grande Community Hospital

Adopted May 2022

Dignity Health
Marian Regional Medical Center

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I. Acknowledgements

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Alison O'Neill (he/him)
Ana Macias
Anabel Gonzales
Aracely Alvarez
Bessy Hoffman
Carmen Aguila
Carmen DeReal
Catalina Darwisch
Cesar Vega
Cris Castaneda
Denise Taylor, MD (she/her)
Elda Garcia
Elizabeth Perez
Ester Haldeman
Eustolia Garcia
Heidi Summers
Irebid Gilbert
Irene Castro
Jamie Woolf (she/her)
Judith Sanchez
Lola White-Sanborn (she/her)
Leticia Chavez
Leticia Sanchez
Margarita Aguirre
Maria Salvador
Maria Shira
Maria Troy
Michelle Call (she/her/hers)
Mireya Pina
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Paola Reyes
Patricia Herrera
Rusty Cook
Sam Moore (they/he)
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Oasis Senior Community Center
Oceano Community Center
Santa Barbara Promotoras
Santa Maria Parks and Recreation: Edwin Mussel Senior Center
Santa Barbara County Public Health Department
San Luis Obispo County Public Health Department
Marian Regional Medical Center's Community Health Education Department
Marian Regional Medical Center's Community Benefit Committee

II. Executive Summary

The purpose of this community health needs assessment (CHNA) is to identify and prioritize significant health needs for the 231,000 community members served by Marian Regional Medical Center (MRMC) and Arroyo Grande Community Hospital (AGCH). 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 that not-for-profit hospitals conduct a community health needs assessment at least once every three years.

MRMC is located at 1400 East Church Street in Santa Maria, California and is a Judeo-Christian healthcare ministry founded by the Sisters of St. Francis in 1940. Between 1940 and present day, MRMC has transformed into a state-of-the-art, 191-bed facility that is well-positioned to serve a continuously growing patient population. MRMC is designated a STEMI Receiving Center in Santa Barbara County and a Level III Trauma Center by Santa Barbara County's Emergency Medical Services Agency. Recently, MRMC opened a new Pediatric Emergency Department to enhance care for youth in the community. The hospital license also includes a 95 bed skilled nursing facility, homecare, hospice and home infusion programs, along with outpatient labs and radiology centers throughout the community.

AGCH is located at 345 South Halcyon Road in Arroyo Grande, California and is approximately 15 miles north of Santa Maria. The AGCH has been serving the health care needs of the "Five Cities" area since it became a member of Dignity Health in 2004. Recently, AGCH completed the construction of their new Emergency Department to better meet the needs of the growing community. The hospital license also includes a 20 bed acute rehab center.

The MRMC community includes zip codes 93454, 93455, 93458 (Santa Maria), 93434 (Guadalupe), 935444 (Nipomo) and 93455 (Orcutt) and is home to 150,072 residents. The MRMC community is a culturally diverse area, with the majority of residents (67.2%) identifying as Hispanic or Latino(a). Within the MRMC community, 26.6% of individuals over the age of five speak English less than "very well," and 31.1% of residents (age 25 and over) did not complete high school. In addition to the residents mentioned above, the Santa Maria Valley is home to a transient farmworker population drawn to work in the fields, which includes indigenous migrants from the Mexican states of Oaxaca and Guerrero. These individuals are often monolingual in their native pre-Hispanic indigenous language of Mixtec or Zapotec, and have an estimated population of 32,000 people in Santa Barbara County. The 2022 Point in Time Count for Santa Barbara County reported 457 persons experiencing homelessness in Santa Maria.

AGCH serves the "Five Cities" community of southern San Luis Obispo County and includes zip codes 93420 (Arroyo Grande), 93433 (Grover Beach), 93444 (Nipomo), 93445 (Oceano), and 93449 (Pismo Beach). The community served by AGCH is home to 81,148 residents, with nearly two-thirds (64.8%) considering themselves White, not Hispanic or Latino(a). The Hispanic or Latino(a) population of the AGCH community is approximately one-quarter (26.8%)

of the total population. The AGCH community has a high school graduation rate of 91.0% for those aged 25 and older, and poverty rates below state and national levels.

Two medically underserved communities have been designated within the MRMC and AGCH community by the Health Resources and Services Administration (HRSA), including Guadalupe (MUA/P ID: 00301) and Arroyo Grande (MUA/P: 00395). HRSA has also designated three different areas within the MRMC and AGCH community as health professional shortage areas.

The hospital's dedication to engaging with the community, assessing priority needs, and helping to address them with community health program activities 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 CHNA process was completed through quantitative and qualitative methods to collect and analyze primary and secondary data. This mixed-methods approach validates data by cross verifying from multiple sources, providing a broader perspective of the community and population health needs.

In order to gain a thorough understanding of the medically underserved, low-income and minority populations living in MRMC's primary service area, an original community health survey was developed. A 38 question community health survey served as a primary data source. The community health survey was based upon select questions from the Centers for Disease Control and Prevention (CDC) Behavioral Risk Factor Surveillance System Survey Questionnaire (BRFSS) and previous CHNA reports prepared by Dignity Health. The final survey was distributed in-person in the community and was available online, to adults age 18 and older, in Spanish, English, and Mixteco.

Using convenience sampling (non-probability) methods, survey responses were collected from 18 different locations within the community, including churches, senior centers, community events, homeless shelters, etc. Survey locations were selected based on the perception of being able to encounter the most vulnerable populations, including the medically underserved, low-income, and minority populations. A total of 770 individuals invested ten minutes of their time and completed the health survey in hopes of bettering their health and bringing better programs to the community.

The significant community health needs identified for the MRMC and AGCH community extend far beyond health and health care. Social factors, including education, employment status, income level, gender, and ethnicity, all contribute to health inequities. According to the CDC, racial and ethnic minority groups throughout the United States experience higher rates of illness

and death across a wide range of health conditions, including diabetes, hypertension, obesity, asthma, and heart disease, when compared to their White counterparts.[1]

Based upon perceptions of the community, the known health needs, and secondary health metrics, the three most significant health needs were identified. In accordance with Dignity Health policy, the following criteria were utilized to evaluate the prioritization of community needs, including:

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

Attaining health equity in the MRMC and AGCH community will require addressing the greatest disparities and helping the pockets of the community that are facing a constant uphill battle with everyday life.

The following significant community health needs were determined for this 2022 CHNA Report, including:

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

Low levels of adult educational attainment was identified in the 2016 CHNA, the 2019 CHNA and now again in this 2022 CHNA Report. Education has been described as the most important modifiable social determinant of health, and low educational attainment levels are linked with poor health, more stress, higher poverty, and lower self-efficacy. Overall, 22.3% of the MRMC and AGCH community (or 32,438 individuals) over the age of 25 did not graduate high school or equivalent. Furthermore, in zip code 93458 (Santa Maria), less than half of the population (46.8%), over the age of 25, reported graduating high school (or equivalent).

The need for an improvement in access to primary health care, behavioral health care, and oral health has been substantiated through primary data, secondary data, and HRSA. HRSA has designated two medically underserved communities within the MRMC and AGCH community, including Guadalupe (MUA/P ID: 00301) and Arroyo Grande (MUA/P: 00395). Mental health professional shortages were designated for the low income migrant farmworker population in Santa Maria, CA (HPSA ID: 7062407340) and Solvang/Lompoc/Guadalupe (HPSA ID: 7062778515).

[1] U.S. Department of Health and Human Services, 2022. Centers for Disease Control and Prevention, Health Equity. Retrieved from https://www.cdc.gov/healthequity/racism-disparities/index.html.

Lastly, health promotion and prevention is the third identified need within this CHNA Report. Heart disease and cancer are the leading causes of death at local, state, and national levels, while the most vulnerable members of the MRMC and AGCH community struggle to access health care. If the vulnerable communities are struggling to access health care, they are less likely to understand their current health status and access preventative cancer screenings. Besides difficulty accessing health care, the vulnerable communities face increased risk for heart disease and cancer due to their social determinants of health. They face food insecurity and more often live in areas that have higher levels of pollution. In order to help the most vulnerable communities reduce their chances of developing heart disease, cancer, or another chronic condition, targeted upstream health promotion and prevention is needed.

While potential resources are available to address the identified needs of the community, the needs are too significant for any one organization. Making a substantial and upstream impact will require the collaborative efforts of community organizations, local government, local business leaders, and other institutions. The greater Santa Maria Valley and Five Cities area are home to a wealth of organizations, businesses and non-profits, including our local community colleges and our own healthcare system.

This CHNA report was adopted by the Marian Regional Medical Center community board in May 2022. The report is widely available to the public on the hospital's web site, and a paper copy is available for inspection upon request at MRMC's Mission Integration and Education Office in Santa Maria. Written comments on this report can be submitted to MRMC's Mission Integration and Education Office at 1400 E. Church Street, Santa Maria, CA 93454 or you may request a copy by email to CHNA-CCSAN@DignityHealth.org.

III. Community Definition

Marian Regional Medical Center (MRMC) and Arroyo Grande Community Hospital (AGCH) serve an aggregate community that encompasses all residents of northern Santa Barbara County and southern San Luis Obispo County, CA. The aggregate community is home to over 231,000 individuals residing in Santa Maria, Guadalupe, Nipomo, Orcutt, Arroyo Grande, Grover Beach, Oceano, and Pismo Beach, CA. The MRMC and AGCH defined community does not exclude any low-income or underserved populations and includes all members of the community. The communities served by MRMC and AGCH align with the residence location for 75% of all inpatient discharges, as well as the most recent Community Benefit Report. The geographic area of the communities served by MRMC and AGCH are shown on the following Figure 1.

Figure 1. MRMC and AGCH Communities' Served

Medically Underserved Areas/Populations (MUA/P) and Health Professional Shortage Areas (HPSA) have been identified in the MRMC and AGCH communities by the Health Resources and Services Administration (HRSA). These designations are provided on the following table.

Table 1. MUA/P and HPSA as Identified by HRSA in the Community[2][3]

Discipline	ID Number	HPSA or Service Area Name	Designation Type	Designation Date
Primary Care	1062140915	ME-MSSA 180.1/Orcutt/Santa Maria	Medicaid Eligible Population HPSA	7/8/20
Mental Health	7062778515	MSSAs 178.1/178.2/179/180.2 - Solvang/Lompoc/Guadalupe	Geographic HPSA	11/8/21
Mental Health	7062407340	LI/MFW - MSSA 180.1/Santa Maria	Low Income Migrant Farmworker Population HPSA	12/4/15
Primary Care	00301	Guadalupe Service Area	Medically Underserved Area	12/22/92
Mental Health	7063481715	MSSA 171/172 – Arroyo Grande/San Luis Obispo	High Needs Geographic Area	3/7/2022
Primary Care	00395	Arroyo Grande Service Area	Medically Underserved Area	5/11/94

Marian Regional Medical Center

Marian Regional Medical Center is located in the City of Santa Maria in northern Santa Barbara County, CA. The community served by MRMC includes six zip codes representing the following four cities:

- 93454, 93455, 93458 (Santa Maria);
- 93434 (Guadalupe);
- 93455 (Orcutt); and,
- 93444 (Nipomo).

The City of Santa Maria, Guadalupe and Orcutt are located in northern Santa Barbara County and Nipomo is located in southernmost San Luis Obispo County. Nipomo (93444) is unique because it is equidistant between MRMC and AGCH and is considered a community served by both hospitals. Nipomo's demographic information will be included in the AGCH discussion to prevent duplication of data, and Orcutt's demographic information is included under zip code 93445 (Santa Maria).

According to the American Community Survey (2016-2020, 5-year average), the MRMC community is home to 150,072 residents, with the majority (73%) residing within Santa Maria City.[4] Santa Maria is the largest city in Santa Barbara County both in land area and population.[5]

[2] Health Resources and Services Administration, 2022. *MUA Find.* https://data.hrsa.gov/tools/shortage-area/mua-find.
[3] Health Resources and Services Administration, 2022. *HPSA Find.* https://data.hrsa.gov/tools/shortage-area/hpsa-find.
[4] U.S. Census Bureau (2022). *2016-2020 American Community Survey 5-Year Estimate.* https://data.census.gov/cedsci/profile?g=1600000US0669196
[5] County of Santa Barbara. *Section G, County Statistical Profile.* Retrieved from https://www.countyofsb.org/ceo/asset.c/2794.

The MRMC community is a culturally diverse area with the majority of residents (67.2%) considering themselves Hispanic or Latino(a) origin. In the MRMC community, 26.6% of individuals over the age of five speak English less than "very well." Educational attainment for adults age 25 and older continues to be a challenge for the MRMC community. Overall, 31.1% of the MRMC community residents age 25 and over did not complete high school. Furthermore, over half (53.2%) of the adults (age 25 and over) residing in zip code 93458 (Santa Maria), and 44.3% of adults residing in 93434 (Guadalupe) have less than a high school education. Conversely, the highest levels of education can be found in the adult population (age 25 and over) residing in zip code 93455 (Santa Maria/Orcutt) where 69.1% reported having at least some college/associates degree or higher.[6]

According to the U.S. Census, 2016-2020 American Community Survey 5-Year Estimates, poverty levels exceed state (12.6%) and national levels (12.8%) in the following MRMC community locations:

- Zip code 93434 (Guadalupe) approximately 1 in 4 people live in poverty (24.0%);
- Zip code 93458 (Santa Maria), 15.0% of the population are below 100% of the poverty level, and another 14.2% have income between 100 to 149% of the poverty level.

In addition to the residents captured by the formalized data sources above, the transient farmworker population drawn to work in the fields of Santa Barbara County and San Luis Obispo County are supported by indigenous migrants from the Mexican states of Oaxaca and Guerrero. These indigenous migrants are often monolingual in their native pre-Hispanic indigenous language of Mixtec or Zapotec. According to the National Center for Farmworker Health in 2017, there were an estimated 32,066 farmworkers in Santa Barbara County and 17,771 farmworkers in San Luis Obispo County.[7]

The 2022 Point in Time Count for Santa Barbara County reported 457 persons experiencing homelessness in Santa Maria and 2 in Guadalupe. The homeless population in Santa Maria in 2022 is similar to the 2019 total of 464 and higher than the 2020 total of 382.[8] Table 2 below provides additional population characteristics for the MRMC community.

[6] U.S. Census Bureau (2022). *2016-2020 American Community Survey 5-Year Estimate.* https://data.census.gov/cedsci/table?q=ZCTA5%2093420%20Populations%20and%20People&g=860XX00US93420,93433,93434,93444,93445,93449,93454,93455,93458&tid=ACSST5Y2020.S0601

[7] National Center for Farmworker Health, 2022. *Agricultural Worker Estimates – 2017.* Retrieved from http://www.ncfh.org/number-of-ag-workers.html.

[8] County of Santa Barbara, Community Services (2022). *2022 Point in Time Homelessness Count Preliminary Results Released.* https://countyofsb.org//uploadedFiles/housing/Content/Homeless_Assistance/PIT%20Count%202022%20Release.pdf

Table 2. U.S. Census Data (2016-2020) Marian Regional Medical Center Community[9]

U.S. Census Data[1]	93434 (Guadalupe)	93454 (Santa Maria)	93455 (Santa Maria & Orcutt)	93458 (Santa Maria)
Total population (2016-2020)	7,654	40,600	45,246	56,572
Median age (years)	27.6	31.4	37.5	26.2
RACE AND HISPANIC OR LATINO ORIGIN				
One race	88.0%	87.2%	88.4%	87.5%
White	61.7%	73.1%	75.9%	70.2%
Black or African American	0.4%	1.3%	2.0%	1.2%
American Indian and Alaska Native	1.8%	0.7%	1.2%	1.2%
Asian	3.6%	4.1%	4.5%	4.4%
Native Hawaiian and Other Pacific Islander	1.0%	0.0%	0.2%	0.0%
Some other race	19.5%	8.0%	4.6%	10.5%
Two or more races	12.0%	12.8%	11.6%	12.5%
Hispanic or Latino origin (of any race)	91.9%	70.8%	35.7%	86.6%
White alone, not Hispanic or Latino	4.4%	21.4%	53.3%	7.4%

Arroyo Grande Community Hospital

AGCH in Arroyo Grande, California serves the "Five Cities" community of southern San Luis Obispo County. The "Five Cities" area consists of the neighboring cities of Arroyo Grande, Grover Beach, Nipomo, Oceano, and Pismo Beach. The AGCH community extends from the northern most boundary of the MRMC community, and includes the following San Luis Obispo County communities and zip codes:

- 93420 (Arroyo Grande);
- 93433 (Grover Beach);
- 93444 (Nipomo);
- 93445 (Oceano); and,
- 93449 (Pismo Beach).

The community served by AGCH is home to 81,148 residents, with nearly two-thirds (64.8%) considering themselves White, not Hispanic or Latino(a). The Hispanic or Latino(a) population of the AGCH community is approximately one-quarter (26.8%) of the total population. The AGCH community has a high school graduation rate of 91.0% for those aged 25 and older, and poverty rates below state and national levels.

According to the U.S. Census, the median age in California is 36.7 years, which is lower than the median age of the five AGCH communities. The median age in 93433 (Grover Beach) is closest

[9] U.S. Census Bureau (2022). 2016-2020 American Community Survey 5-Year Estimates. https://api.census.gov/data/2020/acs/acs5/subject

to the state level, however 93420 (Arroyo Grande) and 93449 (Pismo Beach) are more than 10 points above the state median age. In 93420 (Arroyo Grande) nearly 25% of the population is age 65 or over and in 93449 (Pismo Beach) this number increases to nearly 32%.

Due to the COVID-19 pandemic, the 2021 the local homeless population count in San Luis Obispo County was not completed and delayed to 2022. The 2022 Homeless Census and Survey for San Luis Obispo County was completed in February 2022 and their results should be referenced and utilized for any future programming once released. According to the 2019 Homeless Census and Survey for San Luis Obispo County, 211 persons experiencing homelessness were encountered in South County.[10]

Table 3 below provides additional population characteristics for the AGCH community. Additional population details from the U.S. Census for MRMC and AGCH communities can be found in Appendix A.

Table 3. U.S. Census Data (2016-2020) Arroyo Grande Community Hospital Community[11]

U.S. Census Data[1]	93420 (Arroyo Grande)	93433 (Grover Beach)	93444 (Nipomo)	93445 (Oceano)	93449 (Pismo Beach)
Total population (2016-2020)	29,915	13,481	22,383	7,327	8,042
Median age (years)	47.1	38.4	42.2	42.6	57.5
RACE AND HISPANIC OR LATINO ORIGIN					
One race	92.3%	89.7%	88.4%	91.5%	97.0%
White	82.7%	79.6%	77.1%	68.3%	88.3%
Black or African American	1.2%	2.5%	1.2%	1.7%	1.2%
American Indian and Alaska Native	0.7%	0.6%	0.9%	1.2%	0.1%
Asian	3.4%	2.6%	3.1%	6.9%	3.3%
Native Hawaiian and Other Pacific Islander	0.4%	0.2%	0.2%	0.0%	0.0%
Some other race	3.8%	4.1%	5.9%	13.3%	4.1%
Two or more races	7.7%	10.3%	11.6%	8.5%	3.0%
Hispanic or Latino origin (of any race)	13.9%	30.3%	42.9%	43.7%	8.3%
White alone, not Hispanic or Latino	75.6%	62.3%	51.7%	44.1%	84.3%

[10] Applied Survey Research (2019). *2019 San Luis Obispo County Homeless Census and Survey Comprehensive Report.* https://www.slocounty.ca.gov/getdoc/ba133495-851b-4ef4-8c63-70c4a203c9d0/2019-PIT-Count_SanLuisObispo_Final.pdf

[11] U.S. Census Bureau (2022). 2016-2020 American Community Survey 5-Year Estimates. https://api.census.gov/data/2020/acs/acs5/subject

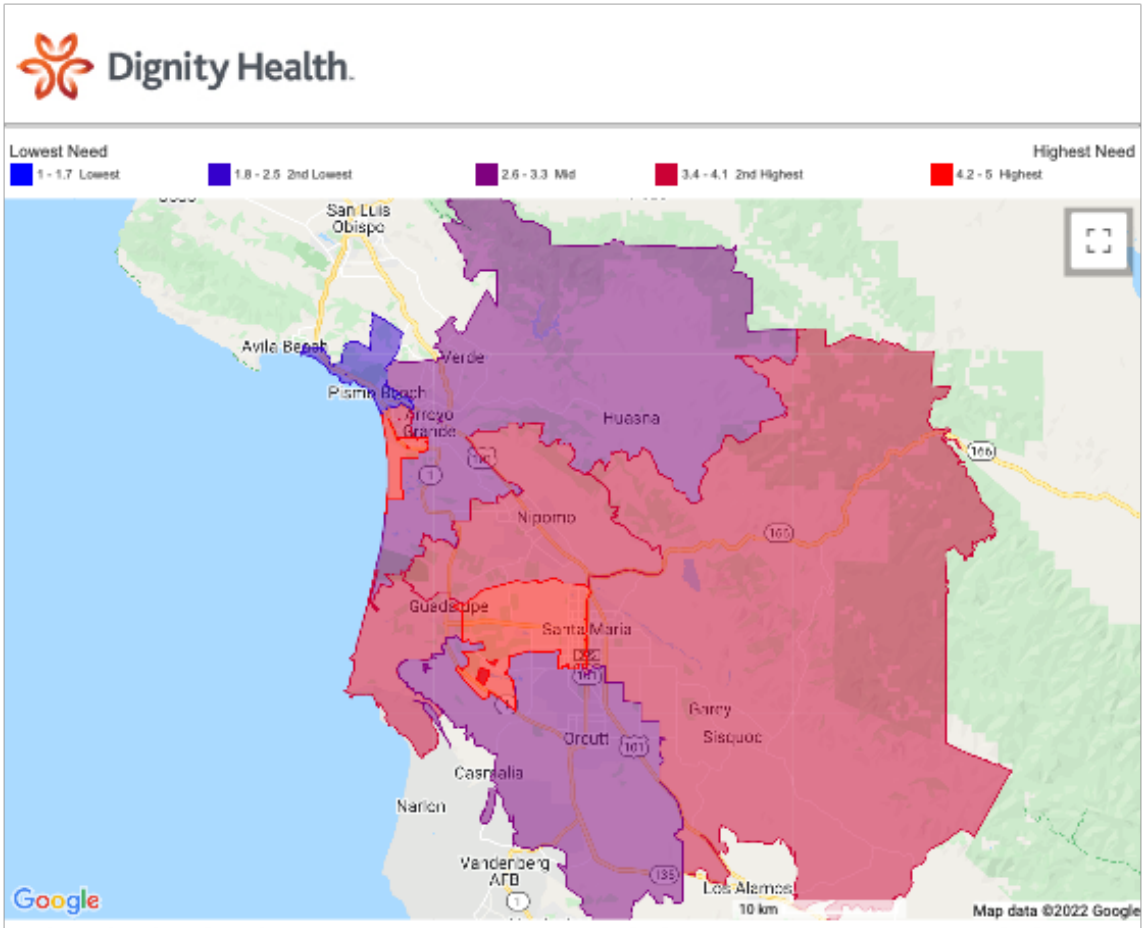
Community Needs Index

One tool used to assess health need is the Community Need Index (CNI). The CNI analyzes data at the zip code level for five factors known to contribute, or are barriers to health care access, including income, culture/language, education, housing status, and insurance coverage. Scores from 1.0 (lowest barriers) to 5.0 (highest barriers) for each factor are averaged to calculate a CNI score for each zip code in the community. Research has shown that communities with the highest CNI scores experience twice the rate of hospital admissions for ambulatory care sensitive conditions as those with the lowest scores.

The average CNI score for the MRMC and AGCH communities was 3.6 The CNI scores range from a low of 2.4 in Pismo Beach to greater than 4 in Oceano, Santa Maria (93454 and 93458), and Guadalupe. The geographic areas with a CNI greater than 4, represents a geographic area with over 100,000 residents. The following Figure 2 provides further detail for the geographical distribution of CNI scores.[12]

[12] Dignity Health (2022). *Community Need Index*. Retrieved from: http://cni.dignityhealth.org/

Figure 2. MRMC and AGCH Community Needs Index Scores



Mean(zipcode): 3.6 / Mean(person): 3.6 CNI Score Median: 3.8 CNI Score Mode: 4

Zip Code	CNI Score	Population	City	County	State
93420	2.8	29901	Arroyo Grande	San Luis Obispo	California
93433	3.8	13202	Grover Beach	San Luis Obispo	California
93434	4	7699	Guadalupe	Santa Barbara	California
93444	3.6	21779	Nipomo	San Luis Obispo	California
93445	4.2	6908	Oceano	San Luis Obispo	California
93449	2.4	7965	Pismo Beach	San Luis Obispo	California
93454	4	40126	Santa Maria	Santa Barbara	California
93455	3	45046	Santa Maria	Santa Barbara	California
93458	4.2	61804	Santa Maria	Santa Barbara	California

TRUVEN HEALTH ANALYTICS

IV. Assessment Process and Methods

The 2022 CHNA was completed using quantitative and qualitative data from a variety of primary and secondary data sources. Primary data sources included a community health survey, a qualitative community health needs survey, and focus groups of priority populations. Secondary data sources at the local, state, and national level provided quantitative data. This mixed-methods approach validates data by cross verifying from multiple sources, providing a broader perspective of the community and population health needs. Each data source and the process utilized for assessment and collection is described in the following subsections.

Community Health Survey, Vulnerable Populations

As in prior CHNAs, MRMC once again solicited, and took into account, feedback from the medically underserved, low-income, and minority MRMC community members, including those with limited English proficiency, using an original community health survey.

The original community health survey was developed based upon select questions from the Centers for Disease Control and Prevention (CDC) Behavioral Risk Factor Surveillance System Survey Questionnaire (BRFSS) and previous CHNA reports prepared by Dignity Health. Input on the community health survey was also provided by the Community Benefit Committee at MRMC and San Luis Obispo County Public Health Department. Santa Barbara County Public Health Department was also provided the opportunity to comment on the survey before it was widely distributed. A cultural competency review of the draft survey and translation into Spanish was completed by MRMC's Community Health Education Department. The final survey contained a total of 38 questions and was available in Spanish, English, and Mixteco languages. A copy of the English version can be found in Appendix B.

Prior to launching the community health survey collection, a surveyor training was held on June 3, 2021. The purpose of the training was for all surveyors to understand the process and requirements for survey collection activities. Surveyors were trained how to complete a one-on-one interview with the participant, if they requested assistance to complete the health survey. The community health surveyors were members of the Dignity Health Community Health Department, Herencia Indígena, and the promotores network in Santa Barbara and San Luis Obispo Counties.

The anonymous community health surveys were distributed using a convenience sampling strategy (non-probability) to survey adults (age 18 and over) living in the MRMC and AGCH community. This survey was not designed to be statistically representative of all residents in the community, but rather to provide an understanding of the social and health needs of the most vulnerable adult community members. Therefore, survey collection locations were selected based upon the perception of being able to encounter the target survey population. Before any community health surveys were collected, the responsible party at each location was contacted and permission was requested.

A total of 770 community health surveys were collected between June and July 2021 at 18 different locations in the MRMC and AGCH communities. Survey locations included churches, senior centers, community events, homeless shelters, housing development locations, farm worker housing, a COVID-19 vaccination site, and foodbanks. Survey participants did not receive any compensation or incentive in exchange for completing the health survey. During this same time period, the community health survey was also input into Survey Monkey and the link to participate was advertised through various local agencies. A complete list of the community locations where surveys were collected can be found in Appendix B.

The community health survey data was compiled in Survey Monkey, which increased data quality and streamlined data analysis. Survey responses were analyzed using IBM SPSS statistics package and the results are discussed in the following chapter of this CHNA Report. Survey responses were analyzed as compared to various independent variables, including, place of residence, educational attainment, race/origin, and age. Complete results from the community health survey are provided in Appendix B.

The community health survey was completed by 770 individuals residing in the MRMC and AGCH community ranging from 18 to over 90 years of age. As previously stated, the purpose of the community health survey was to gain a thorough understanding of the medically underserved, low-income, and minority populations living in the MRMC and AGCH community. The effort to capture responses from these individuals resulted in the majority of survey participants (73.6%) electing to complete their community health survey in Spanish and 27 individuals completing their health survey interview in Mixteco. Individuals who do not speak English can face challenges in many areas, including access to health care and understanding medical information. The survey participants' place of residence and their community health survey language is provided on the following table.

Table 4. Survey Participants' Place of Residence and Survey Language

Place of Residence	Selected Language to Complete Survey		
	English	Spanish	Mixteco
Arroyo Grande, CA 93420	17	11	0
Grover Beach, CA 93433	15	9	0
Guadalupe, CA 93434	8	38	0
Nipomo, CA 93444	12	15	0
Oceano, CA 93445	7	58	0
Pismo Beach, CA 93449	7	**	0
Santa Maria, CA 93454	55	88	**
Santa Maria, CA 93455	26	22	**
Santa Maria, CA 93458	29	322	22
Totals	176	563	27

** Cell values less than 5 were suppressed.

The community health survey participants' identified race or origin are depicted in the following table.

Table 5. Survey Participants' Identified Race or Origin

Race or Origin	Percent
White	17.8%
Black/African American	<1.0%
Mexican/Mexican American	47.5%
Other Hispanic or Latino	28.3%
Asian or Asian American	1.0%
American Indian or Alaska Native	<1.0%
Native Hawaiian or other Pacific Islander	0.0%
Other	0.7%
Indigenous	3.9%

Broad Interests of Community

Qualitative data were collected from persons representing broad interests of the community using various methods, including an online survey, focus groups, and collaborative meetings with San Luis Obispo County Public Health Department and Santa Barbara County Public Health Department.

Qualitative Targeted Outreach

A qualitative survey was prepared and distributed to targeted organizations seeking their input to help identify and prioritize significant health needs in the adult and youth population and to identify any potential resources. Dignity Health reached out to various community partners including those representing the following communities: Laino(a), African American, Homeless, LGBTQ+, Seniors, the Community Benefit Committee of the MRMC Community Board, other local health care providers, and county public health departments. The list of organizations that were provided the opportunity to complete the qualitative survey can be found in Appendix C.

The survey was prepared and made available between January 14 – February 4, 2022 using a cloud-based survey software. An email was sent to each organization with the chance to respond to the online survey (via Survey Monkey) or request an open discussion instead. The original survey and email transmission is available in Appendix C and specifically sought feedback on the following six items:

- As an organization and/or community member, what do you view as the top 5 greatest health needs facing our community?
- As an organization or community member, how would you address these needs?
- Are you aware of any potential resources that are available to help address these needs?

- What is the most important youth health need in our community?
- What would you say is the most important thing that can be done to improve child health in our community?
- What is the greatest barrier to child wellness in our community?

A total of 39 responses were received from various individuals between January and February of 2022. These responses were downloaded from the cloud-based survey software and the responses were grouped based on the response. After the responses were grouped, the data was tabulated and utilized in the decision making process of developing the identified needs for this CHNA. Survey response grouping and the tabulated responses can be found in Appendix C.

Gala Pride and Diversity Center

The Gala Pride and Diversity Center supports and empowers people of all sexual orientations, gender identities, and expressions to strengthen and unite the Central Coast Community. The Gala Pride and Diversity Center advocates for the Central Coast's LGBTQ+ community and helps them find support services. A focus group was facilitated by Patty Herrera, MA, Manager of Community Health, Dignity Health Central Coast, with six members of the Gala Pride and Diversity Center via a video conference.

The purpose of the discussion was to discuss the health needs facing LGBTQ+ community of all kinds (transgender, intersex individuals, people with expansive gender or sexual orientations, gender identities, expression, youth, seniors) and discuss their responses to the six qualitative CHNA questions. The focus group participants specifically support the trans and nonbinary people residing in Northern Santa Barbara County and San Luis Obispo County. The Gala participants identified the greatest health needs as follows:

- They want to be treated with dignity and respect, regardless of their gender identity or sexual orientation.
- Access to culturally competent, respectful physicians, behavioral health providers, nurses, and office staff that accept CenCal. Many trans people are underemployed/unemployed, and finding health care that accepts their insurance is a "huge" problem. Focus group participants said they often feel they are treated as a "piece of meat."
- Beyond cultural competency, many times health care is not specialized in addressing their health needs. They "face an uphill battle accessing gender diverse health care" and need local gender affirming providers and specialists that accept CenCal. There are currently only two known providers that take CenCal that specialize in the LGBTQ+ community.
- The focus group participants said they want to feel safe at medical facilities. They spoke of the harsh and discriminatory situations they often face when trying to access local providers and hospitals. Nonbinary people seem to be facing more discrimination in the health care system because they do not fit into a "male" or "female" box.

- Many LGBTQ+ youth face bullying by other classmates and parents "gate keep" and put up "roadblocks" to children seeking care. Unaffirming families often impact the youth mental health and can have youth in crisis.

MRMC Medically Vulnerable Pediatric Program

The MRMC Medically Vulnerable Pediatric (MVP) Program cares for high-risk medically fragile infants and children following their discharge from the hospital. The program provides support to families at their homes, providing essential resources and helping them navigate the health care system for their high-risk pediatric family member, to ensure they thrive. Two separate sessions were held with families in the MVP program on January 28, 2022 and January 31, 2022. The sessions were an open discussion facilitated by Community Health Educators, Leticia Sanchez and Irene Castro, to discuss their responses to the six qualitative CHNA questions. Both conducted interviews with six families that participate in the MVP program. The participating families all resided in Santa Maria or Guadalupe and are monolingual in Spanish. During the two sessions, the families were aligned on the top three health needs they identified and were very similar with the last two health needs. The MVP families identified and prioritized the greatest health needs as follows:

1. COVID-19 and shortages in medical supplies, especially for those with medical needs.
2. The need for more doctors and therapists; more mental health programs.
3. Health care for all family members; no health insurance for parents.
4. Cost of health care and no affordable living.
5. Lack of health information. Not enough daycare for children/overpopulated schools.

The MVP families also provided input on how they would address the needs and potential resources that may be available. This information will be incorporated into later sections of this CHNA Report and the Implementation Plan. The MVP families identified mental health and drugs and alcohol as the greatest youth health need in the community. The MVP families also said the schools need more healthy foods and better after school programs. The MVP families said they felt the greatest barrier to child wellness in the community was

> "*exposure to pesticides because most of the parents work in agriculture and they feel this might have some effect on their children and family."*

Other barriers to child wellness discussed by the MVP families included finances, mental health programs, healthy foods in school, and more schools/education. The full responses from the MVP families can be found in Appendix D.

County Public Health Departments

Representatives from the Santa Barbara County Public Health Department (SBPHD) and the San Luis Obispo County Public Health Department (SLOPHD) were initially approached in early 2021, regarding the CHNA process Dignity Health was initiating for their 2022 CHNA Report. During this time period COVID-19 was all consuming at both public health departments and

limited their ability to fully participate; however periodic status updates were provided to each public health department through 2021.

In January 2022, a one-hour meeting was requested with each public health department to share the preliminary results of the community health survey and gather their feedback/input. On February 7 and 8, 2022, Dignity Health shared a presentation with each public health department that provided a status update of the CHNA process to date, shared preliminary results of the community survey, and requested their feedback/input. Both public health departments were complimentary of Dignity Health's ability to reach the most vulnerable population and agreed with the preliminary results. Both public health departments shared the desire to collaboratively approach the implementation strategy. Following the adoption of this CHNA, additional meetings will be scheduled with SBPHD and SLOPHD.

Written Comments from 2019 CHNA

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

Secondary Data Sources

The CHNA includes a multitude of secondary data indicators that help illustrate the health of the community. Secondary data from local, county, state, and national sources were reviewed and includes data points about demographics, mortality, morbidity, social determinant of health, health behaviors, clinical care, health outcomes, and physical environment. A limitation of the secondary data was that it often pulls from a larger geographic area that does not align with the demographics of the MRMC and AGCH community. Additionally, not all secondary data was stratified by demographic characteristics, which limited the ability to identify health disparities.

A multitude of primary and secondary data sources were evaluated and considered for this CHNA Report. The community health survey addressed COVID-19 and attempted to begin to document its impact to the community. Many secondary data sources are three to five years old and do not include the recent trends in health statistics including the detrimental changes in health due to the COVID-19 pandemic.

This CHNA Report utilized the following secondary data sources, and, where possible, was compared directly to data collected during the community health survey providing a comparison of service area data to county, state, or national levels:

- California Cancer Registry;
- California Department of Education;
- California Department of Public Health;
- CDC Healthy People 2030;
- CDC Morbidity and Mortality;

- Center for Disease Control (CDC) Behavioral Risk Factor Surveillance System;
- County Health Rankings and Roadmaps;
- Santa Barbara County Public Health Department; and,
- U.S. Census.

All secondary data sources were thoroughly evaluated and every effort was made to use the best available data at the time of report publishing. While there are always data limitations, the assembled data, information, and analyses completed provide a comprehensive identification and description of significant community health needs.

CHNA Report Preparers

This CHNA Report and the preceding data collection process was completed as a collaborative effort between Marian Regional Medical Center's, Patty Herrera, MA, Manager of Community Health and Amanda Tamburro, MPH, Principal at Tamburro Consulting Group, LLC. Patty has been the champion of community health in Santa Barbara County since 1991. Patty has been responsible for the community health survey data collection process and compilation since 2016. Patty conducted the critical outreach to community partners and contracted and trained her staff, staff from Herencia Indígena, and the promotores networks from both counties to conduct the health survey outreach. Patty also was responsible for managing the community health surveys collected and the data compilation. Amanda was responsible for data analysis and the report preparation. Amanda served as the primary author and lead researcher for the 2016 and 2019 Community Health Needs Assessment Reports for Marian Regional Medical Center, Arroyo Grande Community Hospital, and French Hospital Medical Center.

V. Assessment Data and Findings

The data assessment for this CHNA Report will consist of a systematic review of the primary and secondary data sources mentioned above. The data assessment will compare the community against county, state, and national levels, as well as Healthy People 2030 (HP 2030) benchmarks. Data will be analyzed for health and social inequities, health indicators, health behaviors, and health conditions. The analysis will specifically note population segments that are particularly vulnerable or experiencing disproportionate unmet health needs or poor outcomes.

Social Determinants of Health and Barriers to Care

According to the U.S. Centers for Disease Control and Prevention, the conditions of the places where people live, learn, work, and play affect a wide range of health and quality of life risks and outcomes. These factors include economic stability, health care access and quality, education access and quality, neighborhood and built environment, and social and community context are known as the social determinants of health (SDOH). [13] SDOH contribute to a wide range of health disparities and inequities and are fundamental in assessing a community.

Economic Stability

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.
Employment status is linked to several barriers to care, including lack of health insurance, inability to pay for health care services and copays, and the inability to pay for transportation to health care appointments.

HP 2030 Goal: Help people earn steady incomes that allow them to meet their health needs.

According to the U.S. Census, American Community Survey 5-Year Estimates (2016-2020), 1 in 8 people or 12.6% 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. Similarly, in Santa Barbara County, 12.9% of all residents live below the poverty level, and in San Luis Obispo County this number improves slightly to 11.1%.[14]

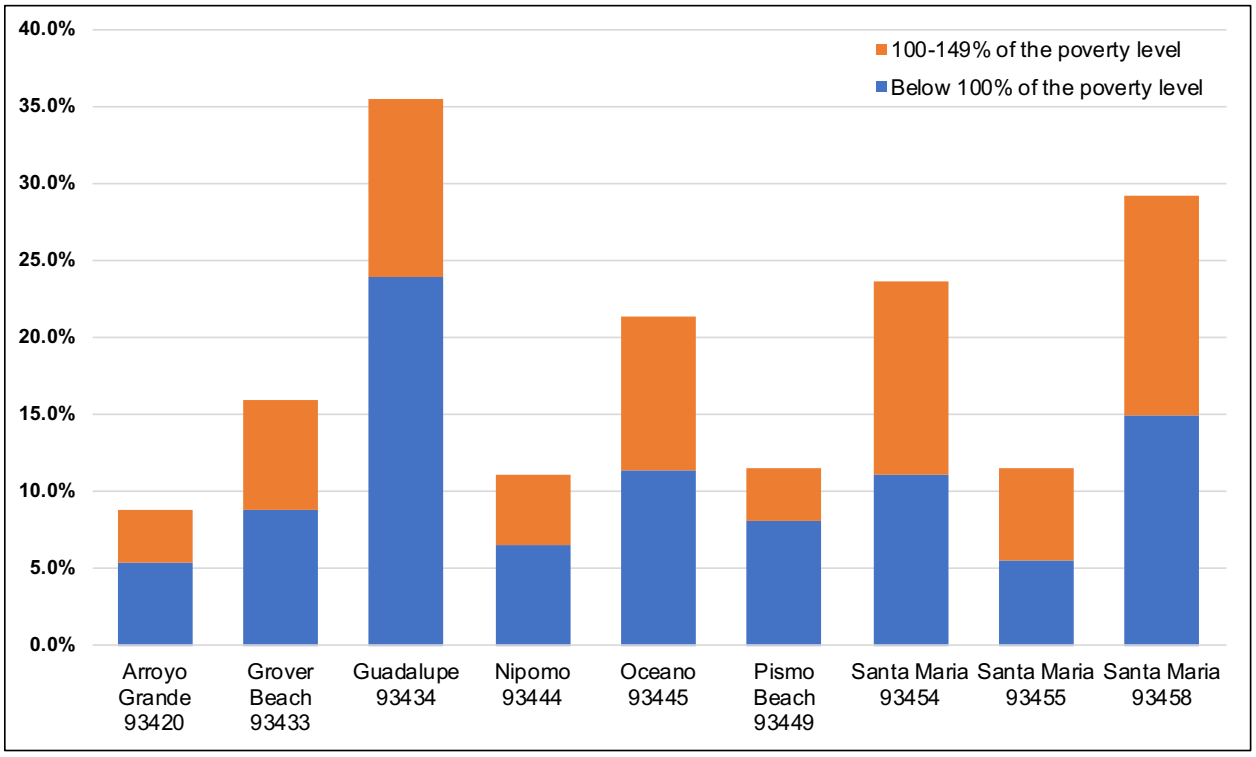
In the MRMC and AGCH communities, the poverty rates range from a low of 5.4% in Arroyo Grande to a high of 24.0% in Guadalupe. According to the U.S. Census, only two zip codes in the MRMC and AGCH community are exceeding the state poverty rate of 12.6%, including zip code 93458 (Santa Maria) and 93434 (Guadalupe). However, this secondary data does not include any recent community impacts due to the COVID-19 pandemic. According to the 2022

[13] U.S. Department of Health and Human Services, 2022. Centers for Disease Control and Prevention, Social Determinants of Health: Know What Affects Health. Retrieved from: https://www.cdc.gov/socialdeterminants/about.html
[14] U.S. Census Bureau (2022). 2016-2020 American Community Survey 5-Year Estimates. https://data.census.gov/cedsci/table?q=san%20luis%20obispo%20county%20poverty

community health survey, when survey participants were asked if they had over $300 in a savings account, 58.9% (n=438) of those residing in the community responded "no" to the question. This is an 11.7% increase in community members that do not have $300 in a savings account as compared to the 2019 CHNA results. Over half of the survey participants from zip codes 93458 (Santa Maria), 93454 (Santa Maria), and 93434 (Guadalupe) do not have $300 in a savings account. Also, over half of the community health survey participants (56.5%, n=435) reported having food insecurity/not having enough food, due to the COVID-19 pandemic. In addition, 26.1% (n=201) said they suffered a loss of job/employment due to the pandemic.

The following figure depicts the percent of the total population from each community that are either living below 100% of the poverty level or 100 to 149% of the poverty level.

Figure 3. Percent of Community Members Residing in Poverty[15]



The 2021 poverty guidelines published by the U.S. Department of Health and Human Services, published a poverty guideline of $12,880 for a one person household and $26,500 for a family of four.[16] While the official poverty measure primarily accounts for the cost of food, the Real Cost Measure (RCM), published by the United Ways of California, factors costs related to housing, health care, child care, transportation and other basic needs to reveal what it really costs to live in California. According to their 2021 report, nearly one in three California households do not earn

[15] U.S. Census Bureau (2022). 2016-2020 American Community Survey 5-Year Estimates. https://api.census.gov/data/2020/acs/acs5/subject

[16] U.S. Health and Human Services, 2022. Office of the Assistant Secretary for Planning and Evaluation, 2021 Poverty Guidelines. Retrieved from: https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines/prior-hhs-poverty-guidelines-federal-register-references/2021-poverty-guidelines#threshholds

sufficient income to meet basic needs. Of the 33% that do not earn sufficient income to meet basic needs, 97% of these households have at least one working adult. The RCM data for San Luis Obispo County found 26% of households living below the RCM, and in Santa Barbara County 36% of households were living below the RCM. In Santa Barbara County, 42% of all households and 38% of households in San Luis Obispo County spend more than 30% of their income on housing. The United Way RCM reports for Santa Barbara County and San Luis Obispo County can be found in Appendix E.[17]

Education Access and Quality

Education has been described as the most important modifiable social determinant of health.[18] Research has shown that lower educational attainment levels are linked with poor health, more stress, higher poverty, and lower self-efficacy. People with higher levels of education are more likely to be healthier and live longer.

According to the U.S. Census, the highest level of education for the population age 25 and older in the MRMC and AGCH community was distributed as follows:

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

- 22.3% had less than a high school diploma or equivalent (or 32,438 individuals);
- 20.5% had high school graduate as their highest level of school completed;
- 32.6% had some college or an associate degree as their highest level of school completed;
- 16.1% had a bachelor's degree as their highest degree; and,
- 8.5% had completed an advanced degree such as a master's degree, professional degree or doctoral degree.[19]

The educational disparity increases as each zip code within the MRMC and AGCH community is examined. The following figure displays the percentage of the population over the age of 25 that completed high school or equivalent, as compared to the State of California.

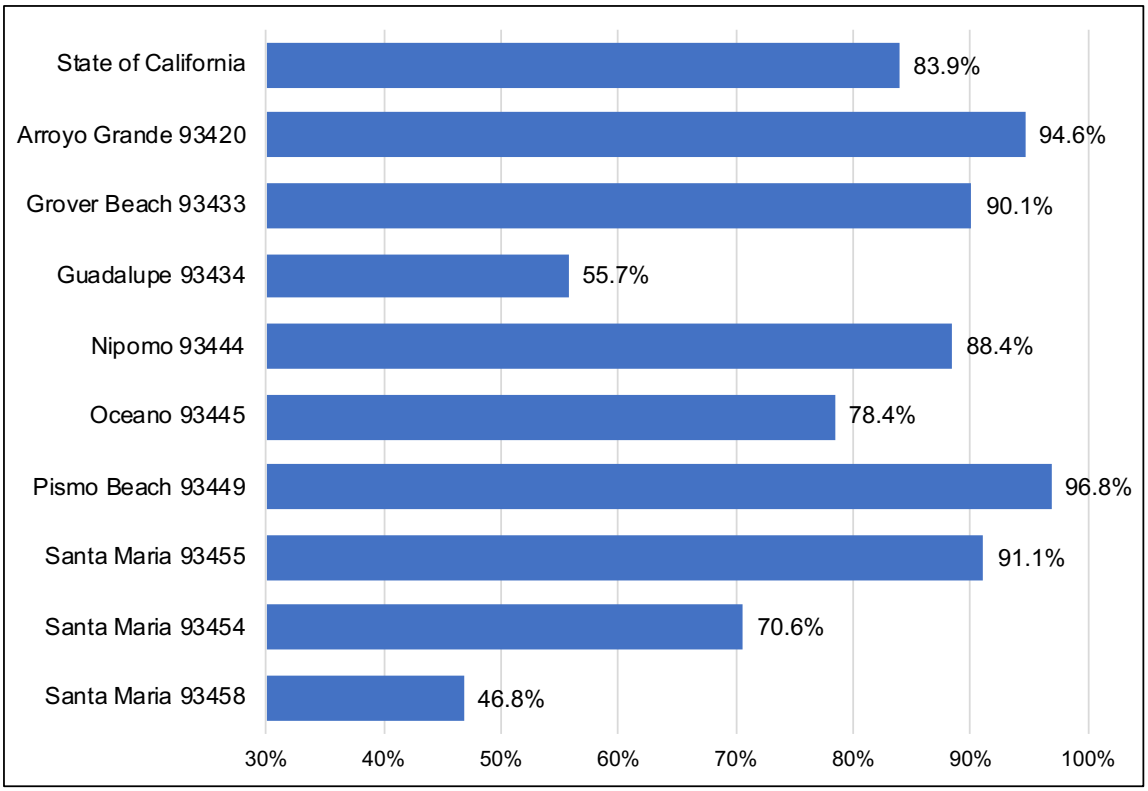
Less than half of the population (46.8%), over the age of 25, residing in zip code 93458 (Santa Maria) reported graduating high school (or equivalent). A similarly low high school completion rate of 55.7% can be found in 93434 (Guadalupe) and 70.6% in zip code 93454 (Santa Maria).

[17] United Ways of California, 2022. The Real Cost Measure in California 2021. Retrieved from https://www.unitedwaysca.org/realcost

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

[19] U.S. Census (2022). 2016-2020 American Community Survey 5-Year Estimates Subject Tables. https://data.census.gov/cedsci/table?q=ZCTA5%2093420%20Populations%20and%20People&g=860XX00US93420,93433,93434,93444,93445,93449,93454,93455,93458&tid=ACSST5Y2020.S0601

Figure 4. Percent High School Graduate, 2016-2020 (25 years and over)[20]



According to the community health survey, only 26.1% (n=201) of survey participants reported attaining a high school diploma, and over 50% (n=391) of survey participants reported having a 6th grade education or less. The educational attainment and average age for the community health survey participants is detailed on the following table.

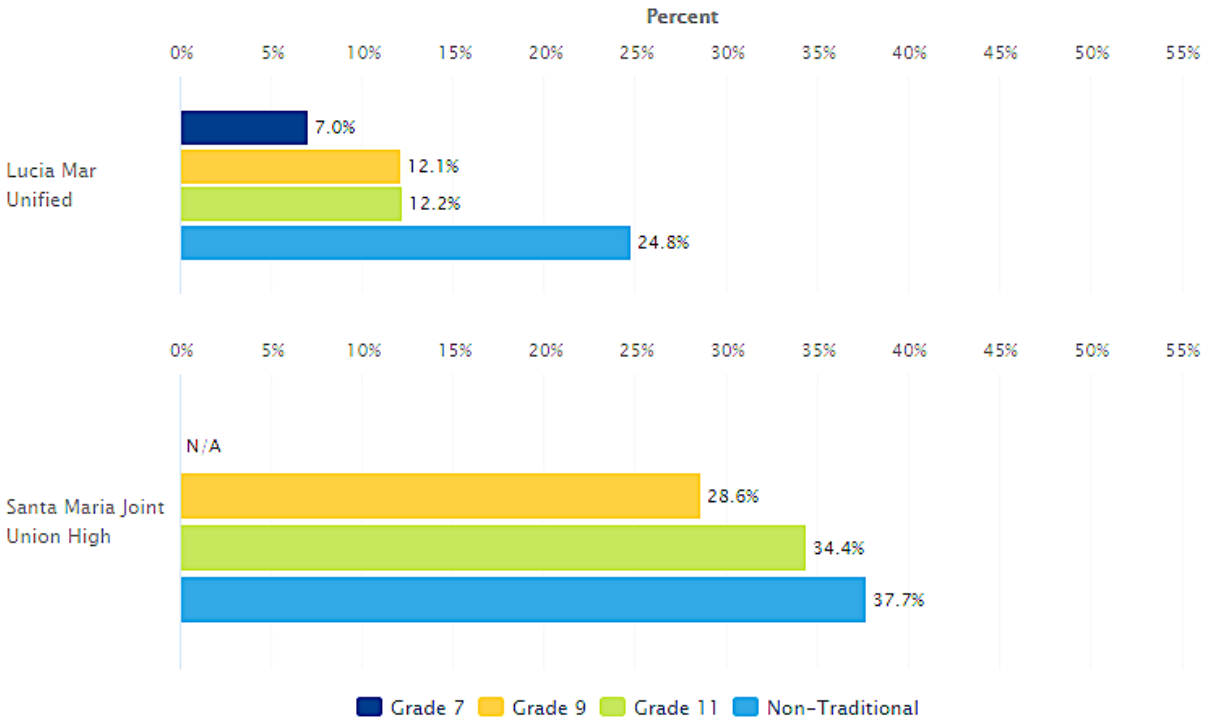
Table 5. Community Health Survey Participants' Educational Attainment

Educational Attainment	n	Percent	Average Age
No formal education	98	12.7%	42.9
Elementary school	293	38.1%	40.9
Jr high or middle school	105	13.7%	37.2
Some high school	72	9.4%	39.1
High school diploma	64	8.3%	50.2
Some college	49	6.4%	58.2
AA, AS, Trade School	29	3.8%	59.9
BA, BS	35	4.6%	53.3
Grad school	24	3.1%	67.9
Preferred not to answer	1	0.0	

[20]U.S. Census (2022). 2016-2020 American Community Survey 5-Year Estimates Subject Tables. https://data.census.gov/cedsci/table?q=ZCTA5%2093420%20Populations%20and%20People&t=Educational%20Attainment&g=860XX00US93420,93433,93434,93444,93445,93449,93454,93455,93458&d=ACS%205-Year%20Estimates%20Subject%20Tables&tid=ACSST5Y2020.S1501

The educational level of parents has been linked to the academic and economic success of their children. The following two charts were published by the California Department of Education and depict the highest level of parental education for students in Lucia Mar Unified and Santa Maria Joint Union High School. Children with less-educated parents are less likely to succeed in school. Children from low-income families, children with disabilities, and children who regularly experience social discrimination (i.e., bullying) are more likely to struggle with math and reading. [21]

Figure 5. Percent of Parents that Did Not Finish High School, by Child's Grade Level: 2015-2017[22]



Definition: Highest level of education completed by parents of public school students in grades 7, 9, 11, and non-traditional programs (e.g., in 2015-2017, an estimated 40.3% of California 7th graders had at least one parent who completed a 4-year college degree).

[21] U.S. Department of Health and Human Services, 2022. Healthy People 2030, Education Access and Quality. Retrieved from: https://health.gov/healthypeople/objectives-and-data/browse-objectives/education-access-and-quality

[22] WestEd, California Healthy Kids Survey (CHKS) and Biennial State CHKS (2022). California Dept. of Education (Mar. 2019). https://www.kidsdata.org/topic/2152/parent-education-grade/Bar#fmt=2669&loc=292&tf=122&pdist=33&ch=69,305,306,431,1316&sort=loc

Neighborhood and Built Environment

The physical and built environment surrounding where an individual lives, learns, works, and plays are important to health. Access to the outdoors, commerce, public safety, public transportation, clean water, clean air, sidewalks, parks all impact an individuals' decision-making process to further their wellness.

HP 2030 Goal: Create neighborhoods and environments that promote health and safety.

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. According to the 2020 Santa Barbara County Agricultural Production Report, Santa Barbara County had a reported gross agricultural production value of $1.8 billion.[23] In order to produce the high value crops to meet industry standards, in 2018 the California Department of Pesticide Regulation (CA DPR) reported that 4,865,420 pounds of pesticide were used to treat 2,418,410 acres in Santa Barbara County. Similarly, 3,055,467 pounds of pesticide were used to treat 1,498,665 acres in San Luis Obispo County. Santa Barbara County was ranked 13th of all California counties for pounds of pesticide applied and San Luis Obispo County was ranked 16th.[24] The Top 5 Pesticides used in each county are detailed as follows:

Table 6. Top 5 Pesticides by Pounds – 2018[25]

Santa Barbara County		*San Luis Obispo County*	
Pesticide	***Pounds***	***Pesticide***	***Pounds***
1. Chloropicrin	1,287,493	1. Sulfur	648,886
2. Sulfur	977,871	2. Chloropicrin	643,370
3. 1,3-dichloropropene	572,342	3. Sodium bromide	302,121
4. Potassium n-methyldithiocarbamate	308,712	4. 1,3-dichloropropene	242,792
5. Mineral oil	270,846	5. Mineral oil	192,282

The most commonly used pesticide by total pounds in the MRMC and AGCH community is chloropicrin. Chloropicrin is listed by The National Institute for Occupational Safety and Health (NIOSH) as a lung damaging agent and is severely irritating to the lungs, eyes, and skin. Chloropicrin is used as a soil fumigant and historically was used as a chemical warfare agent (military designation, "PS") and a riot control agent. Chloropicrin (PS) has the characteristics of

[23] County of Santa Barbara, Agricultural Commissioner's Office (2020). *2020 Agricultural Production Report.* Retrieved from: https://www.sbcfb.com/_files/ugd/a196f7_4955c740e40d4cfa9ab595ebff55e268.pdf
[24] California Department of Pesticide Regulation (2022). *Total Pounds, Applications, and Acres Treated by County: 2018.* https://www.cdpr.ca.gov/docs/pur/pur18rep/top5lists/county_subtotals.pdf
[25] California Department of Pesticide Regulation (2022). *The Top Five Chemicals by Pounds in each County in 2018 and the Top Five Commodities.* https://www.cdpr.ca.gov/docs/pur/pur18rep/top5lists/top_5_pesticides_by_pounds.pdf

tear gas and was used in large quantities during World War I and stockpiled during World War II, but is no longer authorized for military use.[26]

Another commonly used pesticide in the MRMC and AGCH community that is listed above is 1,3-dichloropropene. 1,3-dichloropropene has been classified by the U.S. Environmental Protection Agency (EPA) as a probable human carcinogen based on sufficient evidence of carcinogenicity in animals.[27]

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 standardized value that was developed by the EPA so the public understands whether air pollution levels are healthy or unhealthy. In 2020, Santa Barbara County had 79 "moderate" air quality days, 8 days that were unhealthy for sensitive groups, and 4 days that were unhealthy. A moderate air quality means that there is moderate health concern for individuals who are unusually sensitive to air pollution.[28]

The air quality in San Luis Obispo County in 2020 declined as a result of historic wildfire impacts when compared to previous years. Particulate concentration records for the county were broken with record highs measured on 10 days. Besides wildfire smoke, windblown dust continued to impact air quality in South County.[29]

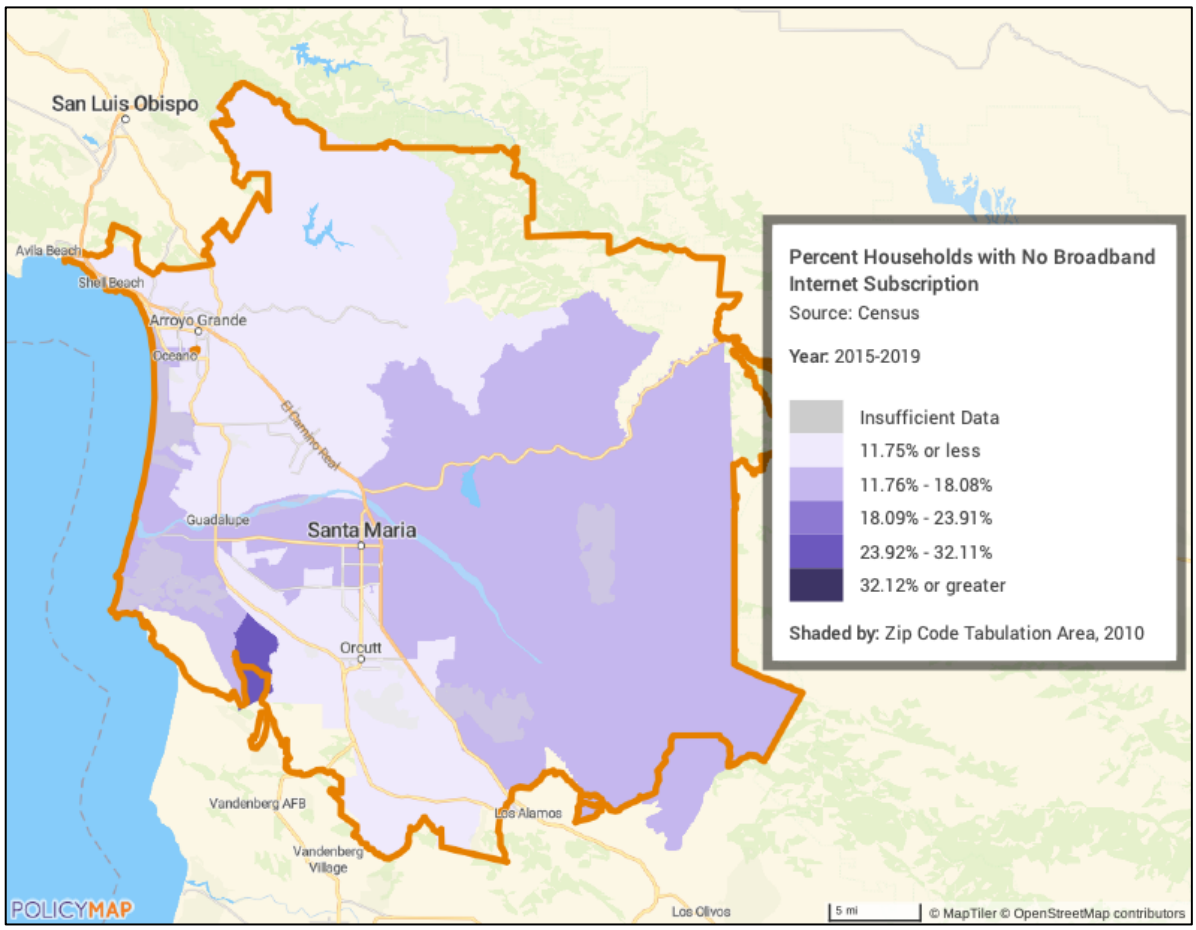
According to the community health survey, 6.2% of survey participants responded that they have been diagnosed with asthma compared to 9.1% of individuals in 2019. According to the CDC, 8.7% of adults in Santa Barbara County and 9.1% of adults in San Luis Obispo County currently have asthma.[30]

Following the COVID-19 pandemic, the importance of access to broadband internet was amplified and disparities in access were exposed. In the MRMC and AGCH community broadband internet subscriptions vary by geographic location and are presented in the following figure. In zip code 93454 over 16% of the population reported no broadband internet subscription between 2015-2019. As more health systems are using internet-based communication and health care tools, internet access is important to improve health and health

[26] Centers for Disease Control and Prevention, The National Institute for Occupational Safety and Health (NIOSH), 2022. *Chloropicrin (PS): Lung Damaging Agent*. https://www.cdc.gov/niosh/ershdb/emergencyresponsecard_29750034.html
[27] United States Environmental Protection Agency, IRIS, 2022. *1,3-Dichloropropene.* https://iris.epa.gov/ChemicalLanding/&substance_nmbr=224
[28] Santa Barbara County, Air Pollution Control District, 2022. *2020 Annual Air Quality Report*. https://ourair.org/wp-content/uploads/2020-Annual-Air-Quality-Report.pdf
[29] San Luis Obispo County, Air Pollution Control District, 2022. *Report on 2020 Air Quality in San Luis Obispo County.* https://storage.googleapis.com/slocleanair-org/images/cms/upload/files/%28E-2%29.pdf
[30] Centers for Disease Control and Prevention, 500 Cities and Places Data Portal (2022). Local Data for Better Health, 2019 County Data Released 2021. https://chronicdata.cdc.gov/browse?category=500+Cities+%26+Places

literacy. The HP2030 objective is to increase the proportion of adults with broadband access to the Internet.

Figure 6. MRMC and AGCH Community Without Broadband Internet



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:

HP 2030 Goal: Increase social and community support.

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

The MRMC and AGCH 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 foster community engagement. An example of the multitude of community organizations supporting the MRMC and AGCH communities are provided in Section 7. According to the voting records for Santa

Barbara County, nearly 78% of registered voters cast ballots in the 2020 election for Santa Maria Mayor.[31]

Crime in the City of Santa Maria continues to plague this city and the overall number of crimes from 2020 to 2021 increased over 10% from 2020 levels. The City of Santa Maria Police Department reported the following crimes, as outlined below in 2020 and 2021.[32]

Part 1 Category	2020	2021
Homicide	2	6
Rape	81	66
Robbery	179	120
Aggravated Assault	572	435
Burglary	328	885
Larceny-Theft	1114	1149
Motor Vehicle Theft	1030	1058
Arson	22	23
Total Part 1 Crimes	3328	3742

While there were six homicides reported in 2021, there was a reported 121 shootings in Santa Maria during the same time period. In the first two weeks of January 2022 there were already 10 shootings in Santa Maria, and at least two people were killed between January 1 – March 15, 2022.

Discrimination and bullying/teasing can have detrimental effects on an individual, especially students. One goal of HP 2030 is to reduce bullying of transgender students. According to the California Department of Education, between 2020-2021, 28% of 11th grade students at Santa Maria Joint Union High School reported being harassed or bullied in the past 12 months. At Lucia Mar Unified between 2019-2020, 30% of 11th grade students reported being harassed or bullied in the past 12 months.[33]

Aside from having broadband internet access as discussed above, understanding health conditions and having needed health literacy to understand health conditions are indicators of social and community context. As individuals use computers to better understand their health conditions, having social support (family and friends) to talk with is also important and improve health navigation.

[31] Santa Barbara County Elections, 2020. *Elections Summary Report, Presidential General Election, November 3, 2020, Certified Results.* https://countyofsb.org/care/elections/results/2020november03/results-1.htm
[32] City of Santa Maria Police Department (2022). 2021 Annual Report. https://www.cityofsantamaria.org/home/showpublisheddocument/30256/637828622341570000
[33] California Department of Education (CDE) (2022). *California Health Kids Survey Most Recent Data (2019-20).* https://calschls.org/reports-data/public-dashboards/secondary-student/

Health Care Access and Quality

Access to comprehensive, quality health care services is important for the achievement of health equity and for increasing the quality of a healthy life for everyone. Inadequate health insurance coverage is one of the largest barriers to health care access, and the unequal distribution of coverage contributes to disparities in health. Out of pocket medical care costs may lead individuals to delay or forgo needed care (such as doctor visits, dental care, and medications), and medical debt is common among both insured and uninsured individuals. Vulnerable populations including seniors, Latino(a) (monolingual Spanish speaking), Indigenous, LGBTQ+, and homeless are particularly at risk for insufficient health insurance coverage; people with lower incomes are often uninsured and minorities account for over half of the uninsured population.[34]

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

The communities' ability to access health care was measured through multiple community health survey responses compared to secondary data. The qualitative survey responses identified access to health care and access to behavioral health care as the two greatest needs facing the community, including the youth population. Select details are presented on the following Table 6.

Table 6. Access to Health Care Status

Health Behavior/Status	2022 CHNA (N=770)	2019 CHNA (N=866)	CDC BRFSS[35]	
			California	U.S.
Health care coverage (any kind) (Q10)	47.6%	66.1%	89.3%	89.3%
No health care coverage any kind (Q10)	31.1%	26.4%	10.7%	10.7%
Visited doctor within past year for routine checkup (Q12)	73.0%	78.5%	65.6%	76.0%
Received dental care in past year (Q14) (BRFSS 2016)	51.2%	60.9%	64.6%	66.7%

Comparing 2022 community health survey results to the 2019 and 2016 community health surveys, there was a measurable decline in survey participants with any kind of health care coverage. Health insurance coverage rates have decreased nearly 20% from 2016 and 2019 levels. However, an analysis of the health insurance status for survey participants' age 65 or younger found the following:

[34] Office of Disease Prevention and Health Promotion, 2022. *Access to Health Services.* Retrieved from: https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources/access-to-health

[35] Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Population Health (2022). BRFSS Prevalence & Trends Data (online). 2020 Data. https://www.cdc.gov/brfss/brfssprevalence/

- After the removal of potential Medicare beneficiaries, a lesser 38.0% (n=241) of survey participants reported having health insurance;
- 35.1% (n=223) of survey participants reported having no health insurance coverage of which 94.2% (n=210) completed their survey in Spanish; and,
- 23.6% (n=150) reported having only emergency/restricted Medi-Cal

The 2022 community health survey results also showed a decline in oral health with only one out of every two survey participants reporting visiting a dentist in the past year. Survey participants that delayed getting medical care in 2022 cited cost as the primary reason, followed by fear of COVID-19.

Mortality

The most recent publicly available mortality data is from 2020, published by both the CDC and also the California Health and Human Services Agency.

A review of the 2020 California mortality data, by the California Department of Public Health, revealed that after many years of decreasing death rates in California, the rate increased substantially (15.9%) in 2020, and continued to increase in 2021. This increase in deaths, or excess mortality, is due to COVID-19 and other causes of death. The excess mortality differed by race/ethnicity, with the greatest increase among the Latino(a) population. Compared to prior years, deaths increased 34.1% among the Latino(a) population, and 7.8% among Whites. As the year continued, excess mortality increased within all racial groups, and the disparities between groups increased.[36]

The following two tables list the leading causes of death for Santa Barbara County and San Luis Obispo County in 2020. The tables also detail the leading causes of death for the Latino(a) population residing in each county in 2020. A full data table detailing total deaths and the age-adjusted rate per 100,000 for years 2018-2020 can be found in Appendix F.

Table 7. Top 5 Leading Causes of Death – 2020[37]

Santa Barbara County	*San Luis Obispo County*
1. Heart disease	1. Cancer
2. Cancer	2. Heart disease
3. Alzheimer disease	3. Cerebrovascular disease
4. Cerebrovascular disease	4. Accidents (unintentional injuries)
5. Accidents (unintentional injuries)	5. Alzheimer disease

[36] California Department of Public Health, Fusion Center, 2021. Data Brief: 2020 Increases in Deaths in California. https://skylab.cdph.ca.gov/communityBurden/_w_e8c2a1be/xMDA/2020_Excess_Mortality-FINAL.pdf

[37] Centers for Disease Control and Prevention, National Center for Health Statistics (2021). Underlying Cause of Death 2018-2020 on CDC WONDER Online Database. https://wonder.cdc.gov/controller/datarequest/D158;jsessionid=204610BAE540A9B597F1C0F6C79D

Table 8. Top 5 Leading Causes of Death, Latino(a) Population – 2020[38]

Santa Barbara County	*San Luis Obispo County*
1. Cancer	1. Cancer
2. Heart disease	2. Heart disease
3. COVID-19	3. Accidents (unintentional injuries)
4. Accidents (unintentional injuries)	4. COVID-19
5. Cerebrovascular diseases	5. Diabetes mellitus

As depicted in the above tables, the leading causes of death in Santa Barbara County is heart disease, followed closely by cancer. In San Luis Obispo County, cancer was the leading cause of death followed closely by heart disease. While the leading cause of death differs for each county, heart disease and cancer can be attributed to approximately 42-43% of all deaths occurring between 2018-2020 in Santa Barbara County and San Luis Obispo County. In San Luis Obispo County and Santa Barbara County, accidents (unintentional injuries) were the third leading cause of death for the Latino(a) community (between 2018-2020). Intentional self-harm (suicide) was the tenth leading cause of death in Santa Barbara County in 2020. [39]

The top five leading causes of death for Californians between 2018-2020, were as follows:

1. Heart disease,
2. Cancer,
3. Alzheimer disease,
4. Cerebrovascular diseases, and
5. Accidents (unintentional injuries).

While the state results mirror the leading causes of death in Santa Barbara County, it differs from San Luis Obispo County data. Similarly, heart disease and cancer were listed as the cause of death for 43% of all deaths in California.[40]

One length of life measure is premature death, which is tabulated through the years of potential life lost before age 75 per 100,000 (age-adjusted). Secondary data for the years of potential life lost (YPLL) from 2017-2019 was available at the national, state, and county level. Overall, the State of California is considered the healthiest state in the nation for having the lowest years of potential life lost before age 75 (5,703 years), compared to the national rate of 7,337 years.[41] The YPLL for Santa Barbara County and San Luis Obispo County was 5,200 years each.[42]

[38] Ibid 37.
[39] Ibid 37.
[40] Ibid 37.
[41] United Health Foundation (2022). *American's Health Rankings analysis of CDC Wonder, Multiple Cause of Death Files (2019).* https://www.americashealthrankings.org/explore/annual/measure/YPLL/state/CA
[42] County Health Rankings (2022). *2021 County Health Rankings Premature Death (data from 2017-2019).* *https://www.countyhealthrankings.org/app/california/2021/measure/outcomes/1/datasource*

Santa Barbara County and San Luis Obispo County's Health Status Profile Reports for 2019, as prepared by the California Department of Public Health, have been provided for reference in Appendix G. The county health status profile provides additional information regarding mortality, morbidity, infant mortality, and natality.

Chronic Conditions

Chronic disease and injury are reported as the leading cause of death, disability, and diminished quality of life in the U.S. and California. Chronic diseases are defined as conditions that last more than one year and require ongoing medical attention or limit activities of daily living or both. Chronic conditions many times are caused by unhealthy or risky behaviors, such as tobacco use, unhealthy diet, lack of physical activity, and excessive alcohol use.[43] Chronic conditions also encompass mental health conditions, including depression and anxiety.

Heart Disease and Stroke

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. In 2020, diseases of the heart was the leading cause of death in Santa Barbara County and the second leading cause of death in San Luis Obispo County.

HP 2030 Goal: Improve cardiovascular health and reduce deaths from heart disease and stroke.

The community health survey included questions that are considered risk factors for heart disease and stroke. These indicators are presented on the following Table 9 and compared to state and national levels.

Table 9. Prevalence of Heart Disease and Stroke Indicators

Heart Disease and Stroke Indicators	2022 CHNA (N=770)	2019 CHNA (N=866)	CDC BRFSS[44]	
			California	U.S.
Lifetime Cholesterol Check (Q22)	44.7%	51.7%	87.8%	86.6%
Informed Blood Cholesterol High (Q23)	24.2%	33.4%	29.9%	33.1%
Lifetime High Blood Pressure (Q20)	27.2%	34.5%	27.8%	32.3%

[43] Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion (2018). *About Chronic Disease*. https://www.cdc.gov/chronicdisease/about/index.htm
[44] Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Population Health (2022). BRFSS Prevalence & Trends Data (online). 2019 Data. https://www.cdc.gov/brfss/brfssprevalence/

Diabetes

The prevalence of diabetes in the community varies depending upon an individual's age and ethnicity. The community health survey asked participants (Q25) if they were ever told by a doctor they had diabetes, pre-diabetes, or gestational diabetes. Primary and secondary data sources were evaluated and presented on the following table.

HP 2030 Goal: Reduce the burden of diabetes and improve quality of life for all people who have, or are at risk for, diabetes.

Table 10. Diabetes Prevalence

Have you ever been told by a doctor you have diabetes?	2022 CHNA (N=770)	2019 CHNA (N=866)	CDC BRFSS[45]	
			California	U.S.
Yes	12.6%	17.3%	9.8%	10.6%
Yes, pregnancy related	3.5%	2.7%	1.6%	0.9%
No, pre-diabetes or borderline diabetes	7.8%	4.4%	3.4%	1.8%

The community health survey revealed pre-diabetes and gestational diabetes rates approximately twice the state level. Survey participants reporting a diabetes diagnosis in 2022 is below 2019 levels, but still above state and national levels.

Cancer

As mentioned above, in 2020 cancer was the leading cause of death in San Luis Obispo County and the second leading cause of death in Santa Barbara County. Aside from cancer screening tests, there are vaccines and healthy choices that can reduce an individual's risk of cancer, such as limiting alcohol and tobacco use, skin protection, maintaining a healthy weight, and physical fitness. Cancer disparities are thought to reflect the relationship of socioeconomic factors, culture, diet, stress, the environment, and biology. 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.[46]

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

According to the California Cancer Registry, between 2015 and 2017, 6,236 cancer cases occurred in Santa Barbara County and 4,855 occurred in San Luis Obispo County. The California Cancer Registry determined the crude rate of cancer for each county and then adjusted

[45] Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Population Health (2022). BRFSS Prevalence & Trends Data (online). 2020 Data. https://www.cdc.gov/brfss/brfssprevalence/

[46] National Cancer Institute, "Cancer Disparities" Retrieved from https://www.cancer.gov/about-cancer/understanding/disparities Last Updated March 11, 2019.

it for age, so that an "apples to apples" comparison could be completed between the 58 counties in California. These rates were ranked from highest to lowest, with San Luis Obispo County being ranked 10th highest in the state overall and Santa Barbara County being ranked 12th. The most common cancer sites with age adjusted rates for the county and state are provided on the following Table 11.

Table 11. Age-Adjusted Invasive Cancer Incidence Rates (2013-2017)[47]

Site	Santa Barbara County		San Luis Obispo County		California
	Total Cases	Age Adjusted Rate*	Total Cases	Age Adjusted Rate*	Age Adjusted Rate*
All Sites	10,281	426.4	7,913	429.2	393.8
Lung and Bronchus	957	38.3	836	43.0	40.9
Prostate, Males	1,142	98.0	1040	107.3	91.2
Colon & Rectum	777	32.3	596	32.2	34.8
Breast	1,664	71.5	1,335	75.7	64.4
* All rates are per 100,000. Rates are age adjusted to the 2000 US Standard Population.					

Cancer mortality rates are provided by the California Cancer Registry. A 5-year profile for the most recent data available (2013-2017) of the leading cancer mortality rates by site for Santa Barbara County and San Luis Obispo County is provided on the following table.

Table 12. Age-Adjusted Cancer Mortality Rates (2013-2017)[48]

Site	Santa Barbara County		San Luis Obispo County		California
	Total Deaths	Age Adjusted Rate*	Total Deaths	Age Adjusted Rate*	Age Adjusted Rate*
All Sites	3,437	136.3	2,642	137.9	142.0
Lung and Bronchus	625	24.7	586	30.5	29.4
Prostate, Males	199	17.8	160	18.8	19.7
Colon & Rectum	254	9.9	231	12.0	12.6
Breast	285	11.6	202	11.1	10.7
Miscellaneous	245,247	9.8	206	10.6	9.6
* All rates are per 100,000. Rates are age adjusted to the 2000 US Standard Population.					

The 2022 community health survey asked multiple questions regarding survey participants' cancer screening history. Female survey participants over the age of 40, were asked if they received a mammogram in the past year. According to 2022 community health survey, 67.8% (n=196) of females over the age of 40 reported receiving a mammogram in the past year. Further evaluation into the health insurance status of females age 40 and older revealed the following:

[47] California Cancer Registry (2022). Age-Adjusted Cancer Incidence Rates in California, All Sites, 2013-2017. https://www.cancer-rates.info/ca/

[48] California Cancer Registry (2022). Age-Adjusted Cancer Mortality Rates in California, All Sites, 2013-2017. https://www.cancer-rates.info/ca/

- For women age 40 and over, 28.9% (n=50) with health insurance and 36.9% (n=24) without health insurance did not receive their annual mammogram.
- Nearly 61.5% of women (n=123), age 40 and over, without health insurance, reported receiving their annual mammogram in the community health survey.

While the number of survey participants reporting an annual mammogram is a decrease of approximately 10% from the 2019 community health survey results, it is most likely the result of the COVID-19 pandemic.

Community health survey participants over the age of 45 were asked about their colorectal screening habits and if they ever had a lifetime colonoscopy. Additional questions were asked of survey participants to determine if they ever were screened for lung cancer through a CT scan, as well as a prostate cancer screening question. The community health survey results related to cancer prevention have been tabulated and are provided on the following table.

Table 13. Cancer Prevention Prevalence

Cancer Screening Questions	2022 CHNA	CDC BRFSS[49]	
		California	U.S.
Lifetime lung cancer screening (CT) (Q27)	9.4%	N/A	N/A
Lifetime colonoscopy (Age 45+) (Q28)	51.3%	N/A	N/A
Mammogram Past Year (Women, 40+) (Q29)	67.8%	66.2%	71.5%
Pap Test Past 3-years (Women, 18-65) (Q30)	76.8%	79.3%	77.7%
Prostate Cancer Screening (Men, 50+)(Q31)	47.1%	N/A	N/A

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. The status of these health behaviors was measured through several community health survey questions.

Obesity, Diet and Exercise

Body mass index (BMI) for each participant was calculated based on self-reported height and weight. When BMI was calculated for the community health survey participants, over 76% of all 2022 community health survey participants responding to this question (n=500) had BMIs considered overweight or obese. BMI measurements that fall within the range of 18.5 to 24.9 are considered to be normal weight. BMI measurements between 25.0 and 29.9 are considered to be overweight and those greater than 30.0 are considered obese. Overall, 62.9% of community

[49] Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Population Health (2022). BRFSS Prevalence & Trends Data (online). 2020 Data. https://www.cdc.gov/brfss/brfssprevalence/

health survey participants reported participating in an exercise or physical activity at least three times per week.

Smoking

Community health survey participants were asked two questions related to their smoking habits. Survey participants were asked if they ever smoked on average at least one pack of cigarettes per day for 20 years, or two packs a day for 10 years. Overall 6.6% or 50 individuals, out of 752, responded "yes" to this question. Furthermore, community health survey participants were asked if they used any of the following the products in the past 30 days, this includes cigarettes, e-cigarettes, cigars, cigarillos, chewing tobacco, pipes, or smoking marijuana. Cigarettes were used the most, with 4.5% of survey participants saying they used cigarettes in the past 30 days. Approximately 2% of survey participants said they used e-cigarettes or vape, and similarly, 2% said they smoked marijuana.

According to the California Healthy Kids Survey, 6% of 11th grade students in Santa Maria Joint Union High School (2020-2021 data) reported currently vaping. However, 18% of 11th grade students at Lucia Mar Unified (2019-2020 data) reported currently vaping.[50]

Social and Emotional Wellness

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

Intentional harm was ranked as the 10th leading cause of death between 2018-2020 in Santa Barbara and San Luis Obispo Counties.[51] According to the CDC's 500 Cities and PLACES Data in 2019, 13.1% of adults in Santa Barbara County reported their mental health was not good for more than 14 days in the past month, and 12.9% of adults in San Luis Obispo County.[52] As previously stated, this secondary data from 2019 is not representative of the social and emotional impact on the community due to the COVID-19 pandemic. Over 15% of 2022 community health survey participants responded that they (or a member of their household) needed to talk to a health care professional about problems like stress, emotional problems, family, drugs, or alcohol. The most commonly encountered social and emotional conditions at MRMC are anxiety, possible alcohol concern, and depression.

Research suggests that LGBTQ+ individuals face health disparities linked to societal stigma, discrimination, and denial of their civil and human rights. Discrimination against LGBTQ+ persons has been associated with high rates of psychiatric disorders, substance abuse, and suicide.

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[50] California Department of Education (CDE) (2019). *California Health Kids Survey Most Recent Data (2017-18).* Retrieved from: https://calschls.org/reports-data/dashboard/.
[51] Ibid 37.
[52] Centers for Disease Control and Prevention, 500 Cities and Places Data Portal (2022). Local Data for Better Health, 2019 County Data Released 2021. https://chronicdata.cdc.gov/browse?category=500+Cities+%26+Places

According to the California Healthy Kids Survey most recent data (2020-21), 12% of 9th grade students at Santa Maria Joint Union High School reported considering suicide. At Lucia Mar Unified where the most recent data is a year behind (2019-20) and does not include any potential impacts from the pandemic, 19% of 9th grade students and 21% of 11th grade students reported considering suicide.[53]

Substance Abuse

Substance abuse is a high risk behavior that can lead to immediate or long-term health problems, and ultimately impacts individuals, families, and communities. The California Overdose Surveillance Dashboard provides opioid-related death and hospitalization information at the county level. The most recent data provided is from 2020 and is presented below:[54]

- Santa Barbara County (total population 446,475)
    - 16 deaths related to opioids
    - 202 emergency department visits related to any opioid overdose
    - 47 hospitalizations related to any opioid overdose
    - 175,297 prescriptions were written for opioids

- San Luis Obispo County (total population 283,159)
    - 57 deaths related to opioids (zip codes 93444 and 93445 have second and third highest rate of deaths in the county)
    - 151 emergency department visits related to any opioid overdose
    - 36 hospitalizations related to any opioid overdose
    - 132,358 prescriptions were written for opioids.

[53] California Department of Education (CDE) (2019). *California Health Kids Survey Most Recent Data (2017-18).* Retrieved from: https://calschls.org/reports-data/dashboard/.
[54] California Department of Public Health (2022). California Overdose Surveillance Dashboard 2020 data. https://skylab.cdph.ca.gov/ODdash/

VI. Prioritized Description of Significant Community Health Needs

The significant community health needs identified for the MRMC and AGCH community extend far beyond health and health care. Social factors, including education, employment status, income level, gender, and ethnicity all contribute to health inequities. According to the CDC, racial and ethnic minority groups throughout the United States experience higher rates of illness and death across a wide range of health conditions, including diabetes, hypertension, obesity, asthma, and heart disease, when compared to their White counterparts.[55]

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.

The significant community health needs were thoughtfully determined by the Dignity Health Community Health Education Department. Primary and secondary quantitative data, as well as the qualitative data and the anecdotal stories all pointed to the following priorities. The same concerns and needs consistently rose to the surface and were repeated time and time again. In accordance with Dignity Health policy, the following criteria were also utilized to evaluate the prioritization of community needs, including:

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

Attaining health equity in the MRMC and AGCH community will require addressing the greatest disparities and helping the pockets of the community that are facing a constant uphill battle with everyday life. The following paragraphs provide a prioritized list of the significant health needs identified through the CHNA.

Priority 1: Educational attainment

Low levels of adult educational attainment was identified in the 2016 CHNA, the 2019 CHNA, and now again in this 2022 CHNA Report. Educational attainment is one of the five social determinants of health, and low educational attainment levels are linked with poor health, more stress, higher poverty, and lower self-efficacy. Overall, 22.3% of the MRMC and AGCH

[55] U.S. Department of Health and Human Services, 2022. Centers for Disease Control and Prevention, Health Equity. Retrieved from https://www.cdc.gov/healthequity/racism-disparities/index.html.

community (or 32,438 individuals) over the age of 25 did not graduate high school or equivalent. However, the 2022 community health survey found that 73.9% (n=568) survey participants reported they did not complete high school (or equivalent). The high school graduation rate (age 25 and over) for the MRMC and AGCH community is below the state level of 83.9% in the following communities:

- 93458 (Santa Maria) – 46.8%;
- 93434 (Guadalupe) – 55.7%;
- 93454 (Santa Maria) – 70.6%; and,
- 93445 (Oceano) – 78.4%.

A review of parents' educational attainment for the Santa Maria Joint Union High found that the parents of almost 35% of 11th grade students did not finish high school. Children with less-educated parents are less likely to succeed in school, and they may not reach their full potential.

Priority 2: Access to primary health care, behavioral health care, and oral health

The need for an improvement in access to primary health care, behavioral health care, and oral health has been substantiated through primary data, secondary data, and HRSA. HRSA has designated two medically underserved communities within the MRMC and AGCH community, including Guadalupe (MUA/P ID: 00301) and Arroyo Grande (MUA/P: 00395). Mental health professional shortages were designated for the low income migrant farmworker population in Santa Maria, CA (HPSA ID: 7062407340) and Solvang/Lompoc/Guadalupe (HPSA ID: 7062778515).

Even if the community was not struggling with documented shortages of health care providers and medically underserved areas, inadequate health insurance coverage is one of the largest barriers to health care access. The vulnerable populations within the MRMC and AGCH community, include seniors, Latino(a) (monolingual Spanish speaking individuals), Indigenous, homeless, and LGBTQ+ individuals. These vulnerable communities are well documented as being either uninsured, or underinsured, and face limited providers willing to treat them unless they can private pay. In addition, the vulnerable populations do not have jobs that offer them paid time off, or sick time, to leave work and go to a middle of the day physician's appointment or preventative screening. If they do take the time off of work, they will lose their pay for the day or potentially their position. Many are faced with choosing between going to a doctor or keeping their job and feeding their family.

Aside from difficulty in accessing all types of health care, the vulnerable populations including the aging community struggle with navigating the health care system. The lack of educational attainment mentioned and language barrier creates a situation that many find intimidating and difficult to navigate.

Priority 3: Health promotion and prevention

Heart disease and cancer are the leading causes of death at local, state, and national levels. As documented above, the most vulnerable members of the MRMC and AGCH community struggle to access health care. If the vulnerable communities are struggling to access health care, they are less likely to understand their current health status and access preventative cancer screenings. Besides difficulty accessing health care, the vulnerable communities face increased risk for heart disease and cancer due to their social determinants of health. They face food insecurity and more often live in areas that have higher levels of pollution. In order to help the most vulnerable communities reduce their chances of developing heart disease, cancer, or another chronic condition, targeted upstream health promotion and prevention is needed. Therefore, health promotion and prevention is the third significant health need within this CHNA Report.

Within the MRMC and AGCH community, approximately 45% (n=334) of the 2022 community health survey participants had a lifetime cholesterol check. If the responses are filtered for health insurance status, 60.5% those survey participants with health insurance have had their cholesterol checked. Meanwhile an early indicator for heart disease in the majority of survey participants is unknown. Another risk factor for heart disease is obesity. Over 76% of the 2022 survey participants had BMIs that were considered overweight or obese.

The 2022 community health survey asked multiple questions regarding survey participants' cancer screening history. Overall 67.8% (n=196) of female survey participants over the age of 40 reported receiving a mammogram in the past year. Community health survey participants over the age of 45 were asked about their colorectal screening habits and if they ever had a lifetime colonoscopy. Only 51.3% (n=157) of eligible survey participants reported having a lifetime colonoscopy.

Lastly, good health requires proper nutrition. Over half of the community health survey participants (56.5%, n=435) reported having food insecurity/not having enough food, due to the COVID-19 pandemic.

VII. Resources Potentially Available to Address Needs

While potential resources are available to address the needs of the community, the needs are too significant for any one organization. Making a substantial and upstream impact will require the collaborative efforts of community organizations, local government, local business leaders, and institutions. The greater Santa Maria Valley and "Five Cities" area are home to a wealth of organizations, businesses, and non-profits, including colleges and universities within each county.

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

Educational Attainment

- Alan Hancock Community College
- Boys and Girls Club, Oceano
- Boys and Girls Club, Santa Maria
- Catholic Churches
- City of Santa Maria, Recreation and Parks Department
- County of Santa Barbara
- San Luis Obispo County
- Cuesta College
- Discovery Museum
- Five Cities Homeless Coalition
- Little House by the Park (Guadalupe Family Resource Center)
- Local Agriculture
- Other Shelters
- Santa Maria Valley YMCA
- United Way
- University of California, Santa Barbara
- Cal Poly
- Future Leaders of America Inc.
- Santa Maria Valley Youth and Family Center
- First 5
- Center for Family Strengthening
- CAPSLO (Community Action Partnership of SLO County
- Marian Regional Medical Center

Access to primary health care, behavioral health care, and oral health

- 5 Cities Homeless Coalition
- Alliance for Pharmaceutical Access
- Child Abuse Listening Mediation (CALM)
- CommUnify
- Community Counseling Center
- Community Health Clinics of Central Coast (CHC)
- Council on Alcohol and Drug Abuse (CADA)
- Santa Maria Valley Youth and Family
- Pacific Health Centers of the Central Coast
- Planned Parenthood of Santa Barbara, Ventura, and San Luis Obispo Counties, Inc.
- Santa Barbara County Department of Behavioral Wellness-Planning the inpatient behavioral health unit in northern Santa Barbara County
- Santa Barbara County Public Health
- San Luis Obispo County Public Health
- Transitions Mental Health Association
- SLO Noor Foundation
- Family Pediatric Group
- Center for Family Strengthening
- CAPSLO (Community Action Partnership of SLO County
- Herencia Indígena
- Street Medicine Program

Health Promotion and Prevention

- Area Agency on Aging
- Catholic Charities
- CommUnify
- Oasis Senior Center
- Santa Maria Parks and Recreation: Edwin Mussel Senior Center
- Community Health Centers of the Central Coast (CHC)
- Family Pediatric Group
- Pacific Health Centers of the Central Coast
- Santa Barbara County Public Health Department
- San Luis Obispo County Public Health Department
- Center for Family Strengthening

- SLO Noor Foundation
- CAPSLO (Community Action Partnership of SLO County
- Hearst Cancer Resource Center
- Mission Hope: Marian Cancer Center
- Herencia Indígena
- Planned Parenthood of Santa Barbara, Ventura, and San Luis Obispo Counties, Inc.
- Cal Poly Women's Mobile Clinic
- Marian Regional Medical Center Community Health Education Programs

VIII. Impact of Actions Taken Since the Preceding CHNA

Following the 2019 CHNA Report and Implementation Plan, MRMC and AGCH worked tirelessly to address the identified health needs. Several new programs were initiated, including a new Street Medicine Program that is now in its second year of service. Since July 2019, MRMC and AGCH faithfully provided $69,123,975 in community benefits, detailed in the following table.

Table 15. MRMC & AGCH Community Benefits Summary, FY20 and FY21

Period	7/1/2019 – 6/30/2020		7/1/2020 – 6/30/2021	
Community Benefit Category	Persons	Net Benefit	Persons	Net Benefit
Benefits for Poor				
Financial Assistance	7,869	$6,293,237	12,514	$6,688,280
Medicaid	90,327	$8,858,300	93,351	$22,181,259
Community Services	33,855	$4,721,023	23,563	$4,977,442
Totals for Poor	132,052	$19,872,636	129,428	$33,846,981
Benefits for Broader Community				
Community Services	4,123	$6,543,209	2,948	$8,861,149
Totals for Broader Community	4,123	$6,543,209	2,948	$8,861,149
TOTAL COMMUNITY BENEFIT	**136,175**	**$26,415,845**	**132,376**	**$42,708,130**

In addition to addressing the identified 2019 community health needs, MRMC and AGCH expended an unprecedented effort and focus on helping the community through the COVID-19 pandemic. When the stay home orders and COVID-19 restrictions began to be lifted, MRMC remained vigilant and proactive in collaborating with Santa Barbara County Public Health, and accessing the needs of our community partners. Due the resurgence of COVID-19 and the Delta Variant, the bilingual COVID-19 Information line was reactivated and staffed by the MRMC Community Health Department with the focus of assisting those callers needing help obtaining a vaccine appointment. Bilingual vaccine public service announcements were developed and aired on the local radio stations and television stations. Ongoing collaboration efforts between Santa Barbara County Public Health, Community Health Centers of the Central Coast, and MRMC Community Education focused on developing COVID-19 vaccine education outreach to the Latino(a) population which resulted in the establishing mobile vaccine clinics in strategic neighborhoods in San Luis Obispo County.

Besides addressing the unexpected impact from the COVID-19 pandemic, the 2019 CHNA Report identified the following health needs:

- Educational attainment;
- Access to primary health care, including behavioral health;
- Aging, more mature population; and
- Chronic disease and management.

The following subsections provide select details and impacts from the various community benefit programs currently addressing each 2019 identified health need. Further information can be found in the most recent community benefit report.

Educational attainment

- Funded programs whose goal was to encourage higher education, adult literacy, and medical literacy.
- Implemented bilingual support groups for cancer, diabetes, and grief.
- Provide Spanish and Mixteco interpreters and outreach workers.

Access to primary health care, including behavioral health

- Funded Accountable Care Communities (ACC) whose goal is to provide access to health care, medical prescriptions, and behavioral health care.
- Provided financial assistance programs to cover basic needs, hospital bills, transportation vouchers, hotel vouchers.
- Provide bilingual mental health support to families impacted by perinatal mood and anxiety disorder.
- Developed and launched the Street Medicine Program which has two monthly outings to homeless encampments in the community..
    - Provided basic health and basic needs assessments to 264 unsheltered individuals in the community in FY2021.
- The Perinatal Mood Anxiety Disorder Program provided mental health support to new mothers after childbirth.
    - Licensed clinical social worker supervises the community health educator who leads a bilingual support group once a month.
    - Bilingual community health educators offers a once a month lecture on the signs Perinatal Mood Anxiety Disorder in Spanish.
    - Program served 963 (total is combine for both monthly support and lecture) and connected 105 patients with a therapist.

Aging, more mature population

- Funded Accountable Care Communities (ACC) whose goal is to provide access to health care, medical prescriptions, and behavioral health care.
- Provided free evidence based self-management disease workshops.
- Provided financial assistance programs to cover basic needs, hospital bills, transportation vouchers, hotel vouchers.
- The Faith Community Nursing/Health Ministry program addressed the spiritual, physical, mental, and social health of the individual in their faith community. Currently, there are 9 trained community faith nurses who support their congregation in various ways. Some

provide free blood pressure screens, COVID-19 vaccines, and flu vaccines. Some give informal community resources referrals. A total of 596 individuals were served in this program in FY21.

Chronic disease and management

- Provided free evidence based self-management disease workshops.
    - In FY2021, a total of 127 participants attended the ZOOM Healthy for Life workshops indicating a 13% increase from last year. A total of 63 participants attended the ZOOM DEEP workshops which indicated a 5% increase from last year. Demographics of the participants were 115 Latino, 12 white, 112 females, and 15 males.
- Provided free screening mammograms to women who are uninsured or underinsured.
- Funded Accountable Care Communities (ACC) whose goal is to provide access to health care, medical prescriptions, and behavioral health care.
- Cancer Prevention and Screening Program provided cancer awareness, prevention activities, screenings, and genetic counseling to largely rural and medically underserved population.
    - 1,710 medically underserved patients were screened and referred to social support services in FY2021.
    - 65 medically underserved individuals received free counseling services with follow up assessments.
    - 1,302 individuals were connected to various supportive services.
    - 86 under/uninsured patients were served by the genetic counseling program (29% increase from FY20) 72 were assisted financially.
    - 341 under/uninsured patients have been provided financial assistance for cancer care needs: (60%) female; (67%) Hispanic; (60%) unemployed; (34%) laborers; (70%) under 60 years of age; and (28%) supporting two or more children.

Appendix A: MRMC and AGCH Community, Population Details

U.S. Census Data[1]	93420 (Arroyo Grande)	93433 (Grover Beach)	93434 (Guadalupe)	93444 (Nipomo)	93445 (Oceano)	93449 (Pismo Beach)	93454 (Santa Maria)	93455 (Santa Maria)	93458 (Santa Maria)
Total population (2016-2020)	29,915	13,481	7,654	22,383	7,327	8,042	40,600	45,246	56,572
AGE									
Under 5 years	4.9%	7.7%	9.7%	3.9%	6.0%	3.8%	9.1%	6.7%	11.1%
5 to 17 years	16.6%	15.9%	26.7%	17.8%	16.0%	6.1%	20.7%	16.6%	22.8%
18 to 24 years	7.7%	7.3%	11.3%	9.1%	4.5%	4.0%	10.6%	11.0%	14.2%
25 to 44 years	19.3%	30.5%	25.1%	21.8%	27.8%	24.2%	27.2%	23.2%	26.6%
45 to 54 years	11.3%	9.6%	9.9%	13.5%	13.6%	7.4%	11.2%	11.8%	10.3%
55 to 64 years	15.7%	13.9%	9.3%	11.7%	8.1%	22.7%	8.2%	13.6%	7.8%
65 to 74 years	14.5%	8.7%	4.2%	15.0%	12.7%	20.2%	7.0%	9.1%	4.1%
75 years and over	10.0%	6.4%	3.8%	7.1%	11.3%	11.7%	6.0%	7.9%	3.2%
Median age (years)	47.1	38.4	27.6	42.2	42.6	57.5	31.4	37.5	26.2
SEX									
Male	46.4%	51.5%	50.8%	51.5%	52.8%	49.7%	50.1%	49.3%	49.9%
Female	53.6%	48.5%	49.2%	48.5%	47.2%	50.3%	49.9%	50.7%	50.1%
RACE AND HISPANIC OR LATINO ORIGIN									
One race	92.3%	89.7%	88.0%	88.4%	91.5%	97.0%	87.2%	88.4%	87.5%
White	82.7%	79.6%	61.7%	77.1%	68.3%	88.3%	73.1%	75.9%	70.2%
Black or African American	1.2%	2.5%	0.4%	1.2%	1.7%	1.2%	1.3%	2.0%	1.2%
American Indian and Alaska Native	0.7%	0.6%	1.8%	0.9%	1.2%	0.1%	0.7%	1.2%	1.2%
Asian	3.4%	2.6%	3.6%	3.1%	6.9%	3.3%	4.1%	4.5%	4.4%
Native Hawaiian and Other Pacific Islander	0.4%	0.2%	1.0%	0.2%	0.0%	0.0%	0.0%	0.2%	0.0%
Some other race	3.8%	4.1%	19.5%	5.9%	13.3%	4.1%	8.0%	4.6%	10.5%
Two or more races	7.7%	10.3%	12.0%	11.6%	8.5%	3.0%	12.8%	11.6%	12.5%
Hispanic or Latino origin (of any race)	13.9%	30.3%	91.9%	42.9%	43.7%	8.3%	70.8%	35.7%	86.6%

Appendix A: MRMC and AGCH Community, Population Details

U.S. Census Data[1]	93420 (Arroyo Grande)	93433 (Grover Beach)	93434 (Guadalupe)	93444 (Nipomo)	93445 (Oceano)	93449 (Pismo Beach)	93454 (Santa Maria)	93455 (Santa Maria)	93458 (Santa Maria)
White alone, not Hispanic or Latino	75.6%	62.3%	4.4%	51.7%	44.1%	84.3%	21.4%	53.3%	7.4%
LANGUAGE SPOKEN AT HOME AND ABILITY TO SPEAK ENGLISH									
Population 5 years and over	28,455	12,444	6,908	21,501	6,891	7,739	36,918	42,198	50,317
Speak language other than English	11.5%	19.6%	79.4%	28.7%	31.3%	9.3%	58.4%	24.6%	77.2%
Speak English "very well"	7.8%	13.3%	42.9%	19.3%	16.0%	6.9%	30.0%	16.7%	37.4%
Speak English less than "very well"	3.7%	6.3%	36.5%	9.4%	15.2%	2.4%	28.3%	7.9%	39.8%
MARITAL STATUS									
Population 15 years and over	24,815	10,780	5,398	18,636	6,088	7,438	30,385	36,686	39,852
Never married	24.20%	29.50%	44.20%	28.00%	28.90%	30.30%	35.70%	29.90%	45.20%
Now married, except separated	57.50%	44.20%	45.40%	58.40%	48.30%	49.50%	46.90%	54.00%	43.40%
Divorced or separated	12.60%	19.50%	5.60%	8.90%	18.60%	12.20%	12.40%	10.90%	8.00%
Widowed	5.70%	6.90%	4.80%	4.70%	4.20%	8.10%	5.00%	5.20%	3.30%
EDUCATIONAL ATTAINMENT									
Population 25 years and over	21,190	9,308	3,998	15,479	5,393	6,931	24,213	29,706	29,428
Less than high school graduate	5.4%	9.9%	44.3%	11.6%	21.6%	3.2%	29.4%	8.9%	53.2%
High school graduate (includes equivalency)	20.2%	21.1%	17.1%	22.5%	21.5%	16.0%	21.4%	22.0%	18.8%
Some college or associate's degree	35.0%	33.9%	28.5%	33.6%	42.4%	32.9%	33.3%	40.7%	19.8%
Bachelor's degree	25.5%	23.5%	7.3%	19.2%	10.2%	30.3%	11.0%	18.8%	5.8%
Graduate or professional degree	13.9%	11.7%	2.9%	13.1%	4.3%	17.5%	4.9%	9.6%	2.4%

Appendix A: MRMC and AGCH Community, Population Details

U.S. Census Data[1]	93420 (Arroyo Grande)	93433 (Grover Beach)	93434 (Guadalupe)	93444 (Nipomo)	93445 (Oceano)	93449 (Pismo Beach)	93454 (Santa Maria)	93455 (Santa Maria)	93458 (Santa Maria)
INDIVIDUALS' INCOME IN THE PAST 12 MONTHS (IN 2020 INFLATION-ADJUSTED DOLLARS)									
Population 15 years and over	24,815	10,780	5,398	18,636	6,088	7,438	30,385	36,686	39,852
$1 to $9,999 or loss	12.7%	8.1%	15.0%	8.8%	13.5%	9.7%	12.3%	12.7%	9.6%
$10,000 to $14,999	5.6%	9.5%	10.4%	9.1%	7.1%	4.9%	7.9%	6.0%	9.5%
$15,000 to $24,999	10.1%	12.0%	15.5%	8.3%	18.8%	15.0%	17.8%	11.8%	19.7%
$25,000 to $34,999	10.0%	16.5%	12.9%	12.1%	10.1%	6.6%	14.0%	8.2%	15.5%
$35,000 to $49,999	11.4%	12.8%	12.7%	14.2%	10.1%	10.2%	13.1%	10.8%	13.2%
$50,000 to $64,999	9.6%	12.2%	6.6%	9.8%	10.2%	9.7%	8.3%	10.4%	4.6%
$65,000 to $74,999	5.2%	3.8%	3.0%	3.5%	6.5%	5.8%	3.1%	4.5%	1.8%
$75,000 or more	24.3%	16.0%	4.4%	18.9%	11.2%	29.4%	8.0%	22.3%	5.3%
Median income (dollars)	$41,532	$34,274	$24,257	$39,003	$27,750	$47,040	$26,927	$ 41,024	$ 25,298
POVERTY STATUS IN THE PAST 12 MONTHS									
Population for whom poverty status is determined	29,729	13,458	7,641	22,262	7,313	7,990	40,113	45,038	55,629
Below 100 percent of the poverty level	5.4%	8.8%	24.0%	6.6%	11.4%	8.1%	11.1%	5.6%	15.0%
100 to 149 percent of the poverty level	3.4%	7.2%	11.5%	4.5%	10.0%	3.5%	12.5%	6.0%	14.2%
At or above 150 percent of the poverty level	91.2%	84.0%	64.5%	89.0%	78.6%	88.4%	76.4%	88.4%	70.8%

Source:

1. Source: U.S. Census Bureau (2022). 2016-2020 American Community Survey 5-Year Estimates. https://api.census.gov/data/2020/acs/acs5/subject

Appendix B: Community Health Survey, Vulnerable Populations

Dignity Health

CHNA 2022
Questionnaire

1. What is your age? (If under 18, STOP survey.) _____

2. Where do you live?

- ☐ Arroyo Grande, CA 93420
- ☐ Atascadero, CA 93422
- ☐ Cambria, CA 93428
- ☐ Grover Beach, CA 93433
- ☐ Guadalupe, CA 93434
- ☐ Los Osos, CA 93402
- ☐ Morro Bay, CA 93442
- ☐ Nipomo, CA 93444
- ☐ North San Luis Obispo, CA 93405
- ☐ Oceano, CA 93445
- ☐ Orcutt, CA 93455
- ☐ Paso Robles, CA 93446
- ☐ Pismo Beach, CA 93449
- ☐ San Luis Obispo, CA 93401
- ☐ Santa Maria, CA 93454
- ☐ Santa Maria, CA 93455
- ☐ Santa Maria, CA 93458
- ☐ Other (please specify): _____

3. What is your gender identity?

- ☐ Male
- ☐ Female
- ☐ Transgender male
- ☐ Transgender female
- ☐ Nonbinary
- ☐ Genderfluid
- ☐ Other (please specify): _____

4. What is the highest grade or year of school you completed?

- ☐ No formal education
- ☐ Elementary school (6th Grade or less)
- ☐ Junior high or middle school (7th to 8th Grade)
- ☐ Some high school
- ☐ High school diploma
- ☐ Some college
- ☐ Associate of arts degree (AA, AS)
- ☐ Trade school (electrician, mechanic)
- ☐ Bachelor's degree (BA, BS)
- ☐ Graduate school

5. What best describes your current housing situation?

- ☐ Single family home (house, trailer)
- ☐ Single family in an apartment
- ☐ Multiple families living together in one house, apartment, or trailer
- ☐ Temporarily staying with others
- ☐ Student living situation (dorm, multiple students in one house, etc.)
- ☐ Homeless shelter
- ☐ Vehicle or tent
- ☐ Other (please specify):_____

6. What do you consider as your race or origin?

- ☐ White
- ☐ Black or African American
- ☐ Mexican or Mexican American
- ☐ Other Hispanic, Latino(a) or Spanish
- ☐ Asian or Asian American
- ☐ American Indian or Alaska Native
- ☐ Native Hawaiian or other Pacific Islander
- ☐ Other (please specify):_____

7. Please check all that currently apply to you.

- ☐ Veteran
- ☐ Active duty military
- ☐ Agricultural worker
- ☐ Work full-time, year-round
- ☐ Work part-time, year-round
- ☐ Work part-time, but want full-time work
- ☐ Temporarily employed
- ☐ Unemployed and looking for work
- ☐ Homemaker
- ☐ Retired
- ☐ Unable to work
- ☐ Other (please specify): _____

8. In general, how would you rate your health?

☐ Poor ☐ Fair ☐ Good ☐ Very Good ☐ Excellent

9. Do you currently participate in any physical activities or exercises, for example, walking, running, or any other physical fitness activity at least three times a week?

☐ Yes ☐ No ☐ Don't know/not sure

10. Do you have any kind of health insurance (including prepaid plans, HMO's private insurance, Medicare or Medi-Cal/CenCal)?

☐ Yes ☐ No ☐ Don't know/not sure

☐ Yes, but only medical restricted, emergency, or pregnancy restricted Medi-Cal

11. Have you ever received any of the following vaccinations? (Check all that apply.)

- ☐ Pneumonia or pneumococcal
- ☐ Tdap-Tetanus, Diphtheria and Pertussis (or whooping cough)
- ☐ Flu
- ☐ Shingles or zoster
- ☐ HPV (asked of those 11-45, also called the cervical cancer or genital warts vaccine)
- ☐ COVID-19

12. How long has it been since you last visited a doctor for a routine checkup?

- ☐ Within the past year (1-12 months ago)
- ☐ Within the past 5 years (1-5 years ago)
- ☐ 5 or more years ago
- ☐ Never
- ☐ Don't Know/Not Sure

13. In the last 12 months, how many times did you go to the emergency room to get care for yourself? _____

14. How long has it been since you last visited a dentist or dental clinic for any reason? Include visits to a dental specialist, such as an orthodontist.

- ☐ Within the past year (1-12 months)
- ☐ Within the past 5 years (1-5 years ago)
- ☐ 5 or more years ago
- ☐ Never
- ☐ Don't know/not sure

15. Please mark all the reasons you delayed getting medical care during the last twelve months.

- ☐ I did not delay getting medical care
- ☐ Cost
- ☐ Loss of health insurance
- ☐ Public charge
- ☐ Other (please specify): _____
- ☐ Fear of COVID-19
- ☐ Frustrated trying to schedule an appointment
- ☐ Wait too long for next available appointment or to see doctor

16. Not including over the counter medications, was there a time in the past 12 months when you did not take your medication as prescribed because of cost?

☐ Yes ☐ No ☐ I was not prescribed medication ☐ Don't know/not sure

17. Have you or a member of your household needed to talk to a health care professional about problems like stress, emotional problems, family, drugs or alcohol?

☐ Yes ☐ No ☐ Don't know/not sure

18. Due to the COVID-19 pandemic, have you and/or your family experienced any of the following (mark all that apply)?

- ☐ Loss of job/employment
- ☐ Food insecurity/not having enough food
- ☐ Loss of health insurance
- ☐ Eviction
- ☐ Utilities turned off
- ☐ Emotional/spiritual loss
- ☐ Grief/loss of family or friend

19. Please select your top three concerns about growing older (aging)?

- ☐ Health
- ☐ Physical assistance
- ☐ Finances
- ☐ Loneliness
- ☐ Safety
- ☐ Abuse or neglect
- ☐ Transportation
- ☐ Memory
- ☐ Other: _____

20. Have you ever been told by a doctor, nurse or other health professional that you have high blood pressure?

- ☐ Yes
- ☐ Yes, but only during my pregnancy
- ☐ Told borderline high or pre-hypertensive
- ☐ No
- ☐ Don't know/not sure

21. Have you ever been told by a doctor that you suffered a stroke?

☐ Yes ☐ No ☐ Don't know/not sure

22. Blood cholesterol is a fatty substance found in the blood. Have you ever had your blood cholesterol checked?

☐ Yes ☐ No ☐ Don't know/not sure

23. Have you ever been told by a doctor or other health professional that your blood cholesterol is high?

☐ Yes ☐ No ☐ Don't know/not sure

24. Have you ever had a heart attack?

☐ Yes ☐ No ☐ Don't know/not sure

25. Have you ever been told by a doctor that you have diabetes?

- ☐ Yes
- ☐ Yes, but only during my pregnancy
- ☐ No
- ☐ No, but pre-diabetes or borderline diabetes
- ☐ Don't know/not sure

26. Have you ever been diagnosed with asthma?

☐ Yes ☐ No ☐ Don't know/not sure

27. Have you ever been screened for lung cancer through a CT or CAT scan (when you lie flat on your back on a table and a donut shaped x-ray machine takes a scan)?

☐ Yes ☐ No ☐ Don't know/not sure

28. A colonoscopy is when a tube is inserted in the rectum to view the bowel for signs of cancer or other health problems and typically begins at age 45. Have you ever had this exam?

☐ Yes ☐ No ☐ Don't know/not sure

29. **For women**, a mammogram is an x-ray of each breast to look for breast cancer and screenings typically begin at age 40. Have you had a mammogram in the past year?

☐ Yes ☐ No ☐ Don't know/not sure

30. **For women**, a Pap test is a test for cancer of the cervix. Have you had a Pap test during the past three years?

☐ Yes ☐ No ☐ Don't know/not sure

31. **For men**, a prostate cancer screening can be done through a blood test (called PSA test) or a digital rectal exam. Screenings typically begin at age 50. Have you ever been checked for prostate cancer?

☐ Yes ☐ No ☐ Don't know/not sure

32. I am aware of the cancer services offered at (check all that apply):

- ☐ Mission Hope Cancer Center (Santa Maria)
- ☐ Mission Hope Cancer Center (Arroyo Grande)
- ☐ Hearst Cancer Resource Center (San Luis Obispo)

33. Do you or do you live with anyone who uses street drugs or misuses prescription medications?

☐ Yes ☐ No ☐ Don't know/not sure

34. Thinking back, have you ever smoked on average at least one pack of cigarettes per day for 20 years or two packs a day for 10 years?

☐ Yes ☐ No ☐ Don't know/not sure

35. In the past 30 days, have you used any of the following products (check all that apply)?

- ☐ Cigarettes
- ☐ E-cigarettes or vaping
- ☐ Cigars, cigarillos, little cigars
- ☐ Chewing tobacco, snuff
- ☐ Pipes
- ☐ Smoke marijuana

36. I am _____ feet _____ inches tall and weigh _____ pounds.

37. One drink is equivalent to a 12-ounce beer, a 5-ounce glass of wine, or a drink with one shot of liquor. Considering all types of alcoholic beverages, how many times during the past 30 days did you have more than 5 drinks for a man or 4 drinks for a woman at one time?
_____ days

38. Do you have over $300 in a savings account?

☐ Yes ☐ No ☐ Don't know/not sure

Source:
Most survey questions adapted from Centers for Disease Control and Prevention (CDC). *Behavioral Risk Factor Surveillance System Survey Questionnaire.* Atlanta, Georgia: US. Department of Health and Human Services, CDC, 2019.

OFFICE USE ONLY

Interviewer No.: _____

Survey Language: _____

Location No.: _____

Data Input: Y N By: _____

Appendix B: Community Health Survey, Vulnerable Populations

Community Health Survey Location	City
Elwin Mussel Senior Center	Santa Maria
Good Samaritan Center	Santa Maria
Little House by the Park Guadalupe	Guadalupe
Oasis Senior Citizens Center	Orcutt
Catholic Charities	Santa Maria
St. John Newman	Santa Maria
Rancho Hermosa	Santa Maria
Evans Park	Santa Maria
Guadalupe Ranch Acres	Guadalupe
Neighborhood food distribution	Russel St., Santa Maria
Neighborhood food distribution	West New Love, Santa Maria
Neighborhood food distribution	Morrison St., Santa Maria
Cawalti Court	Arroyo Grande
Valentine Court I	Santa Maria
Valentine Court II	Santa Maria
Valentine Court III	Santa Maria
Sierra Madre Cottages	Santa Maria
Oceano Community Center, Mobile COVID-19 vaccine clinic	Oceano

Appendix B: Community Health Survey, Vulnerable Populations

2022 MRMC and AGCH Community Health Survey Results (N=770)

1. What is your age?

AVERAGE -->		44.4	years

2. Where do you live?

Arroyo Grande, CA 93420	n=	28	3.6%
Grover Beach, CA 93433	n=	24	3.1%
Guadalupe, CA 93434	n=	46	6.0%
Nipomo, CA 93444	n=	27	3.5%
Oceano, CA 93445	n=	65	8.4%
Pismo Beach, CA 93449	n=	11	1.4%
Santa Maria, CA 93454	n=	146	19.0%
Santa Maria, CA 93455	n=	50	6.5%
Santa Maria, CA 93458	n=	373	48.4%

3. What is your gender identity?

Male	n=	146	19.0%
Female	n=	608	79.2%
Transgender male	n=	8	0.3%
Transgender female	n=	11	1.4%
Nonbinary	n=	0	0.0%
Genderfluid	n=	1	0.1%
Other	n=	0	0.0%
Prefer not to answer	n=	2	

4. What is the highest grade or year of school you completed?

No formal education	n=	98	12.7%
Elementary school	n=	293	38.1%
Jr high or middle school	n=	105	13.7%
Some high school	n=	72	9.4%
High school diploma	n=	64	8.3%
Some college	n=	49	6.4%
AA, AS	n=	27	3.5%
Trade school	n=	2	0.3%
BA, BS	n=	35	4.6%
Grad school	n=	24	3.1%
Prefer not to answer	n=	1	

5. What best describes your current housing situation?

Single family home	n=	215	28.0%
Single family in an apartment	n=	406	52.8%
Multiple families living together in one house, apartment, or trailer	n=	90	11.7%
Temporarily staying with others	n=	12	1.6%
Student living situation	n=	2	0.3%
Homeless shelter	n=	28	3.6%
Vehicle or tent	n=	2	0.3%
Other	n=	14	1.8%
Prefer not to answer	n=	1	

Appendix B: Community Health Survey, Vulnerable Populations

6. What do you consider as your race or origin?

White	n=	137	17.8%
Black/African American	n=	4	0.5%
Mexican/Mexican American	n=	365	47.5%
Other Hispanic or Latino	n=	218	28.3%
Asian or Asian American	n=	8	1.0%
American Indian or Alaska Native	n=	2	0.3%
Native Hawaiian or other Pacific Islander	n=	0	0.0%
Other	n=	5	0.7%
Indigenous	n=	30	3.9%
Prefer not to answer	n=	1	

7. Please check all that currently apply to you.

Veteran	n=	10	1.3%
Active Duty Military	n=	1	0.1%
Agricultural worker	n=	252	32.7%
Work full-time, year-round	n=	137	17.8%
Work part-time, year round	n=	54	7.0%
Work part-time, but want full-time work	n=	30	3.9%
Temporarily employed	n=	65	8.4%
Unemployed and looking for work	n=	35	4.5%
Homemaker	n=	200	26.0%
Retired	n=	110	14.3%
Unable to work	n=	29	3.8%
Other	n=	21	2.7%

8. In general, how would you rate your health?

Poor	n=	5;	0.7%
Fair	n=	85	11.2%
Good	n=	516	68.3%
Very Good	n=	83	11.0%
Excellent	n=	67	8.9%
Prefer not to answer	n=	14	

9. Do you currently participate in any physical activities or exercises, for example, walking, running, or any other physical fitness activity at least three times a week?

No	n=	269	35.7%
Yes	n=	474	62.9%
Don't know/not sure	n=	10	1.3%
Prefer not to answer	n=	17	

Appendix B: Community Health Survey, Vulnerable Populations

10. Do you have any kind of health insurance (including prepaid plans, HMO's private insurance, Medicare or Medi-Cal/CenCal)?

No	n=	234	31.1%
Yes	n=	358	47.6%
Don't know/not sure	n=	6	0.8%
Yes, but only medical restricted, emegency, or pregnancy restricted Medi-Cal	n=	154	20.5%
Prefer not to answer	n=	18	

11. Have you ever received any of the following vaccinations? (Check all that apply.)

Pneumonia or pneumococcal	n=	135	17.5%
Pneumonia or pneumococcal (age 65 and over)	n=	91	68.9%
Tdap	n=	205	26.6%
Flu	n=	389	50.5%
Shingles	n=	74	9.6%
Shingles (age 50 and over)	n=	67	26.7%
HPV (18-49)	n=	24	3.1%
COVID-19	n=	425	55.2%

12. How long has it been since you last visited a doctor for a routine checkup?

Within the past year	n=	548	73.0%
Within the past 5 years	n=	97	12.9%
5 or more years ago	n=	22	2.9%
Never	n=	58	7.7%
Don't know/not sure	n=	26	3.5%
Prefer not to answer	n=	19	

13. In the last 12 months, how many times did you go to the emergency room to get care for yourself?

	n=	643	100.0%
0	n=	533	82.9%
1	n=	76	11.8%
2	n=	18	2.8%
3	n=	10	1.6%
4	n=	4	0.6%
5	n=	1	0.2%
6			
7			
10			
12	n=	1	0.2%
Prefer not to answer	n=	127	

14. How long has it been since you last visited a dentist or dental clinic for any reason? Include visits to a dental specialist, such as an orthodontist.

Within the past year	n=	385	51.2%
Within the past 5 years	n=	158	21.0%
5 or more years ago	n=	52	6.9%
Never	n=	139	18.5%
Don't know/not sure	n=	18	2.4%
Prefer not to answer	n=	18	

15. Please mark all the reasons you delayed getting medical care during the last twelve months.

I did not delay getting medical care	n=	291	37.8%
Cost	n=	186	24.2%
Loss of health insurance	n=	63	8.2%
Public charge	n=	22	2.9%
Fear of COVID-19	n=	94	12.2%
Frustrated trying to schedule an appointment	n=	44	5.7%
Wait too long for next available appointment or to see doctor.	n=	50	6.5%
Other (please specify):	n=	24	

16. Not including over the counter medications, was there a time in the past 12 months when you did not take your medication as prescribed because of cost?

No	n=	563	75.0%
Yes	n=	94	12.5%
Don't know/not sure	n=	12	1.6%
I was not prescribed medication	n=	82	10.9%
Prefer not to answer	n=	19	

17. Have you or a member of your household needed to talk to a health care professional about problems like stress, emotional problems, family, drugs or alcohol?

No	n=	618	83.0%
Yes	n=	116	15.6%
Don't know/not sure	n=	11	1.5%
Prefer not to answer	n=	25	

18. Due to the COVID-19 pandemic, have you and/or your family experienced any of the following (mark all that apply)?

Loss of job/employment	n=	201	26.1%
Food insecurity/not having enough food	n=	435	56.5%
Loss of health insurance	n=	24	3.1%
Eviction	n=	14	1.8%
Utilities turned off	n=	34	4.4%
Emotional/spiritual loss	n=	85	11.0%
Grief/loss of family or friend	n=	109	14.2%

19. Please select your top three concerns about growing older (aging)?

Health	n=	574	74.5%
Physical assistance	n=	111	14.4%
Finances	n=	309	40.1%
Loneliness	n=	238	30.9%
Safety	n=	112	14.5%
Abuse or neglect	n=	71	9.2%
Transportation	n=	87	11.3%
Memory	n=	226	29.4%
Other	n=	16	2.1%

20. Have you ever been told by a doctor, nurse or other health professional that you have high blood pressure?

No	n=	512	68.2%
Yes	n=	204	27.2%
Don't know/not sure	n=	15	2.0%
Yes, but only during my pregnancy	n=	11	1.5%
Told borderline high	n=	9	1.2%
Prefer not to answer	n=	19	

21. Have you ever been told by a doctor that you suffered a stroke?

No	n=	728	95.4%
Yes	n=	25	3.3%
Don't know/not sure	n=	10	1.3%
Prefer not to answer	n=	7	

22. Blood cholesterol is a fatty substance found in the blood. Have you ever had your blood cholesterol checked?

No	n=	399	52.3%
Yes	n=	341	44.7%
Don't know/not sure	n=	23	3.0%
Prefer not to answer	n=	7	

23. Have you ever been told by a doctor or other health professional that your blood cholesterol is high?

No	n=	552	72.5%
Yes	n=	184	24.2%
Don't know/not sure	n=	25	3.3%
Prefer not to answer	n=	9	

24. Have you ever had a heart attack?

No	n=	737	97.4%
Yes	n=	16	2.1%
Don't know/not sure	n=	4	0.5%
Prefer not to answer	n=	13	

25. Have you ever been told by a doctor that you have diabetes?

No	n=	550	74.3%
Yes	n=	93	12.6%
Don't know/not sure	n=	13	1.8%
Yes, but only during my pregnancy	n=	26	3.5%
No, but pre-diabetes or borderline diabetes	n=	58	7.8%
Prefer not to answer	n=	30	

26. Have you ever been diagnosed with asthma?

No	n=	707	93.3%
Yes	n=	47	6.2%
Don't know/not sure	n=	4	0.5%
Prefer not to answer	n=	12	

27. Have you ever been screened for lung cancer through a CT or CAT scan (when you lie flat on your back on a table and a donut shaped x-ray machine takes a scan)?

No	n=	673	89.0%
Yes	n=	71	9.4%
Don't know/not sure	n=	12	1.6%
Prefer not to answer	n=	14	

28. A colonoscopy is when a tube is inserted in the rectum to view the bowel for signs of cancer or other health problems and typically begins at age 45. Have you ever had this exam?

Total	n=	306	100.0%
No	n=	147	48.0%
Yes	n=	157	51.3%
Don't know/not sure	n=	2	0.7%
Prefer not to answer	n=	8	

29. For women, a mammogram is an x-ray of each breast to look for breast cancer and screenings typically begin at age 40. Have you had a mammogram in the past year?

Total	n=	289	100.0%
No	n=	92	31.8%
Yes	n=	196	67.8%
Don't know/not sure	n=	1	0.3%
Prefer not to answer	n=	12	

30. For women, a Pap test is a test for cancer of the cervix. Have you had a Pap test during the past three years? (Women between 18-65)

Total	n=	482	100.0%
No	n=	106	22.6%
Yes	n=	360	76.8%
Don't know/not sure	n=	3	0.6%
Prefer not to answer	n=	13	

31. For men, a prostate cancer screening can be done through a blood test (called PSA test) or a digital rectal exam. Screenings typically begin at age 50. Have you ever been checked for prostate cancer?

Total	n=	51	100.0%
No	n=	24	47.1%
Yes	n=	24	47.1%
Don't know/not sure	n=	3	5.9%
Prefer not to answer	n=	2	

32. I am aware of the cancer services offered at (check all that apply):

Mission Hope Cancer Center (Santa Maria)	n=	279	36.2%
Mission Hope Cancer Center (Arroyo Grande)	n=	52	6.8%
Hearst Cancer Resource Center (San Luis Obispo)	n=	26	3.4%

33. Do you or do you live with anyone who uses street drugs or misuses prescription medications?

No	n=	714	96.0%
Yes	n=	24	3.2%
Don't know/not sure	n=	6	0.8%
Prefer not to answer	n=	26	

34. Thinking back, have you ever smoked on average at least one pack of cigarettes per day for 20 years or two packs a day for 10 years?

No	n=	695	92.4%
Yes	n=	50	6.6%
Don't know/not sure	n=	7	0.9%
Prefer not to answer	n=	18	

35. In the past 30 days, have you used any of the following products (check all that apply).

Cigarettes	n=	35	4.5%
E-cigarettes or vaping	n=	16	2.1%
Cigars, cigarillos, little cigars	n=	4	0.5%
Chewing tobacco, snuff	n=	2	0.3%
Pipes	n=	2	0.3%
Smoke marijuana	n=	17	2.2%

36. Body Mass Index (BMI)

Average ==>		29.3	
		n=500	
Overweight	n=	176	35.2%
Obese	n=	205	41.0%

37. One drink is equivalent to a 12-ounce beer, a 5-ounce glass of wine, or a drink with one shot of liquor. Considering all types of alcoholic beverages, how many times during the past 30 days did you have more than 5 drinks for a man or 4 drinks for a woman at one time? _____ days

Total Responses	n=	493	100.0%
No	n=	424	86.0%
Yes	n=	69	14.0%
Average of those reporting greater than or = to 1.		2.26	

38. Do you have over $300 in a savings account?

No	n=	438	58.9%
Yes	n=	259	34.8%
Don't know/not sure	n=	47	6.3%
Prefer not to answer	n=	26	

SURVEY LANGUAGE

English	n=	176	22.9%
Spanish	n=	567	73.6%
Mixteco	n=	27	3.5%

Completed Face to Face	n=	754	97.9%
Online	n=	16	2.1%

Appendix C: Qualitative Targeted Outreach

Distribution List of Organizations for Qualitative Survey

1. Allan Hancock Community College
2. Boys and Girls Club, Oceano
3. Boys and Girls Club, Santa Maria
4. Catholic Churches
5. City of Santa Maria, Recreation and Parks Department
6. County of Santa Barbara
7. Five Cities Homeless Coalition
8. Good Samaritan Shelter
9. Little House by the Park (Guadalupe Family Resource Center)
10. Santa Maria Valley YMCA
11. United Way
12. UCSB
13. Cal Poly
14. Alliance for Pharmaceutical Access
15. CommUnify (new name for Community Active Commission (CAC))
16. Community Counseling Center
17. Community Health Clinics of Central Coast (CHC)
18. Santa Maria Valley Youth and Family
19. Good Samaritan Shelter
20. Planned Parenthood of Santa Barbara, Ventura, and San Luis Obispo Counties, Inc.
21. Santa Barbara County Department of Behavioral Wellness
22. Santa Barbara County Promotores Coalition
23. Santa Barbara County Public Health
24. San Luis Obispo County Public Health
25. Santa Maria Valley Fighting Back
26. Transitions Mental Health Association
27. Area Agency on Aging
28. Oasis Senior Center
29. Community Health Centers of the Central Coast (CHC)
30. Gala Pride and Diversity Center
31. ECHO (El Camino Homeless Organization)
32. Center for Family Strengthening
33. Family Service Agency
34. CAPSLO (Community Action Partnership of SLO County)
35. Herencia Indígena
36. Promotores Collaborative of SLO County
37. MRMC Community Benefits Committee of the Board
38. FHMC Community Benefits Committee of the Board

Appendix C: Qualitative Targeted Outreach

Monday, March 28, 2022 at 20:11:28 Eastern Daylight Time

Subject: 2022 Dignity Health Community Health Needs Assessment Survey
Date: Wednesday, January 12, 2022 at 12:42:37 PM Eastern Standard Time
From: Patty Herrera CA-Santa Maria
To: Patty Herrera CA-Santa Maria
CC: Amanda Tamburro, Heidi Summers CA-Santa Maria

Good morning,
Dignity Health Central Coast Hospitals is currently working on our 2022 Community Health Needs Assessment (CHNA) Report. We are asking for your input to help identify and prioritize significant health needs and identify potential resources.

Please let us know what your community health concerns are by completing our community health survey found here https://www.surveymonkey.com/r/QCG6PWL by February 4, 2022.

The responses collected will be included in our 2022 CHNA Report and will help guide our program development for community health over the next three years.

Please let me know if you have any questions or would prefer to have an open discussion instead.

Thank you,

Patty Herrera, MA

Manager of Community Health

Dignity Health CA Central Coast

1400 East Church St.

Santa Maria, CA 93454

805-739-3593 (Marian)

805-542-6268 (French)

805-331-0381 (cell)

(Note my change in email: patty.herrera@commonspirit.org)

patty.herrera@commonspirit.org

Compassion | Integrity | Inclusion | Collaboration | Excellence

Page 1 of 2

Appendix C: Qualitative Targeted Outreach

Thank you for participating in our survey! Your responses will be compiled and included in our 2022 Community Health Needs Assessment Report. While there are many community health needs facing communities across our state and nation, we ask that your responses are specific to Northern Santa Barbara County and San Luis Obispo County. As a reminder, community health needs can include a wide range of topics such as social inequities, institutional inequities, living conditions, risk behaviors, and chronic disease and prevention.

1. What community do you most commonly serve, or what community are you a member?

2. As an organization and/or community member, what do you view as the top 5 greatest health needs facing our community? Please be as specific as possible.
   Response #1
   Response #2
   Response #3
   Response #4
   Response #5

3. As an organization or community member, how would you address these needs?

4. Are you aware of any potential resources that are available to help address these needs?

The next three questions will focus on the youth population (under 18 years of age) residing within our community.

5. What would you say is the most important youth health need in our community?

6. What would you say is the most important thing that can be done to improve child health in our community?
7. What is the greatest barrier to child wellness in our community?

Please provide the following information if you wish to be identified as a contributor to our 2022 CHNA Report.

Name

Title (if applicable)

Organization (if applicable)

City/Town

Appendix C: Qualitative Targeted Outreach

2. As an organization and/or community member, what do you view as the top 5 greatest health needs facing our community?

	No. of Mentions					
	Rank #1	Rank #2	Rank #3	Rank #4	Rank #5	Total
Access to healthcare	**7**	**7**	**7**	**7**	**7**	**35**
Access to healthcare, homeless	1	1				2
Caregiver support	1	1		1	1	4
Chronic disease	**3**	**3**	**3**	**3**	**3**	**15**
COVID-19	**6**	**6**	**4**	**5**	**4**	**25**
Dental Care, Access	2	2	2	2		8
Gender diverse healthcare	1	1	1	1		4
Health education	1	1	1	1	1	5
Health equity	1	1	1	1	1	5
Health literacy	1	1	1	1	1	5
Homelessness	1	1	1	1		4
Housing	4	4	4	4	4	20
Individual financial resources	1	1	1	1	1	5
Mental health, Access	**6**	**6**	**6**	**6**	**6**	**30**
Mental health, Adolescents	1	1	1	1	1	5
Other	1	1	1			3
Substance abuse disorders	1	1	1	1	1	5
Grand Total	39	39	35	36	31	

5. What would you say is the most important youth health need in our community?

Response	No. of Mentions
Covid-19	1
Access to healthcare	1
Basic needs	1
Dental Health	1
Educational attainment	1
Health education	4
Mental health	**16**
Mental health, access	1
Obesity	2
Other	3
Substance Abuse Disorder	2
Vaccinations	2
Grand Total	35

Appendix D: MRMC MVP Family Summary

Feed back From MVP Families

After interviewing several families in that reside in Santa Maria, these were the top 5 health needs in the community:

1. Covid and shortages in medical supplies specially for those with medical needs.
2. Need for more doctors and therapist
3. Health care for all family members
4. Able to go for medical care without worrying about finances/cost.
5. In general, lack of information

The families interviewed believe more education on how some health conditions could be avoided or delayed. One mom with a Down Syndrome child said if she had only known the benefits of Folic Acid while pregnant or the importance of nutrition. Others also felt the need to have better access to doctors instead of having to go to the emergency room or having to wait for long periods before getting an appointment with a doctor. Several families felt the long waiting period for appointments made health matters worse. Another idea for preventing health problems was nutrition and exercise, knowing what kind of exercise would be more beneficial depending on the medical condition.

Some known resources mentioned were:
Food Bank, Salvation Army, Family Service Agency,

The most important youth health needs are: Mental health, drugs and alcohol, healthy eating, STD education.

Families believe in the importance of medical evaluations/screenings, education, proper nutrition, access to doctors and therapists, parent education and knowing how to access resources.

The families interviewed also felt that the greatest barrier to child wellness in our community is exposure to pesticides because most of the parents work in agriculture and they feel this might have some effect on their children and family, finances was also a barrier, and education.

Appendix D: MRMC MVP Family Summary

MVP families

Survey Questions

1. What community do you most commonly serve, or what community are you a member?
   Santa Maria and Guadalupe

2. As an organization and/or community member, what do you view as the top 5 greatest health needs facing our community? Please be as specific as possible.

   1: Covid-19
   2: Mental health programs
   3: No insurance for parents
   4: No affordable living
   5: Not enoughs daycare for childrens, and School overpopulated.

3: As an organization or community member, how would you address these needs?

building more schools and more accessible healthy foods for our children at school. More affordable medical insurance for parents and more affordable houses for rent. More daycare for children, more parks, more after school programs at no cost and more tutoring for kids. More mental health programs for children and adults.

4: Are you aware of any potential resources that are available to help address these needs?

Food bank and only one Boy and Girl in Santa Maria

5: What would you say is the most important youth health need in our community?

More education in drugs and tobacco free.

6: What would you say is the most important thing that can be done to improve child health in our community?

More healthy foods in schools and more after school programs.

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

Mental health programs and healthy foods in our School and more schools.

Appendix E: United Way Real Cost Measure, Santa Barbara County and San Luis Obispo County

Santa Barbara County
The Real Cost Measure in California 2021

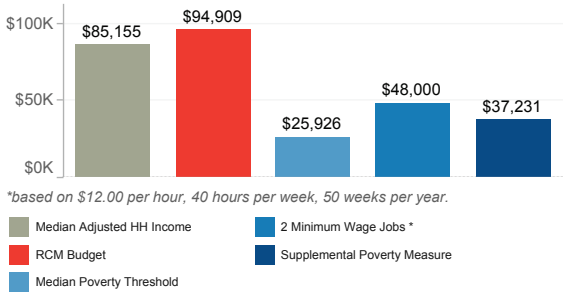
United Ways of California

The Real Cost Measure (RCM) estimates the amount of income required to meet basic needs (the "Real Cost Budget") for a given household type in a specific community. The Real Cost Measure builds a bare-bones budget that reflects constrained yet reasonable choices for essential expenses: housing, food, transportation, health care, taxes and child care.

If any results show blank values, that indicates the sample size is too small to illustrate Real Cost Measure results. Per our methodology, estimates with a cell size of greater than 5,000 are assumed to be accurate within +/-1% based on design factor analysis. Cell sizes less than 5,000 are suppressed.

# of Households below Real Cost Measure	% of Households below Real Cost Measure	% of Households below Real Cost Measure with at least 1 Working Adult
43,188	36%	95%

Annual Income Comparison
(based on a household of 2 adults, 1 pre-schooler, 1 school-aged child)



*based on $12.00 per hour, 40 hours per week, 50 weeks per year.

Household Budgets

	1 Adult	2 Adults	2 Adults 1 Pre-schooler 1 School-aged
Housing	$16,836	$20,004	$23,412
Food	$4,056	$7,440	$11,483
Health Care	$2,328	$4,655	$9,312
Child Care	$0	$0	$18,984
Transportation	$5,303	$10,596	$10,596
Miscellaneous	$2,856	$4,272	$7,379
Taxes/Credits	$5,915	$7,422	$13,743
FINAL BUDGET	$37,294	$54,389	$94,909

Households of color struggle disproportionately...
- Across the county, African Americans and Latinos have a disproportionate number of households with incomes below the Standard. In this area, of the 43,188 households below the Real Cost Measure, 25,534 are Latino.

Families with children face a larger barrier to economic security...
- 62% of households with children under six struggle, a rate much greater than that of the rest of the county.
- Single mothers are most likely to struggle. 82% in the county are below the Real Cost Measure.

Families work, but don't earn enough…
- 95% of households below RCM have at least one working adult.
- 73% of heads of household who work are employed full time and year round.
- A family of four (2 adults, 1 infant, 1 school-aged child) would need to hold more than 3 full time, minimum-wage jobs to achieve economic security.**

High housing costs are a major challenge for struggling households...
- 42% of all households in the county spend more than 30% of their income on housing.

**based on $12.00 per hour, 40 hours per week, 50 weeks per year.

Education	# below RCM	% below RCM
Less than High School	13,441	79%
High School Diploma or Equivalent	9,103	48%
Some College, Assoc. or Voc.	14,386	37%
College degree or higher	6,258	13%

Ethnicity	# below RCM	% below RCM
Latino	25,534	58%
African American		
Asian American/Pacific Islander		
White	15,749	23%
Native American/Alaska Native		

Household Type	# below RCM	% below RCM
Single Mothers	8,558	82%
Seniors	5,943	21%
Married Couples	15,063	34%
Informal Families	9,082	32%

Citizenship/Nativity	# below RCM	% below RCM
Foreign Born, Non-Citizen	15,420	69%
Foreign Born, Naturalized	5,067	40%
Born a US Citizen	22,701	26%

Findings drawn from The Real Cost Measure in California 2021, by United Ways of California in partnership with B3 Consults. Data calculated for this geographic profile is from 2019. For detailed methodology, visit http://unitedwaysca.org/realcost.

Appendix E: United Way Real Cost Measure, Santa Barbara County and San Luis Obispo County

San Luis Obispo County
The Real Cost Measure in California 2021

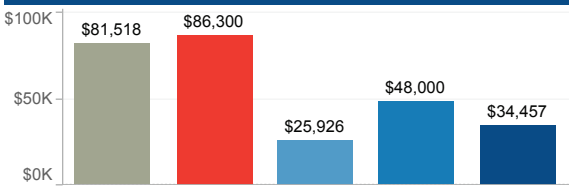
United Ways of California

The Real Cost Measure (RCM) estimates the amount of income required to meet basic needs (the "Real Cost Budget") for a given household type in a specific community. The Real Cost Measure builds a bare-bones budget that reflects constrained yet reasonable choices for essential expenses: housing, food, transportation, health care, taxes and child care.

If any results show blank values, that indicates the sample size is too small to illustrate Real Cost Measure results. Per our methodology, estimates with a cell size of greater than 5,000 are assumed to be accurate within +/-1% based on design factor analysis. Cell sizes less than 5,000 are suppressed.

# of Households below Real Cost Measure	% of Households below Real Cost Measure	% of Households below Real Cost Measure with at least 1 Working Adult
22,408	26%	96%

Annual Income Comparison
(based on a household of 2 adults, 1 pre-schooler, 1 school-aged child)



*based on $12.00 per hour, 40 hours per week, 50 weeks per year.

Median Adjusted HH Income
RCM Budget
Median Poverty Threshold
2 Minimum Wage Jobs *
Supplemental Poverty Measure

Household Budgets

	1 Adult	2 Adults	2 Adults 1 Pre-schooler 1 School-aged
Housing	$12,708	$14,352	$18,504
Food	$4,128	$7,572	$11,688
Health Care	$2,364	$4,740	$9,480
Child Care	$0	$0	$17,448
Transportation	$5,376	$10,740	$10,740
Miscellaneous	$2,460	$3,744	$6,780
Taxes/Credits	$4,703	$5,907	$11,660
FINAL BUDGET	$31,739	$47,055	$86,300

Households of color struggle disproportionately...
- Across the county, African Americans and Latinos have a disproportionate number of households with incomes below the Standard. In this area, of the 22,408 households below the Real Cost Measure, None are Latino.

Families with children face a larger barrier to economic security...
- None of households with children under six struggle, a rate much greater than that of the rest of the county.
- Single mothers are most likely to struggle. None in the county are below the Real Cost Measure.

Families work, but don't earn enough…
- 96% of households below RCM have at least one working adult.
- 63% of heads of household who work are employed full time and year round.
- A family of four (2 adults, 1 infant, 1 school-aged child) would need to hold more than 2 full time, minimum-wage jobs to achieve economic security.**

High housing costs are a major challenge for struggling households...
- 38% of all households in the county spend more than 30% of their income on housing.

**based on $12.00 per hour, 40 hours per week, 50 weeks per year.

Education	# below RCM	% below RCM
Less than High School		
High School Diploma or Equivalent		
Some College, Assoc. or Voc.	9,958	34%
College degree or higher	5,385	14%

Ethnicity	# below RCM	% below RCM
Latino		
African American		
Asian American/Pacific Islander		
White	16,501	25%
Native American/Alaska Native		

Household Type	# below RCM	% below RCM
Single Mothers		
Seniors		
Married Couples	7,134	21%
Informal Families	8,183	40%

Citizenship/Nativity	# below RCM	% below RCM
Foreign Born, Non-Citizen		
Foreign Born, Naturalized		
Born a US Citizen	18,855	25%

Support for this county profile is made possible by Wacker Wealth Partners.

Findings drawn from The Real Cost Measure in California 2021, by United Ways of California in partnership with B3 Consults. Data calculated for this geographic profile is from 2019. For detailed methodology, visit http://unitedwaysca.org/realcost.

Appendix F: Mortality, Santa Barbara County and San Luis Obispo County

County	San Luis Obispo County				Santa Barbara County			
Population	All Origins		Hispanic or Latino		All Origins		Hispanic or Latino	
Leading Causes of Death	Deaths	Age Adjusted Rate	Deaths	Age Adjusted Rate	Deaths	Age Adjusted Rate	Deaths	Age Adjusted Rate
All Causes	7,380	606.6	638	500.1	9,952	603.1	2,116	543.7
Malignant neoplasms	1,666	132.9	143	116.1	2,075	129	431	109.9
Diseases of the heart	1,412	110.0	95	77.5	2,210	128.8	388	106.8
Cerebrovascular diseases	774	58.1	47	42.3	624	35.8	123	35.1
Accidents (unintentional injuries)	393	50.6	57	31.7	585	42.2	179	34.2
Alzheimer disease	390	30.4	27	26.2	733	39.6	99	30.2
Chronic lower respiratory diseases	387	25.0	17	Unreliable	437	25.3	37	10.8
Chronic liver disease and cirrhosis	161	15.9	31	20.1	189	13.3	67	14.8
Essential hypertension and hypertensive renal disease	152	11.6	11	Unreliable	122	6.8	32	9.5
Diabetes mellitus	148	14.7	26	19.7	262	16.3	97	27.6
Intentional self-harm (suicide)	146	15.8	10	Unreliable	164	11.6	36	6.5
Influenza and pneumonia	142	11.2	Unreliable	Unreliable	174	10.1	43	12.3
COVID-19	116	9.2	22	17.5	177	10.8	96	25.5

Source:

Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 2018-2020 on CDC WONDER Online Database, released in 2021. Data are from the Multiple Cause of Death Files, 2018-2020, 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

Appendix G: County Health Status Profiles

SAN LUIS OBISPO COUNTY'S HEALTH STATUS PROFILE FOR 2019

FOR PUBLIC RELEASE

MORTALITY

RANK ORDER	HEALTH STATUS INDICATOR	2015-2017 DEATHS (AVERAGE)	CRUDE DEATH RATE	AGE-ADJUSTED DEATH RATE	95% CONFIDENCE LIMITS LOWER	95% CONFIDENCE LIMITS UPPER	HP 2020 NATIONAL OBJECTIVE	AGE-ADJUSTED DEATH RATE CALIFORNIA CURRENT	AGE-ADJUSTED DEATH RATE COUNTY PREVIOUS
19	ALL CAUSES	2,428.0	873.1	609.9	584.6	635.2	a	610.3	608.2
16	ALL CANCERS	528.0	189.9	130.6	119.0	142.1	161.4	137.4	141.9
18	COLORECTAL CANCER	44.7	16.1	11.2	8.1	15.0	14.5	12.5	13.0
18	LUNG CANCER	112.3	40.4	27.4	22.2	32.5	45.5	27.5	31.7
33	FEMALE BREAST CANCER	39.0	28.7	19.3	13.7	26.4	20.7	18.9	23.5
24	PROSTATE CANCER	34.0	23.9	18.9	13.1	26.4	21.8	19.4	19.0
13	DIABETES	56.3	20.3	13.9	10.5	18.0	b	21.2	12.6
46	ALZHEIMER'S DISEASE	177.7	63.9	41.1	35.0	47.2	a	35.7	19.8
10	CORONARY HEART DISEASE	275.3	99.0	65.8	57.8	73.8	103.4	87.4	70.8
52	CEREBROVASCULAR DISEASE (STROKE)	199.7	71.8	47.6	40.8	54.3	34.8	36.3	52.7
10	INFLUENZA/PNEUMONIA	42.3	15.2	10.2	7.4	13.8	a	14.2	9.6
24	CHRONIC LOWER RESPIRATORY DISEASE	149.3	53.7	36.1	30.2	42.0	a	32.0	33.3
25	CHRONIC LIVER DISEASE AND CIRRHOSIS	40.3	14.5	12.4	8.9	16.9	8.2	12.2	13.9
21	ACCIDENTS (UNINTENTIONAL INJURIES)	116.7	42.0	38.3	30.9	45.7	36.4	32.2	34.6
19	MOTOR VEHICLE TRAFFIC CRASHES	27.3	9.8	9.8	6.5	14.2	12.4	9.5	10.0
39	SUICIDE	55.0	19.8	17.1	12.9	22.3	10.2	10.4	16.5
9	HOMICIDE	5.7	2.0 *	2.2 *	0.8	5.0	5.5	5.2	1.7 *
15	FIREARM RELATED DEATHS	23.7	8.5	7.5	4.8	11.1	9.3	7.9	9.5
35	DRUG INDUCED DEATHS	50.0	18.0	17.5	13.0	23.1	11.3	12.7	13.8

MORBIDITY

RANK ORDER	HEALTH STATUS INDICATOR	2015-2017 CASES (AVERAGE)	CRUDE CASE RATE	95% CONFIDENCE LIMITS LOWER	95% CONFIDENCE LIMITS UPPER	HP 2020 NATIONAL OBJECTIVE	CRUDE CASE RATE CALIFORNIA CURRENT	CRUDE CASE RATE COUNTY PREVIOUS
33	HIV/AIDS INCIDENCE (AGE 13 AND OVER)†	519.0	215.0	196.5	233.5	a	397.7	274.5
35	CHLAMYDIA INCIDENCE	1,162.7	418.1	394.1	442.1	c	514.6	351.6
11	GONORRHEA INCIDENCE FEMALE AGE 15-44	76.7	154.3	121.7	192.9	251.9	252.4	64.8
6	GONORRHEA INCIDENCE MALE AGE 15-44	103.0	172.4	139.1	205.7	194.8	444.8	92.2
10	TUBERCULOSIS INCIDENCE	3.0	1.1 *	0.2	3.2	1.0	5.3	1.2 *
	CONGENITAL SYPHILIS	<11.0	NM *	<0.1	167.6	9.6	44.4	LNE *
	PRIMARY SECONDARY SYPHILIS FEMALE	<11.0	M *	<0.1	4.9	1.3	3.5	LNE *
7	PRIMARY SECONDARY SYPHILIS MALE	12.0	8.4 *	4.4	14.7	6.7	26.2	LNE *

INFANT MORTALITY

RANK ORDER	HEALTH STATUS INDICATOR	2014-2016 DEATHS (AVERAGE)	BIRTH COHORT (BC) INFANT DEATH RATE	95% CONFIDENCE LIMITS LOWER	95% CONFIDENCE LIMITS UPPER	HP 2020 NATIONAL OBJECTIVE	BC INFANT DEATH RATE CALIFORNIA CURRENT	BC INFANT DEATH RATE COUNTY PREVIOUS
20	INFANT MORTALITY: ALL RACES	12.7	4.8 *	2.6	8.3	6.0	4.4	6.1 *
	INFANT MORTALITY: ASIAN/PI	<11.0	NM *	<0.1	63.0	6.0	3.2	-
8	INFANT MORTALITY: BLACK	0.0	-	-	-	6.0	9.8	-
	INFANT MORTALITY: HISPANIC	<11.0	NM *	2.5	15.0	6.0	4.4	LNE *
	INFANT MORTALITY: WHITE	<11.0	M *	1.2	8.1	6.0	3.6	LNE *

NATALITY

RANK ORDER	HEALTH STATUS INDICATOR	2015-2017 BIRTHS (AVERAGE)	PERCENT	95% CONFIDENCE LIMITS LOWER	95% CONFIDENCE LIMITS UPPER	HP 2020 NATIONAL OBJECTIVE	PERCENTAGE CALIFORNIA CURRENT	PERCENTAGE COUNTY PREVIOUS
11	LOW BIRTHWEIGHT INFANTS	154.3	5.9	5.0	6.9	7.8	6.9	5.9
24	FIRST TRIMESTER PRENATAL CARE	2,050.7	79.5	76.1	83.0	77.9	83.5	80.3
2	ADEQUATE/ADEQUATE PLUS PRENATAL CARE	2,220.0	86.3	82.7	89.9	77.6	77.9	86.9

RANK ORDER	HEALTH STATUS INDICATOR	2015-2017 BIRTHS (AVERAGE)	AGE-SPECIFIC BIRTH RATE	95% CONFIDENCE LIMITS LOWER	95% CONFIDENCE LIMITS UPPER	HP 2020 NATIONAL OBJECTIVE	AGE-SPECIFIC BIRTH RATE CALIFORNIA CURRENT	AGE-SPECIFIC BIRTH RATE COUNTY PREVIOUS
13	BIRTHS TO MOTHERS AGED 15-19	108.3	10.4	8.5	12.4	a	15.7	14.2

BREASTFEEDING

RANK ORDER	HEALTH STATUS INDICATOR	2015-2017 BREASTFED (AVERAGE)	PERCENT	95% CONFIDENCE LIMITS LOWER	95% CONFIDENCE LIMITS UPPER	HP 2020 NATIONAL OBJECTIVE	PERCENTAGE CALIFORNIA CURRENT	PERCENTAGE COUNTY PREVIOUS
7	BREASTFEEDING INITIATION	2,183.3	97.4	93.3	100.0	81.9	94.0	97.1

CENSUS

RANK ORDER	HEALTH STATUS INDICATOR	2016 NUMBER	PERCENT	95% CONFIDENCE LIMITS LOWER	95% CONFIDENCE LIMITS UPPER	HP 2020 NATIONAL OBJECTIVE	PERCENTAGE CALIFORNIA CURRENT	PERCENTAGE COUNTY PREVIOUS
9	PERSONS UNDER 18 IN POVERTY	5,537.0	10.7	10.4	11.0	a	19.3	14.5

- Rates, percentages and confidence limits are not calculated for zero events.
***** Rates are deemed unreliable when based on fewer than 20 data elements.
<0.1 Indicates lower confidence limit is less than 0.1 but greater than 0.0.
<11.0 Refers to Data De-Identification Guidelines (DDG) used to assess risk of publicly released data; as a result, suppression and masking have been applied to this tabular data.
a Healthy People (HP) 2020 National Objective has not been established.
b HP 2020 National Objective is based on both underlying and contributing cause of death which requires use of multiple cause of death files. California's data exclude multiple/contributing causes of death.
c Prevalence data are not available in all California counties to evaluate the HP 2020 National Objective STD-1, as the objective is restricted to females who are 15-24 years old and identified at a family planning clinic, and males and females under 24 years old who participate in a national job-training program.
M Met (M) refers to the Healthy People 2020 National objectives only.
NM Not Met (NM) refers to the Healthy People 2020 National objectives only.
NA Not Applicable (NA) refers to the Healthy People 2020 National Objectives only.
LNE Low Number Evaluated; rates/percentages are masked per Data De-Identification Guidelines.
Notes Crude death rates, crude case rates, and age-adjusted death rates are per 100,000 population. Birth cohort infant death rates are per 1,000 live births.
The age-specific birth rates are per 1,000 female population aged 15 to 19 years old.
Previous refers to previous period rates. These periods vary by type of rate: Mortality 2012-2014, Morbidity 2012-2014, Infant Mortality 2011-2013, Natality 2012-2014, Census 2016.
† California Department of Public Health, Office of AIDS, Surveillance Section reporting periods are: Current Period 2014-2016, Previous Period 2011-2013.
Sources California Department of Finance. Demographic Research Unit. 2018. State and county population projections 2010-2060. Sacramento: California Department of Finance. January 2018.
California Department of Public Health, California Comprehensive Master Death Files, [2015-2017] Compiled, August 2018.
California Department of Public Health, Office of AIDS, Surveillance Section, Data Requested, August 2018.
California Department of Public Health, STD Control Branch, Data Requested, August 2018. Chlamydia and Gonorrhea data.
California Department of Public Health, Tuberculosis Control Branch, Data Requested, July 2018.
California Department of Public Health: 2014-2016 Birth Cohort-Perinatal Outcome Files.
California Department of Public Health: 2015-2017 Birth Statistical Master Files.
California Department of Public Health, Center for Family Health, Genetic Disease Screening Program, Newborn Screening Data, 2015-2017, Date Requested, July 2018.
California Department of Public Health, Center for Family Health, Maternal, Child and Adolescent Health Program, Data Requested, July 2018.
U.S. Census Bureau, Small Area Income and Poverty Estimates. http://www.census.gov/data/datasets/2016/demo/saipe/2016-state-and-county.html, Accessed, July 2018.

Appendix G: County Health Status Profiles

SANTA BARBARA COUNTY'S HEALTH STATUS PROFILE FOR 2019

FOR PUBLIC RELEASE

MORTALITY

RANK ORDER	HEALTH STATUS INDICATOR	2015-2017 DEATHS (AVERAGE)	CRUDE DEATH RATE	AGE-ADJUSTED DEATH RATE	95% CONFIDENCE LIMITS LOWER	95% CONFIDENCE LIMITS UPPER	HP 2020 NATIONAL OBJECTIVE	AGE-ADJUSTED DEATH RATE CALIFORNIA CURRENT	AGE-ADJUSTED DEATH RATE COUNTY PREVIOUS
15	ALL CAUSES	3,170.3	708.8	596.9	575.7	618.2	a	610.3	597.7
15	ALL CANCERS	670.3	149.9	130.4	120.3	140.5	161.4	137.4	147.9
4	COLORECTAL CANCER	46.3	10.4	8.9	6.5	11.9	14.5	12.5	13.0
11	LUNG CANCER	128.3	28.7	24.9	20.5	29.3	45.5	27.5	25.5
44	FEMALE BREAST CANCER	56.7	25.5	20.8	15.7	26.9	20.7	18.9	21.4
14	PROSTATE CANCER	35.7	15.8	16.1	11.2	22.3	21.8	19.4	22.6
19	DIABETES	87.7	19.6	16.8	13.4	20.7	b	21.2	14.5
42	ALZHEIMER'S DISEASE	225.7	50.4	38.5	33.4	43.7	a	35.7	31.0
19	CORONARY HEART DISEASE	413.0	92.3	75.1	67.7	82.5	103.4	87.4	85.2
18	CEREBROVASCULAR DISEASE (STROKE)	180.7	40.4	32.4	27.5	37.2	34.8	36.3	35.1
7	INFLUENZA/PNEUMONIA	53.0	11.8	9.5	7.1	12.5	a	14.2	11.2
17	CHRONIC LOWER RESPIRATORY DISEASE	166.0	37.1	31.0	26.2	35.8	a	32.0	26.0
19	CHRONIC LIVER DISEASE AND CIRRHOSIS	54.3	12.1	11.9	8.9	15.5	8.2	12.2	12.5
19	ACCIDENTS (UNINTENTIONAL INJURIES)	176.3	39.4	36.7	31.1	42.3	36.4	32.2	25.5
14	MOTOR VEHICLE TRAFFIC CRASHES	40.7	9.1	8.3	5.9	11.2	12.4	9.5	6.4
32	SUICIDE	60.0	13.4	12.9	9.9	16.6	10.2	10.4	11.2
19	HOMICIDE	15.3	3.4 *	3.3 *	1.9	5.5	5.5	5.2	2.5 *
17	FIREARM RELATED DEATHS	35.3	7.9	7.5	5.2	10.4	9.3	7.9	5.6
29	DRUG INDUCED DEATHS	71.3	15.9	16.0	12.5	20.2	11.3	12.7	12.3

MORBIDITY

RANK ORDER	HEALTH STATUS INDICATOR	2015-2017 CASES (AVERAGE)	CRUDE CASE RATE	95% CONFIDENCE LIMITS LOWER	95% CONFIDENCE LIMITS UPPER	HP 2020 NATIONAL OBJECTIVE	CRUDE CASE RATE CALIFORNIA CURRENT	CRUDE CASE RATE COUNTY PREVIOUS
27	HIV/AIDS INCIDENCE (AGE 13 AND OVER)†	610.3	164.2	151.2	177.3	a	397.7	155.1
46	CHLAMYDIA INCIDENCE	2,351.0	525.6	504.3	546.8	c	514.6	431.5
10	GONORRHEA INCIDENCE FEMALE AGE 15-44	141.0	151.5	126.5	176.5	251.9	252.4	82.8
7	GONORRHEA INCIDENCE MALE AGE 15-44	180.0	175.1	149.5	200.6	194.8	444.8	76.2
36	TUBERCULOSIS INCIDENCE	12.7	2.8 *	1.5	4.9	1.0	5.3	6.0
	CONGENITAL SYPHILIS	<11.0	NM *	2.7	120.1	9.6	44.4	LNE *
	PRIMARY SECONDARY SYPHILIS FEMALE	<11.0	NM *	0.3	4.2	1.3	3.5	LNE *
11	PRIMARY SECONDARY SYPHILIS MALE	30.3	13.5	9.1	19.2	6.7	26.2	7.8 *

INFANT MORTALITY

RANK ORDER	HEALTH STATUS INDICATOR	2014-2016 DEATHS (AVERAGE)	BIRTH COHORT (BC) INFANT DEATH RATE	95% CONFIDENCE LIMITS LOWER	95% CONFIDENCE LIMITS UPPER	HP 2020 NATIONAL OBJECTIVE	BC INFANT DEATH RATE CALIFORNIA CURRENT	BC INFANT DEATH RATE COUNTY PREVIOUS
18	INFANT MORTALITY: ALL RACES	26.3	4.6	3.0	6.8	6.0	4.4	3.4 *
	INFANT MORTALITY: ASIAN/PI	<11.0	M *	0.3	27.8	6.0	3.2	-
	INFANT MORTALITY: BLACK	<11.0	NM *	1.6	132.5	6.0	9.8	-
16	INFANT MORTALITY: HISPANIC	17.0	4.6 *	2.7	7.4	6.0	4.4	3.7 *
	INFANT MORTALITY: WHITE	<11.0	M *	0.7	6.5	6.0	3.6	LNE *

NATALITY

RANK ORDER	HEALTH STATUS INDICATOR	2015-2017 BIRTHS (AVERAGE)	PERCENT	95% CONFIDENCE LIMITS LOWER	95% CONFIDENCE LIMITS UPPER	HP 2020 NATIONAL OBJECTIVE	PERCENTAGE CALIFORNIA CURRENT	PERCENTAGE COUNTY PREVIOUS
32	LOW BIRTHWEIGHT INFANTS	380.7	6.8	6.1	7.5	7.8	6.9	6.1
28	FIRST TRIMESTER PRENATAL CARE	4,337.7	78.1	75.8	80.4	77.9	83.5	76.8
5	ADEQUATE/ADEQUATE PLUS PRENATAL CARE	4,712.3	84.9	82.5	87.3	77.6	77.9	83.2

RANK ORDER	HEALTH STATUS INDICATOR	2015-2017 BIRTHS (AVERAGE)	AGE-SPECIFIC BIRTH RATE	95% CONFIDENCE LIMITS LOWER	95% CONFIDENCE LIMITS UPPER	HP 2020 NATIONAL OBJECTIVE	AGE-SPECIFIC BIRTH RATE CALIFORNIA CURRENT	AGE-SPECIFIC BIRTH RATE COUNTY PREVIOUS
29	BIRTHS TO MOTHERS AGED 15-19	353.3	18.5	16.6	20.4	a	15.7	23.1

BREASTFEEDING

RANK ORDER	HEALTH STATUS INDICATOR	2015-2017 BREASTFED (AVERAGE)	PERCENT	95% CONFIDENCE LIMITS LOWER	95% CONFIDENCE LIMITS UPPER	HP 2020 NATIONAL OBJECTIVE	PERCENTAGE CALIFORNIA CURRENT	PERCENTAGE COUNTY PREVIOUS
24	BREASTFEEDING INITIATION	4,751.7	96.0	93.2	98.7	81.9	94.0	95.3

CENSUS

RANK ORDER	HEALTH STATUS INDICATOR	2016 NUMBER	PERCENT	95% CONFIDENCE LIMITS LOWER	95% CONFIDENCE LIMITS UPPER	HP 2020 NATIONAL OBJECTIVE	PERCENTAGE CALIFORNIA CURRENT	PERCENTAGE COUNTY PREVIOUS
21	PERSONS UNDER 18 IN POVERTY	15,975.0	15.5	15.3	15.7	a	19.3	19.4

- Rates, percentages and confidence limits are not calculated for zero events.
***** Rates are deemed unreliable when based on fewer than 20 data elements.
<0.1 Indicates lower confidence limit is less than 0.1 but greater than 0.0.
<11.0 Refers to Data De-Identification Guidelines (DDG) used to assess risk of publicly released data; as a result, suppression and masking have been applied to this tabular data.
a Healthy People (HP) 2020 National Objective has not been established.
b HP 2020 National Objective is based on both underlying and contributing cause of death which requires use of multiple cause of death files. California's data exclude multiple/contributing causes of death.
c Prevalence data are not available in all California counties to evaluate the HP 2020 National Objective STD-1, as the objective is restricted to females who are 15-24 years old and identified at a family planning clinic, and males and females under 24 years old who participate in a national job-training program.
M Met (M) refers to the Healthy People 2020 National objectives only.
NM Not Met (NM) refers to the Healthy People 2020 National objectives only.
NA Not Applicable (NA) refers to the Healthy People 2020 National Objectives only.
LNE Low Number Evaluated; rates/percentages are masked per Data De-Identification Guidelines.
Notes Crude death rates, crude case rates, and age-adjusted death rates are per 100,000 population. Birth cohort infant death rates are per 1,000 live births.
The age-specific birth rates are per 1,000 female population aged 15 to 19 years old.
Previous refers to previous period rates. These periods vary by type of rate: Mortality 2012-2014, Morbidity 2012-2014, Infant Mortality 2011-2013, Natality 2012-2014, Census 2016.
† California Department of Public Health, Office of AIDS, Surveillance Section reporting periods are: Current Period 2014-2016, Previous Period 2011-2013.
Sources California Department of Finance. Demographic Research Unit. 2018. State and county population projections 2010-2060. Sacramento: California Department of Finance. January 2018.
California Department of Public Health, California Comprehensive Master Death Files, [2015-2017] Compiled, August 2018.
California Department of Public Health, Office of AIDS, Surveillance Section, Data Requested, August 2018.
California Department of Public Health, STD Control Branch, Data Requested, August 2018. Chlamydia and Gonorrhea data.
California Department of Public Health, Tuberculosis Control Branch, Data Requested, July 2018.
California Department of Public Health: 2014-2016 Birth Cohort-Perinatal Outcome Files.
California Department of Public Health: 2015-2017 Birth Statistical Master Files.
California Department of Public Health, Center for Family Health, Genetic Disease Screening Program, Newborn Screening Data, 2015-2017, Date Requested, July 2018.
California Department of Public Health, Center for Family Health, Maternal, Child and Adolescent Health Program, Data Requested, July 2018.
U.S. Census Bureau, Small Area Income and Poverty Estimates. http://www.census.gov/data/datasets/2016/demo/saipe/2016-state-and-county.html, Accessed, July 2018.