2025
COMMUNITY HEALTH NEEDS ASSESSMENT

Salinas Valley Health Medical Center Service Area
Monterey County, California

Sponsored by
Salinas Valley Health Medical Center

In collaboration with
Monterey County Health Needs Collaborative

- County of Monterey Health Department
- Mee Memorial Healthcare System
- Montage Health
- Natividad
- Salinas Valley Health
- United Way Monterey County
- California State University Monterey Bay (CSUMB)
- Central California Alliance for Health (Alliance)

With coordination from
Hospital Council – Northern & Central California

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INTRODUCTION

PROJECT OVERVIEW

A Community Health Needs Assessment provides information so that communities may identify issues of greatest concern and decide to commit resources to those areas, thereby making the greatest possible impact on community health status.

This Community Health Needs Assessment — a follow-up to a similar study conducted in 2022 — is a systematic, data-driven approach to determining the health status, behaviors, and needs of residents in the service area of Salinas Valley Health Medical Center. Subsequently, this information may be used to inform decisions and guide efforts to improve community health and wellness.

This report was prepared for Salinas Valley Health Medical Center by Professional Research Consultants, Inc. (PRC), a nationally recognized health care consulting firm with extensive experience conducting Community Health Needs Assessments in hundreds of communities across the United States since 1994. The data presented in this report was collected as part of a broader, countywide assessment sponsored by the Monterey County Health Needs Collaborative and facilitated by the Hospital Council – Northern & Central California.

> This report, as well as those produced for the county and other individual partners of the Collaborative, are available at www.healthymontereycounty.org.

Methodology

This assessment incorporates data from multiple sources, including primary research (through the PRC Community Health Survey and PRC Online Key Informant Survey), as well as secondary research (vital statistics and other existing health-related data). It also allows for trending and comparison to benchmark data at the county, state, and national levels.

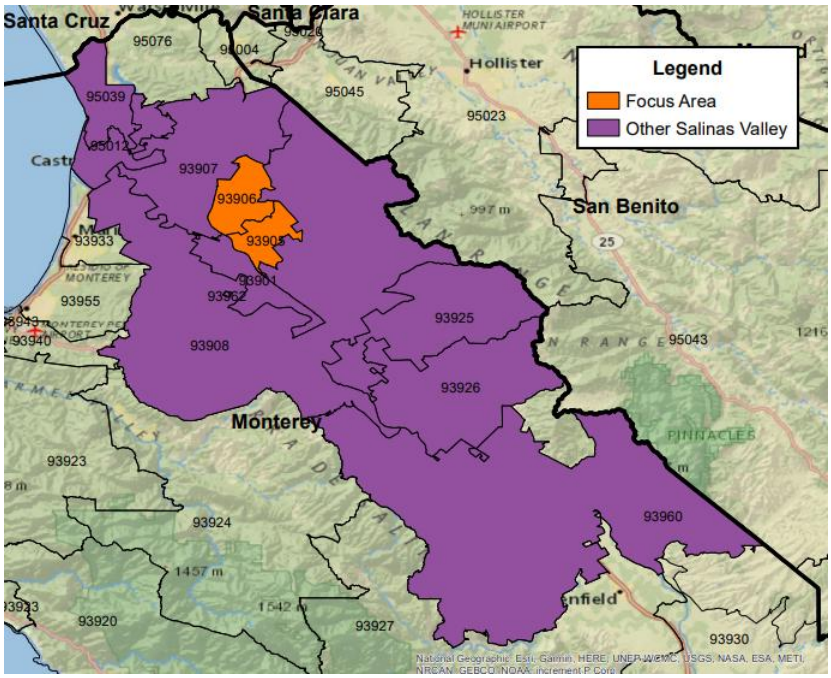
PRC Community Health Survey

Survey Instrument

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

Community Defined for This Assessment

The study area for this report (referred to as the “SVHMC Service Area” or “SVHMC”) is defined as each of the residential ZIP Codes comprising the service area of Salinas Valley Health Medical Center, including 93905 and 93906 (the Focus Area), as well as 93901, 93907, 93908, 93925, 93926, 93960, 93962, 95012, and 95039 (collectively, Other Salinas Valley or Other SVHMC). This community definition is illustrated in the following map.



Sample Approach & Design

A precise and carefully executed methodology is critical in asserting the validity of the results gathered in the PRC Community Health Survey. Thus, to ensure the best representation of the population surveyed, a mixed-mode methodology was implemented. This included targeted surveys conducted by PRC via telephone (landline and cell phone) or through online questionnaires, as well as a community outreach component promoted by the study sponsors through social media posting and other communications. These surveys were administered and collected between January 27 and May 20, 2025.

> **RANDOM-SAMPLE SURVEYS** (PRC) ► For the targeted administration, PRC administered 306 surveys throughout the service area.
>
> **COMMUNITY OUTREACH SURVEYS** (Monterey County Health Needs Collaborative) ► PRC also created a link to an online version of the survey, and the study sponsors promoted this link locally in order to drive additional participation and bolster overall samples. This yielded an additional 760 surveys to the overall sample.

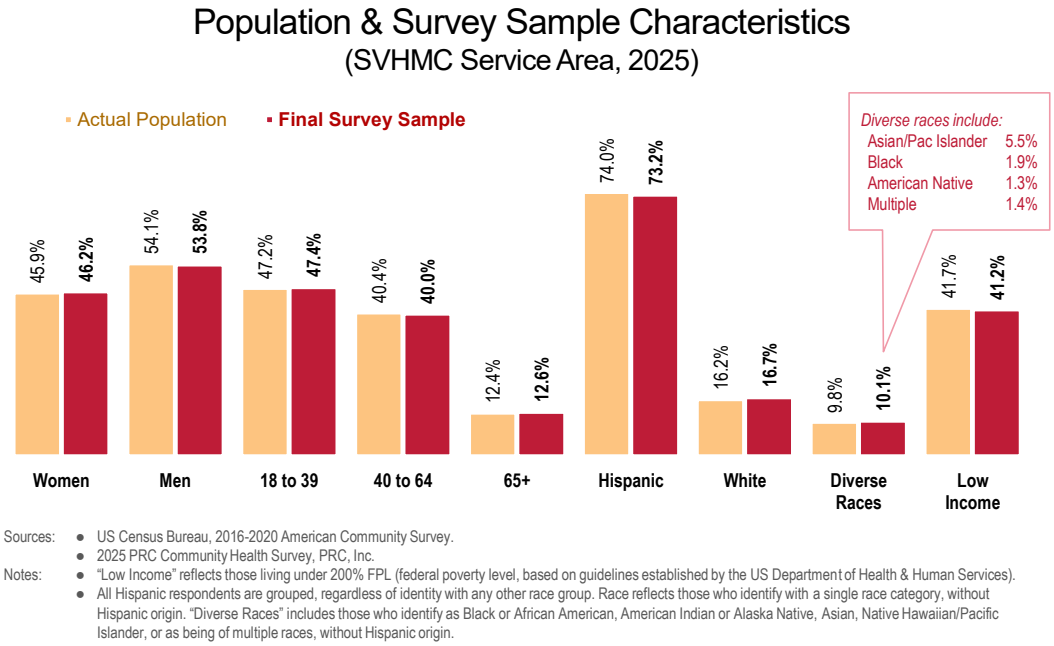
In all, 1,066 surveys were completed through these mechanisms, including 477 in the Focus Area (ZIP Codes 93905 and 93906) and 589 in the remainder of the SVHMC Service Area (Other Salinas Valley/Other SVHMC). Once the interviews were completed, these were weighted in proportion to the actual population distribution so as to appropriately represent the SVHMC Service Area as a whole. All administration of the surveys, data collection, and data analysis was conducted by PRC.

For statistical purposes, for questions asked of all respondents, the maximum rate of error associated with a sample size of 1,066 respondents is ±3.0% at the 95 percent confidence level.

Sample Characteristics

To accurately represent the population studied, PRC strives to minimize bias through application of a proven telephone methodology and random-selection techniques. While this random sampling of the population produces a highly representative sample, it is a common and preferred practice to “weight” the raw data to improve this representativeness even further. This is accomplished by adjusting the results of a random sample to match the geographic distribution and demographic characteristics of the population surveyed (poststratification), so as to eliminate any naturally occurring bias.

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



Sources:
- US Census Bureau, 2016-2020 American Community Survey.
- 2025 PRC Community Health Survey, PRC, Inc.

Notes:
- "Low Income" reflects those living under 200% FPL (federal poverty level, based on guidelines established by the US Department of Health & Human Services).
- All Hispanic respondents are grouped, regardless of identity with any other race group. Race reflects those who identify with a single race category, without Hispanic origin. "Diverse Races" includes those who identify as Black or African American, American Indian or Alaska Native, Asian, Native Hawaiian/Pacific Islander, or as being of multiple races, without Hispanic origin.

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

Online Key Informant Survey

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

Key informants were contacted by email, introducing the purpose of the survey and providing a link to take the survey online; reminder emails were sent as needed to increase participation. In all, 96 community representatives took part in the Online Key Informant Survey, as outlined in the table that follows:

ONLINE KEY INFORMANT SURVEY PARTICIPATION	
KEY INFORMANT TYPE	NUMBER PARTICIPATING
Physicians	16
Public Health Representatives	6
Other Health Providers	8
Social Services Providers	27
Other Community Leaders	39

Through this process, input was gathered from individuals whose organizations work with low-income, minority, or other medically underserved populations. Final participation included representatives of the organizations outlined below.

- Action Council of Monterey County
- Alisal High School
- Alliance on Aging
- Aspire Health
- Blue Zones Project Monterey County
- Bright Beginnings
- Bright Futures - Hartnell College Foundation
- Brighter Bites
- Building Healthy Communities Monterey County
- Buttgereit-Pettitt & Davis Agency
- California State University Monterey Bay
- Cancer Patients Alliance
- CASA of Monterey County
- Central California Alliance for Health
- City of Carmel
- City of Seaside
- City of Soledad
- Clinica de Salud del Valle de Salinas
- Community Builders for Monterey County
- Community Foundation for Monterey County
- Community Hospital of the Monterey Peninsula
- Community Partnership for Youth
- Cypress Healthcare Partners/Doctors on Duty
- Diora/Delicato Wines
- Eddington Funeral Services
- Farm Bureau
- Gathering for Women
- Girls' Health in Girls' Hands
- Gonzales Adult School
- Grower-Shipper Association
- Hartnell College
- Hartnell College Foundation
- ITNMontereyCounty
- Japanese American Citizens League
- King City Union School District
- KION
- Kobrinsky Group
- Maurine Church Coburn School of Nursing
- Meals on Wheels of the Monterey Peninsula
- MoGo Urgent Care
- Montage Health
- Montage Medical Group
- Monterey Bay Central Labor Council

- Monterey County Health Department
- Monterey County Office of Education
- Monterey Peninsula Unified School District
- Natividad
- Natividad Foundation
- Pajaro Valley Prevention and Student Assistance
- RotaCare
- Salinas Regional Soccer Complex
- Salinas Valley Health
- Salinas Valley Medical Clinic Salinas Valley Memorial Hospital Foundation
- Salinas Valley Pride
- San Ardo Union Elementary School District
- Santa Cruz and Monterey County
- Second Harvest Food Bank
- Sol Treasures
- Soledad Community Health Care District
- Soledad Unified School District
- United Way Monterey County
- Whites for Racial Equity
- YMCA

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

Public Health, Vital Statistics & Other Data

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

- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension, SparkMap (sparkmap.org)
- Centers for Disease Control & Prevention, Office of Infectious Disease, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
- Centers for Disease Control & Prevention, Office of Public Health Science Services, National Center for Health Statistics
- National Cancer Institute, State Cancer Profiles
- US Census Bureau, American Community Survey
- US Census Bureau, County Business Patterns
- US Census Bureau, Decennial Census
- US Department of Agriculture, Economic Research Service
- US Department of Health & Human Services
- US Department of Health & Human Services, Health Resources and Services Administration (HRSA)
- US Department of Justice, Federal Bureau of Investigation
- US Department of Labor, Bureau of Labor Statistics

Note that secondary data reflect the entirety of Monterey County.

Benchmark Data

Trending

A similar survey was administered in the SVHMC Service Area in 2022 by PRC on behalf of Salinas Valley Health Medical Center. Trending data, as revealed by comparison to prior survey results, are provided throughout this report whenever available. (Note that because ZIP Codes 93926 and 93960 were added to the study area in 2025, they are not reflected in the 2022 results). Historical data for secondary data indicators are also included for the purposes of trending.

Monterey County Data

Because this assessment was part of a broader, county-wide project conducted by PRC for the Monterey County Health Needs Collaborative, a county-level benchmark for survey indicators is also available.

California Data

Statewide risk factor data are provided where available as an additional benchmark against which to compare local survey findings; these data represent the most recent *BRFSS (Behavioral Risk Factor Surveillance System) Prevalence and Trends Data* published online by the Centers for Disease Control and Prevention. For other indicators, these draw from vital statistics, census, and other existing data sources.

National Data

Nationwide risk factor data, which are also provided in comparison charts, are taken from the *2023 PRC National Health Survey*; the methodological approach for the national study is similar to that employed in this assessment, and these data may be generalized to the US population with a high degree of confidence. National-level vital findings (from various existing resources) are also provided for comparison of secondary data indicators.

Healthy People 2030

Healthy People provides 10-year, measurable public health objectives — and tools to help track progress toward achieving them. Healthy People identifies public health priorities to help individuals, organizations, and communities across the United States improve health and well-being. Healthy People 2030, the initiative's fifth iteration, builds on knowledge gained over the first four decades.

The Healthy People 2030 framework was based on recommendations made by the Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2030. After getting feedback from individuals and organizations and input from subject matter experts, the US Department of Health and Human Services (HHS) approved the framework which helped guide the selection of Healthy People 2030 objectives.

Determining Significance

Differences noted in this report represent those determined to be significant. For survey-derived indicators (which are subject to sampling error), statistical significance is determined based on confidence intervals (at the 95 percent confidence level), using question-specific samples and response rates. For the purpose of this report, "significance" of secondary data indicators (which do not carry sampling error but might be subject to reporting error) is determined by a 15% variation from the comparative measure.

Information Gaps

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

For example, certain population groups — such as the homeless, institutionalized persons, or those who only speak a language other than English or Spanish — are not represented in the survey data. Other

population groups — for example, pregnant women, undocumented residents, and members of certain racial/ethnic or immigrant groups — while included in the overall findings, might not be identifiable or might not be represented in numbers sufficient for independent analyses.

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

SUMMARY OF FINDINGS

Significant Health Needs of the Community

The following "Areas of Opportunity" represent the significant health needs of the community, based on the information gathered through this Community Health Needs Assessment. From these data, opportunities for health improvement exist in the area with regard to the following health issues (see also the summary tables presented in the following section).

The Areas of Opportunity were determined after consideration of various criteria, including: standing in comparison with benchmark data (particularly national data); identified trends; the preponderance of significant findings within topic areas; the magnitude of the issue in terms of the number of persons affected; and the potential health impact of a given issue. These also take into account those issues of greatest concern to the key informants giving input to this process.

AREAS OF OPPORTUNITY IDENTIFIED THROUGH THIS ASSESSMENT	
ACCESS TO HEALTH CARE SERVICES	▪ Barriers to Access ○ Inconvenient Office Hours ○ Cost of Physician Visits ○ Appointment Availability ○ Difficulty Finding a Physician ▪ Primary Care Physician Ratio ▪ Specific Source of Ongoing Medical Care ▪ Ratings of Local Health Care ▪ Key Informants: *Access to Health Care Services* ranked as a top concern.
CANCER	▪ Leading Cause of Death ▪ Female Breast Cancer Screening ▪ Cervical Cancer Screening
DIABETES	▪ Prevalence of Borderline/Pre-Diabetes ▪ Kidney Disease Deaths ▪ Key Informants: *Diabetes* ranked as a top concern.
HEART DISEASE & STROKE	▪ Leading Cause of Death ▪ Stroke Deaths ▪ High Blood Cholesterol Prevalence
HOUSING	▪ Housing Insecurity ▪ Housing Conditions ▪ Key Informants: *Social Determinants of Health (including Housing)* ranked as a top concern.
INFANT HEALTH & FAMILY PLANNING	▪ Teen Births
INJURY & VIOLENCE	▪ Unintentional Injury Deaths
MENTAL HEALTH	▪ "Fair/Poor" Mental Health ▪ Awareness of Pediatric Mental Health Resources [Parents] ▪ Key Informants: *Mental Health* ranked as a top concern.
NUTRITION, PHYSICAL ACTIVITY & WEIGHT	▪ Overweight & Obesity [Adults & Children]
SUBSTANCE USE	▪ Alcohol-Induced Deaths ▪ Unintentional Drug-Induced Deaths ▪ Sought Help for Alcohol/Drug Issues

Community Feedback & Prioritization

On October 7, 2025, the Monterey County Health Needs Collaborative convened an online meeting attended by 116 local providers and other community leaders (representing a cross-section of community-based agencies and organizations) to evaluate, discuss and prioritize health issues for the community, based on findings of this Community Health Needs Assessment (CHNA). PRC began the meeting with a presentation of key findings from the CHNA, highlighting the significant health issues identified from the research (see Areas of Opportunity above). Following the data review, PRC answered any questions. Finally, participants were provided an overview of the prioritization exercise that followed.

In order to assign priority to the identified health needs (i.e., Areas of Opportunity), an online voting platform was used in which each participant was able to register their ratings using a mobile device or web browser.

The participants were asked to evaluate each health issue along two criteria:

SCOPE & SEVERITY ► The first rating was to gauge the magnitude of the problem in consideration of the following:

- How many people are affected?
- How does the local community data compare to state or national levels, or Healthy People 2030 targets?
- To what degree does each health issue lead to death or disability, impair quality of life, or impact other health issues?

Ratings were entered using a scale of 1 (not very prevalent at all, with only minimal health consequences) to 10 (extremely prevalent, with very serious health consequences).

ABILITY TO IMPACT ► A second rating was designed to measure the perceived likelihood of having a positive impact on each health issue, given available resources, competencies, spheres of influence, etc. Ratings were entered on a scale of 1 (no ability to impact) to 10 (great ability to impact).

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

1. Diabetes
2. Access to Health Care Services
3. Nutrition, Physical Activity & Weight
4. Mental Health
5. Heart Disease & Stroke
6. Substance Use
7. Cancer
8. Housing
9. Infant Health & Family Planning
10. Injury & Violence

Summary Tables: Comparisons With Benchmark Data

Reading the Summary Tables

In the following tables, SVHMC Service Area results are shown in the larger, gray column.

The columns to the left of the service area column provide comparisons between the Focus Area and the remaining ZIP Codes, identifying differences for each as “better than” (🌞), “worse than” (🌧), or “similar to” (☁) the opposing area.

The columns to the right of the SVHMC Service Area column provide trending, as well as comparisons between local data and any available county, state, and national findings, and any available Healthy People 2030 objectives. Again, symbols indicate whether the SVHMC Service Area compares favorably (🌞), unfavorably (🌧), or comparably (☁) to these external data.

TREND SUMMARY

(Current vs. Baseline Data)

SURVEY DATA INDICATORS:

Trends for survey-derived indicators represent significant changes since 2022. Note that survey data reflect the ZIP Code-defined SVHMC Service Area.

OTHER (SECONDARY) DATA INDICATORS:

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

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

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

Tip: Indicator labels beginning with a “%” symbol are taken from the PRC Community Health Survey; the remaining indicators are taken from secondary data sources.

SOCIAL DETERMINANTS	DISPARITY BETWEEN SUBAREAS		SVHMC	SVHMC vs. BENCHMARKS				
	Focus Area	Other SVHMC	SVHMC	vs. Monterey County	vs. CA	vs. US	vs. HP2030	TREND
Linguistically Isolated Population (Percent)			9.8 [County-Level Data]		7.2	3.9		
Population in Poverty (Percent)			12.6 [County-Level Data]		12.0	12.4	8.0	
Children in Poverty (Percent)			18.1 [County-Level Data]		15.2	16.3	8.0	
No High School Diploma (Age 25+, Percent)			26.7 [County-Level Data]		15.4	10.6		
Unemployment Rate (Age 16+, Percent)			8.5 [County-Level Data]		5.2	3.9		10.4
% Unable to Pay for a $400 Emergency Expense	40.0	29.0	34.9	32.3		34.0		33.2
% Worry/Stress Over Rent/Mortgage in Past Year	57.8	45.3	51.9	47.5		45.8		47.9
% Unhealthy/Unsafe Housing Conditions	24.9	19.3	22.3	20.3		16.4		26.4
% Multi-Generational Housing	20.1	16.9	18.6	15.0				23.6
% Share Housing Expenses With Non-Family	14.2	7.4	11.0	11.3				11.5
Population With Low (Geographic) Food Access (Percent)			16.6 [County-Level Data]		13.3	22.2		

SOCIAL DETERMINANTS (continued)	DISPARITY BETWEEN SUBAREAS		SVHMC	SVHMC vs. BENCHMARKS				
	Focus Area	Other SVHMC		vs. Monterey County	vs. CA	vs. US	vs. HP2030	TREND
% Food Insecure	48.1	39.8	44.2	42.9		43.3		43.8

Note: In the section above, each subarea is compared against the other. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

OVERALL HEALTH	DISPARITY BETWEEN SUBAREAS		SVHMC	SVHMC vs. BENCHMARKS				
	Focus Area	Other SVHMC		vs. Monterey County	vs. CA	vs. US	vs. HP2030	TREND
% "Fair/Poor" Overall Health	18.3	21.4	19.7	18.7	20.8	15.7		21.5

Note: In the section above, each subarea is compared against the other. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

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ACCESS TO HEALTH CARE	DISPARITY BETWEEN SUBAREAS		SVHMC	SVHMC vs. BENCHMARKS				
	Focus Area	Other SVHMC		vs. Monterey County	vs. CA	vs. US	vs. HP2030	TREND
% [Age 18-64] Lack Health Insurance	7.3	9.2	8.2	7.5	8.9	8.1	7.6	10.6
% Difficulty Accessing Health Care in Past Year (Composite)	63.5	67.4	65.3	65.8		52.5		69.5
% Cost Prevented Physician Visit in Past Year	26.4	24.9	25.7	23.0	10.7	21.6		26.7
% Cost Prevented Getting Prescription in Past Year	20.4	21.0	20.7	18.4		20.2		25.6

ACCESS TO HEALTH CARE (continued)	DISPARITY BETWEEN SUBAREAS		SVHMC	SVHMC vs. BENCHMARKS				
	Focus Area	Other SVHMC		vs. Monterey County	vs. CA	vs. US	vs. HP2030	TREND
% Difficulty Getting Appointment in Past Year	48.0	50.9	49.3	52.6		33.4		53.2
% Inconvenient Hrs Prevented Dr Visit in Past Year	32.2	28.3	30.4	24.5		22.9		33.3
% Difficulty Finding Physician in Past Year	36.0	33.6	34.9	33.8		22.0		33.5
% Transportation Hindered Dr Visit in Past Year	13.0	13.7	13.3	14.8		18.3		14.3
% Language/Culture Prevented Care in Past Year	4.5	4.7	4.6	3.2		5.0		8.7
% Stretched Prescription to Save Cost in Past Year	14.3	19.9	16.9	18.1		19.4		19.2
% Difficulty Getting Child's Health Care in Past Year	12.8	12.9	12.9	12.8		11.1		15.2
Primary Care Doctors per 100,000			98.4 [County-Level Data]		115.0	118.0		
% Have a Specific Source of Ongoing Care	61.6	70.5	65.8	64.7		69.9	84.0	73.9
% Routine Checkup in Past Year	64.8	61.4	63.2	63.7	74.5	65.3		58.6
% [Child 0-17] Routine Checkup in Past Year	89.2	83.3	86.5	84.7		77.5		88.5
% Two or More ER Visits in Past Year	12.5	12.5	12.5	15.2		15.6		10.2

ACCESS TO HEALTH CARE (continued)	DISPARITY BETWEEN SUBAREAS		SVHMC	SVHMC vs. BENCHMARKS				
	Focus Area	Other SVHMC		vs. Monterey County	vs. CA	vs. US	vs. HP2030	TREND
% Low Health Literacy	25.4	28.9	27.1	25.0		25.1		29.5
% Rate Local Health Care "Fair/Poor"	20.8	24.0	22.3	24.3		11.5		25.5

Note: In the section above, each subarea is compared against the other. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

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CANCER	DISPARITY BETWEEN SUBAREAS		SVHMC	SVHMC vs. BENCHMARKS				
	Focus Area	Other SVHMC		vs. Monterey County	vs. CA	vs. US	vs. HP2030	TREND
Cancer Deaths per 100,000			134.8 [County-Level Data]		153.5	182.5	122.7	130.1
Lung Cancer Deaths per 100,000			21.2 [County-Level Data]		26.0	39.8	25.1	
Female Breast Cancer Deaths per 100,000			22.1 [County-Level Data]		23.3	25.1	15.3	
Prostate Cancer Deaths per 100,000			18.4 [County-Level Data]		19.9	20.1	16.9	
Colorectal Cancer Deaths per 100,000			10.6 [County-Level Data]		14.3	16.3	8.9	
Cancer Incidence per 100,000			373.8 [County-Level Data]		397.4	444.4		
Lung Cancer Incidence per 100,000			28.3 [County-Level Data]		36.7	53.1		

CANCER (continued)	DISPARITY BETWEEN SUBAREAS: Focus Area	DISPARITY BETWEEN SUBAREAS: Other SVHMC	SVHMC	SVHMC vs. BENCHMARKS: vs. Monterey County	SVHMC vs. BENCHMARKS: vs. CA	SVHMC vs. BENCHMARKS: vs. US	SVHMC vs. BENCHMARKS: vs. HP2030	TREND
Female Breast Cancer Incidence per 100,000			113.1 [County-Level Data]		124.0	129.8		
Prostate Cancer Incidence per 100,000			109.3 [County-Level Data]		98.6	113.2		
Colorectal Cancer Incidence per 100,000			31.0 [County-Level Data]		33.5	36.4		
% Cancer	5.8	7.6	6.7	9.2	9.5	7.4		10.1
% [Women 40-74] Breast Cancer Screening	74.1	82.4	78.2	77.1		64.0	80.5	85.6
% [Women 21-65] Cervical Cancer Screening	70.8	77.4	73.8	70.6		75.4	84.3	81.9
% [Age 45-75] Colorectal Cancer Screening	77.4	77.4	77.4	75.8		71.5	74.4	78.9

Note: In the section above, each subarea is compared against the other. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

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DIABETES	DISPARITY BETWEEN SUBAREAS: Focus Area	DISPARITY BETWEEN SUBAREAS: Other SVHMC	SVHMC	SVHMC vs. BENCHMARKS: vs. Monterey County	SVHMC vs. BENCHMARKS: vs. CA	SVHMC vs. BENCHMARKS: vs. US	SVHMC vs. BENCHMARKS: vs. HP2030	TREND
Diabetes Deaths per 100,000			18.2 [County-Level Data]		29.4	30.5		19.2
% Diabetes/High Blood Sugar	15.1	10.3	12.8	11.1	11.5	12.8		14.5

DIABETES (continued)	DISPARITY BETWEEN SUBAREAS		SVHMC	SVHMC vs. BENCHMARKS				
	Focus Area	Other SVHMC		vs. Monterey County	vs. CA	vs. US	vs. HP2030	TREND
% Borderline/Pre-Diabetes	25.6	15.1	20.7	19.0		15.0		20.2
% [Non-Diabetics] Blood Sugar Tested in Past 3 Years	46.3	41.5	44.0	48.0		41.5		47.2
Kidney Disease Deaths per 100,000			14.7 [County-Level Data]		12.4	16.9		8.5

Note: In the section above, each subarea is compared against the other. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

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DISABLING CONDITIONS	DISPARITY BETWEEN SUBAREAS		SVHMC	SVHMC vs. BENCHMARKS				
	Focus Area	Other SVHMC		vs. Monterey County	vs. CA	vs. US	vs. HP2030	TREND
% 3+ Chronic Conditions	37.0	36.0	36.5	34.0		38.0		41.0
% Activity Limitations	23.5	24.8	24.1	30.2		27.5		29.3
% High-Impact Chronic Pain	18.2	15.3	16.9	17.3		19.6	6.4	19.7
Alzheimer's Disease Deaths per 100,000			26.8 [County-Level Data]		43.5	35.8		28.0
% Caregiver to a Friend/Family Member	22.2	21.7	22.0	25.7		22.8		30.7

Note: In the section above, each subarea is compared against the other. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

HEART DISEASE & STROKE	DISPARITY BETWEEN SUBAREAS: Focus Area	DISPARITY BETWEEN SUBAREAS: Other SVHMC	SVHMC	SVHMC vs. BENCHMARKS: vs. Monterey County	vs. CA	vs. US	vs. HP2030	TREND
Heart Disease Deaths per 100,000			126.8 [County-Level Data]		168.0	209.5	127.4	113.9
% Heart Disease	5.9	6.0	5.9	9.2	5.2	10.3		8.8
Stroke Deaths per 100,000			42.5 [County-Level Data]		46.9	49.3	33.4	34.1
% Stroke	1.1	2.0	1.5	2.6	2.9	5.4		4.3
% High Blood Pressure	39.4	36.6	38.1	36.6	30.6	40.4	42.6	38.6
% High Cholesterol	37.1	36.6	36.8	37.6		32.4		39.9

Note: In the section above, each subarea is compared against the other. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better | similar | worse

INFANT HEALTH & FAMILY PLANNING	DISPARITY BETWEEN SUBAREAS: Focus Area	DISPARITY BETWEEN SUBAREAS: Other SVHMC	SVHMC	SVHMC vs. BENCHMARKS: vs. Monterey County	vs. CA	vs. US	vs. HP2030	TREND
No Prenatal Care in First Trimester (Percent of Births)			20.5 [County-Level Data]		14.8	22.3		21.3
Teen Births per 1,000 Females 15-19			20.5 [County-Level Data]		11.6	15.5		
Low Birthweight (Percent of Births)			6.5 [County-Level Data]		7.1	8.4		

INFANT HEALTH & FAMILY PLANNING (continued)	DISPARITY BETWEEN SUBAREAS		SVHMC	SVHMC vs. BENCHMARKS				
	Focus Area	Other SVHMC		vs. Monterey County	vs. CA	vs. US	vs. HP2030	TREND
Infant Deaths per 1,000 Births			3.7 [County-Level Data]		3.9	5.5	5.0	4.5

Note: In the section above, each subarea is compared against the other. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

INJURY & VIOLENCE	DISPARITY BETWEEN SUBAREAS		SVHMC	SVHMC vs. BENCHMARKS				
	Focus Area	Other SVHMC		vs. Monterey County	vs. CA	vs. US	vs. HP2030	TREND
Unintentional Injury Deaths per 100,000			50.8 [County-Level Data]		53.8	67.8	43.2	31.3
Motor Vehicle Crash Deaths per 100,000			13.0 [County-Level Data]		12.3	13.3	10.1	
Homicide Deaths per 100,000			6.4 [County-Level Data]		6.0	7.6	5.5	11.5
% Victim of Violent Crime in Past 5 Years	5.6	6.8	6.2	5.7		7.0		8.1
% Victim of Intimate Partner Violence	13.7	13.4	13.6	17.9		20.3		17.7

Note: In the section above, each subarea is compared against the other. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

MENTAL HEALTH	DISPARITY BETWEEN SUBAREAS		SVHMC	SVHMC vs. BENCHMARKS				
	Focus Area	Other SVHMC		vs. Monterey County	vs. CA	vs. US	vs. HP2030	TREND
% "Fair/Poor" Mental Health	28.6	30.9	**29.7**	27.5		24.4		33.5
% Diagnosed Depression	25.2	24.3	**24.8**	27.3	17.0	30.8		26.8
% Symptoms of Chronic Depression	47.8	37.8	**43.2**	45.1		46.7		52.6
% Typical Day Is "Extremely/Very" Stressful	19.1	17.8	**18.5**	21.9		21.1		22.7
Suicide Deaths per 100,000			**11.0** [County-Level Data]		10.8	14.7	12.8	10.5
Mental Health Providers per 100,000			**332.3** [County-Level Data]		340.6	325.6		
% Receiving Mental Health Treatment	17.8	19.5	**18.6**	21.7		21.9		17.6
% Unable to Get Mental Health Services in Past Year	15.5	14.1	**14.9**	15.0		13.2		17.5
% [Age 5-17] Child Needed Mental Health Services in the Past Year	17.1	30.2	**22.4**	21.6				20.0
% [Age 5-17] Child Has Taken Prescribed Meds for Mental Health	6.8	13.3	**9.5**	8.5				10.0
% [Age 5-17] Aware of Mental Health Resources for Children	47.4	53.7	**50.0**	53.2		67.5		51.4

Note: In the section above, each subarea is compared against the other. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

NUTRITION, PHYSICAL ACTIVITY & WEIGHT	DISPARITY BETWEEN SUBAREAS		SVHMC	SVHMC vs. BENCHMARKS				
	Focus Area	Other SVHMC	SVHMC	vs. Monterey County	vs. CA	vs. US	vs. HP2030	TREND
% 7+ Sugar-Sweetened Drinks in Past Week	19.3	17.5	18.4	20.3				15.6
% "Very/Somewhat" Difficult to Buy Fresh Produce	33.8	28.8	31.4	27.5		30.0		32.2
% Meet Physical Activity Guidelines	37.1	38.9	38.0	34.5	30.1	30.3	29.7	26.5
% [Child 2-17] Physically Active 1+ Hours per Day	31.3	24.9	28.5	31.3		27.4		28.7
Recreation/Fitness Facilities per 100,000			12.1 [County-Level Data]		13.6	12.5		
% Overweight (BMI 25+)	77.4	73.4	75.5	71.1	64.0	63.3		74.3
% Obese (BMI 30+)	44.6	43.8	44.2	36.4	27.7	33.9	36.0	42.0
% [Child 5-17] Overweight (85th Percentile)	45.7	46.8	46.3	41.8		31.8		46.5
% [Child 5-17] Obese (95th Percentile)	25.9	37.1	30.9	25.8		19.5	15.5	32.0

Note: In the section above, each subarea is compared against the other. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

ORAL HEALTH	DISPARITY BETWEEN SUBAREAS: Focus Area	DISPARITY BETWEEN SUBAREAS: Other SVHMC	SVHMC	SVHMC vs. BENCHMARKS: vs. Monterey County	SVHMC vs. BENCHMARKS: vs. CA	SVHMC vs. BENCHMARKS: vs. US	SVHMC vs. BENCHMARKS: vs. HP2030	TREND
% Have Dental Insurance	80.4	78.3	**79.5**	75.4		72.7	75.0	73.7
% Dental Visit in Past Year	63.7	69.0	**66.2**	63.9	66.2	56.5	45.0	55.6
% [Child 2-17] Dental Visit in Past Year	81.6	81.1	**81.4**	80.6		77.8	45.0	80.1

Note: In the section above, each subarea is compared against the other. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better | similar | worse

RESPIRATORY DISEASE	DISPARITY BETWEEN SUBAREAS: Focus Area	DISPARITY BETWEEN SUBAREAS: Other SVHMC	SVHMC	SVHMC vs. BENCHMARKS: vs. Monterey County	SVHMC vs. BENCHMARKS: vs. CA	SVHMC vs. BENCHMARKS: vs. US	SVHMC vs. BENCHMARKS: vs. HP2030	TREND
Lung Disease Deaths per 100,000			**24.8** [County-Level Data]		30.2	43.5		27.8
Pneumonia/Influenza Deaths per 100,000			**7.3** [County-Level Data]		12.8	13.4		11.8
% Asthma	14.3	14.1	**14.2**	11.6	8.8	17.9		15.6
% [Child 0-17] Asthma	12.1	17.3	**14.4**	14.1		16.7		10.5
% COPD (Lung Disease)	6.7	4.5	**5.6**	5.8	4.2	11.0		6.7

Note: In the section above, each subarea is compared against the other. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

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SEXUAL HEALTH	DISPARITY BETWEEN SUBAREAS: Focus Area	DISPARITY BETWEEN SUBAREAS: Other SVHMC	SVHMC	SVHMC vs. BENCHMARKS: vs. Monterey County	SVHMC vs. BENCHMARKS: vs. CA	SVHMC vs. BENCHMARKS: vs. US	SVHMC vs. BENCHMARKS: vs. HP2030	TREND
HIV Prevalence per 100,000			214.7 [County-Level Data]		418.7	386.6		
Chlamydia Incidence per 100,000			498.0 [County-Level Data]		491.1	492.2		
Gonorrhea Incidence per 100,000			70.3 [County-Level Data]		190.2	179.0		

Note: In the section above, each subarea is compared against the other. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

SUBSTANCE USE	DISPARITY BETWEEN SUBAREAS: Focus Area	DISPARITY BETWEEN SUBAREAS: Other SVHMC	SVHMC	SVHMC vs. BENCHMARKS: vs. Monterey County	SVHMC vs. BENCHMARKS: vs. CA	SVHMC vs. BENCHMARKS: vs. US	SVHMC vs. BENCHMARKS: vs. HP2030	TREND
Alcohol-Induced Deaths per 100,000			15.3 [County-Level Data]		17.7	15.7		12.7
% Excessive Drinking	15.7	16.2	15.9	18.6	15.4	34.3		22.3
Unintentional Drug-Induced Deaths per 100,000			22.9 [County-Level Data]		26.6	29.7		9.1
% Used an Illicit Drug in Past Month	1.1	4.3	2.6	4.5		8.4		2.9
% Used a Prescription Opioid in Past Year	9.4	8.6	9.0	10.3		15.1		7.4
% Ever Sought Help for Alcohol or Drug Problem	3.8	3.6	3.7	5.0		6.8		3.9

SUBSTANCE USE (continued)	DISPARITY BETWEEN SUBAREAS		SVHMC	SVHMC vs. BENCHMARKS				
	Focus Area	Other SVHMC		vs. Monterey County	vs. CA	vs. US	vs. HP2030	TREND
% Personally Impacted by Substance Use	37.5	43.6	40.3	41.8		45.4		46.4

Note: In the section above, each subarea is compared against the other. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

TOBACCO USE	DISPARITY BETWEEN SUBAREAS		SVHMC	SVHMC vs. BENCHMARKS				
	Focus Area	Other SVHMC		vs. Monterey County	vs. CA	vs. US	vs. HP2030	TREND
% Smoke Cigarettes	4.6	8.1	6.3	9.0	8.5	23.9	6.1	5.9
% Someone Smokes at Home	8.6	10.5	9.5	7.1		17.7		9.4
% Use Vaping Products	6.7	8.0	7.3	7.7	5.9	18.5		5.5

Note: In the section above, each subarea is compared against the other. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

DATA CHARTS & KEY INFORMANT INPUT

The following sections present data from multiple sources, including the population-based PRC Community Health Survey, public health and other existing data sets (secondary data), as well as qualitative input from the Online Key Informant Survey.

Data indicators from these sources are intermingled and organized by health topic. To better understand the source data for specific indicators, please refer to the footnotes accompanying each chart.

COMMUNITY CHARACTERISTICS

Population Characteristics

Land Area, Population Size & Density

Data from the US Census Bureau reveal the following statistics for our community relative to size, population, and density. [COUNTY-LEVEL DATA]

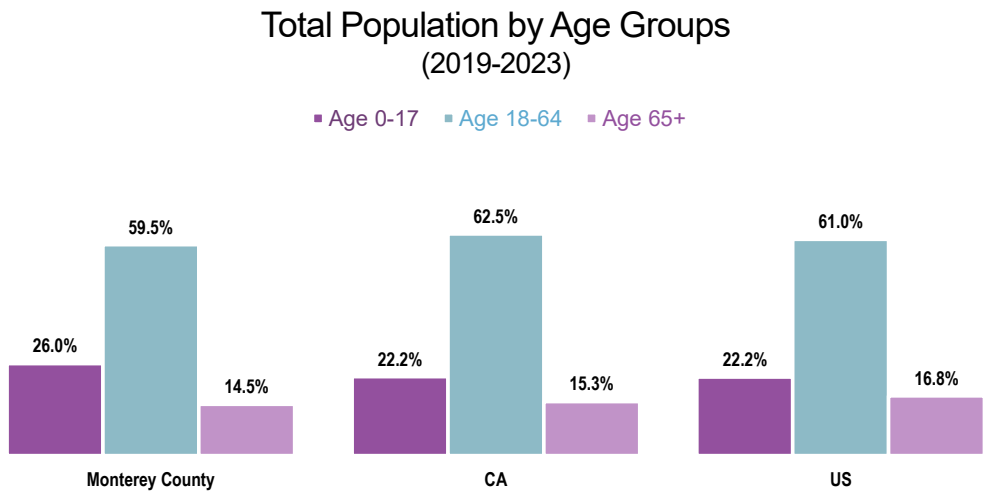
Total Population
(Estimated Population, 2019-2023)

	TOTAL POPULATION	TOTAL LAND AREA (square miles)	POPULATION DENSITY (per square mile)
Monterey County	435,834	3,281.72	133
California	39,242,785	155,859.14	252
United States	332,387,540	3,533,298.58	94

Sources:
- US Census Bureau American Community Survey, 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved July 2025 via SparkMap (sparkmap.org).

Age

It is important to understand the age distribution of the population, as different age groups have unique health needs that should be considered separately from others along the age spectrum. [COUNTY-LEVEL DATA]



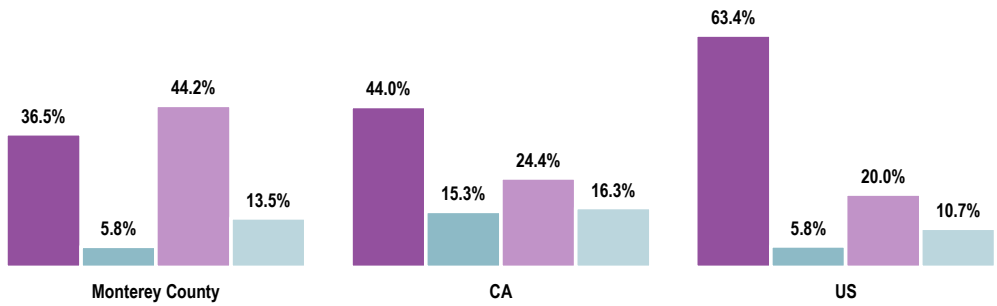
Sources:
- US Census Bureau American Community Survey, 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved July 2025 via SparkMap (sparkmap.org).

Race & Ethnicity

Race reflects those who identify with a single race category, regardless of Hispanic origin. People who identify their origin as Hispanic, Latino, or Spanish may be of any race.

The following charts illustrate the racial and ethnic makeup of our community. [COUNTY-LEVEL DATA]

Total Population by Race Alone
(2019-2023)

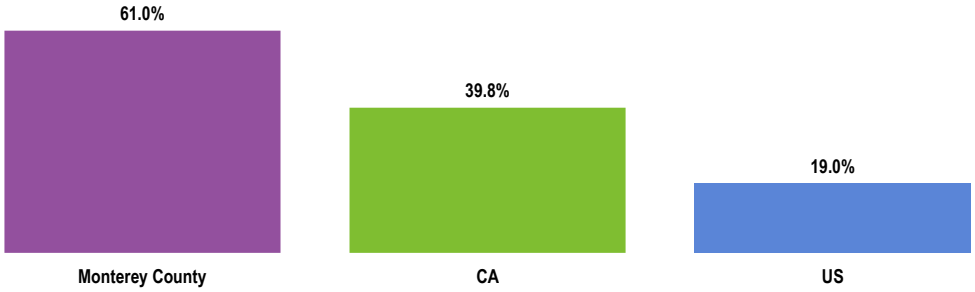


Sources:
- US Census Bureau American Community Survey, 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved July 2025 via SparkMap (sparkmap.org).

Notes:
- "Diverse Races" includes those who identify as American Indian or Alaska Native, Asian, or Native Hawaiian/Pacific Islander, without Hispanic origin.

Hispanic Population
(2019-2023)

The Hispanic population increased by 35,317 persons, or 15.4%, between 2010 and 2020.

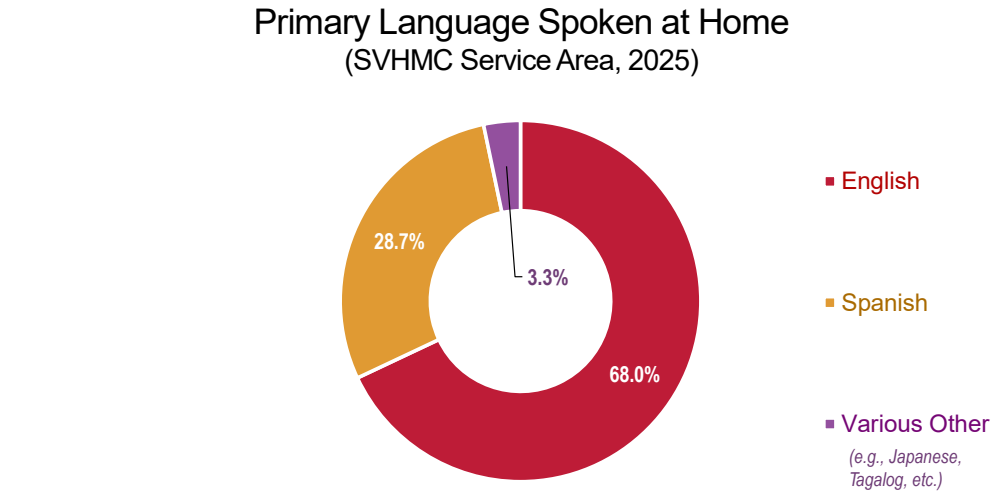


Sources:
- US Census Bureau American Community Survey, 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved July 2025 via SparkMap (sparkmap.org).

Notes:
- People who identify their origin as Hispanic, Latino, or Spanish may be of any race.

Primary Language Spoken at Home

PRC SURVEY ► "What is the primary language spoken in your home?" (Note that surveys were administered in English and Spanish.)



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 311]

Notes:
- Asked of all respondents.
- Note that surveys were administered only in English and Spanish.

Social Determinants of Health

ABOUT SOCIAL DETERMINANTS OF HEALTH

Social determinants of health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

Social determinants of health (SDOH) have a major impact on people's health, well-being, and quality of life. Examples of SDOH include:

- Safe housing, transportation, and neighborhoods
- Racism, discrimination, and violence
- Education, job opportunities, and income
- Access to nutritious foods and physical activity opportunities
- Polluted air and water
- Language and literacy skills

SDOH also contribute to wide health disparities and inequities. For example, people who don't have access to grocery stores with healthy foods are less likely to have good nutrition. That raises their risk of health conditions like heart disease, diabetes, and obesity — and even lowers life expectancy relative to people who do have access to healthy foods.

Just promoting healthy choices won't eliminate these and other health disparities. Instead, public health organizations and their partners in sectors like education, transportation, and housing need to take action to improve the conditions in people's environments.

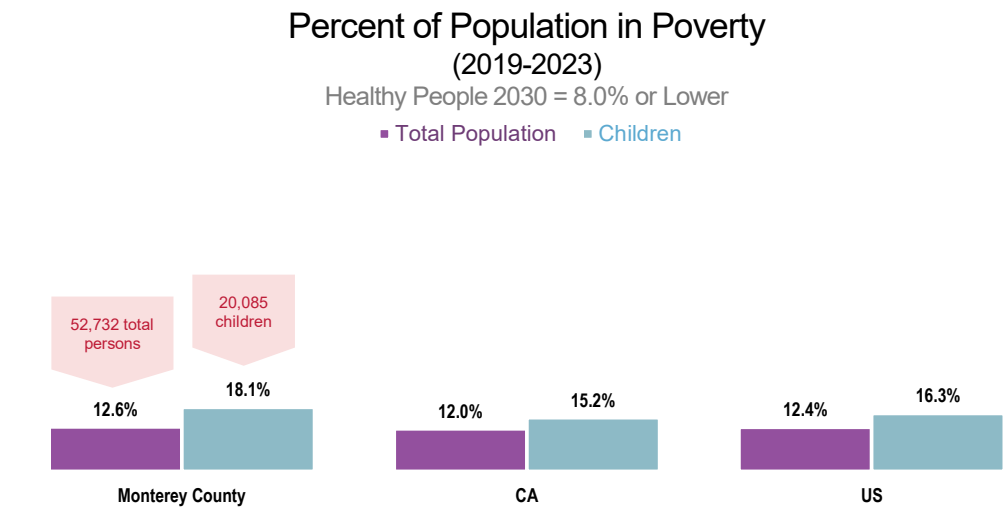
– Healthy People 2030 (https://health.gov/healthypeople)

Income & Poverty

Poverty

Poverty is considered a key driver of health status because it creates barriers to accessing health services, healthy food, and other necessities that contribute to health status.

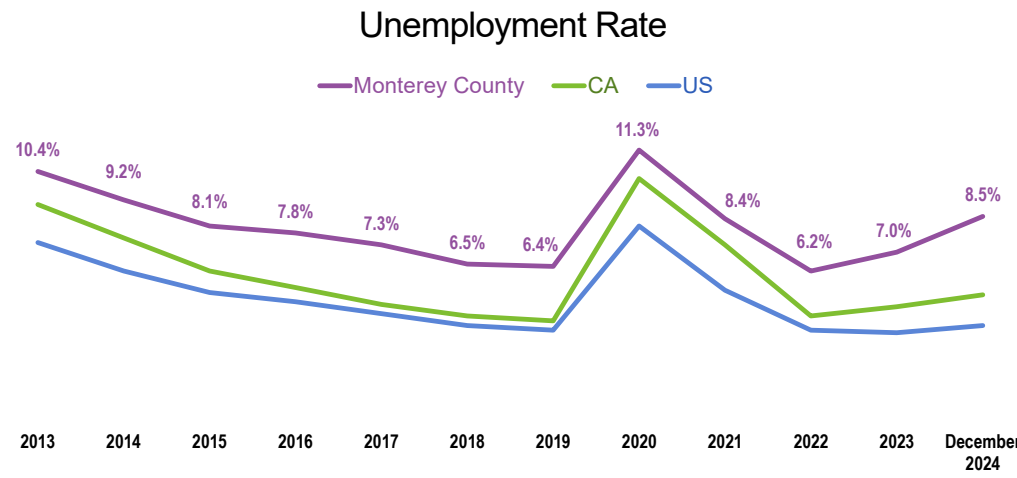
The following chart outlines the proportion of our population below the federal poverty threshold in comparison to state and national proportions. [COUNTY-LEVEL DATA]



Sources:
- US Census Bureau American Community Survey, 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved July 2025 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Employment

Note the following trends in unemployment data derived from the US Department of Labor. [COUNTY-LEVEL DATA]



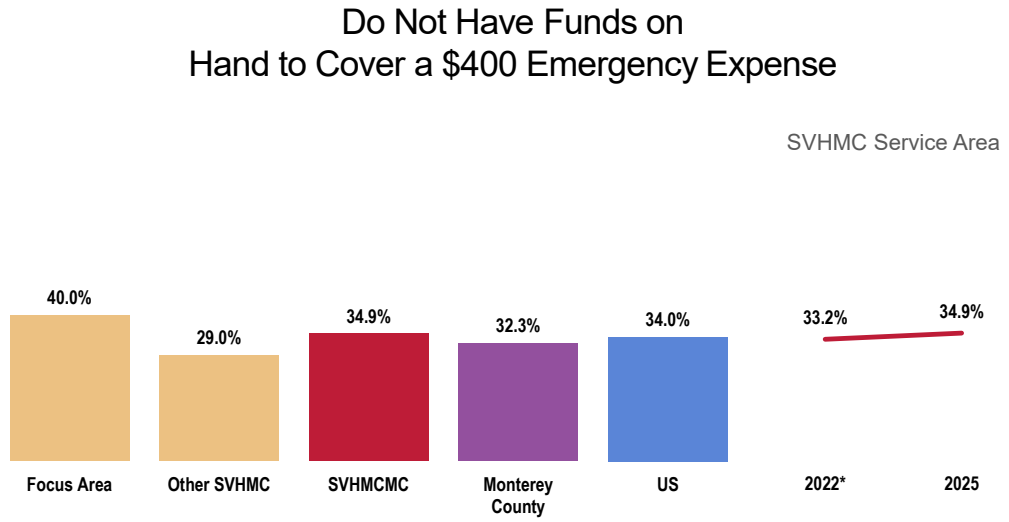
Sources:
- US Department of Labor, Bureau of Labor Statistics.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved July 2025 via SparkMap (sparkmap.org).

Notes:
- Percent of non-institutionalized population age 16+ who are unemployed (not seasonally adjusted).

Financial Resilience

PRC SURVEY ► "Suppose that you have an emergency expense that costs $400. Based on your current financial situation, would you be able to pay for this expense either with cash, by taking money from your checking or savings account, or by putting it on a credit card that you could pay in full at the next statement?"

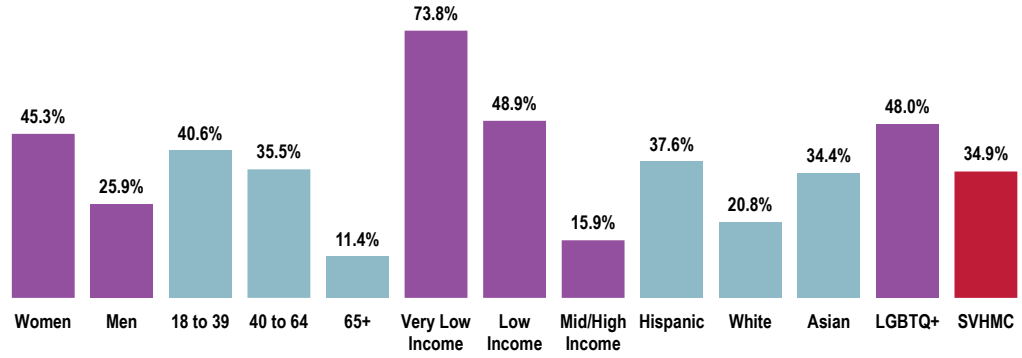
The following details "no" responses in the SVHMC Service Area in comparison to benchmark data, as well as by basic demographic characteristics (such as gender, age groupings, income [based on poverty status], race/ethnicity, and LGBTQ+ identification).



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 53]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes respondents who say they would not be able to pay for a $400 emergency expense either with cash, by taking money from their checking or savings account, or by putting it on a credit card that they could pay in full at the next statement.
- *2022 data does not include ZIP Codes 93926 and 93960.

Do Not Have Funds on Hand to Cover a $400 Emergency Expense
(SVHMC Service Area, 2025)



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 53]
Notes: ● Asked of all respondents.
● Includes respondents who say they would not be able to pay for a $400 emergency expense either with cash, by taking money from their checking or savings account, or by putting it on a credit card that they could pay in full at the next statement.

INCOME & RACE/ETHNICITY

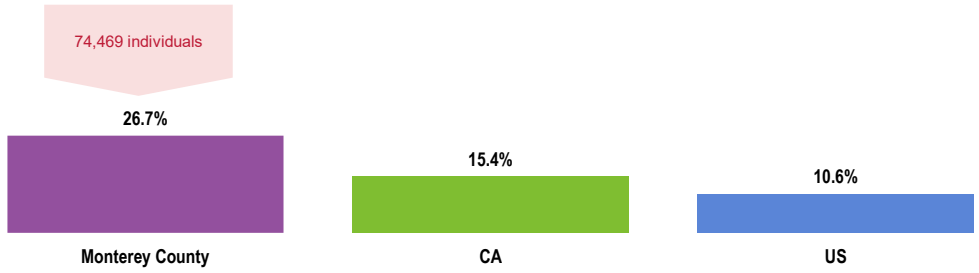
INCOME ► Income categories used to segment survey data in this report are based on administrative poverty thresholds determined by the US Department of Health & Human Services. These guidelines define poverty status by household income level and number of persons in the household (e.g., the 2024 guidelines place the poverty threshold for a family of four at $30,700 annual household income or lower). In sample segmentation: "very low income" refers to community members living in a household with defined poverty status; "low income" refers to households with incomes just above the poverty level and earning up to twice (100%-199% of) the poverty threshold; and "mid/high income" refers to those households living on incomes which are twice or more (≥200% of) the federal poverty level.

RACE & ETHNICITY ► In analyzing survey results, mutually exclusive race and ethnicity categories are used. All Hispanic respondents are grouped, regardless of identity with any other race group. Data are also detailed for individuals identifying with a race category, without Hispanic origin. "White" reflects those who identify as White alone, without Hispanic origin. "Asian" reflects those who identify as Asian alone, without Hispanic origin.

Education

Education levels are reflected in the proportion of our population without a high school diploma. This indicator is relevant because educational attainment is linked to positive health outcomes. [COUNTY-LEVEL DATA]

Population With No High School Diploma
(Adults Age 25 and Older; 2019-2023)



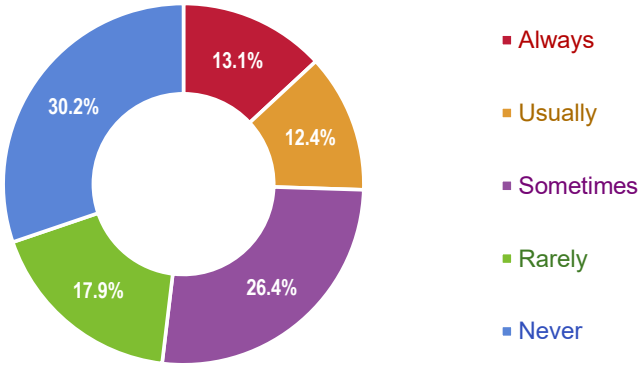
Sources:
- US Census Bureau American Community Survey, 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved July 2025 via SparkMap (sparkmap.org).

Housing

Housing Insecurity

PRC SURVEY ► "In the past 12 months, how often were you worried or stressed about having enough money to pay your rent or mortgage? Would you say you were worried or stressed: always, usually, sometimes, rarely, or never?"

Frequency of Worry or Stress About Paying Rent or Mortgage in the Past Year
(SVHMC Service Area, 2025)



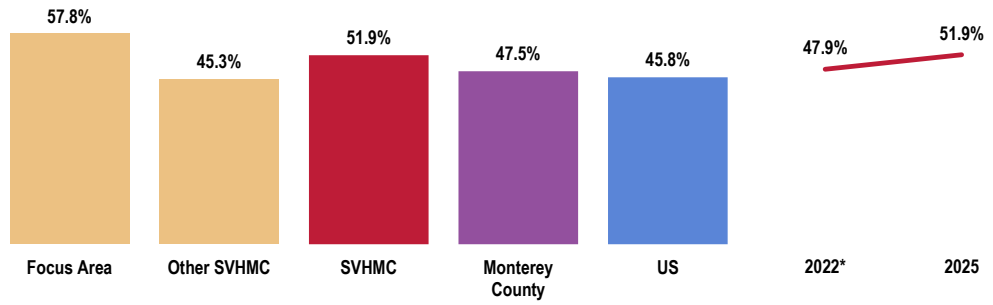
Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 56]

Notes:
- Asked of all respondents.

The following chart further details housing insecurity in the SVHMC Service Area in comparison to benchmark data.

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

SVHMC Service Area



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 56]
- 2023 PRC National Health Survey, PRC, Inc.

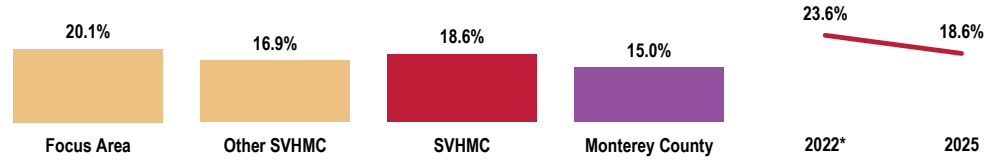
Notes:
- Asked of all respondents.
- *2022 data does not include ZIP Codes 93926 and 93960.

Multigenerational Living

PRC SURVEY ► "Many families live in multigenerational households, which are defined as spanning three or more generations. This may include children, parents and grandparents living together, or it might include extended family or unrelated older adults living with younger adults and their children. Does your household include three or more generations of people living together?"

Household Includes Three or More Generations Living Together

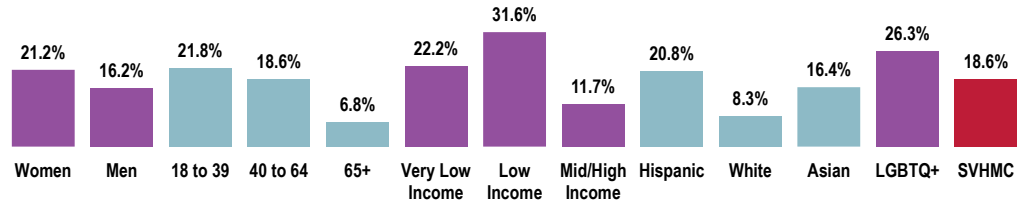
SVHMC Service Area



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 313]

Notes:
- Asked of all respondents.
- May include children, parents, and grandparents living together or may include extended family or unrelated older adults living with younger adults and their children.
- *2022 data does not include ZIP Codes 93926 and 93960.

Household Includes Three or More Generations Living Together
(SVHMC Service Area, 2025)



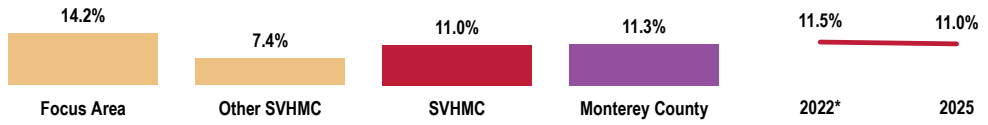
Sources: • 2025 PRC Community Health Survey, PRC, Inc. [Item 313]
Notes: • Asked of all respondents.
• May include children, parents, and grandparents living together or may include extended family or unrelated older adults living with younger adults and their children.

Shared Housing

PRC SURVEY ► "To share housing expenses, do you live with anyone outside your immediate family, such as a roommate or boarder?"

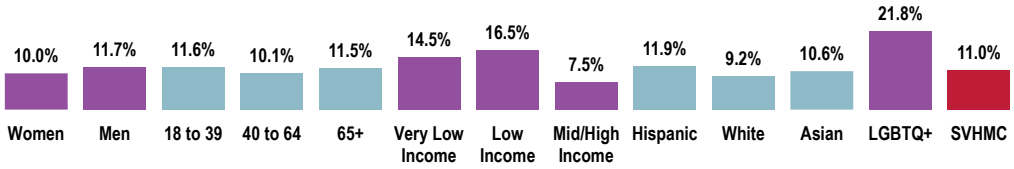
Share Housing Expenses with a Non-Family Member

SVHMC Service Area



Sources: • 2025 PRC Community Health Survey, PRC, Inc. [Item 314]
Notes: • Asked of all respondents.
• Non-family member defined for respondents as anyone outside the respondent's immediate family, such as a roommate or boarder.
• *2022 data does not include ZIP Codes 93926 and 93960.

Share Housing Expenses with a Non-Family Member
(SVHMC Service Area, 2025)



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 314]

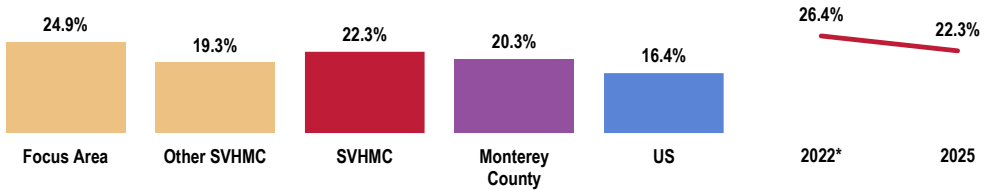
Notes:
- Asked of all respondents.
- Non-family member defined for respondents as anyone outside the respondent's immediate family, such as a roommate or boarder.

Unhealthy or Unsafe Housing

PRC SURVEY ► "Thinking about your current home, over the past 12 months have you experienced ongoing problems with water leaks, rodents, insects, mold, or other housing conditions that might make living there unhealthy or unsafe?"

Unhealthy or Unsafe Housing Conditions in the Past Year

SVHMC Service Area

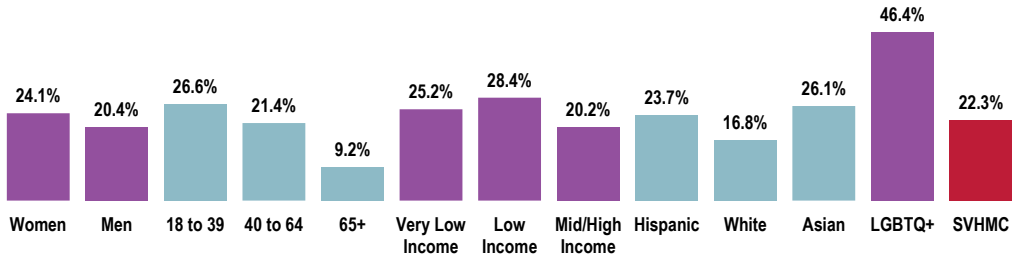


Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 55]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes respondents who say they experienced ongoing problems in their current home with water leaks, rodents, insects, mold, or other housing conditions that might make living there unhealthy or unsafe.
- *2022 data does not include ZIP Codes 93926 and 93960.

Unhealthy or Unsafe Housing Conditions in the Past Year
(SVHMC Service Area, 2025)

Among homeowners	15.0%
Among renters	32.9%



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 55]

Notes:
- Asked of all respondents.
- Includes respondents who say they experienced ongoing problems in their current home with water leaks, rodents, insects, mold, or other housing conditions that might make living there unhealthy or unsafe.

Food Insecurity

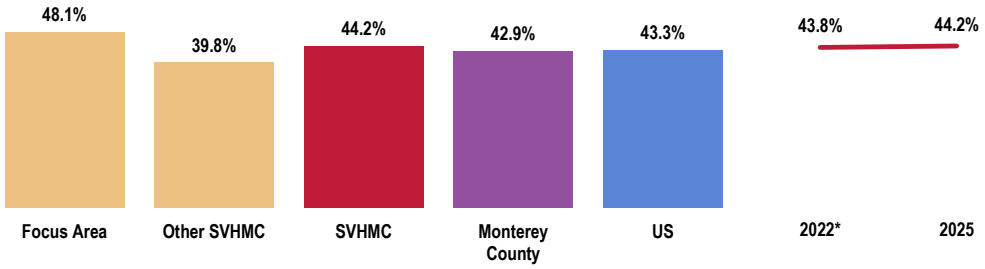
PRC SURVEY ► "Now I am going to read two statements that people have made about their food situation. Please tell me whether each statement was 'often true,' 'sometimes true,' or 'never true' for you in the past 12 months.

- 'I worried about whether our food would run out before we got money to buy more.'
- 'The food that we bought just did not last, and we did not have money to get more.'"

Agreement with either or both of these statements ("often true" or "sometimes true") defines food insecurity for respondents.

Food Insecurity

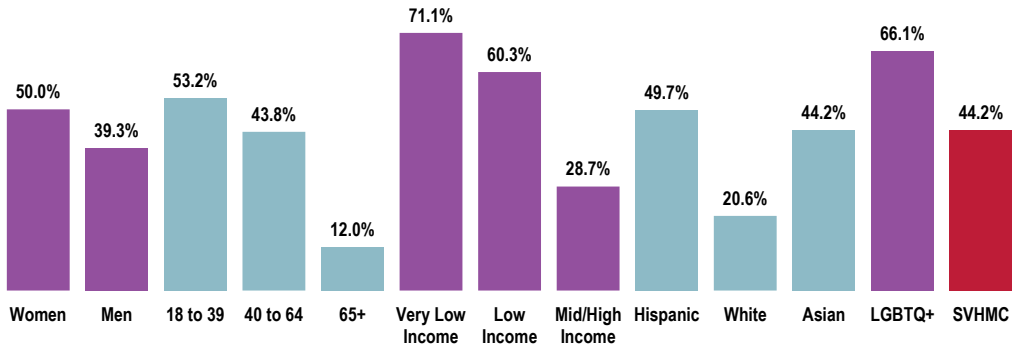
SVHMC Service Area



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 98]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes adults who A) ran out of food at least once in the past year and/or B) worried about running out of food in the past year.
- *2022 data does not include ZIP Codes 93926 and 93960.

Food Insecurity
(SVHMC Service Area, 2025)



Sources: • 2025 PRC Community Health Survey, PRC, Inc. [Item 98]
Notes: • Asked of all respondents.
• Includes adults who A) ran out of food at least once in the past year and/or B) worried about running out of food in the past year.

Health Literacy

PRC SURVEY ► "How often is health information written in a way that is easy for you to understand? Would you say: always; nearly always; sometimes; seldom; or never?"

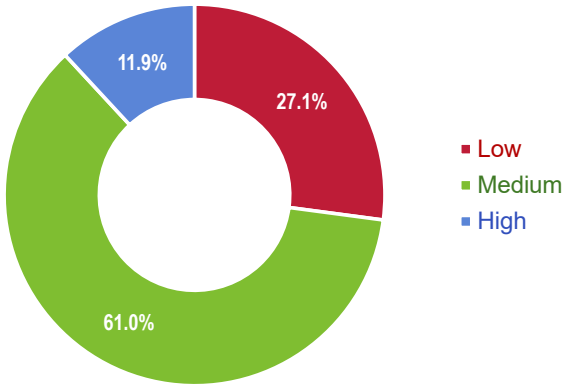
PRC SURVEY ► "How often do you need to have someone help you read health information? Would you say: always; nearly always; sometimes; seldom; or never?"

PRC SURVEY ► "How often is health information spoken in a way that is easy for you to understand? Would you say: always; nearly always; sometimes; seldom; or never?"

PRC SURVEY ► "In general, how confident are you in your ability to fill out health forms yourself? Would you say: extremely confident; somewhat confident; or not at all confident?"

Low health literacy is defined as those respondents who "seldom/never" find written or spoken health information easy to understand, and/or who "always/nearly always" need help reading health information, and who are "not at all confident" in filling out health forms.

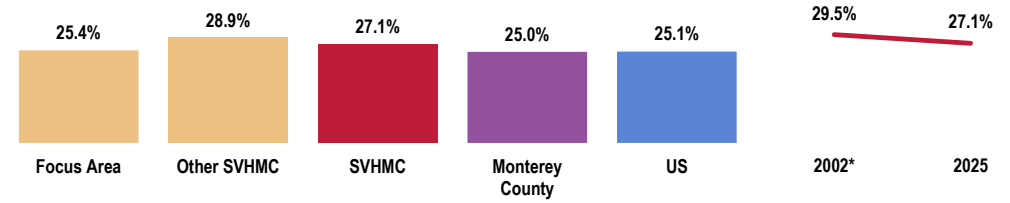
Level of Health Literacy
(SVHMC Service Area, 2025)



Sources: • 2025 PRC Community Health Survey, PRC, Inc. [Item 323]
Notes: • Asked of all respondents.
• Respondents with low health literacy are those who "seldom/never" find written or spoken health information easy to understand, and/or who "always/nearly always" need help reading health information, and/or who are "not at all confident" in filling out health forms.

Low Health Literacy

SVHMC Service Area



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 323]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Respondents with low health literacy are those who "seldom/never" find written or spoken health information easy to understand, and/or who "always/nearly always" need help reading health information, and/or who are "not at all confident" in filling out health forms.
- *2022 data does not include ZIP Codes 93926 and 93960.

Key Informant Input: Social Determinants of Health

The following chart outlines key informants' perceptions of the severity of *Social Determinants of Health* as a problem in the community:

Perceptions of Social Determinants of Health as a Problem in the Community
(Among Key Informants; Monterey County, 2025)

Sources:
- 2025 PRC Online Key Informant Survey, PRC, Inc.

Notes:
- Asked of all respondents.

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

Housing

> Insane house prices and rental fees. — Physician
>
> Affordable housing: affordable transportation is scarce. — Physician
>
> Housing instability drives many health problems. — Social Services Provider
>
> Housing too expensive; income too low; lack of higher education that pay higher salaries. — Social Services Provider
>
> The challenges we face are the lack of affordable housing, lack of affordable health care, fewer higher-paying positions in the county, and the inability of educators to afford housing and health care, which leads to constant teacher and educational staff turnover. — Community Leader Access to housing is limited, period. Demand is greater than supply. The two major sectors in our county are hospitality and agriculture, which pay lower wages. — Public Health Representative
>
> The cost of housing and living in Monterey County is not aligned with the compensation too many residents receive. There are far too many families simply struggling to survive day-to-day. Children suffer from inattention, stress, difficulty getting to school, poor health care, etc. — Community Leader
>
> Affordable housing in Monterey County, along with low wages, cause major problems. Residents have to work long hours just to afford basic needs. — Public Health Representative
>
> Housing is a huge problem. Not enough on the central coast that is affordable. — Health Care Provider

Lack of real affordable housing. Lack of funds to pay for education. The discrepancy between the Peninsula and other parts of the county, especially socioeconomic status. — Social Services Provider

Huge lack of affordable housing, which forces those with lower incomes to not eat healthy, seek preventative medical care, or be able to attend college/pursue higher education. — Social Services Provider

Housing is very expensive, high-wage jobs are not plentiful, education is expensive — all these factors decrease a person's chance to increase economic stability and be healthier. — Social Services Provider

Housing is unaffordable for many people, leading to homelessness, overcrowding, and increased stress for families. Affordable housing has been an issue for many years, getting worse year after year, affecting the mental and physical health of residents. Salinas is one of the most unaffordable cities in California. The gap between the 'haves' and 'have-nots' is widening, affecting access to better schools, healthy food, and opportunities. Public education in much of the county is substandard, and the low socioeconomic areas are most impacted. Underfunded schools leave the most vulnerable kids behind as classroom size grows, programs are outdated, schools pressure parents to not ask for special education services, funding for after-school activities is limited or nonexistent, and there is turnover of teachers. Crime in some areas affects the everyday lives of individuals, adding stress and placing limits on what they feel like they can and cannot do in the neighborhood. Privilege is alive and well here. — Public Health Representative

Even patients with insurance and jobs face difficulty finding affordable housing or are one landlord's death away from homelessness. Poor public health presence/voice after recent Vistra battery fire. Lots of fear about toxic exposure from that with no coherent physician-led response. — Physician

A lack of affordable housing and access to affordable health care increases the likelihood that people will die from preventable illness. It also increases the likelihood and longevity of hospital stays. Many forgo urgent procedures as they do not have adequate after care assistance. — Social Services Provider

King City does a lot of Section 8 for housing, but all of the above questions seem to be a countywide problem, not just for South County. — Community Leader

Cost of housing is the biggest obstacle — cost is so high it impacts the ability to have additional income available for healthy food and physical activity options. — Social Services Provider

Lack of affordable housing in 'safe' areas for low-income families. Under-resourced schools in East Salinas. — Social Services Provider

The cost of living in our community is so high that individuals have to choose between caring for themselves and having a roof over their heads. — Health Care Provider

High cost of housing is out of reach for low- and middle-income families. Discrimination limits opportunities for BIPOC folks. — Community Leader

The cost of housing in our community is out of reach for most residents. Most incomes are close to the poverty level in agricultural jobs. Choosing between healthy food and electricity can be a real choice for many of our residents. Education beyond high school is not attainable to most due to the need to go to work to support the family. — Health Care Provider

The cost of housing forces individuals to work more, which makes a vast majority ineligible for Medi-Cal due to income. — Health Care Provider

Crowded housing causes worse outcomes in the context of communicable diseases (COVID, TB), and substandard housing worsens asthma. Low income is associated with almost all adverse health outcomes. Lack of education impedes self-management of diseases and reduced uptake of preventive care. Pollution and pesticide exposures cause or contribute to a multitude of chronic disease processes. Discrimination and structural racism worsen health outcomes across the board, particularly mental health but also chronic diseases and cancer. — Physician

Income/Poverty

Low wages, high prices of rent result in very little disposable income to eat healthy, access doctors, and address chronic medical issues. If you work in a job that does not allow PTO or time off and impacts your wages which are already limited, then you forego services that are preventative, and then you only go seek help when it is a problem or too late (i.e. diabetic who puts off addressing small ulcer until it spreads and they can no longer work, and eventually gets amputation -- could have been prevented with regular ongoing comprehensive diabetic visits where one stop see doctor, group diet, make sure he/she walks out with meds and supplies they need, maybe a foot exam and or vision, and a coupon for healthy foods and case worker number to call in case any issues, that can be quickly and efficiently resolved). That would be amazing. This is not the reality in most patients' and doctors' experiences, and both sides are frustrated with the current system. — Physician

Tremendous income disparities; limited access to affordable housing; environmental racism in terms of pollution and pesticide exposure; access to healthy affordable food; fear of deportation due to immigration status results in not reaching out for access. — Community Leader

Because of the extreme poverty in Salinas. The community has many sustenance needs. — Physician

This community has a high proportion of families working in low-paying but essential jobs, such as agriculture and hospitality, and a high proportion of families that identify as brown. There are also high rates of diabetes, low educational attainment, etc. It is likely that those are all related. — Social Services Provider

> Poverty has a substantial correlation with life expectations and multiple adverse health outcomes. — Social Services Provider
>
> Low-income, poverty level, migrant families/workers, Spanish-only speaking community members, many people who didn't even finish high school, all the money is in the white agricultural company owners who need the Hispanic community to do all their work. In this political climate, it's a powder keg. — Community Leader
>
> Economics, education access, health care access, neighborhood and built environment, social and community context. — Social Services Provider
>
> Our community still has work to do with respect to social determinants of health. We have members who are still not earning a living wage, others with housing and food insecurity, and educational inequities still exist. While there are significant efforts made by the community, including inclusive economic development efforts, advocacy and youth development programs, there is work to do. — Health Care Provider
>
> Cost of living is very high. Many jobs are seasonal and do not provide steady income. — Health Care Provider
>
> Income and transportation are the largest, as they restrict access to services. — Social Services Provider

Cost of Living

> Being in a rural community where the cost of living is extremely high vs. average income. Many folks have to work long hours to afford to provide for their families. — Community Leader
>
> Cost of living is a huge concern out here, as well as inventory for both buying a house and rentals. The majority of people are not able to afford to live here and become food insecure, homeless, etc. — Physician
>
> Cost of living in Monterey County is very high. — Health Care Provider
>
> Cost of living and housing is very high. — Social Services Provider
>
> The cost of living is exponentially rising, impairing people's ability to cover housing, basic, and health care needs. Lower-income residents often struggle to access higher education and experience inequality and discrimination due to stigma and judgment, which the culmination of these risk factors deter living in and maintaining good health. — Community Leader

Incidence/Prevalence

> SDOHs are a significant health problem in our community. — Physician
>
> 25% of children in this county are growing below the poverty level, and with rising rates of obesity and chronic disease. We have one of the highest proportions of undocumented workers in the state, the great majority of them working in agriculture. Housing is extremely unaffordable, leading to overcrowding (especially in East Salinas). All of these. — Social Services Provider
>
> When it comes to communicable disease, chronic disease, and injuries, the highest rates are among those communities with the worst Healthy Places Index percentiles in Monterey County. — Public Health Representative
>
> North Monterey County is incredibly impacted. — Community Leader

Populations at Risk

> Being undocumented. Uninsured, over-impacted housing, not building on a person's strengths. — Social Services Provider
>
> Monterey County is now over 60% Latino. Low-income Latinos have problems with food insecurity, housing, employment, immigration and legal issues, medical care access, transportation, discrimination, language and cultural barriers. — Community Leader
>
> There are many vulnerable and underserved communities in our county, thinking especially about elderly on fixed income and undocumented families. — Physician
>
> Our community, although diverse, is also a community with many immigrants, undocumented and farm working families that are afraid to seek services due to immigration status. Many of the families are doubled up, multiple families living in a single household due to the high cost of living in our area, which also brings social determinants of health. Many do not have insurance or do not qualify for Medi-Cal. — Community Leader
>
> We have lots of immigrants here with limited resources. They get paid very little, they have to share houses, bedrooms. They have limited access to medical care and are afraid of the government and being deported. — Physician

Affordable Care/Services

> In Monterey County, we have the following determinants of health which negatively impact a large section of our residents. Health care: Has one of the highest health care costs in the state, if not the country. Income: Agriculture and hospitality is the biggest industry in Monterey County, but is also among the lowest-paying industries, which means many of our residents struggle to support themselves and/or their families. Housing: Monthly rent and mortgage payments are extremely high across the county, and although the city of Salinas passed an ordinance to address the high rent, it now appears it is poised to reverse itself. — Community Leader

> Social determinates for health have a direct impact on whether or not an individual can afford to go see a health provider. Many individuals in our community have to choose between paying rent or bills, buying groceries, and seeing the doctor/filling their prescriptions. — Social Services Provider

Access to Care/Services

> It is difficult for patients to take time off to attend appointments. This is why clinics should be open after-hours and on weekends. In addition, accessibility for individuals with disabilities should be looked at to assist them in getting to appointments. Many individuals answer that they have food anxiety, and it's an additional area that the community should be of assistance. — Public Health Representative

> The region of South Monterey County continues to lack access to services and support systems. Median annual household incomes can be under $80,000 and housing costs are significantly higher, $500,000 to $700,000 for a single-family home. Families pay more than 30% of their monthly income toward housing, a mortgage payment or rent. Our area battles with housing overcrowding, and many struggle to own or rent a home due to high costs and annual incomes not being sufficient. Under 10% of the region in South Monterey County has a bachelor's degree or higher. Many students struggle to get into college due to financial impacts, and those able to get scholarships are able to pursue educational goals. However, this is a small percentage of our population. There are limited high-paying jobs in the area. For those working in agricultural and hospitality, the pay is significantly lower. — Community Leader

Lifestyle

> The conditions in which people live their everyday lives determine everything about us.
> — Social Services Provider

> Individuals unable to commit time, energy, or money to physical and mental health care needs when they are with insufficient survival resources. They are also afraid to pursue finding resources when they expect to be told "no" because of race or indigent status. — Physician

Human Trafficking

> Human trafficking. I'm certain this is occurring in multiple industries, and I don't know of any services in place or groups working on this. — Physician

> Human trafficking, ag, and hospitality industry. — Social Services Provider

Basic Needs

> Basic needs are essential to the mental and physical well-being of our residents. A quality education is imperative for positive youth development and a successful future. Acceptance and celebration of people's differences makes for a healthy and rich culture. — Community Leader

Migrant/Seasonal Workers

> Specific health issues linked to migrant and seasonal agricultural workers, ranging from climate exposures and housing needs to work-related health issues. There is a need for urgent and after-hours care for these populations. — Physician

Environmental Contributors

> Because we are an agricultural community, and the conditions of our community sustain the success of the local agricultural industry. — Community Leader

Government/Politics

> Access, especially now with the recent political decisions to depart all immigrants. People are avoiding getting necessary care. — Community Leader

Language Barriers

> Language barriers and cost. The ability of county residents to access due to having to work and not having time to address health issues and preventative health measures. — Community Leader

Systemic

> Systemic work must be addressed to get to the root cause of the symptoms we are addressing.
> — Community Leader

Transportation

> Transportation to services, especially underserved areas like North and South counties, affordable housing, lack of affordable fruits and vegetables. — Community Leader

Awareness/Education

> Lack of awareness. Also, eating healthily is much more expensive than unhealthy options, such as fast food.
> — Community Leader

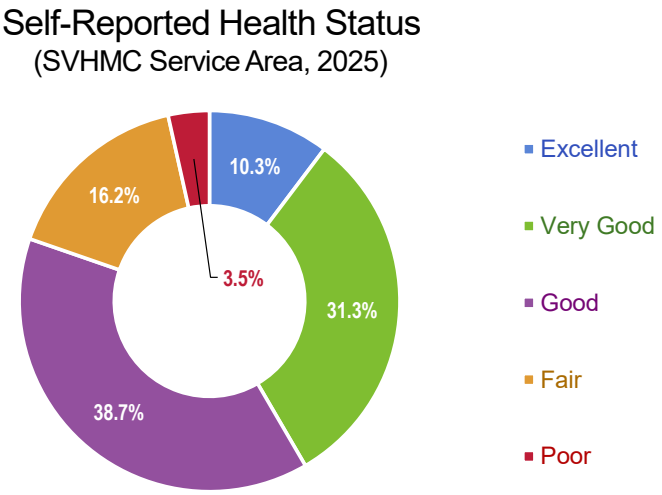
Pesticide Exposure

> Pesticide exposure because of the high percentage of agricultural lands and proximity to housing and schools.
> — Social Services Provider

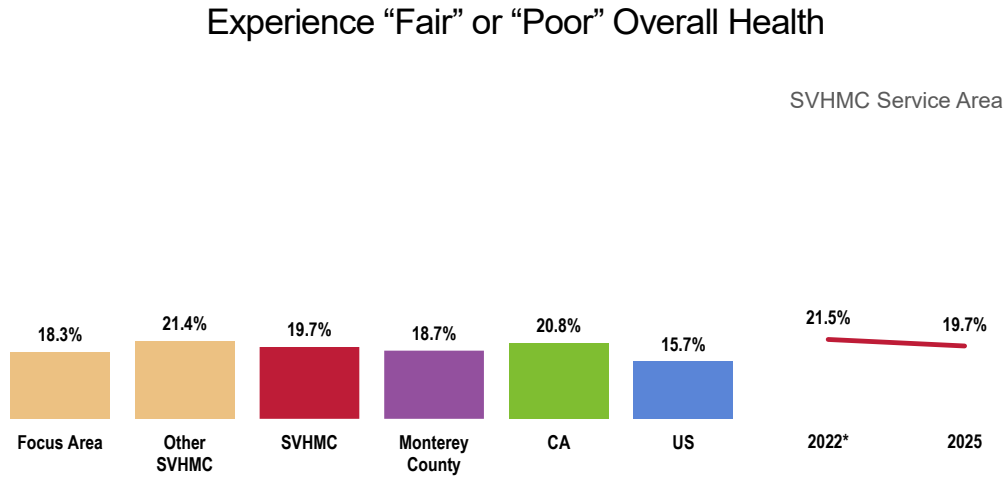
HEALTH STATUS

Overall Health

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

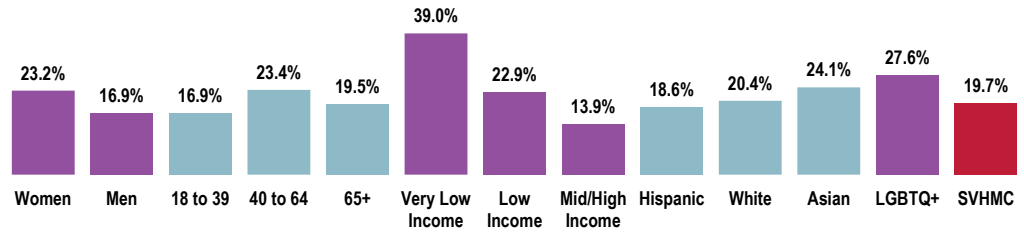


Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 4]
Notes: ● Asked of all respondents.



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 4]
● Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 California data.
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.
● *2022 data does not include ZIP Codes 93926 and 93960.

Experience “Fair” or “Poor” Overall Health
(SVHMC Service Area, 2025)



Sources: • 2025 PRC Community Health Survey, PRC, Inc. [Item 4]
Notes: • Asked of all respondents.

Mental Health

ABOUT MENTAL HEALTH & MENTAL DISORDERS

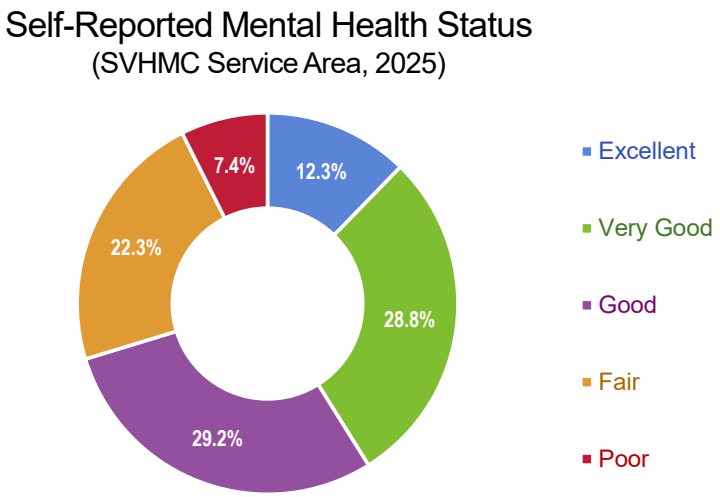
About half of all people in the United States will be diagnosed with a mental disorder at some point in their lifetime. …Mental disorders affect people of all age and racial/ethnic groups, but some populations are disproportionately affected. And estimates suggest that only half of all people with mental disorders get the treatment they need.

In addition, mental health and physical health are closely connected. Mental disorders like depression and anxiety can affect people's ability to take part in healthy behaviors. Similarly, physical health problems can make it harder for people to get treatment for mental disorders. Increasing screening for mental disorders can help people get the treatment they need.

– Healthy People 2030 (https://health.gov/healthypeople)

Mental Health Status

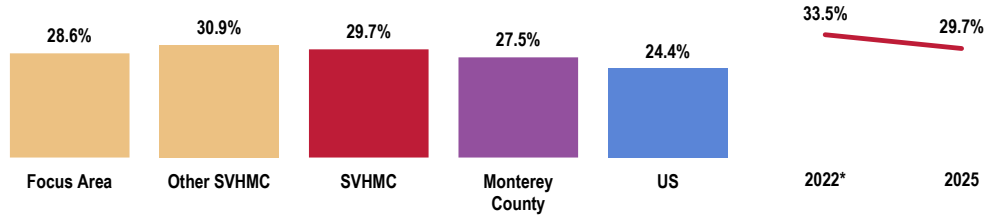
PRC SURVEY ► "Now thinking about your mental health, which includes stress, depression, and problems with emotions, would you say that, in general, your mental health is: excellent, very good, good, fair, or poor?"



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 77]
Notes: ● Asked of all respondents.

Experience “Fair” or “Poor” Mental Health

SVHMC Service Area



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 77]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- *2022 data does not include ZIP Codes 93926 and 93960.

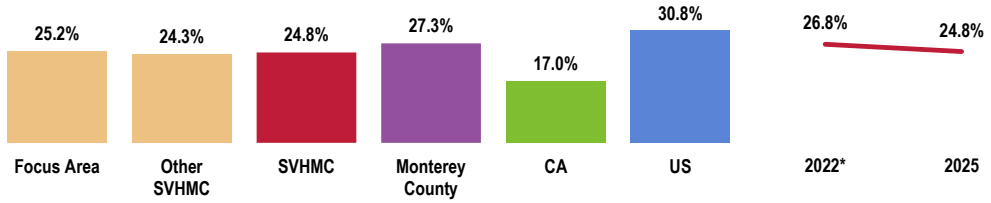
Depression

Diagnosed Depression

PRC SURVEY ► “Has a doctor, nurse, or other health professional ever told you that you have a depressive disorder, including depression, major depression, dysthymia, or minor depression?”

Have Been Diagnosed With a Depressive Disorder

SVHMC Service Area



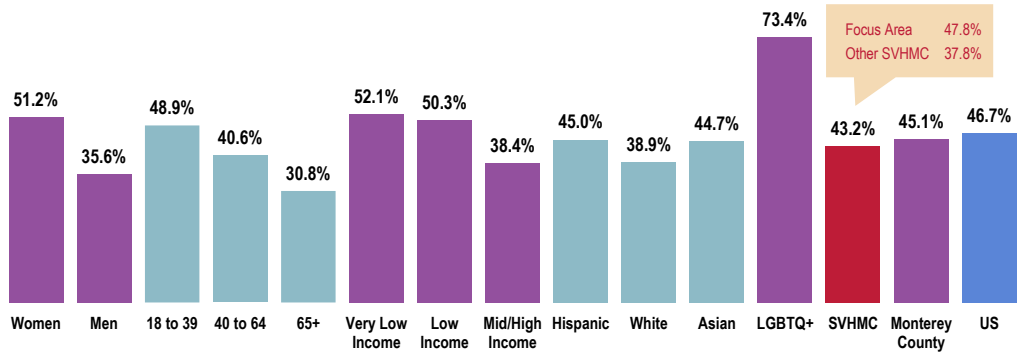
Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 80]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 California data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Depressive disorders include depression, major depression, dysthymia, or minor depression.
- *2022 data does not include ZIP Codes 93926 and 93960.

Symptoms of Chronic Depression

PRC SURVEY ► "Have you had two years or more in your life when you felt depressed or sad most days, even if you felt okay sometimes?"

Have Experienced Symptoms of Chronic Depression
(SVHMC Service Area, 2025)



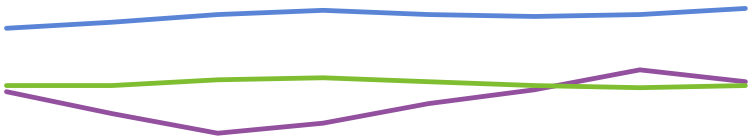
Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 78]
- 2023 PRC National Health Survey, PRC, Inc.

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

Suicide

The following chart outlines the most current mortality rates attributed to suicide in our population. [COUNTY-LEVEL DATA]

Suicide Mortality Trends
(Annual Average Deaths per 100,000 Population)
Healthy People 2030 = 12.8 or Lower



	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
Monterey County	10.5	9.4	8.4	8.9	9.9	10.6	11.6	11.0
CA	10.8	10.8	11.1	11.2	11.0	10.8	10.7	10.8
US	13.7	14.0	14.4	14.6	14.4	14.3	14.4	14.7

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2025.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

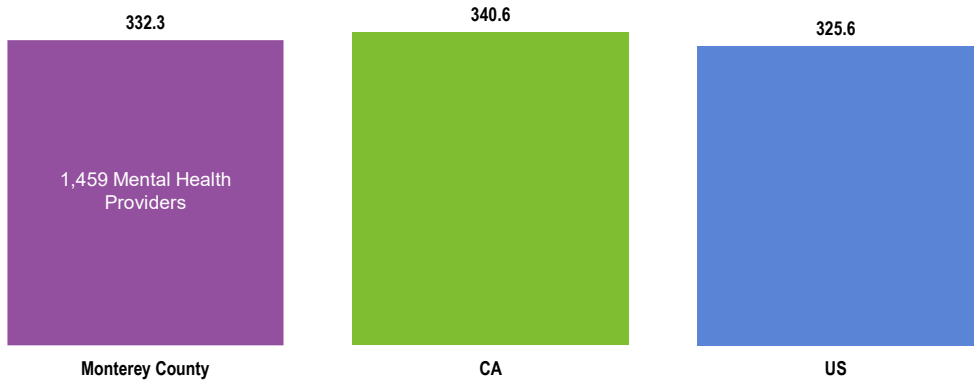
Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.

Mental Health Treatment

Note that this indicator only reflects providers practicing within the study area and residents within the study area; it does not account for the potential demand for services from outside the area, nor the potential availability of providers in surrounding areas.

The following chart outlines access to mental health providers, expressed as the number of providers (psychiatrists, psychologists, clinical social workers, and counselors who specialize in mental health care) per 100,000 residents. [COUNTY-LEVEL DATA]

Number of Mental Health Providers per 100,000 Population
(July 2025)



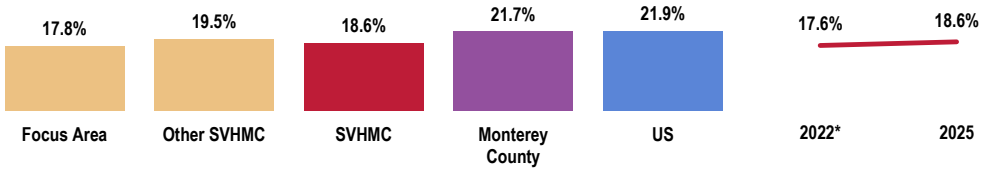
Sources:
- Centers for Medicare and Medicaid Services, National Plan and Provider Enumeration System (NPPES).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved July 2025 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the rate of the county population to the number of mental health providers including psychiatrists, psychologists, clinical social workers, and counselors that specialize in mental health care.

PRC SURVEY ► "Are you now taking medication or receiving treatment from a doctor, nurse, or other health professional for any type of mental health condition or emotional problem?"

Currently Receiving Mental Health Treatment

SVHMC Service Area

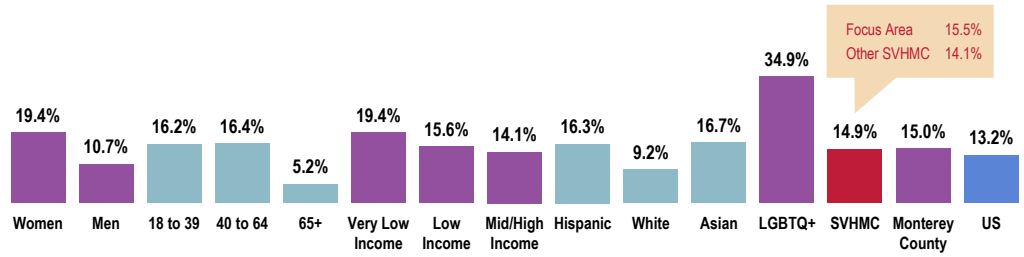


Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 81]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes those now taking medication or otherwise receiving treatment for any type of mental health condition or emotional problem.
- *2022 data does not include ZIP Codes 93926 and 93960.

PRC SURVEY ► "Was there a time in the past 12 months when you needed mental health services but were not able to get them?"

Unable to Get Mental Health Services When Needed in the Past Year
(SVHMC Service Area, 2025)

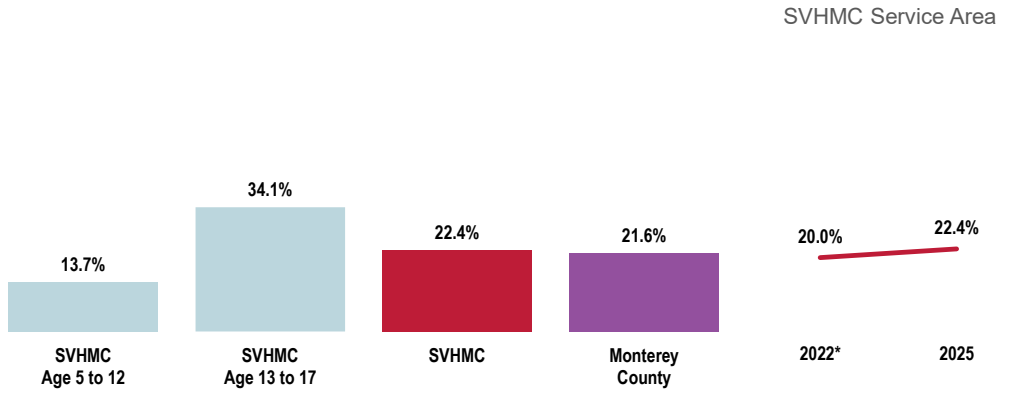


Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 82]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Children's Mental Health

PRC SURVEY ► [Among parents of children age 5-17] "Has this child needed mental health services in the past year?"

Child Has Needed Mental Health Services in the Past Year
(Parents of Children Age 5-17, 2025)

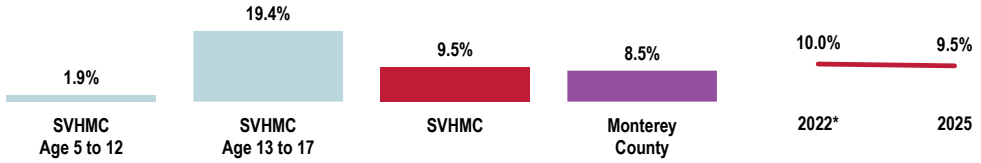


Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 320]
Notes: ● Asked of all respondents with children age 5 through 17.
● *2022 data does not include ZIP Codes 93926 and 93960.

PRC SURVEY ► [Among parents of children age 5-17] **"Has this child ever taken prescribed medications to treat his or her mental health?"**

Child Has Taken Prescription Medication for Mental Health in the Past Year
(Parents of Children Age 5-17, 2025)

SVHMC Service Area

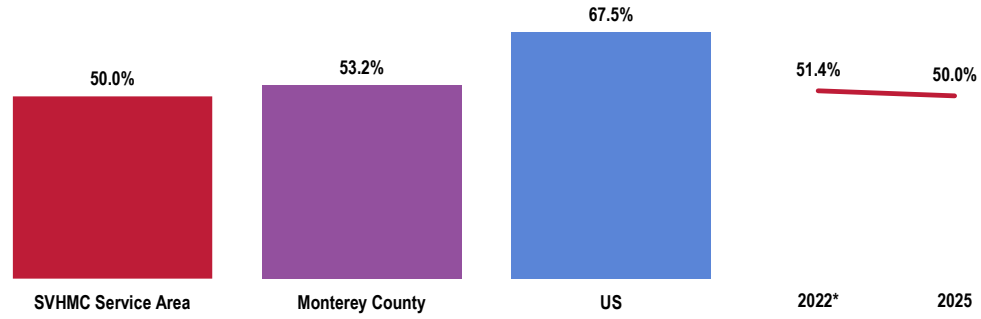


Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 321]
Notes: ● Asked of all respondents with children age 5 through 17.
● *2022 data does not include ZIP Codes 93926 and 93960.

PRC SURVEY ► [Among parents of children age 5-17] **"Are you aware of the resources in the community for mental health of children?"**

Aware of Mental Health Resources for Children
(Parents of Children Age 5-17, 2025)

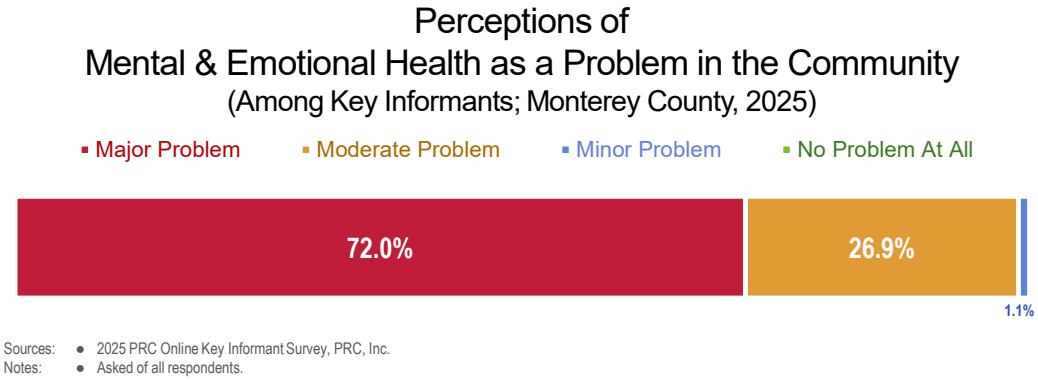
SVHMC Service Area



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 322]
● 2023 PRC National Child & Adolescent Health Survey, PRC, Inc.
Notes: ● Asked of all respondents with children age 5 through 17.
● *2022 data does not include ZIP Codes 93926 and 93960.

Key Informant Input: Mental Health

The following chart outlines key informants' perceptions of the severity of *Mental Health* as a problem in the community:



Sources: • 2025 PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

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

Access to Care/Services

> Access to mental health services. — Community Leader
>
> Accessing care from psychiatrists (accurate diagnosis for more involved presentations and for ongoing therapy, especially in a person getting neuropsychic testing for anyone). Expensive and not paid for easily, though can offer immense information to patients in making treatment or capacity decisions. Poor support for people with dual diagnoses — inpatient or outpatient. — Physician
>
> People find it difficult to navigate the process of getting connected to services due to complications applying/filling out documents, as well as delayed entry due to intake being scheduled for weeks or months after initial application. People may not have health insurance or necessary health insurance to access services to meet their mental health needs. Often, due to functionality challenges, people require a peer support person to keep them accountable to participating in mental health services but may not have anyone in their lives available to meet this role. — Community Leader
>
> Access to mental health care, especially for individuals who do not have health insurance. — Health Care Provider
>
> Lack of wraparound referrals and service providers to connect and empower those with mental health needs. — Social Services Provider
>
> Lack of access to treatment and housing. — Physician
>
> Access to services that do not result in incarceration and fear of deportation due to immigration status result in not reaching out for access. — Community Leader
>
> Accessibility, transportation, cost, stigma and lack of knowledge of resources. — Social Services Provider
>
> Not enough resources for our community in need of mental health services. County workers not trained sufficiently to work with elderly population with chronic mental health issues. Not enough resources or support for dual-diagnosis residents unhoused in the community. Inability to connect with unhoused residents with chronic mental health issues. — Social Services Provider
>
> A lack of resources and staffing for the entire continuum of care, ranging from prevention and mild to moderate to specialty mental health services. — Physician
>
> Access and outreach. — Physician
>
> Access to in-person services. — Community Leader
>
> Perceived access issues. Lack of insight and/or motivation, direct result of illness by victims to seek help. Differentiating homelessness or houselessness from mental illness. — Physician
>
> There aren't enough resources available to the people that have referrals, and the department of behavioral health is overwhelmed with people on public assistance. In order to get a therapist or a psychiatrist to assist you, you have to go to Salinas, where there are tons of providers. Not only that, it feels like everyone working in any of these departments or offices in the community are short with people. People are already ashamed to need mental health assistance oftentimes, so when their experience is overwhelming and causes more anxiety, it's counterproductive. — Community Leader
>
> Lack of availability and access to mental health care services, like therapists and counselors. — Social Services Provider
>
> Access to care and to social support that would decrease the severity of symptoms and relapse. — Physician

> Access to care. — Community Leader
>
> Access. — Social Services Provider
>
> Access to services. — Social Services Provider
>
> Access to care. — Health Care Provider
>
> Long wait times, limited psychiatrists and therapists, and even more limitation in Spanish and nonexistent in indigenous languages. Extreme limitations for Spanish- or any non-English speaking patients with health insurance in the county. — Physician
>
> Access to care. I'm a primary care physician and I can't get patients in to counseling. Very long waits. Loneliness/isolation/lack of social support. Psychological or physical abuse. Substance use disorders very prevalent. — Physician
>
> Access and follow-up. — Physician
>
> Inpatient acute beds and substance use treatment. — Physician
>
> One of the biggest challenges for people with mental health issues in our community is the lack of accessible, affordable, and culturally competent mental health services. There's also a strong stigma around mental health in many households, especially in Latino communities, where talking about emotions or seeking help can be seen as weakness. This keeps people from reaching out until they're in crisis. Schools and workplaces aren't always equipped with the resources to catch early warning signs or provide ongoing support. — Social Services Provider

Denial/Stigma

> There is still a stigma about mental health. There's a lack of facilities, programs, and services to address mental health issues. — Social Services Provider
>
> Many times, in communities that are predominantly Latino, there is still a stigma about mental health, and people do not seek treatment or discussion. More awareness is needed in spaces where people feel safe and information is provided in a culturally sensitive manner. The diagnosis of mental health is challenging, as many people do not seek therapy, medication, or treatment. Mental health services can be costly if you don't have health insurance. Families struggling financially struggle with high costs of medications and opt to not take if offered as part the mental health treatment. Finding quality mental health services is also a challenge, as many of the offices are located outside of South County or in Monterey, and transportation remains a barrier for families. — Community Leader
>
> The biggest challenge is accepting they need help and then finding the right resources to help.
> — Social Services Provider
>
> Acknowledging that there is a problem, reaching out for help, and finding help once they do reach out. So many mental health professionals have gone to video meets instead of in-person, and I do not agree that this is as accurate, and when there is an emergency, those doctors cannot be reached and are not local.
> — Social Services Provider
>
> Stigma and challenges of understanding the system. — Social Services Provider
>
> Stigma and discrimination, access to care, lack of support, co-occurring issues, and workplace challenges.
> — Social Services Provider

Lack of Providers

> Access to providers, chronic financial stress, dysfunctional family systems, governmental policies.
> — Social Services Provider
>
> Lack of access. People with mental health disorders are not easily seen in clinics. — Physician
>
> Lack of access to psychiatrists and psychologists in the community. — Physician
>
> No therapists available. — Physician
>
> Access to specialists and stigma. — Physician
>
> Low access to mental health providers. Need more access in our community. — Community Leader
>
> Not enough psychiatrists, inpatient/acute care beds, follow-up services, or affordable mental health services.
> — Social Services Provider
>
> A lack of affordable and easily accessible providers. — Social Services Provider
>
> Very hard to get licensed providers. There is a shortage of psychiatrists in the valley, and it's very hard to bring them to the county due of the cost of living. — Social Services Provider
>
> There is a relatively low number of behavioral health providers, amplified by reduced visibility as to who they are.
> — Community Leader

Affordable Care/Services

> Access to affordable mental health services. — Community Leader

> Access to affordable care. It is incredibly hard to find providers. It is actually worse if you are not eligible for Medi-Cal and don't have the disposable income for services, even if you can find them. Schools are not equipped to provide services to students with mental health issues. There is a stigma around mental health issues. — Public Health Representative
>
> Fear of cost associated with therapy services. — Community Leader
>
> Again, cost for receiving services, especially on a regular basis. There are a few low-cost mental health providers; however, the barrier for entry is still quite high. — Social Services Provider

Incidence/Prevalence

> I believe that the percentage of people with mental health issues, stress, depression, and anxiety are on the rise. — Community Leader
>
> More and more people are suffering from mental health issues. — Health Care Provider
>
> Societally, there seems to be an increase in mental health issues, and Monterey County is no different. Additionally, access to mental health specialists is challenging for our community. — Health Care Provider
>
> Many people right now are experiencing anxiety, depression, and suicidal ideation. We also have a huge number of individuals who are addicted to opioids or other substances, and many of these individuals are homeless due to their drug addiction behaviors. We see more and more homeless individuals in our county and across the state. While not all homeless individuals are experiencing mental health challenges, many are. — Community Leader
>
> Depression among the youth. — Community Leader

Homelessness

> Homelessness is prevalent in all areas of the county. The conditions lead to mental health issues that, I believe, are not being addressed due to lack of resources and empathy/concern for this particular population. Also, mental health among our youth. — Social Services Provider
>
> Homeless encampments are rampant and full of people with mental health issues. Drug abuse and alcohol. — Community Leader

Access to Care for Uninsured/Underinsured

> Access to mental health care, especially for individuals who do not have health insurance. — Health Care Provider

Co-Occurrences

> Chemical dependency, unhoused individuals, and overall stressors, especially for young adults and teens. — Community Leader
>
> Anxiety and its effects on depression, substance abuse, etc. — Social Services Provider

LGBTQ+ Population

> LGBTQ+ community members continue to face active discrimination and hostility for simply being who they are. For LGBTQ+ community members with mental health issues, it is really challenging to find gender-affirming and culturally sensitive mental health providers. — Community Leader

Youth

> Children are getting screened for depression, anxiety, autism, and delay. Health care providers trying to refer children with suspected mental health issues struggle to get responses from behavioral health providers. When there is a response, they are told there are no services, or if there are, the wait time is months. — Public Health Representative

Trauma

> So many youth and families dealing with trauma. Abuse, eviction, undocumented, abandonment, parents in prison, living 10 to 12 in a house , families sleeping in the same bedroom, consistent moving, alcohol, and weed. Lack of financial resources. — Social Services Provider

Language Barriers

> South County lacks necessary MHU bilingual clinicians that accept Medi-Cal. This causes a great barrier to accessing necessary care. — Public Health Representative

Prevention/Screenings

> We do have Sun Street, but it is for active drug and alcohol abuse. It would be great to have counselors who could catch the problem before it exacerbates. — Community Leader

Due to COVID-19

> Post-COVID and overexposure to social media that has conditioned a population to unhealthy, violent, degrading, and culturally deficient engagement. — Community Leader

Income/Poverty

> Socioeconomic status, unmet needs, current federal policy changes, and lack of access to mental health services. — Public Health Representative

Lack of Culturally Appropriate Services

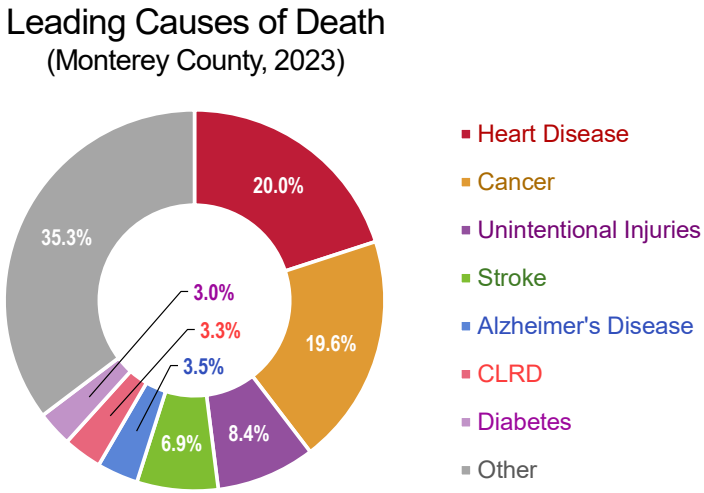
> Lack of culturally appropriate services/support. — Social Services Provider

DEATH, DISEASE & CHRONIC CONDITIONS

Leading Causes of Death

Distribution of Deaths by Cause

The following outlines leading causes of death in the community. [COUNTY-LEVEL DATA]



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2025.

Notes:
- Lung disease includes deaths classified as chronic lower respiratory disease.

Death Rates for Selected Causes

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

Here, deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10). Rates are per 100,000 population.

The following chart outlines annual average death rates per 100,000 population for selected causes of death. [COUNTY-LEVEL DATA]

Death Rates for Selected Causes
(2021-2023 Deaths per 100,000 Population)

	Monterey County	California	US	Healthy People 2030
Cancers (Malignant Neoplasms)	134.8	153.5	182.5	122.7
Heart Disease	126.8	168.0	209.5	127.4*
Unintentional Injuries	50.8	53.8	67.8	43.2
Stroke (Cerebrovascular Disease)	42.5	46.9	49.3	33.4
Alzheimer's Disease	26.8	43.5	35.8	—
Lung Disease (Chronic Lower Respiratory Disease)	24.8	30.2	43.5	—
Unintentional Drug-Induced Deaths	22.9	26.6	29.7	—
Diabetes	18.2	29.4	30.5	—
Alcohol-Induced Deaths	15.3	17.7	15.7	—
Kidney Disease	14.7	12.4	16.9	—
Motor Vehicle Deaths	13.0	12.3	13.3	10.1
Suicide	11.0	10.8	14.7	12.8
Pneumonia/Influenza	7.3	12.8	13.4	—
Homicide	6.4	6.0	7.6	5.5

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2025.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople.

Note:
- *The Healthy People 2030 coronary heart disease target is adjusted here to account for all diseases of the heart.
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.

Cardiovascular Disease

ABOUT HEART DISEASE & STROKE

Heart disease is the leading cause of death in the United States, and stroke is the fifth leading cause. …Heart disease and stroke can result in poor quality of life, disability, and death. Though both diseases are common, they can often be prevented by controlling risk factors like high blood pressure and high cholesterol through treatment.

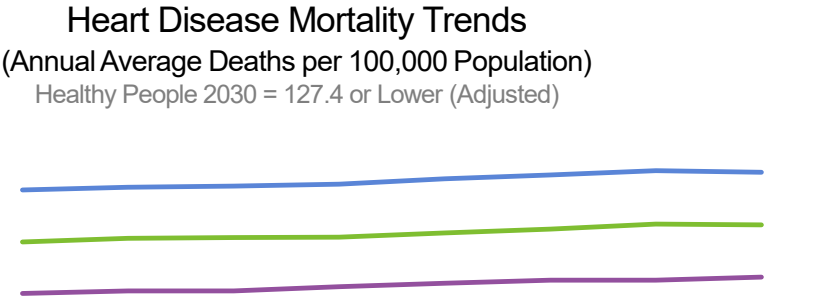
In addition, making sure people who experience a cardiovascular emergency — like stroke, heart attack, or cardiac arrest — get timely recommended treatment can reduce their risk for long-term disability and death. Teaching people to recognize symptoms is key to helping more people get the treatment they need.

– Healthy People 2030 (https://health.gov/healthypeople)

Heart Disease & Stroke Deaths

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

The following charts outline mortality rates for heart disease and for stroke in our community. [COUNTY-LEVEL DATA]



	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
Monterey County	113.9	115.8	115.8	119.3	121.9	124.3	124.3	126.8
CA	154.5	157.4	157.9	158.3	161.7	164.6	168.6	168.0
US	195.5	197.5	198.6	200.0	204.2	207.3	210.7	209.5

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2025.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- The Healthy People 2030 coronary heart disease target is adjusted here to account for all diseases of the heart.
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.

Stroke Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 33.4 or Lower

	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
Monterey County	34.1	33.7	34.6	34.6	38.3	41.2	41.6	42.5
CA	37.9	39.9	41.0	41.9	43.2	45.0	46.5	46.9
US	43.1	44.2	44.7	45.3	46.5	47.8	49.1	49.3

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2025.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

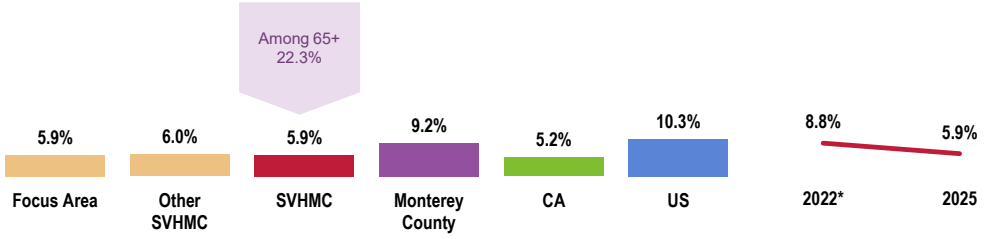
Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.

Prevalence of Heart Disease & Stroke

PRC SURVEY ► "Have you ever suffered from or been diagnosed with heart disease, including heart attack or myocardial infarction, angina, or coronary heart disease?"

Prevalence of Heart Disease

SVHMC Service Area



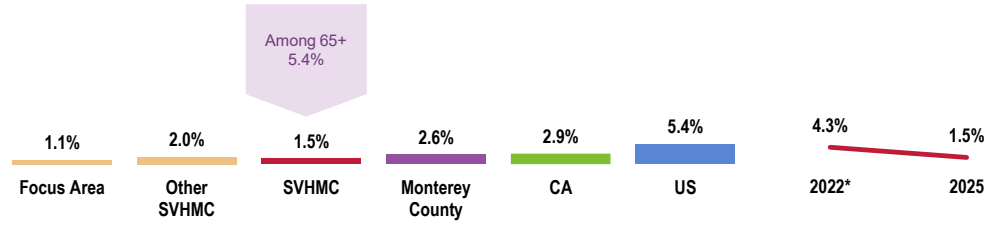
Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 22]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 California data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes diagnoses of heart attack, angina, or coronary heart disease.
- *2022 data does not include ZIP Codes 93926 and 93960.

PRC SURVEY ► "Have you ever suffered from or been diagnosed with a stroke?"

Prevalence of Stroke

SVHMC Service Area



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 23]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 California data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- *2022 data does not include ZIP Codes 93926 and 93960.

Cardiovascular Risk Factors

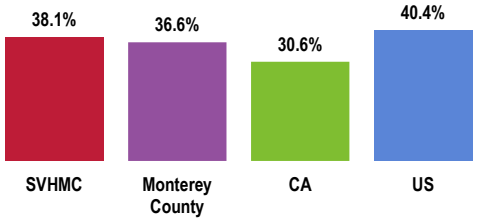
Blood Pressure & Cholesterol

PRC SURVEY ► "Have you ever been told by a doctor, nurse, or other health care professional that you had high blood pressure?"

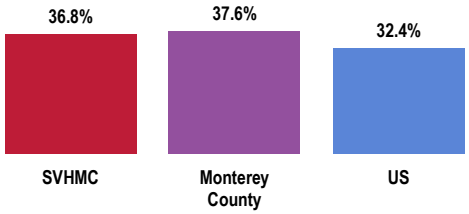
PRC SURVEY ► "Blood cholesterol is a fatty substance found in the blood. Have you ever been told by a doctor, nurse, or other health care professional that your blood cholesterol is high?"

Prevalence of High Blood Pressure

Healthy People 2030 = 42.6% or Lower

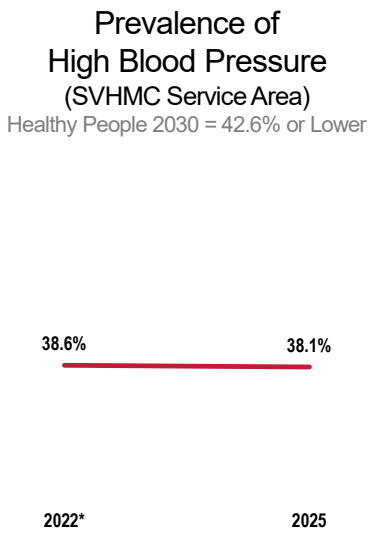


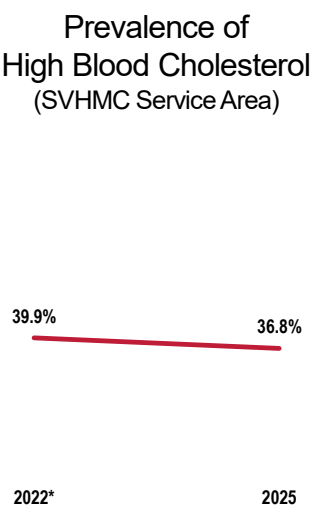
Prevalence of High Blood Cholesterol



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Items 29-30]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 California data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Asked of all respondents.

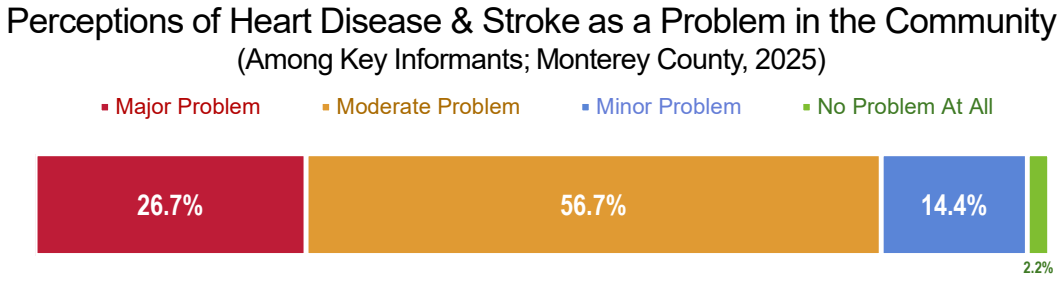




Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Items 29-30]
● US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople
Notes: ● Asked of all respondents.
● *2022 data does not include ZIP Codes 93926 and 93960.

Key Informant Input: Heart Disease & Stroke

The following chart outlines key informants' perceptions of the severity of *Heart Disease & Stroke* as a problem in the community:



Sources: ● 2025 PRC Online Key Informant Survey, PRC, Inc.
Notes: ● Asked of all respondents.

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

Incidence/Prevalence

> Based on personal experience and cases of people that I know and serve. — Community Leader
>
> High incidence. — Physician
>
> Incidence is high. — Community Leader
>
> Heart disease is prevalent everywhere. — Social Services Provider
>
> This is a major problem everywhere. — Physician
>
> Higher incidence rates with our ethnic population of Latinos and Asians. Fear of deportation due to immigration status results in not reaching out for access. — Community Leader
>
> Sadly, it continues to be one of the leading causes of death in Monterey County. Uncontrolled diabetes and hypertension are leading causes of heart disease and stroke. — Public Health Representative
>
> High prevalence of diabetes and HTN with poor access to care, so uncontrolled DM and HTN lead to vascular disease. — Physician
>
> I understand that statistics show widespread incidence of heart disease and stroke in Monterey County. I believe generally that our population is less healthy than it should be. — Community Leader

> More and more of my peers, associates, and people I am in contact with are being treated for heart issues (I am in the 60-plus demographic.) I've been surprised at an increase of younger people (under 50) who have had heart attacks. Having a cardiologist is as common as having a primary care doctor. The good news is that treatments are helping and allowing people to live longer and healthier lives. (That is, if they get treatment!) — Social Services Provider

Access to Care/Services

> Misappropriation of efforts and resources to clinical conditions that may not carry as much of a risk as cardiovascular disease. Education, aging population, stressors that get in the way of healthy living. — Physician
>
> Lack of regular preventive doctor visits due to lack of insurance coverage, high medical care costs, healthy lifestyle principles, high stress levels, basic needs are not met, an impediment on the focus of overall health. — Community Leader
>
> Again, there is a lack of resources and education on health and nutrition. — Community Leader
>
> Patients' access to primary care. Patients understanding their risk and access to medications. — Health Care Provider

Lifestyle

> A lot of patients with poor health choices and diseases. Coronary artery disease is a huge problem here. — Physician
>
> Diet and exercise. Individuals are not taking action to improve themselves and feel they don't have the resources or income to do so. — Social Services Provider
>
> Overweight, no exercise, no education, and no cardiologist in this town. — Community Leader

Aging Population

> Monterey County has a large elderly population and obesity. — Social Services Provider
>
> There are parts of this county that have a larger population of seniors. Aging populations are often associated with heart disease and stroke. The number of obese individuals and those with undiagnosed type 2 diabetes in this county are a risk factor for additional heart disease and stroke. — Public Health Representative
>
> Retirement and elderly community. — Health Care Provider

Access to Affordable Healthy Food

> Access to healthy foods and health care are still issues for community members, and based on data, obesity is a major issue in our community, which can impact heart disease and stroke. Compared to other California counties, Monterey County has a higher rate of adults who are overweight or obese. The county also has a higher rate of adults with heart disease compared to other counties and has more adults taking high blood pressure medications than the state average. — Health Care Provider

Awareness/Education

> Due to lack of education and access to healthier living to include nutrition and exercise. — Social Services Provider

Diagnosis/Treatment

> Heart disease is a silent killer/disease. Many of us don't realize we have it. — Social Services Provider

Leading Cause of Death

> Top killers, and higher risk for low-income families. — Social Services Provider

Cancer

ABOUT CANCER

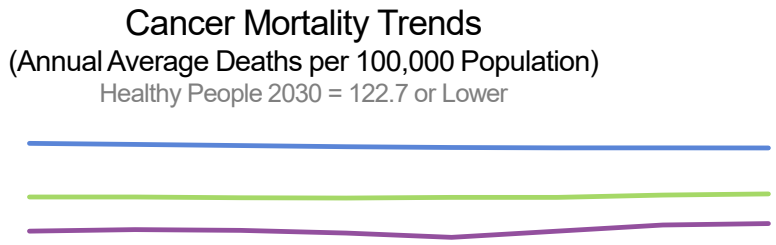
Cancer is the second leading cause of death in the United States. …The cancer death rate has declined in recent decades, but over 600,000 people still die from cancer each year in the United States. Death rates are higher for some cancers and in some racial/ethnic minority groups. These disparities are often linked to social determinants of health, including education, economic status, and access to health care.

Interventions to promote evidence-based cancer screenings — such as screenings for lung, breast, cervical, and colorectal cancer — can help reduce cancer deaths. Other effective prevention strategies include programs that increase HPV vaccine use, prevent tobacco use and promote quitting, and promote healthy eating and physical activity. In addition, effective targeted therapies and personalized treatment are key to helping people with cancer live longer.

– Healthy People 2030 (https://health.gov/healthypeople)

Cancer Deaths

The following chart illustrates cancer mortality (all types). [COUNTY-LEVEL DATA]



	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
Monterey County	130.1	131.1	130.4	128.9	126.1	129.9	133.8	134.8
CA	151.5	151.5	151.2	150.9	151.3	151.3	152.8	153.5
US	185.4	184.8	184.1	183.3	182.9	182.6	182.6	182.5

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2025.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

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

The following outlines death rates for leading cancer sites. [COUNTY-LEVEL DATA]

Cancer Death Rates by Site
(2021-2023 Annual Average Deaths per 100,000 Population)

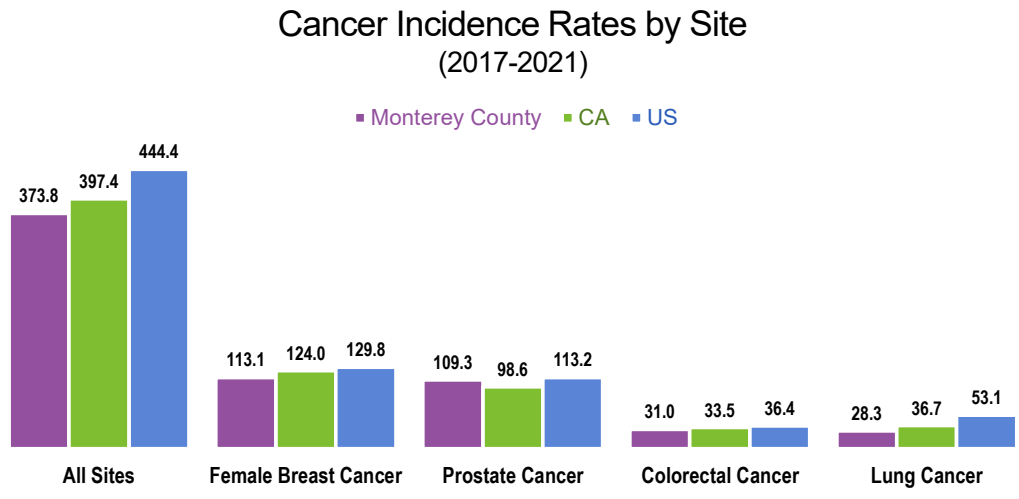
	Monterey County	CA	US	Healthy People 2030
ALL CANCERS	134.8	153.5	182.5	122.7
Female Breast Cancer	22.1	23.3	25.1	15.3
Lung Cancer	21.2	26.0	39.8	25.1
Prostate Cancer	18.4	19.9	20.1	16.9
Colorectal Cancer	10.6	14.3	16.3	8.9

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2025.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

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

Cancer Incidence

"Incidence rate" or "case rate" is the number of newly diagnosed cases in a given population in a given year, regardless of outcome. It is usually expressed as cases per 100,000 population per year. [COUNTY-LEVEL DATA]



Sources:
- State Cancer Profiles.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved July 2025 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the incidence rate (cases per 100,000 population per year) for select cancers.

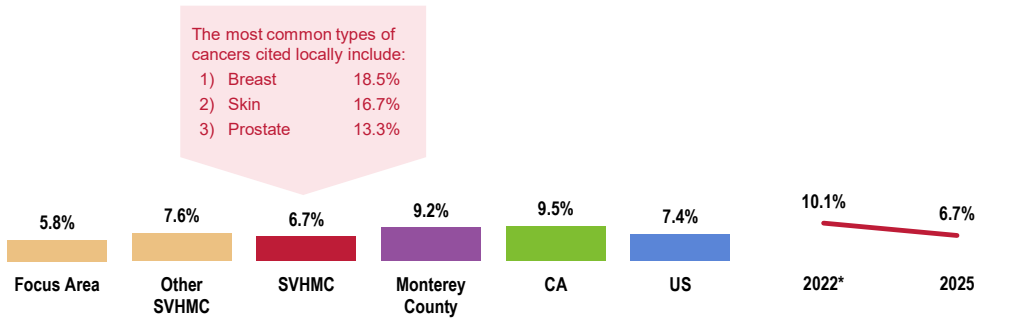
Prevalence of Cancer

PRC SURVEY ► "Have you ever suffered from or been diagnosed with cancer?"

PRC SURVEY ► "Which type of cancer were you diagnosed with?" (If more than one past diagnosis, respondent was asked about the most recent.)

Prevalence of Cancer

SVHMC Service Area



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Items 24-25]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 California data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- *2022 data does not include ZIP Codes 93926 and 93960.

Cancer Screenings

FEMALE BREAST CANCER

The US Preventive Services Task Force (USPSTF) recommends biennial screening mammography for women age 40 to 74 years.

CERVICAL CANCER

The US Preventive Services Task Force (USPSTF) recommends screening for cervical cancer every 3 years with cervical cytology alone in women age 21 to 29 years. For women age 30 to 65 years, the USPSTF recommends screening every 3 years with cervical cytology alone, every 5 years with high-risk human papillomavirus (hrHPV) testing alone, or every 5 years with hrHPV testing in combination with cytology (cotesting). The USPSTF recommends against screening for cervical cancer in women who have had a hysterectomy with removal of the cervix and do not have a history of a high-grade precancerous lesion (i.e., cervical intraepithelial neoplasia [CIN] grade 2 or 3) or cervical cancer.

COLORECTAL CANCER

The US Preventive Services Task Force (USPSTF) recommends screening for colorectal cancer starting at age 45 years and continuing until age 75 years.

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

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

Screening levels in the community were measured in the PRC Community Health Survey relative to the following cancer sites:

Breast Cancer Screening

PRC SURVEY ► "A mammogram is an x-ray of each breast to look for cancer. How long has it been since you had your last mammogram?"

Breast cancer screening is calculated here among women age 40 to 74 who indicate mammography within the past 2 years.

Cervical Cancer Screening

PRC SURVEY ► "A Pap test is a test for cancer of the cervix. How long has it been since you had your last Pap test?"

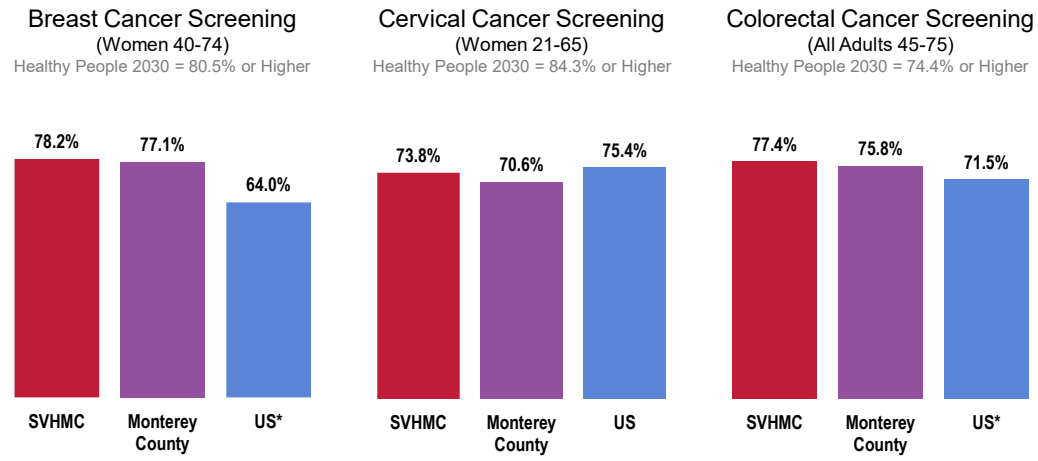
"Appropriate cervical cancer screening" includes Pap smear testing (cervical cytology) every three years in women age 21 to 29 and Pap smear testing every 5 years in women age 30 to 65.

Colorectal Cancer Screening

PRC SURVEY ► "Sigmoidoscopy and colonoscopy are exams in which a tube is inserted in the rectum to view the colon for signs of cancer or other health problems. How long has it been since your last sigmoidoscopy or colonoscopy?"

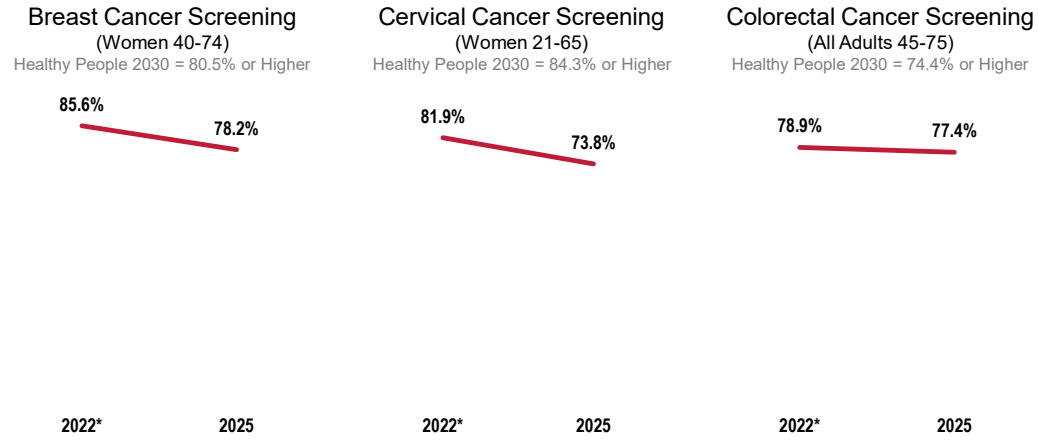
PRC SURVEY ► "A blood stool test is a test that may use a special kit at home to determine whether the stool contains blood. How long has it been since you had your last blood stool test?"

"Appropriate colorectal cancer screening" includes a fecal occult blood test among adults age 45 to 75 within the past year and/or lower endoscopy (sigmoidoscopy or colonoscopy) within the past 10 years.



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Items 101-103]
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Each indicator is shown among the gender and/or age group specified.
- * Note that national data for breast cancer screening reflect women ages 50 to 74. National data for colorectal cancer screening reflect adults ages 50 to 75.

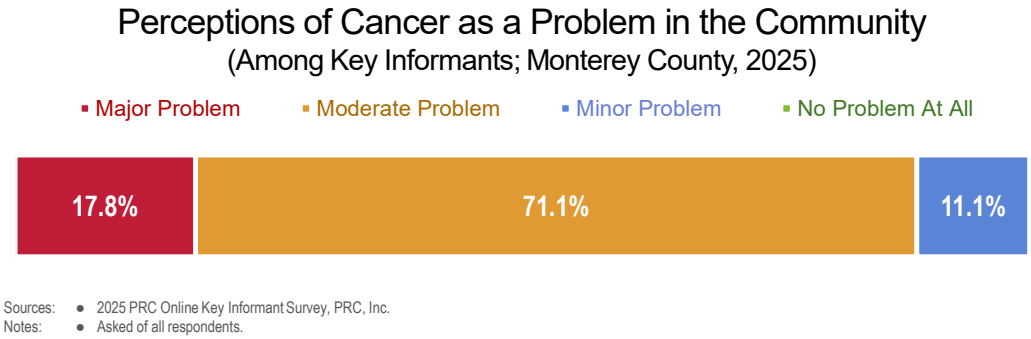


Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Items 101-103]
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Each indicator is shown among the gender and/or age group specified.
- * 2022 data does not include ZIP Codes 93926 and 93960. Further note that trend data for female breast cancer screening reflect the age group (50 to 74) of the previous recommendation; trend data for colorectal cancer screening reflect the age group (50 to 75) of the previous recommendation.

Key Informant Input: Cancer

The following chart outlines key informants' perceptions of the severity of *Cancer* as a problem in the community:



Sources: • 2025 PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

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

Incidence/Prevalence

> Cancer is prevalent everywhere. In our community, testing is not always affordable or accessible. — Social Services Provider
>
> Colon cancer is increasing in younger people. The region is also exposed to environmental risks, such as pesticides. — Social Services Provider
>
> Prior to working in the Pajaro Valley, I have never encountered so many children who have cancer, specifically staff I work with, their children. — Community Leader
>
> Many agricultural workers and/or relatives that I know are dealing with or have dealt with the impacts of cancer. Often, they cite lack of wraparound supports for those going through chemotherapy, like food assistance, transportation assistance, rental/financial assistance, and child care. — Community Leader
>
> I think cancer is a major problem in our county because every single day, I meet a new person or find out from someone I know that someone is fighting cancer. I am aware of several employees in my organization who have cancer and are in treatment. — Community Leader
>
> We have seen data from organizations that serve families with childhood cancer. Data suggests there is increase children diagnosed with various forms of childhood cancer in South Monterey County. Jacob's Heart serves families from South County and transports them for services to their Watsonville facility. Further, I have seen more women in their later years diagnosed with breast cancer. Many women lack the ability to get mammograms or lack preventive care that can diagnose at an early stage. — Community Leader

Access to Care/Services

> To get treatment for cancer, you need to drive for an hour to Salinas/Monterey for the South County residents. — Community Leader
>
> Once again, access to timely care causes late diagnosis that, sadly, continues to have bad outcomes. — Public Health Representative
>
> The only place to get treatment in the Salinas Valley is at SVMH. No option in providers, difficult to get a second opinion, definitely a huge ask for patients living in South County. Lack of options for treatment. — Health Care Provider
>
> No place to get treatments within 50 miles. — Community Leader
>
> Many of our community members aren't able to access the support they need in time to survive cancer. A lack of services hinders the ability to get diagnoses on time. — Community Leader

Environmental Contributors

> I believe the root cause of the cancer in our community is a result of pesticide exposure for farmworker families and residents living and working and learning in too-close proximity to the agricultural industry/fields. — Community Leader
>
> High exposure to pesticides and other industrial chemicals leads to greater incident rates, fear of deportation due to immigration status results in not reaching out for access. — Community Leader
>
> Increased environmental exposures, low-income status, high level of undocumented workers, cancer being the number-one cause of death in Latinos, no medical treatment for cancer offered by Natividad Medical Center, and otherwise thin resources in cancer all contribute to cancer being a major problem for a large segment of Monterey County. — Community Leader

Impact on Quality of Life

> Cancer is a very grave, life-altering disease that affects individuals and their families. It affects people of all ages and income levels. Recovery, if possible, is a long process. Treatment is expensive, invasive, and can be debilitating. — Community Leader

Lifestyle

> High intake of processed foods and animal products, pesticide exposures from an early age, obesity, lack of exercise, alcohol use, and limited access to cancer screening in some populations. — Physician

Respiratory Disease

ABOUT RESPIRATORY DISEASE

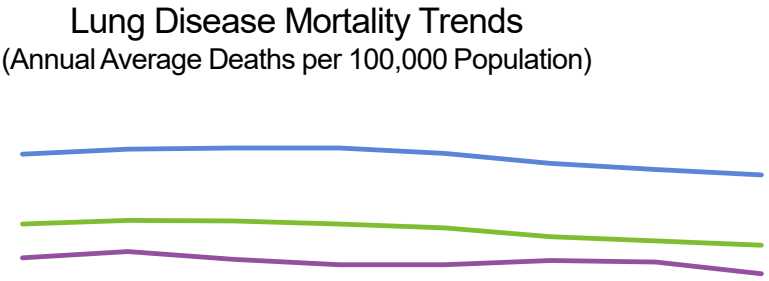
Respiratory diseases affect millions of people in the United States. …More than 25 million people in the United States have asthma. Strategies to reduce environmental triggers and make sure people get the right medications can help prevent hospital visits for asthma. In addition, more than 16 million people in the United States have COPD (chronic obstructive pulmonary disease), which is a major cause of death. Strategies to prevent the disease — like reducing air pollution and helping people quit smoking — are key to reducing deaths from COPD.

– Healthy People 2030 (https://health.gov/healthypeople)

Respiratory Disease Deaths

Lung Disease Deaths

Chronic lower respiratory diseases (CLRD) are diseases affecting the lungs; the most deadly of these is chronic obstructive pulmonary disease (COPD), which includes emphysema and chronic bronchitis. Mortality for lung disease is illustrated in the charts that follow. [COUNTY-LEVEL DATA]



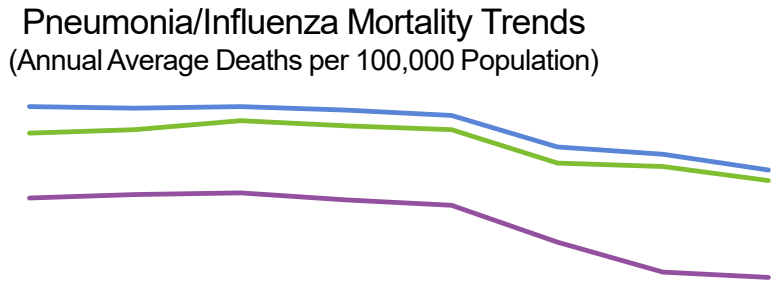
	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
Monterey County	27.8	29.0	27.5	26.5	26.5	27.3	27.0	24.8
CA	34.2	34.9	34.8	34.2	33.5	31.8	31.0	30.2
US	47.4	48.4	48.6	48.6	47.6	45.7	44.5	43.5

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2025.

Notes:
- Here, lung disease reflects chronic lower respiratory disease (CLRD) deaths and includes conditions such as emphysema, chronic bronchitis, and asthma.
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.

Pneumonia/Influenza Deaths

Pneumonia and influenza mortality is illustrated here. [COUNTY-LEVEL DATA]



	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
Monterey County	11.8	12.0	12.1	11.7	11.4	9.3	7.6	7.3
CA	15.5	15.7	16.2	15.9	15.7	13.8	13.6	12.8
US	17.0	16.9	17.0	16.8	16.5	14.7	14.3	13.4

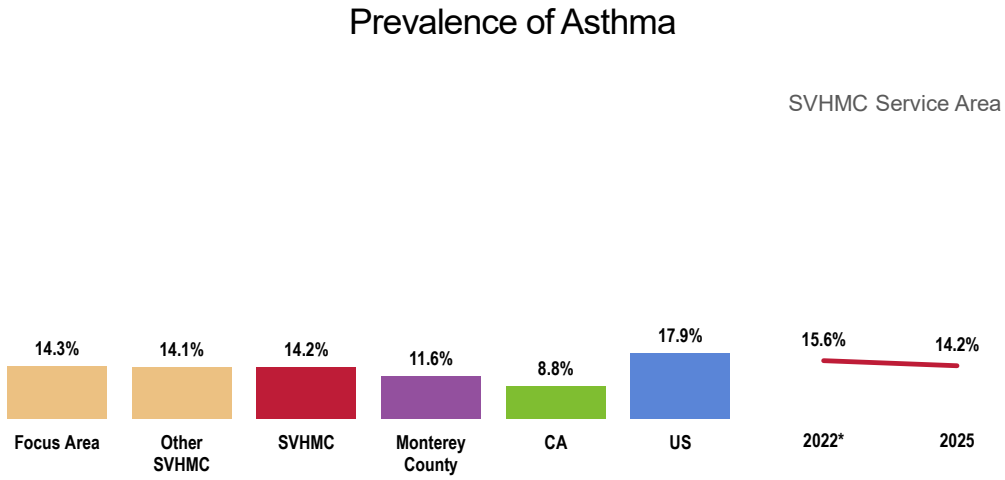
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2025.

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

Prevalence of Respiratory Disease

Asthma

PRC SURVEY ► "Do you currently have asthma?"



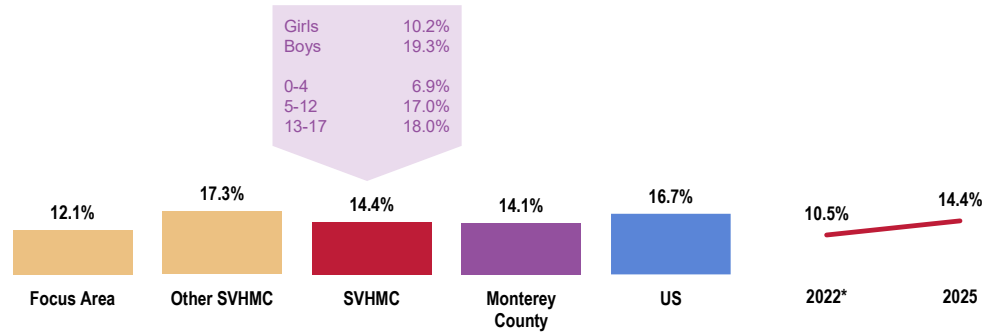
Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 26]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 California data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- *2022 data does not include ZIP Codes 93926 and 93960.

PRC SURVEY ► [Among parents of children age 0-17] **"Has a doctor, nurse, or other health professional ever told you that this child had asthma?"**

Prevalence of Asthma in Children
(Children 0-17)

SVHMC Service Area



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 92]
- 2023 PRC National Health Survey, PRC, Inc.

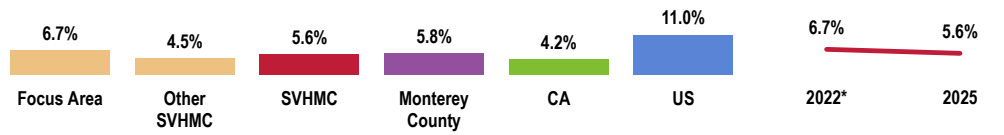
Notes:
- Asked of all respondents with children age 0 to 17 in the household.
- *2022 data does not include ZIP Codes 93926 and 93960.

Chronic Obstructive Pulmonary Disease (COPD)

PRC SURVEY ► **"Have you ever suffered from or been diagnosed with COPD or chronic obstructive pulmonary disease, including chronic bronchitis or emphysema?"**

Prevalence of Chronic Obstructive Pulmonary Disease (COPD)

SVHMC Service Area

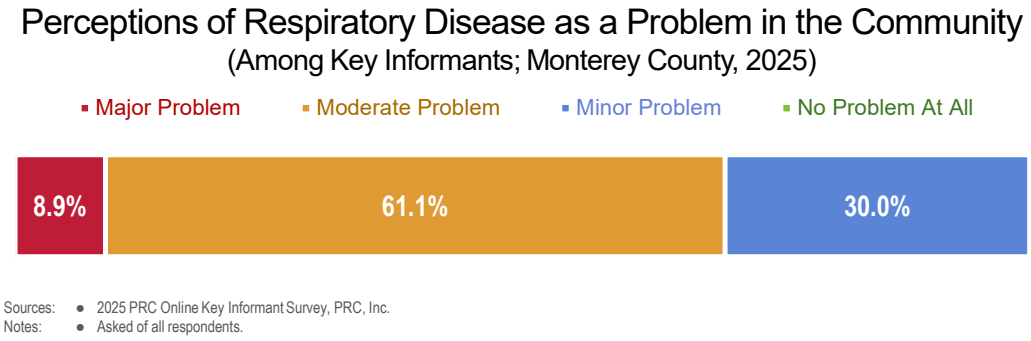


Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 21]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 California data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes conditions such as chronic bronchitis and emphysema.
- *2022 data does not include ZIP Codes 93926 and 93960.

Key Informant Input: Respiratory Disease

The following chart outlines key informants' perceptions of the severity of *Respiratory Disease* as a problem in the community:



Sources: • 2025 PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

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

Due to COVID-19

> The long-term effects of COVID seem to still be very present in our community, as many folks still have deep chronic coughs as lingering effects. — Social Services Provider
>
> So many families lost loved ones during the pandemic. — Social Services Provider
>
> Can't speak to much detail; however, there are still concerns related to COVID-19 and the impact on the most vulnerable at risk of respiratory diseases. — Community Leader

Learnings from COVID-19

> Future influenza pandemics. It is not clear that our learnings from COVID-19 have been institutionalized. Even local learning and collaboration could be derailed by an uninformed federal public health response. — Social Services Provider

Environmental Contributors

> Poor air quality, smoking and secondhand smoke, infections, social determinants of health, workplace exposure. — Social Services Provider

Vaccination Rates

> Vaccine declination is high. Misinformation is rampant. Air quality might be relatively degraded due to Agro activities. — Physician

Lack of Specialists

> No pulmonary doctors at the local clinic. — Community Leader

Infectious Diseases

> Infectious diseases. Lack of diagnoses and treatment. — Physician

Injury & Violence

ABOUT INJURY & VIOLENCE

INJURY ► In the United States, unintentional injuries are the leading cause of death in children, adolescents, and adults younger than 45 years. …Many unintentional injuries are caused by motor vehicle crashes and falls, and many intentional injuries involve gun violence and physical assaults. Interventions to prevent different types of injuries are key to keeping people safe in their homes, workplaces, and communities.

Drug overdoses are now the leading cause of injury deaths in the United States, and most overdoses involve opioids. Interventions to change health care providers' prescribing behaviors, distribute naloxone to reverse overdoses, and provide medications for addiction treatment for people with opioid use disorder can help reduce overdose deaths involving opioids.

VIOLENCE ► Almost 20,000 people die from homicide every year in the United States, and many more people are injured by violence. …Many people in the United States experience physical assaults, sexual violence, and gun-related injuries. Adolescents are especially at risk for experiencing violence. Interventions to reduce violence are needed to keep people safe in their homes, schools, workplaces, and communities.

Children who experience violence are at risk for long-term physical, behavioral, and mental health problems. Strategies to protect children from violence can help improve their health and well-being later in life.

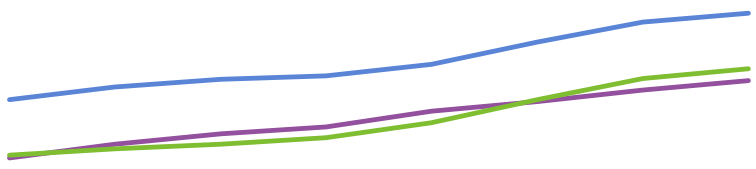
– Healthy People 2030 (https://health.gov/healthypeople)

Unintentional Injury

Unintentional Injury Deaths

The following chart outlines mortality rates for unintentional injury in the area. [COUNTY-LEVEL DATA]

Unintentional Injury Mortality Trends
(Annual Average Deaths per 100,000 Population)
Healthy People 2030 = 43.2 or Lower



	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
Monterey County	31.3	34.8	37.4	39.1	43.1	45.5	48.4	50.8
CA	32.0	33.6	34.8	36.4	40.2	46.0	51.3	53.8
US	46.0	49.2	51.1	52.0	54.9	60.5	65.6	67.8

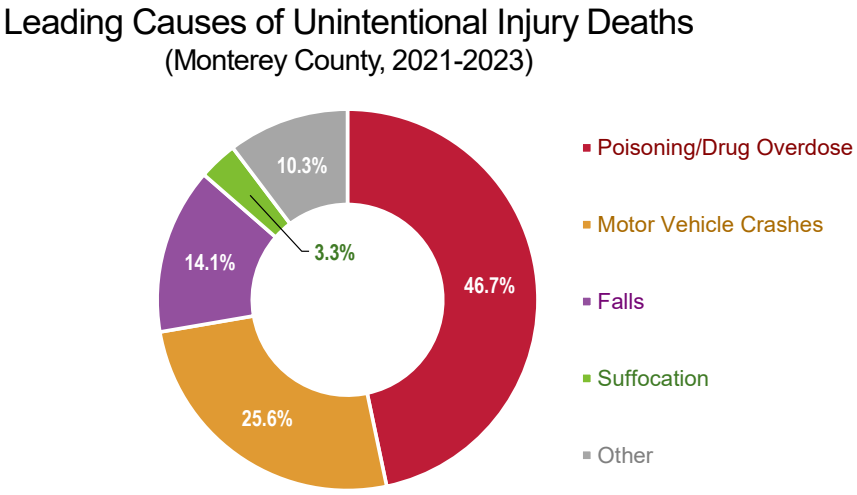
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2025.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

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

Leading Causes of Unintentional Injury Deaths

RELATED ISSUE
For more information about unintentional drug-induced deaths, see also *Substance Use* in the **Modifiable Health Risks** section of this report.

The following outlines leading causes of accidental death in the area. [COUNTY-LEVEL DATA]



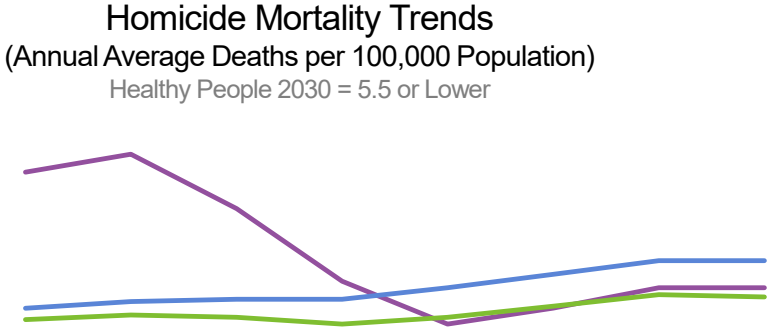
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2025.

Intentional Injury (Violence)

Homicide Deaths

RELATED ISSUE
See also *Mental Health (Suicide)* in the **General Health Status** section of this report.

Mortality attributed to homicide is shown in the following chart. [COUNTY-LEVEL DATA]



	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
Monterey County	11.5	12.3	9.9	6.7	4.8	5.5	6.4	6.4
CA	5.0	5.2	5.1	4.8	5.1	5.6	6.1	6.0
US	5.5	5.8	5.9	5.9	6.4	7.0	7.6	7.6

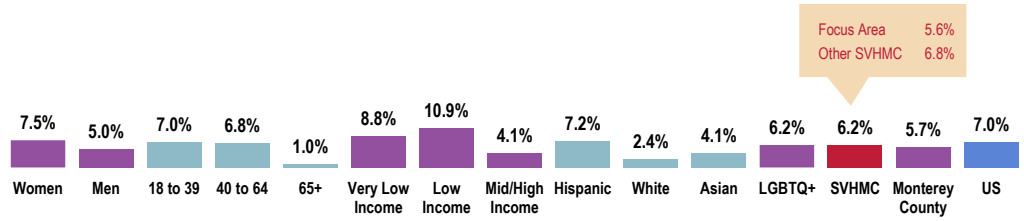
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2025.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

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

Violent Crime Experience

PRC SURVEY ► "Thinking about your own personal safety, have you been the victim of a violent crime in your area in the past 5 years?"

Victim of a Violent Crime in the Past Five Years
(SVHMC Service Area, 2025)



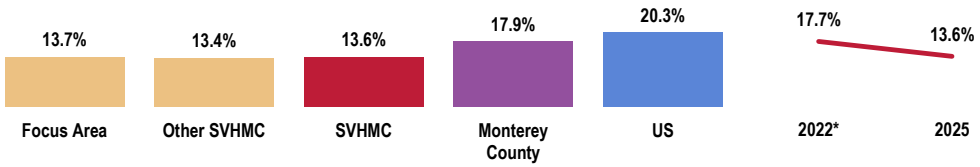
Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 32]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Intimate Partner Violence

PRC SURVEY ► "The next question is about violence in relationships with an intimate partner. By an intimate partner, I mean any current or former spouse, boyfriend, or girlfriend. Someone you were dating, or romantically or sexually intimate with, would also be considered an intimate partner. Has an intimate partner ever hit, slapped, pushed, kicked, or hurt you in any way?"

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

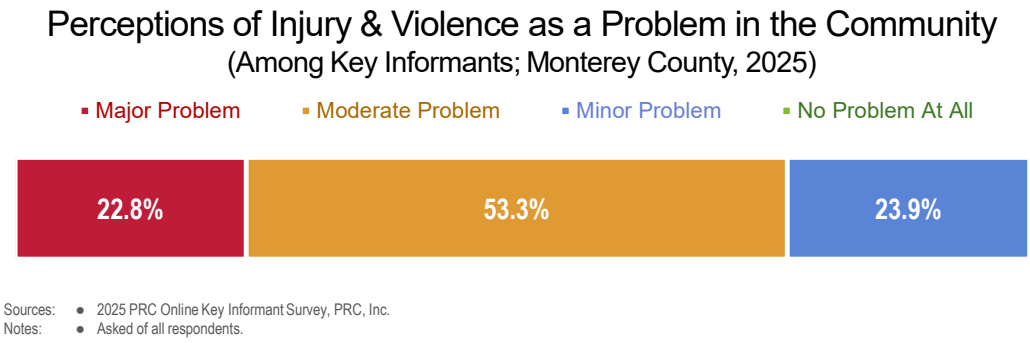
SVHMC Service Area



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 33]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.
● *2022 data does not include ZIP Codes 93926 and 93960.

Key Informant Input: Injury & Violence

The following chart outlines key informants' perceptions of the severity of *Injury & Violence* as a problem in the community:



Sources: • 2025 PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

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

Gang Violence

> Gang violence in Salinas Valley. — Community Leader
>
> The gang presence in the communities of Monterey County. — Community Leader
>
> Gang violence, vehicle accidents, and homelessness all contribute to the strain on medical resources. — Community Leader
>
> Gang violence is increasing, as are domestic violence and behavioral problems in schools. — Community Leader
>
> We continue to have high incidence of gang violence affecting both gang members and general public. Fear of deportation due to immigration status results in not reaching out for access. — Community Leader
>
> There has been an uptick in the number of murders, especially in South County. Gang violence has long been a problem in this county. — Public Health Representative
>
> Salinas continues to be seen as a rough area with gang activity and substance abuse as a driver for violence. — Health Care Provider
>
> We suffer from gang violence in our community. — Health Care Provider

Incidence/Prevalence

> We regularly hear about car accidents and shootings on the news, so it feels like we have major issues with injury and violence. I also read all of the juvenile probation documents and can see all of the violent actions some school-age children and youth are committing. — Community Leader
>
> PTSD, high functional disability as sequelae. — Physician
>
> Hit-and-run accidents involving pedestrians are prevalent in this area. Also, the gang violence, as well as domestic violence. — Social Services Provider
>
> While there have been significant improvements in violence in our community, motor vehicle accidents and violence are still prevalent problems in the community. The county has seen a decrease in homicides in the past few years and are trending downward, but 'Age-Adjusted Death Due to Homicide' is still high and not meeting the Healthy People 2030 target. Alcohol-related deaths are also higher in Monterey County compared to other California counties. — Health Care Provider

Income/Poverty

> Economic violence subjected upon communities that are not able to access appropriate pathways to improve their quality of life. — Community Leader
>
> Socioeconomic status: People do not have livable wages and are attracted to illegal activities. Community tolerance to allow coexistence with gangs and drug trafficking. Distracted drivers: texting, not paying attention to people safely walking and biking on streets. — Public Health Representative
>
> Many Monterey County residents are food insecure, lack enough resources for themselves and their families, and can resort to violence, which leads to injury. When I have witnessed shoplifting at grocery stores, staff acknowledges that this is routine, and they are instructed not to interfere. While shoplifting is not a violent crime, it's indicative of how desperate some people are and could lead to violence. — Social Services Provider

Co-Occurrences

> PTSD, high functional disability as sequelae. — Physician
>
> Mental health problems, poverty, inadequate public education, inadequate support for working families, free day care, preschool, and after-school care. — Physician
>
> Behavioral health. — Social Services Provider

Prevention Activities

> Public safety. The climate is great for accommodating outdoor activity (largely cool to moderate climate), but not nearly enough effort is being put into improving public safety through law enforcement or other means to clean up the city's streets and encourage people to move about freely and safely by foot or other means (bicycle, etc.). People were designed intelligently to move about and to move about for relatively long distances, but instead, most sit idle for many hours. — Community Leader
>
> We don't have enough prevention programs for our kids and places for them to find safe, alternative options to find hobbies, passions, and new friends to surround themselves with. — Social Services Provider

Alcohol/Drug Use

> South Monterey County communities have seen an increase in violence, most specifically with young men under the age of 30. This has been impacted with increase overdoses from fentanyl and other illicit drugs. There is a lack of youth prevention programs or residential treatment facilities for our youth. We have seen an increase in gang violence in the area. Our farmworker women and others also experience sexual violence or harassment that, many times, is unreported for a variety of reasons. — Community Leader

Unhoused Population

> Violence occurs on a frequent basis for those living on the streets, and these instances often lead to emergency ambulance rides and doctors' visits. This creates a cycle of debt that pushes people deeper into their homelessness. — Social Services Provider

Occupational Hazards

> Worker protections are minimal, and violence that occurs is rooted in the local poverty spectrum that can be demonstrated in the form of the multiple degrees of homelessness that exist in communities in and around Salinas. — Community Leader

Generational

> Our community has a high violence rate. It's uncertain what measures are needed to reduce this generational issue. Maybe for education and community events on cultural building and awareness. — Community Leader

Diabetes

ABOUT DIABETES

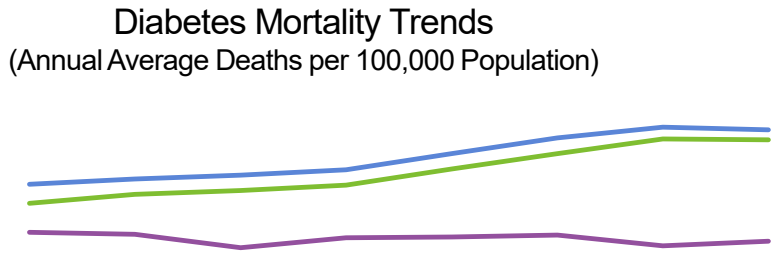
More than 30 million people in the United States have diabetes, and it's the seventh leading cause of death. …Some racial/ethnic minorities are more likely to have diabetes. And many people with diabetes don't know they have it.

Poorly controlled or untreated diabetes can lead to leg or foot amputations, vision loss, and kidney damage. But interventions to help people manage diabetes can help reduce the risk of complications. In addition, strategies to help people who don't have diabetes eat healthier, get physical activity, and lose weight can help prevent new cases.

– Healthy People 2030 (https://health.gov/healthypeople)

Diabetes Deaths

Diabetes mortality for the area is shown in the following chart. [COUNTY-LEVEL DATA]



	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
Monterey County	19.2	19.0	17.5	18.6	18.7	18.9	17.7	18.2
CA	22.4	23.4	23.8	24.4	26.2	27.9	29.5	29.4
US	24.5	25.1	25.5	26.1	27.9	29.6	30.8	30.5

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2025.

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

Prevalence of Diabetes

PRC SURVEY ► "Have you ever been told by a doctor, nurse, or other health professional that you have diabetes, not counting diabetes only occurring during pregnancy?"

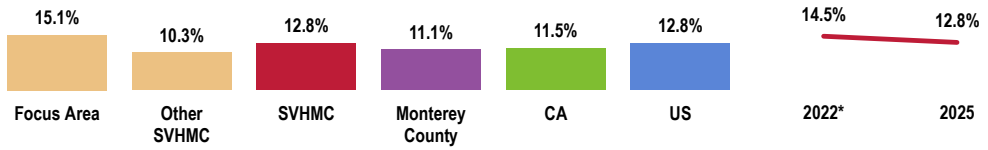
PRC SURVEY ► "Other than during pregnancy, have you ever been told by a doctor, nurse, or other health professional that you have pre-diabetes or borderline diabetes?"

PRC SURVEY ► [Non-diabetics]: **"Have you had a test for high blood sugar or diabetes within the past three years?"**

Prevalence of Diabetes

Another 20.7% of adults have been diagnosed with "pre-diabetes" or "borderline" diabetes.

SVHMC Service Area

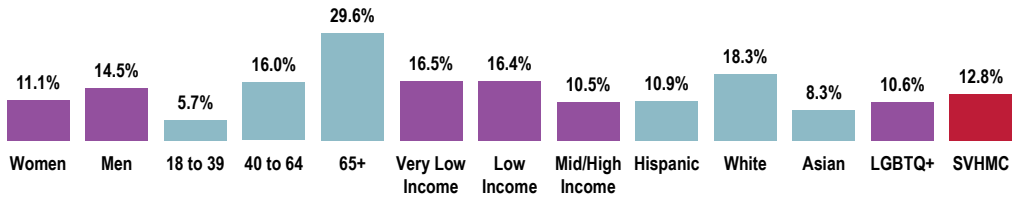


Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 106]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 California data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents. Excludes gestational diabetes (occurring only during pregnancy).
- *2022 data does not include ZIP Codes 93926 and 93960.

Prevalence of Diabetes
(SVHMC Service Area, 2025)

Note that among adults who have not been diagnosed with diabetes, 44.0% report having had their blood sugar level tested within the past three years.

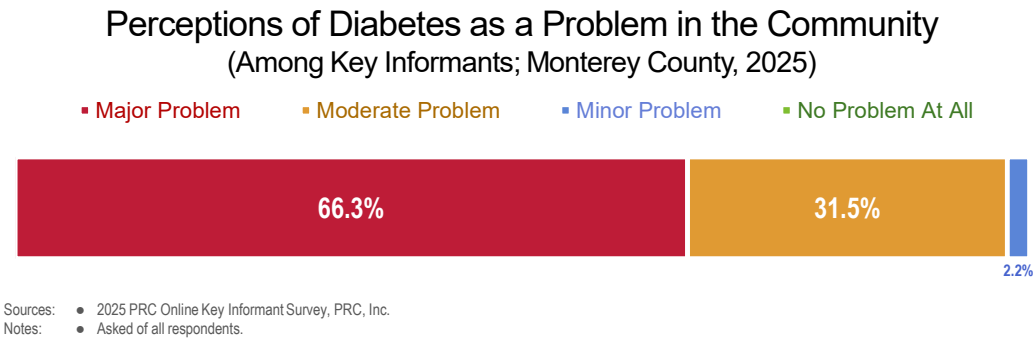


Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Items 106, 309]

Notes:
- Asked of all respondents.
- Excludes gestational diabetes (occurring only during pregnancy).

Key Informant Input: Diabetes

The following chart outlines key informants' perceptions of the severity of *Diabetes* as a problem in the community:



Sources: ● 2025 PRC Online Key Informant Survey, PRC, Inc.
Notes: ● Asked of all respondents.

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

Access to Affordable Healthy Food

> Lack of promotion and facilitation of healthy food and safe, affordable physical activities. — Community Leader
>
> Lack of healthy food, too much junk food at their disposal. We need more programs to promote healthy eating and moving. — Physician
>
> Poverty limiting the ability to purchase healthful foods. — Social Services Provider
>
> Lack of affordable healthy food. Lack of affordable workout spaces. — Community Leader
>
> Access to healthy affordable foods and access to affordable medications. — Public Health Representative
>
> Access to healthy foods and exercise. — Social Services Provider
>
> One of the biggest challenges for people with diabetes in our community is access — access to healthy food, regular medical care, diabetes education, and safe spaces to exercise. Many families live in areas where affordable, nutritious food is limited, and fast food is more accessible than fresh produce. Additionally, health care services can be hard to navigate or financially out of reach, especially for those without insurance or with limited English proficiency. — Social Services Provider
>
> We have too much access to unhealthy foods that are less expensive than the healthy foods in our community. We also have many individuals who work multiple jobs to pay their bills. When one works so many hours, they typically don't have time to exercise or cook a healthier meal with less processed foods at home.
> — Community Leader
>
> We have no "health food" stores (like Sprouts or Whole Foods or Trader Joe's). Many of the farmers markets are daytime hours, when folks work. The few stores that come up in Google as health food, when you enter, there is a bunch of candy and chicharrónes and Takis — no produce whatsoever! If you watch "El Susto," you'll learn about the cultural challenges of getting the Hispanic community to cut down on the sugary options and offer their children healthy snacks (as a whole). — Social Services Provider
>
> Increased options for fast food restaurants and limited affordable healthy options. More many families in a fixed income or working in the field, agricultural or hospitality, the wages are low and families are limited to purchasing processed food that is cheaper in price. The cost of healthy options (organic brands) for families that are making under $20,000 to 30,000 annually is not affordable. Access to medication and dietitians is not always viable or affordable. Cultural eating habits also contribute to this. — Community Leader
>
> Our community has a high number of individuals who have diabetes or pre-diabetes. There are a number of reasons why this is a challenge, including access to healthy foods and safe physical activity, culinary practices of the different cultures in our county, cost of nutritious food, other societal factors. Additionally, the potential resistance to trying healthier culturally familiar foods may be a challenge. The taste of a whole-grain tortilla, for example, may take time to get used to. — Health Care Provider
>
> Affording good quality meals. Access to nutrition services. Access to health food options.
> — Social Services Provider
>
> It's cheaper to buy a hamburger than to get vegetables. — Community Leader
>
> Access to healthy foods, cultural habits associated with unhealthy food choices. — Social Services Provider

Awareness/Education

> Understating and education about what it is. Appreciation that it is a combined genetic and behavioral problem, controllable but not curable. Knowing that lifestyle changes are necessary and that it is not just controlled by medications. — Physician
>
> Lack of education and lack of access to fresh produce and healthier foods. Also, lack of access to gyms due to membership costs. — Social Services Provider
>
> Lack of accessible education — individual or group — to teach people how to choose, access, and prepare fruit and veggie-heavy meals affordably. Poor insurance coverage for/access to continuous glucose monitors, which empower people to make diet and lifestyle changes and lessen their need for (expensive, equally poorly covered/expensive) effective medications. — Physician
>
> There are many resources in our community. The biggest challenge is bringing awareness to the community about all the diabetes resources that are available locally. — Community Leader
>
> Retain little knowledge about diabetes and don't understand disease progression. The need for education regarding proper diet to control diabetes. — Social Services Provider
>
> Education for long-term maintenance of their condition that is culturally relevant. Fear of deportation due to immigration status results in not reaching out for access. — Community Leader
>
> Lack of knowledge, trust, transportation, cost of accessing healthier foods and resources to people like dieticians. — Social Services Provider
>
> Education, easily navigable access to resources and care. — Physician
>
> Knowledge and access to care. — Community Leader
>
> Lack of intervention and early education. Children are allowed to eat all the items that will lead them to diabetes. Parents are not being informed of the importance of food and exercise that can prevent diabetes. Older people need access to weight loss drugs and education about what to eat and how to exercise. — Community Leader
>
> Education and clinical services. — Health Care Provider
>
> Access to education and healthy, affordable food choices. — Health Care Provider

Access to Care/Services

> Having access to treatments and regular monitoring, like with a continuous blood glucose monitor and regular checkups. Not enough access to diabetes education, not enough support for healthy lifestyle choices. — Physician
>
> Having access to the continuum of wellness resources (affordable and easily accessed nutrition; safe spaces and places to exercise; etc.) that support the lifestyle changes that support navigating diabetes care. There are also inequities in health literacy, and not all of the messaging about diabetes diagnosis and care is relevant. Migrant and seasonal farmworker communities work long hours with limited access to the time and spaces for securing and preparing food. The hours and demands of those jobs also impact the capacity to participate in diabetes education programs and medical care. And finally, not all of the self-monitoring tools and supplies are covered by insurance — and the easier tools for use CGMs and phone apps — are not always accessible to the lower-income communities in our service area. — Physician
>
> Fragmented care, health disparities, language barriers — we need a comprehensive, culturally sensitive approach , eliminate bureaucracy in the pharmacy that delays testing strips, supplies, and medication being dispensed in a timely fashion, and, of course, affordable to all so that those who do not have insurance or the underinsured cannot have disruption in their care when they do not have insurance 'off-season.' — Physician
>
> Being uninsured and lack of access to health care. — Community Leader
>
> Access to care and supplies and medication. Also, lifestyle choices where the healthy choice is not well-supported or more difficult to sustain. — Community Leader
>
> Natividad being the county hospital really lacks a comprehensive diabetic center. NMC has a small team for diabetic teaching, appointments are delayed. — Health Care Provider
>
> Access to a regular physician for building and going with a personalized health plan. — Community Leader
>
> Access to care needed to obtain necessary diagnosis and medications. I feel that outreach to encourage people to get tested can help. — Public Health Representative
>
> Lack of access to routine health care visits, medications, and testing tools. Lack of health food access and safe walking communities. — Public Health Representative
>
> Access to health care and physical activities. — Community Leader

Nutrition

> Healthful lifestyles and access to healthful foods. — Health Care Provider
>
> Health and diet. Food is costly; it is so much easier to eat unhealthy. — Social Services Provider
>
> Nutrition. — Social Services Provider
>
> Ability to make lifestyle changes, such as access to healthy foods, regular exercise, and weight management. — Social Services Provider

> Culture of consumption, targeting communities trapped in healthy food deserts while subjected to an obscene amount of unhealthy food sources. — Community Leader
>
> Diet and healthy choices. — Social Services Provider
>
> Diet and weight services. — Social Services Provider
>
> Excess intake of highly processed foods and animal products, lack of exercise, lack of education regarding how to prevent and treat diabetes with healthy diet and exercise. Lack of access to diabetic education — my primary care patients can't access diabetes education in Salinas. — Physician

Affordable Medications/Supplies

> Affordable medication, education, and health food resources. — Social Services Provider
>
> Affordability of newer medications. Lack of meaningful effort to reduce the sugar content of beverages and confectionaries. — Physician
>
> Affordable testing and medication for treatment. — Social Services Provider

Disease Management

> Compliance with treatment plan, access to medications. — Social Services Provider
>
> Treatment is complex and requires management and action multiple times a day. If the individual is a child, that means family members, caregivers, and school personnel must be trained and vigilant. — Community Leader
>
> Diabetes management, including nutrition, medication, and supplies. — Health Care Provider

Diagnosis/Treatment

> Delay in diagnosis secondary to access. Unhealthy and overly processed foods. — Physician
>
> Diagnosis, education, access, nutrition, and peripheral vascular disease. — Physician

Lifestyle

> Lack of desire to exercise and eat healthy. — Community Leader
>
> Lack of exercise and inadequate diet. — Community Leader

Prevention/Screenings

> Access to preventive services. Self-management classes are already offered. Access to affordable fruits and vegetables/food security. — Community Leader
>
> Diabetes prevention education is limited. Access to healthy foods for low-income families is a problem. — Community Leader

Unhoused Population

> People with diabetes that are experiencing homelessness have little to no access to consistent medical services and experience living conditions that can amplify the conditions that one faces with diabetes. Conditions such as cold weather can worsen conditions of people living with diabetes. Poor diet can also worsen the condition of people living with diabetes, especially for folks that have little to no resources for food. — Social Services Provider

Incidence/Prevalence

> Large number of people with diabetes and pre-diabetes in our community. — Health Care Provider

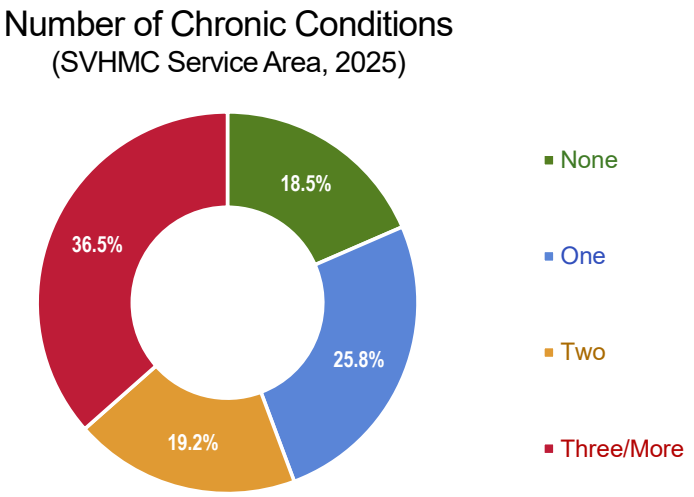
Disabling Conditions

Multiple Chronic Conditions

For the purposes of this assessment, chronic conditions include:

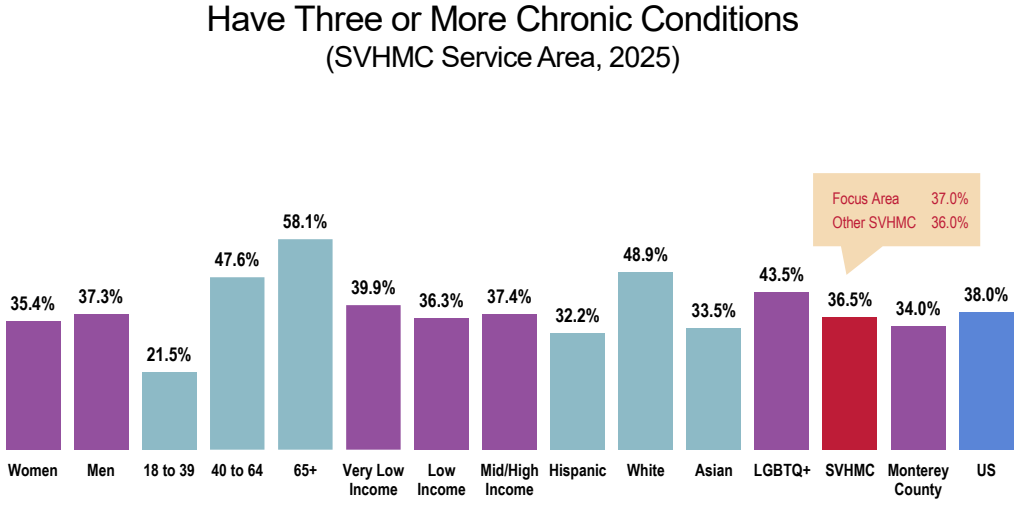
- Asthma
- Cancer
- Chronic pain
- Diabetes
- Diagnosed depression
- Heart disease
- High blood cholesterol
- High blood pressure
- Lung disease
- Obesity
- Stroke

The following charts outline the prevalence of multiple chronic conditions among surveyed adults, taking into account all of the various conditions measured in the survey.



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 107]

Notes:
- Asked of all respondents.
- In this case, chronic conditions include asthma, cancer, chronic pain, diabetes, diagnosed depression, heart disease, high blood cholesterol, high blood pressure, lung disease, obesity, and stroke.



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 107]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- In this case, chronic conditions include asthma, cancer, chronic pain, diabetes, diagnosed depression, heart disease, high blood cholesterol, high blood pressure, lung disease, obesity, and/or stroke.

Activity Limitations

ABOUT DISABILITY & HEALTH

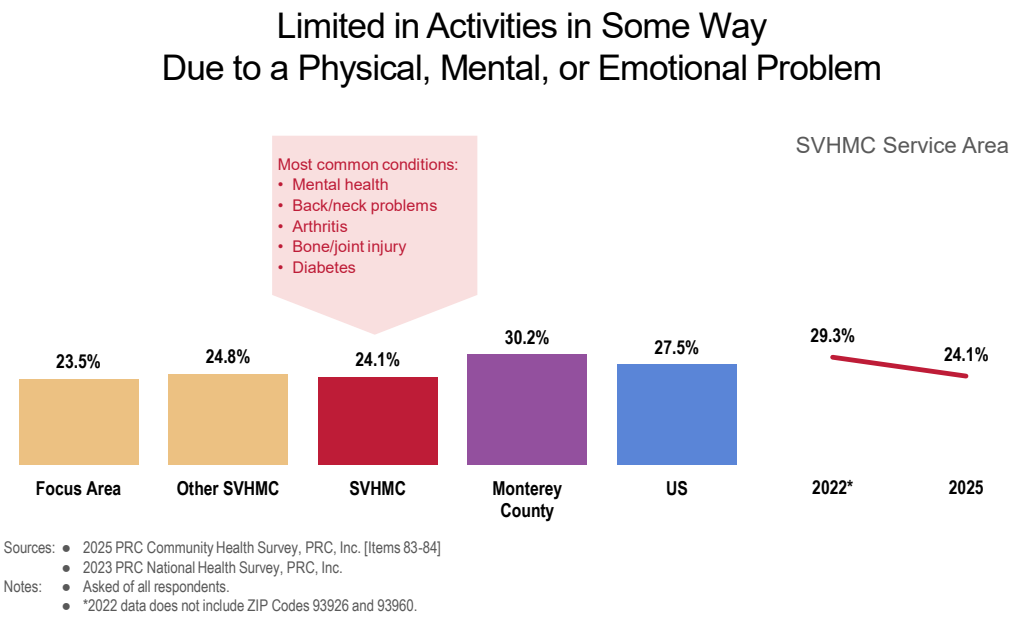
Studies have found that people with disabilities are less likely to get preventive health care services they need to stay healthy. Strategies to make health care more affordable for people with disabilities are key to improving their health.

In addition, people with disabilities may have trouble finding a job, going to school, or getting around outside their homes. And they may experience daily stress related to these challenges. Efforts to make homes, schools, workplaces, and public places easier to access can help improve quality of life and overall well-being for people with disabilities.

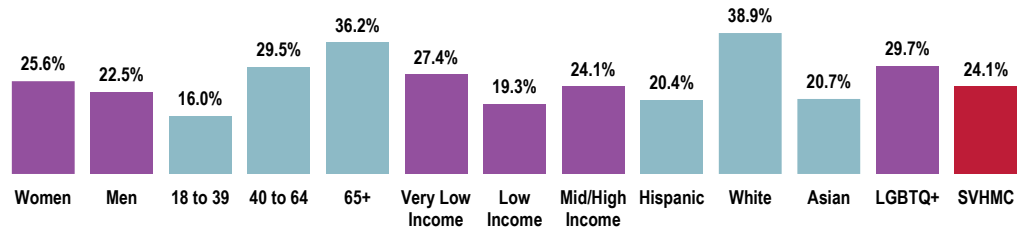
– Healthy People 2030 (https://health.gov/healthypeople)

PRC SURVEY ► "Are you limited in any way in any activities because of physical, mental, or emotional problems?"

PRC SURVEY ► [Adults with activity limitations] **"What is the major impairment or health problem that limits you?"**



Limited in Activities in Some Way Due to a Physical, Mental, or Emotional Problem
(SVHMC Service Area, 2025)

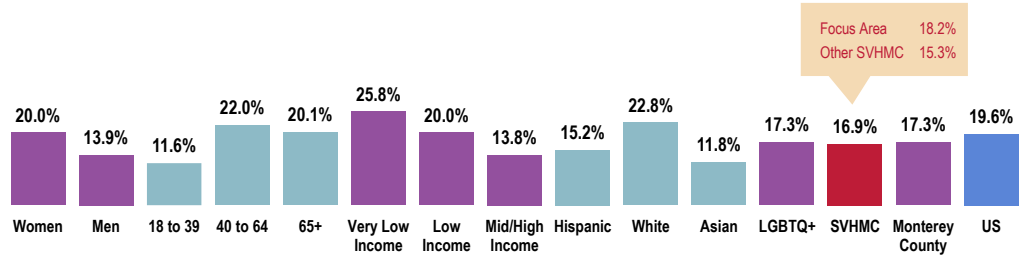


Sources: • 2025 PRC Community Health Survey, PRC, Inc. [Item 83]
Notes: • Asked of all respondents.

High-Impact Chronic Pain

PRC SURVEY ► "Over the past six months, how often did physical pain limit your life or work activities? Would you say: never, some days, most days, or every day?" (Reported here among those responding "most days" or "every day.")

Experience High-Impact Chronic Pain
(SVHMC Service Area, 2025)
Healthy People 2030 = 6.4% or Lower



Sources: • 2025 PRC Community Health Survey, PRC, Inc. [Item 31]
• 2023 PRC National Health Survey, PRC, Inc.
• US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople
Notes: • Asked of all respondents.
• High-impact chronic pain includes physical pain that limits life or work activities on "most days" or "every day" of the past six months.

Alzheimer's Disease

ABOUT DEMENTIA

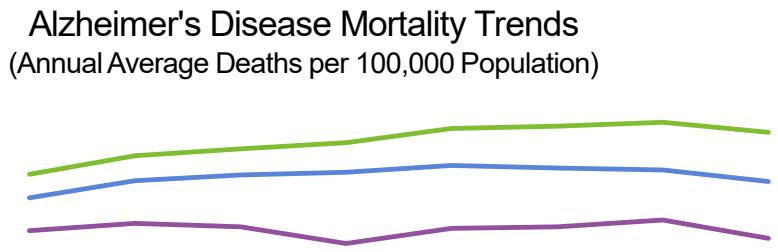
Alzheimer's disease is the most common cause of dementia… . Dementia refers to a group of symptoms that cause problems with memory, thinking, and behavior. People with dementia are more likely to be hospitalized, and dementia is linked to high health care costs.

While there's no cure for Alzheimer's disease, early diagnosis and supportive care can improve quality of life. And efforts to make sure adults with symptoms of cognitive decline — including memory loss — are diagnosed early can help improve health outcomes in people with dementia. Interventions to address caregiving needs can also help improve health and well-being in people with dementia.

– Healthy People 2030 (https://health.gov/healthypeople)

Alzheimer's Disease Deaths

Alzheimer's disease mortality is outlined in the following chart. [COUNTY-LEVEL DATA]



	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
Monterey County	28.0	29.2	28.6	26.0	28.4	28.6	29.7	26.8
CA	36.9	39.8	40.9	41.9	44.1	44.5	45.1	43.5
US	33.2	35.9	36.8	37.2	38.3	37.9	37.6	35.8

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2025.

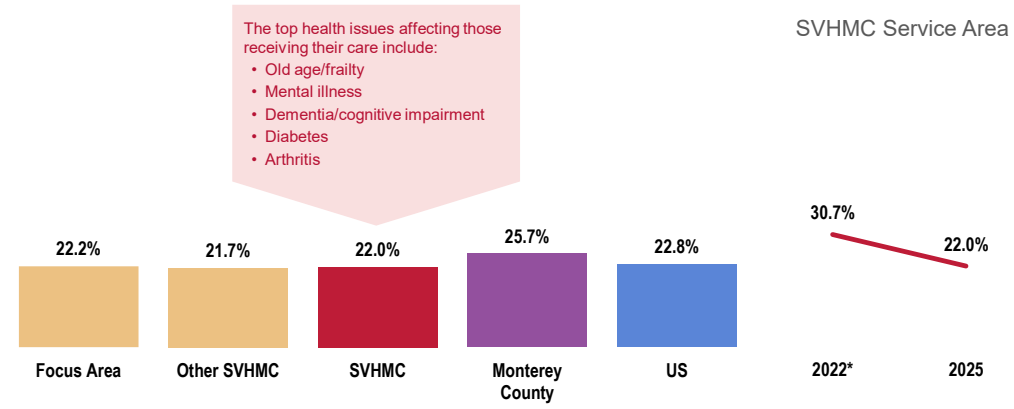
Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.

Caregiving

PRC SURVEY ▶ "People may provide regular care or assistance to a friend or family member who has a health problem, long-term illness, or disability. During the past 30 days, did you provide any such care or assistance to a friend or family member?"

PRC SURVEY ▶ [Among those providing care] **"What is the main health problem, long-term illness, or disability that the person you care for has?"**

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



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Items 85-86]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.
● *2022 data does not include ZIP Codes 93926 and 93960.

Key Informant Input: Disabling Conditions

The following chart outlines key informants' perceptions of the severity of *Disabling Conditions* as a problem in the community:

Perceptions of Disabling Conditions as a Problem in the Community
(Among Key Informants; Monterey County, 2025)

Sources: ● 2025 PRC Online Key Informant Survey, PRC, Inc.
Notes: ● Asked of all respondents.

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

Access to Care/Services

> This is a large county. Getting to care can be difficult in the best of circumstances. If you are disabled and living in the rural parts of the county, it is very difficult to access services, especially if you must depend on public transportation. The school districts do not have adequately trained staff to provide the needed services to disabled students. — Public Health Representative
>
> There is an epidemic of chronic disease nationwide. Particularly if you consider lack of mental health supports and lack of understanding of chronic pain. — Physician

We have a lot of patients with chronic pain in our community. We need resources to help them. — Physician

Limited economic resources. — Health Care Provider

Our community has one hospital, and it is not a well-functioning or staffed medical facility. The equipment is outdated to the point of people starting a series of medical appointments there and then transferring to somewhere in Salinas or Monterey, and the difference is night and day. The community is unique in its demographic makeup, and many undocumented individuals or people with specific dialects that cause language barriers are unable to get the support they need. Due to the poverty level of many of the people in our community, there is a wide use of CalFresh and Medi-Cal. CalFresh, for some horrible reason, allows people to continue to purchase processed goods, when it should be more limited to produce, meat, eggs, and grains. There is a childhood obesity problem, and still there are no less than four ice cream/snack trucks parked outside of the middle school when it gets out, each with lines for over an hour. It's like a drug dealer standing on the curb allowed to do business. — Community Leader

There are limited skilled nursing facilities or long-term beds for patients with dementia. They do have private pay facilities with memory care, but at a huge cost that the average person may not be able to afford. — Health Care Provider

Disabling conditions are a major issue in Monterey County, where limited transportation, housing, and health care access make it difficult for people with disabilities to live independently and stay connected to the community. Rural areas and underserved populations are especially impacted, leading to isolation and reduced quality of life. Addressing these challenges is essential to building a more inclusive and equitable county for all residents. — Social Services Provider

There is local skilled nursing facility at the hospital, but there is a real need for more facilities to treat dementia and to house those with it. There is good eye treatment. There is no facility for hearing loss. — Community Leader

Lack of services to help with education, treatment, and prevention. Stigma associated with dementia, which can cause isolation. — Social Services Provider

Limited resources available to people with these conditions. — Community Leader

Aging Population

For many of our current geriatric population, they have lived through tremendous growth in terms of technology. They were born or grew up in the era when even television was not in their homes, and they now are living in an era of video visits utilizing equipment that they are apprehensive to use. For offices, it is convenient to send texts to inform of visits or referral appointments to specialists, but elderly either do not know how to use the equipment to access information or may have conditions that prevent them from using, such as visual, hearing, dementia, or language barriers. Tele-visits, whether video or phone, are useless for hard-of-hearing. Mobility, whether in the elderly, obese, or for some other reason, is also a challenge, and if the patient does not have assistance, it will likely result in missed appointments, unless we are able to set services to facilitate in their transportation and care. — Physician

Older and aging community, especially on the Peninsula. — Physician

As a country, we are not doing an adequate job of caring for the aging population. Residential care is expensive and often substandard. This puts incredible burden on families, impacting income, emotional health, and financial security. This shortfall is especially true for Monterey County. — Community Leader

All of the above for seniors, leading to isolation. — Social Services Provider

The community has an elderly population that is increasing, so dementia is more noticeable, as is lack of agility. Additionally, trauma and mental illness can be disabling. — Social Services Provider

Seaside has a large older adult population where many live alone and are experiencing challenges supporting their independence. These challenges include activity limitations due to disabilities and lack of mobility/ability to travel, chronic pain, dementia, and other neurological issues impairing daily functioning/inability to complete ADLs. Due to these disabling conditions, other needs for support manifest related to habitability/unsafe living environments. — Community Leader

Incidence/Prevalence

Volume of persons affected, mostly chronic conditions worsening with time. — Physician

Many have problems with ambulation, cognitive changes, and physical disabilities, and cost to support these and to provide appropriate care is expensive. — Physician

Unfortunately, there are very high rates of depression and anxiety in LGBTQ+ community members that often coexist with substance abuse issues or other coping mechanisms. — Community Leader

I know many individuals are experiencing chronic pain, dementia, loss of vision or hearing. We operate the deaf and hard-of-hearing and visually impaired student programs in our county, and this population has remained stable. It is difficult to find nursing homes for patients with dementia, and if you do find a bed, the cost of this support is so high that most individuals can't afford it. — Community Leader

There are many disabled individuals. — Social Services Provider

Impact on Quality of Life

> There's a lot of people who have disabilities who think they are a hindrance with no solution, so they don't aspire to do better. — Social Services Provider

> Loss of vision from DM. Disability due to injuries, occupational, violence-related abuse. Chronic pain related to past injuries and psychological trauma. Dementia due to heavy alcohol use, lack of exercise, and uncontrolled chronic illness. — Physician

Built Environment

> Parks and opportunities for safe, recreational activities are limited and/or families don't have the time to participate. Pain management can sometimes lead to drug abuse, which can result in other serious conditions, crime, and violence. — Social Services Provider

Parkinson's Disease

> Parkinson's disease. Incidence is high, but diagnosis is low. It starts insidiously as tremors that might be ignored or not addressed seriously. Sustained effective treatment is not always possible, and treatment side effects are significant. — Physician

Unhoused Population

> Disabling conditions are often one of the main reasons why people begin experiencing homelessness. Whether it is physical or psychiatric, disabling conditions lead to loss of employment, social connections, and general well-being. — Social Services Provider

Housing

> Lack of affordable housing with built-in support services to facilitate transportation, especially in North Monterey County. This means people with disabilities must lean heavily on family members or close friends. — Physician

Access to Care for Uninsured/Underinsured

> Limited access to care facilities due to low income and insurance coverage. — Social Services Provider

Affordable Care/Services

> They take a lot of time and money, even if the total number of people affected is low. And there are many more people affected than most people are aware of. — Physician

Awareness/Education

> Many families in our community lack the knowledge and resources needed for proper care as they reach retirement age. — Community Leader

BIRTHS

ABOUT INFANT HEALTH

Keeping infants healthy starts with making sure women get high-quality care during pregnancy and improving women's health in general. After birth, strategies that focus on increasing breastfeeding rates and promoting vaccinations and developmental screenings are key to improving infants' health. Interventions that encourage safe sleep practices and correct use of car seats can also help keep infants safe.

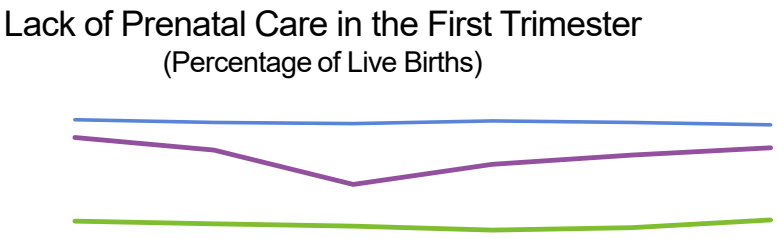
The infant mortality rate in the United States is higher than in other high-income countries, and there are major disparities by race/ethnicity. Addressing social determinants of health is critical for reducing these disparities.

– Healthy People 2030 (https://health.gov/healthypeople)

Prenatal Care

Early and continuous prenatal care is the best assurance of infant health.

This indicator reports the percentage of women who did not receive prenatal care during their first trimester of pregnancy. This indicator can signify a lack of access to preventive care, a lack of health knowledge, or other barriers to services. [COUNTY-LEVEL DATA]



	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
Monterey County	21.3%	20.3%	17.6%	19.2%	19.9%	20.5%
CA	14.7%	14.5%	14.3%	14.0%	14.2%	14.8%
US	22.7%	22.5%	22.4%	22.6%	22.5%	22.3%

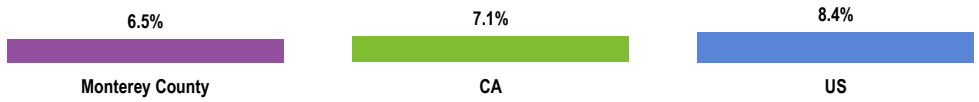
Sources: ● Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER.
Note: ● This indicator reports the percentage of women who do not obtain prenatal care during their first trimester of pregnancy.

Birth Outcomes & Risks

Low-Weight Births

Low birthweight babies, those who weigh less than 2,500 grams (5 pounds, 8 ounces) at birth, are much more prone to illness and neonatal death than are babies of normal birthweight. Largely a result of receiving poor or inadequate prenatal care, many low-weight births and the consequent health problems are preventable. [COUNTY-LEVEL DATA]

Low-Weight Births
(Percent of Live Births, 2017-2023)



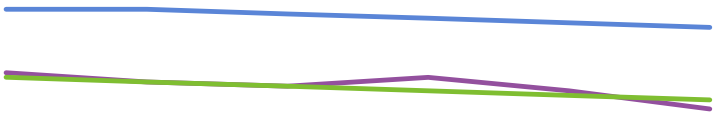
Sources:
- University of Wisconsin Population Health Institute, County Health Rankings.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved July 2025 via SparkMap (sparkmap.org).

Note:
- This indicator reports the percentage of total births that are low birth weight (Under 2500g).

Infant Mortality

Infant mortality rates reflect deaths of children less than 1 year old per 1,000 live births. High infant mortality can highlight broader issues relating to health care access and maternal/child health.
[COUNTY-LEVEL DATA]

Infant Mortality Trends
(Annual Average Infant Deaths per 1,000 Live Births)
Healthy People 2030 = 5.0 or Lower



	2014-2016	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Monterey County	4.5	4.3	4.2	4.4	4.1	3.7
CA	4.4	4.3	4.2	4.1	4.0	3.9
US	5.9	5.9	5.8	5.7	5.6	5.5

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics. Data extracted July 2025.
- Centers for Disease Control and Prevention, National Center for Health Statistics.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Rates are three-year averages of deaths of children under 1 year old per 1,000 live births.

Family Planning

ABOUT FAMILY PLANNING

Nearly half of pregnancies in the United States are unintended, and unintended pregnancy is linked to many negative outcomes for both women and infants. …Unintended pregnancy is linked to outcomes like preterm birth and postpartum depression. Interventions to increase use of birth control are critical for preventing unintended pregnancies. Birth control and family planning services can also help increase the length of time between pregnancies, which can improve health for women and their infants.

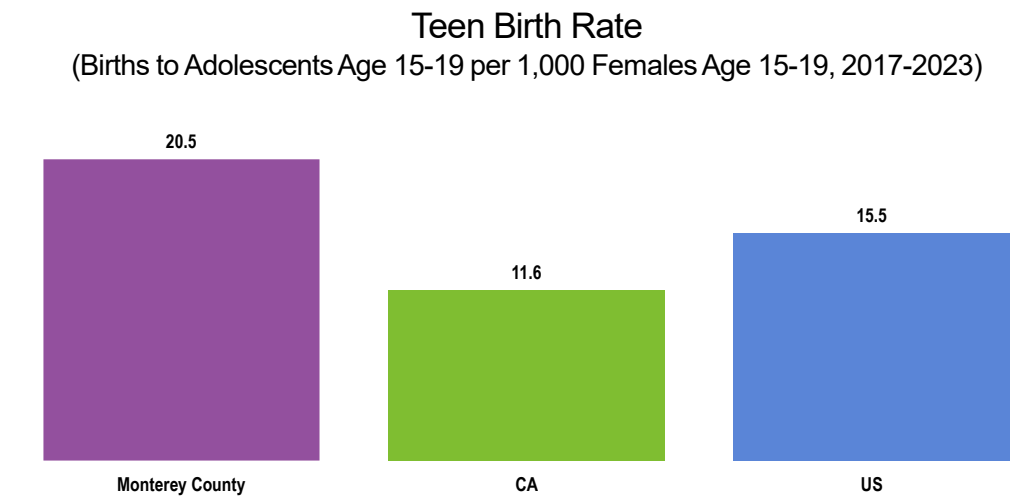
Adolescents are at especially high risk for unintended pregnancy. Although teen pregnancy and birth rates have gone down in recent years, close to 200,000 babies are born to teen mothers every year in the United States. Linking adolescents to youth-friendly health care services can help prevent pregnancy and sexually transmitted infections in this age group.

– Healthy People 2030 (https://health.gov/healthypeople)

Births to Adolescent Mothers

Here, teen births include births to women age 15 to 19 years old, expressed as a rate per 1,000 female population in this age cohort.

The following chart outlines local teen births, compared to the state and nation. In many cases, teen parents have unique health and social needs. High rates of teen pregnancy might also indicate a prevalence of unsafe sexual behavior. [COUNTY-LEVEL DATA]

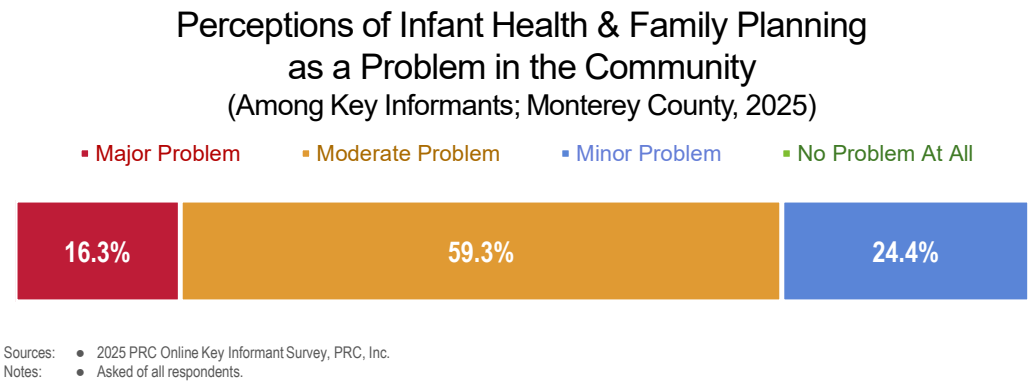


Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved July 2025 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the rate of total births to women under the age of 15–19 per 1,000 female population age 15–19.

Key Informant Input: Infant Health & Family Planning

The following chart outlines key informants' perceptions of the severity of *Infant Health & Family Planning* as a problem in the community:



Sources: 2025 PRC Online Key Informant Survey, PRC, Inc.
Notes: Asked of all respondents.

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

Access to Care/Services

> Inadequate health care and lack of access to family planning services. — Social Services Provider
>
> Access to health care and informed choice for young women of child-bearing age can be difficult, from a cost perspective and accessibility. — Community Leader
>
> More locations in South County have closed over the years. The cost of child care is very high and so is the cost of living. It feels like a struggle for some parents to decide where to prioritize and put their money toward. — Social Services Provider
>
> Access to early care for pregnancy, as well as preconception care. It is often dependent on having health care insurance coverage. — Physician
>
> When my ex-wife was pregnant with our son, we had an OB/GYN and doctor here in King City. He was only here one day a month on a Friday. So, when he wasn't able to be at two different appointments in a row and we were left with questions and fears about the process, we transferred to Salinas. We also went to Mee Memorial Hospital for an ultrasound before switching, and when we got there, the lady said, "Sorry, we had a gunshot victim come in and we are understaffed, so I have to get back to the ER." Come to find out two hours later when she came back, she was the one that was supposed to be doing the ultrasound. The ultrasound was an old one on a small black and green screen in a cold hospital room. When we transferred to Salinas, the room was comforting, beautiful, and warm. There was a huge staff, state-of-the-art equipment, and constant attention to our every question and need ... and they were packed, yet they were well-run, so it was like a 180-degree switch. — Community Leader

Awareness/Education

> As a school educator, I see the issue with young parents with lack of information on infant care. — Community Leader
>
> Lack of education and acceptance around birth control, especially with youth in migrant or immigrant communities. — Social Services Provider
>
> Youth not being taught about birth control. Little to no sex education in school. Parents not sharing with kids on taking care of themselves and partners. — Social Services Provider
>
> We need more early education centers for first-time parents and also just as a hub for parenting information and workshops in our county. — Community Leader

Language Barriers

> Systems are missing the mark due to cultural and language barriers. Leaders have little to no lived experience to help achieve their goals, and if they do have some experience, they may have easily forgotten it because they don't live it today. — Community Leader

Affordable Care/Services

> The high cost and unavailability of child care. — Social Services Provider

Lack of Providers

> There just are not enough providers, and the cost of the existing providers is prohibitively high. Especially for those in our community who may be financially constrained. — Community Leader

Vaccination

> Vaccine declination, anti-abortion attitude. — Physician

MODIFIABLE HEALTH RISKS

Nutrition

ABOUT NUTRITION & HEALTHY EATING

Many people in the United States don't eat a healthy diet. …People who eat too many unhealthy foods — like foods high in saturated fat and added sugars — are at increased risk for obesity, heart disease, type 2 diabetes, and other health problems. Strategies and interventions to help people choose healthy foods can help reduce their risk of chronic diseases and improve their overall health.

Some people don't have the information they need to choose healthy foods. Other people don't have access to healthy foods or can't afford to buy enough food. Public health interventions that focus on helping everyone get healthy foods are key to reducing food insecurity and hunger and improving health.

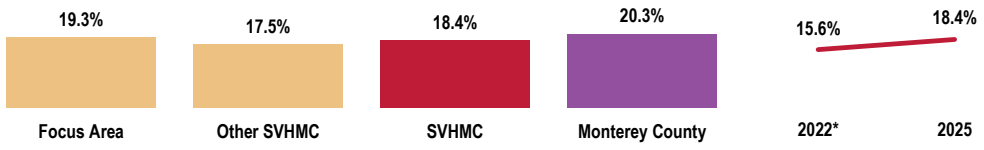
– Healthy People 2030 (https://health.gov/healthypeople)

Sugar-Sweetened Beverages

PRC SURVEY ► "During the past seven days, how many servings of sugar-sweetened beverages did you have? Please include beverages such as soda, Kool-Aid, sweetened fruit juice, sports drinks, energy drinks, sweetened coffee drinks, or sweet tea. Do not include 'diet' drinks."

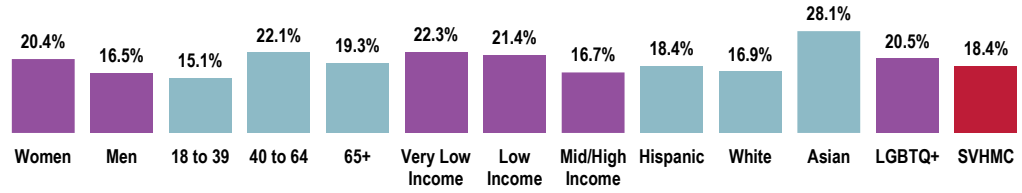
Had Seven or More
Sugar-Sweetened Beverages in the Past Week

SVHMC Service Area



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 324]
Notes: ● Asked of all respondents.
● *2022 data does not include ZIP Codes 93926 and 93960.

Had Seven or More Sugar-Sweetened Beverages in the Past Week
(SVHMC Service Area, 2025)

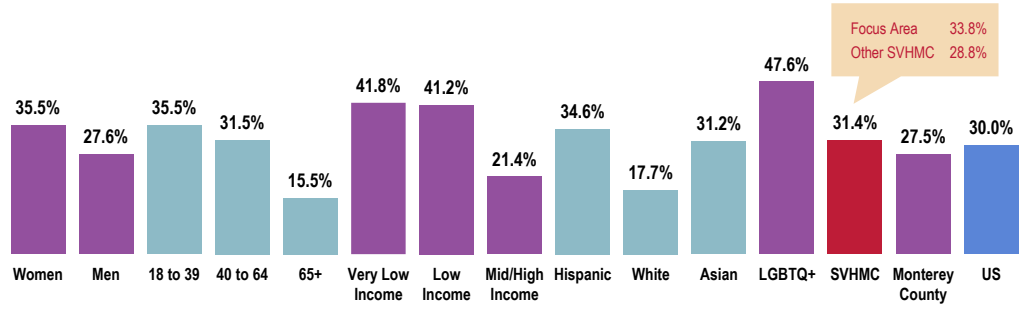


Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 324]
Notes: ● Asked of all respondents.

Access to Fresh Produce

PRC SURVEY ► "How difficult is it for you to buy fresh produce like fruits and vegetables at a price you can afford — would you say: very difficult, somewhat difficult, not too difficult, or not at all difficult?"

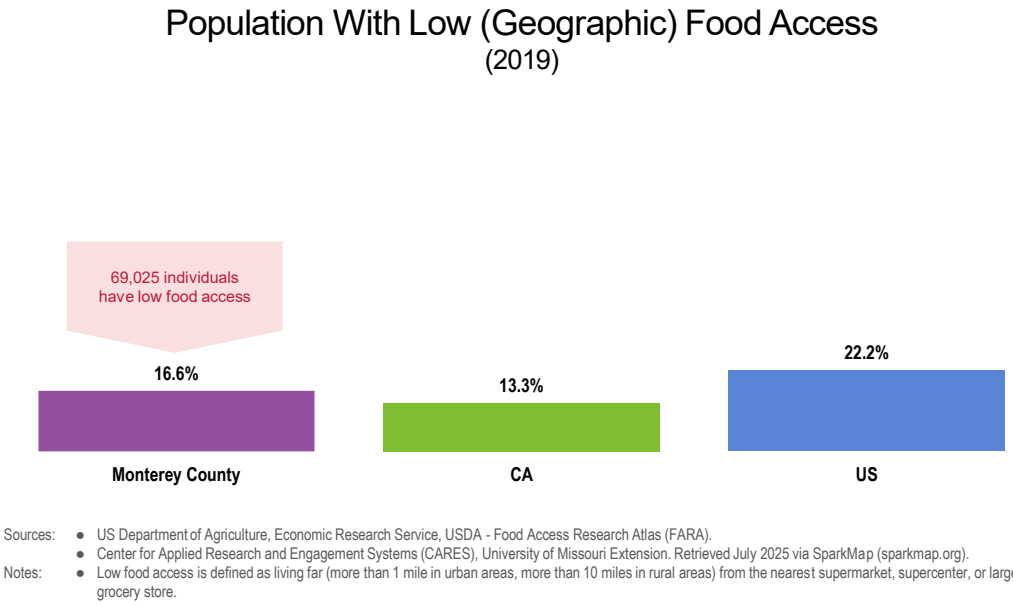
Find It "Very" or "Somewhat" Difficult to Buy Affordable Fresh Produce
(SVHMC Service Area, 2025)



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 66]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Low (Geographic) Food Access

Low food access is defined as living more than one mile from the nearest supermarket, supercenter, or large grocery store in urban areas (10 miles in rural areas). This related chart is based on US Department of Agriculture data. [COUNTY-LEVEL DATA]



Sources:
- US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas (FARA).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved July 2025 via SparkMap (sparkmap.org).

Notes:
- Low food access is defined as living far (more than 1 mile in urban areas, more than 10 miles in rural areas) from the nearest supermarket, supercenter, or large grocery store.

Physical Activity

ABOUT PHYSICAL ACTIVITY

Physical activity can help prevent disease, disability, injury, and premature death. The Physical Activity Guidelines for Americans lays out how much physical activity children, adolescents, and adults need to get health benefits. Although most people don't get the recommended amount of physical activity, it can be especially hard for older adults and people with chronic diseases or disabilities.

Strategies that make it safer and easier to get active — like providing access to community facilities and programs — can help people get more physical activity. Strategies to promote physical activity at home, at school, and at childcare centers can also increase activity in children and adolescents.

– Healthy People 2030 (https://health.gov/healthypeople)

Meeting Physical Activity Recommendations

To measure physical activity frequency, duration and intensity, respondents were asked:

PRC SURVEY ► "During the past month, what type of physical activity or exercise did you spend the most time doing?"

PRC SURVEY ► "And during the past month, how many times per week or per month did you take part in this activity?"

PRC SURVEY ► "And when you took part in this activity, for how many minutes or hours did you usually keep at it?"

Respondents could answer the above series for up to two types of physical activity. The specific activities identified (e.g., jogging, basketball, treadmill, etc.) determined the intensity values assigned to that respondent when calculating total aerobic physical activity hours/minutes.

Respondents were also asked about strengthening exercises:

PRC SURVEY ► "During the past month, how many times per week or per month did you do physical activities or exercises to strengthen your muscles? Do not count aerobic activities like walking, running, or bicycling. Please include activities using your own body weight, such as yoga, sit-ups, or push-ups, and those using weight machines, free weights, or elastic bands."

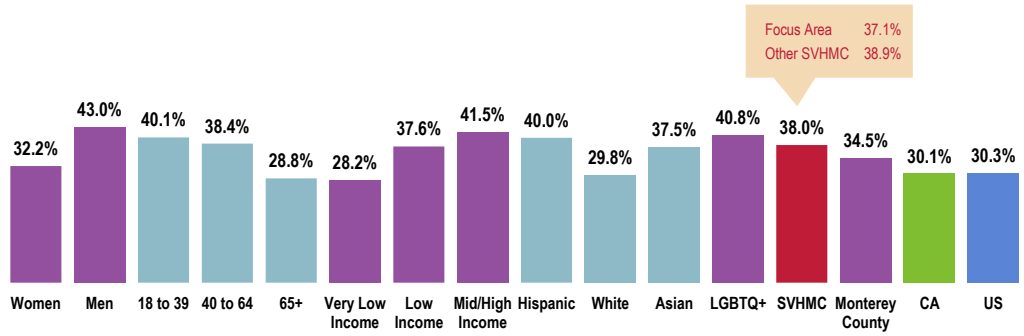
ADULTS: RECOMMENDED LEVELS OF PHYSICAL ACTIVITY

"Meeting physical activity recommendations" includes adequate levels of both aerobic and strengthening activity:

- **Aerobic activity** is at least 150 minutes per week of light-to-moderate activity, 75 minutes per week of vigorous physical activity, or an equivalent combination of both;
- **Strengthening activity** is at least 2 sessions per week of exercise designed to strengthen muscles.

– 2013 Physical Activity Guidelines for Americans, US Department of Health and Human Services. www.cdc.gov/physicalactivity

Meets Physical Activity Recommendations
(SVHMC Service Area, 2025)
Healthy People 2030 = 29.7% or Higher



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 110]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 California data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Asked of all respondents.
- Meeting both guidelines is defined as the number of persons age 18+ who report light or moderate aerobic activity for at least 150 minutes per week or who report vigorous physical activity 75 minutes per week (or an equivalent combination of moderate and vigorous-intensity activity) *and* who also report doing physical activities specifically designed to strengthen muscles at least twice per week.

Children's Physical Activity

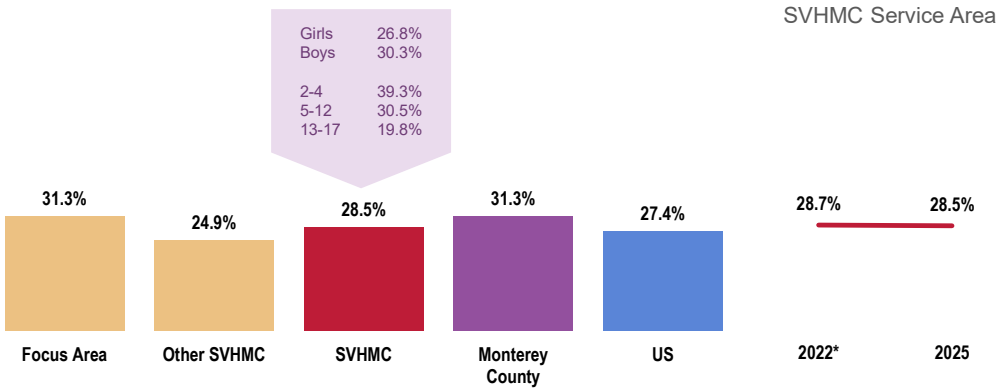
CHILDREN: RECOMMENDED LEVELS OF PHYSICAL ACTIVITY

Children and adolescents should do 60 minutes (1 hour) or more of physical activity each day.

– 2013 Physical Activity Guidelines for Americans, US Department of Health and Human Services. www.cdc.gov/physicalactivity

PRC SURVEY ▶ [Among parents of children age 2-17] **"During the past 7 days, on how many days was this child physically active for a total of at least 60 minutes per day?"**

Child Is Physically Active for One or More Hours per Day
(Children 2-17)



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 94]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents with children age 2 through 7 at home.
- Includes children reported to have one or more hours of physical activity on each of the seven days preceding the survey.
- *2022 data does not include ZIP Codes 93926 and 93960.

Weight Status

ABOUT OVERWEIGHT & OBESITY

Obesity is linked to many serious health problems, including type 2 diabetes, heart disease, stroke, and some types of cancer. Some racial/ethnic groups are more likely to have obesity, which increases their risk of chronic diseases.

Culturally appropriate programs and policies that help people eat nutritious foods within their calorie needs can reduce overweight and obesity. Public health interventions that make it easier for people to be more physically active can also help them maintain a healthy weight.

– Healthy People 2030 (https://health.gov/healthypeople)

Body Mass Index (BMI), which describes relative weight for height, is significantly correlated with total body fat content. The BMI should be used to assess overweight and obesity and to monitor changes in body weight. In addition, measurements of body weight alone can be used to determine efficacy of weight loss therapy. BMI is calculated as weight (kg)/height squared (m^2). To estimate BMI using pounds and inches, use: [weight (pounds)/height squared ($inches^2$)] x 703.

In this report, overweight is defined as a BMI of 25.0 to 29.9 kg/m^2 and obesity as a BMI ≥30 kg/m^2. The rationale behind these definitions is based on epidemiological data that show increases in mortality with BMIs above 25 kg/m^2. The increase in mortality, however, tends to be modest until a BMI of 30 kg/m^2 is reached. For persons with a BMI ≥30 kg/m^2, mortality rates from all causes, and especially from cardiovascular disease, are generally increased by 50 to 100 percent above that of persons with BMIs in the range of 20 to 25 kg/m^2.

– Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. National Institutes of Health. National Heart, Lung, and Blood Institute in Cooperation With The National Institute of Diabetes and Digestive and Kidney Diseases. September 1998.

Adult Weight Status

CLASSIFICATION OF OVERWEIGHT AND OBESITY BY BMI	BMI (kg/m^2)
Underweight	<18.5
Healthy Weight	18.5 – 24.9
Overweight	25.0 – 29.9
Obese	≥30.0

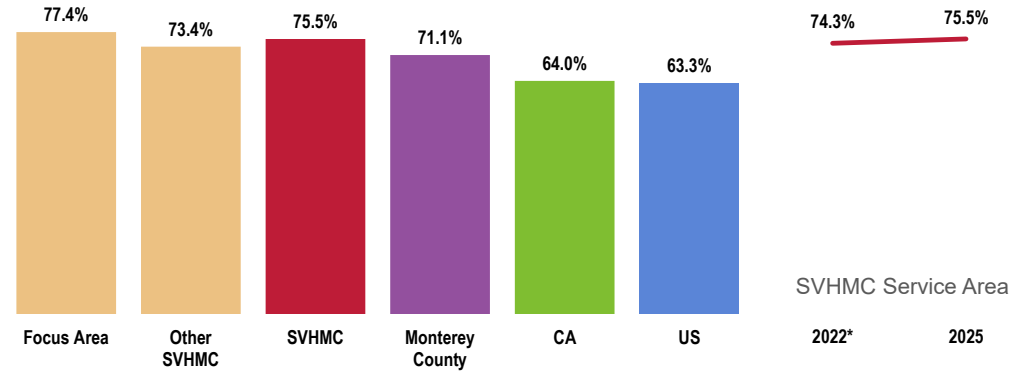
Source: Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. National Institutes of Health. National Heart, Lung, and Blood Institute in Cooperation With The National Institute of Diabetes and Digestive and Kidney Diseases. September 1998.

PRC SURVEY ► "About how much do you weigh without shoes?"

PRC SURVEY ► "About how tall are you without shoes?"

Reported height and weight were used to calculate a Body Mass Index or BMI value (described above) for each respondent. This calculation allows us to examine the proportion of the population who is at a healthy weight, or who is overweight or obese (see table above).

Prevalence of Total Overweight (Overweight and Obese)

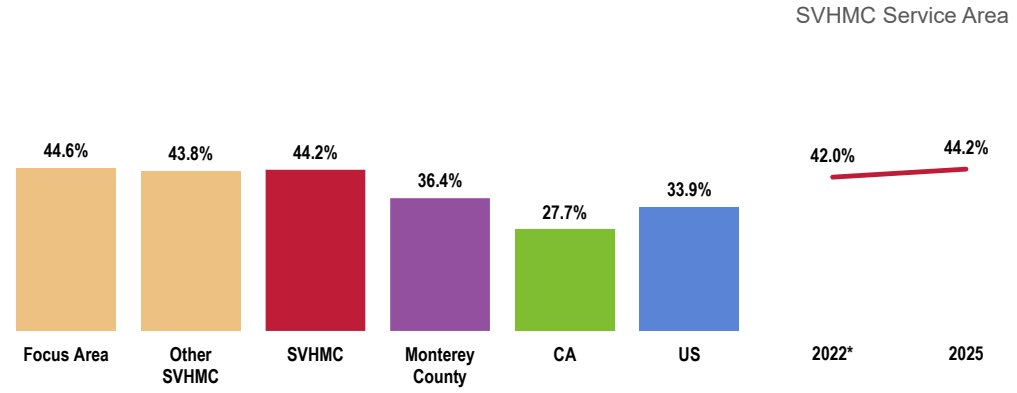


Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 112]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 California data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Based on reported heights and weights, asked of all respondents.
- The definition of overweight is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 25.0. The definition for obesity is a BMI greater than or equal to 30.0.
- *2022 data does not include ZIP Codes 93926 and 93960.

Prevalence of Obesity

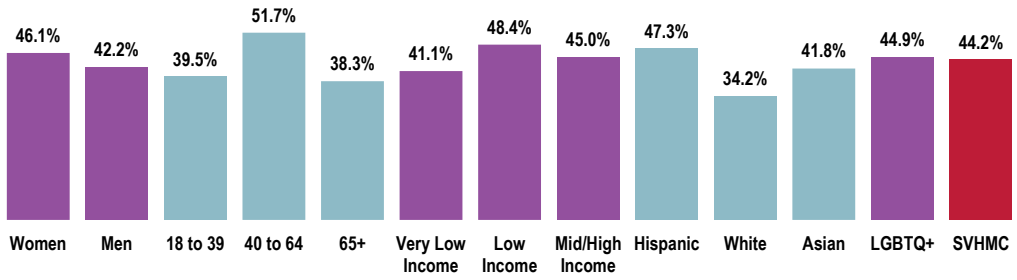
Healthy People 2030 = 36.0% or Lower



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 112]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 California data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Based on reported heights and weights, asked of all respondents.
- The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0.
- *2022 data does not include ZIP Codes 93926 and 93960.

Prevalence of Obesity
(SVHMC Service Area, 2025)
Healthy People 2030 = 36.0% or Lower



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 112]
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Based on reported heights and weights, asked of all respondents.
- The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0, regardless of gender.

Children's Weight Status

ABOUT WEIGHT STATUS IN CHILDREN & TEENS

In children and teens, body mass index (BMI) is used to assess weight status – underweight, healthy weight, overweight, or obese. After BMI is calculated for children and teens, the BMI number is plotted on the CDC BMI-for-age growth charts (for either girls or boys) to obtain a percentile ranking. Percentiles are the most commonly used indicator to assess the size and growth patterns of individual children in the United States. The percentile indicates the relative position of the child's BMI number among children of the same sex and age.

BMI-for-age weight status categories and the corresponding percentiles are shown below:

- Underweight <5th percentile
- Healthy Weight ≥5th and <85th percentile
- Overweight ≥85th and <95th percentile
- Obese ≥95th percentile

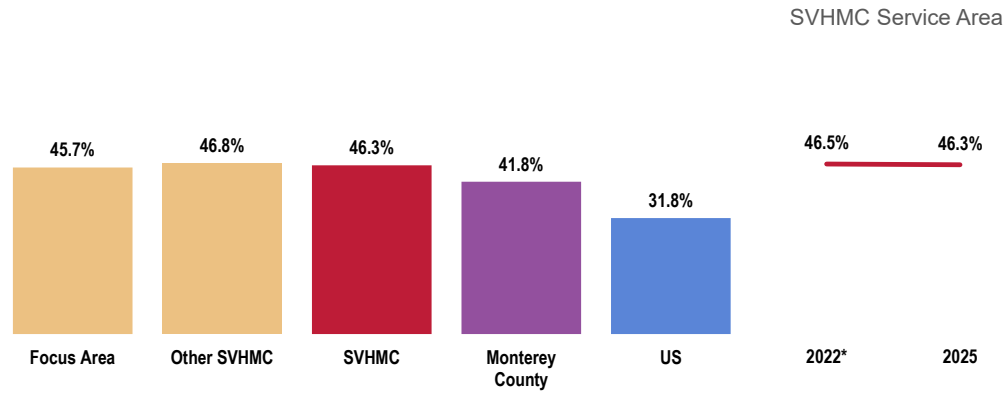
– Centers for Disease Control and Prevention

The following questions were used to calculate a BMI value (and weight classification as noted above) for each child represented in the survey:

PRC SURVEY ► [Among parents of children age 5-17] **"How much does this child weigh without shoes?"**

PRC SURVEY ► [Among parents of children age 5-17] **"About how tall is this child?"**

Prevalence of Overweight in Children
(Children 5-17)



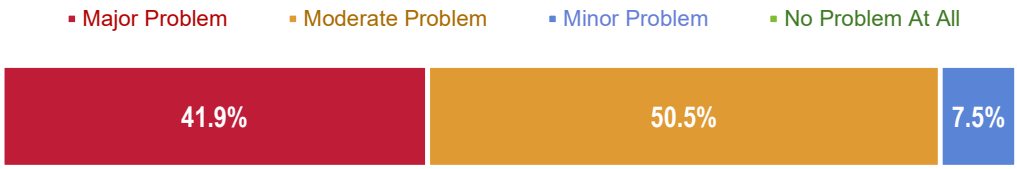
Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 113]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents with children age 5 through 17 at home.
- Overweight among children is determined by children's Body Mass Index status at or above the 85th percentile of US growth charts by gender and age.
- *2022 data does not include ZIP Codes 93926 and 93960.

Key Informant Input: Nutrition, Physical Activity & Weight

The following chart outlines key informants' perceptions of the severity of *Nutrition, Physical Activity & Weight* as a problem in the community:

Perceptions of Nutrition, Physical Activity & Weight as a Problem in the Community
(Among Key Informants; Monterey County, 2025)



Sources:
- 2025 PRC Online Key Informant Survey, PRC, Inc.

Notes:
- Asked of all respondents.

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

Access to Affordable Healthy Food

> Food is expensive. Fast and unhealthy food is more affordable. Opportunities for physical activity are limited. — Social Services Provider
>
> Access to healthy food options, knowledge about how food impacts health, and lack of access to free open space. — Social Services Provider
>
> Lack of affordable healthy foods, especially in low-income regions. Limited safe spaces to be active within the community. — Social Services Provider
>
> Access to affordable food, culturally relevant healthy foods, safe neighborhoods for activity. — Community Leader
>
> Lack to access to healthy eating options and healthy groceries. Lack of access to gyms and other exercise facilities. Lack of education and the effects associated with bad nutrition, lack of exercise, and being over/underweight. — Social Services Provider
>
> Access to good nutrition; poverty; and education. — Physician

> Healthy, affordable food choices. Safe parks for children to go outside and play at. Weight is directly related to the cultural diet in our community. — Health Care Provider
>
> Access to healthy foods, misinformation, busy lifestyles, emotional eating, lack of time, limited access to safe spaces, chronic dieting and weight cycling, stigma and mental health. — Social Services Provider
>
> Access to healthy nutrition. — Community Leader
>
> A lack of access to affordable fruits and vegetables, especially in rural areas. Having said that, the lack of access and affordability also affects populations elsewhere in the county. In general, food prices have continued to rise, forcing people to look for cheaper and often less healthy alternatives. It is very difficult for many to afford food, much less healthy food. There is a lack of walkable streets in many areas. Some of these are infrastructure, lack of sidewalks, etc. Some of these are individuals not feeling safe walking, biking, or playing in the neighborhood. The lack of safety is likely related to crime and possibly, for others, being exposed to the possibility of encountering ICE while out. There is access to some organized sports, depending on location; however, the cost may be out of reach for families. Outdoor areas at schools in most areas are closed up in the evening, weekend, and over the summer, leaving nearby recreational space limited or unavailable. — Public Health Representative
>
> Families that are already income-burdened cannot spend on quality fruits and vegetables as part of a healthy diet, as organic brands are more expensive. We have limited options for affordable organic food. There is a limited amount of affordable gyms in the area. Most are expensive and have limited workout space. Some families opt for exercising in the parks and around the city; however, the weather and wind are a factor and deterrent in our city. Having parks with exercise equipment may facilitate having more physical activity within our city and region. We lack restaurants with a variety of healthy options. We have a high concentration of fast food restaurants that make it easier to grant a cheap and unhealthy meal. Due to lack of high-paying jobs, many residents in South Monterey County commute to work; therefore, they are away from home for long hours during the day, and prepping and cooking healthy meals is not always feasible and prioritized. — Community Leader
>
> Healthier foods are not as affordable and accessible to all community members. The number of individuals who use the food bank is an indication of this. When families have to work far from where they live due to the affordability of housing or for families that work multiple jobs, they don't have as much time to fit in physical activity or to cook at home rather than eating fast, processed foods. — Community Leader

Built Environment

> Access to open spaces; healthy, affordable food; and knowing how to feed our bodies properly. Fear of deportation due to immigration status results in not reaching out for access. — Community Leader
>
> Built environment — lacking greenspace, such as parks and walking trails, biking paths throughout all parts of the county. Incomplete streets and sidewalks — unmaintained roads and broken sidewalks. Lack of access to healthy foods in all retail operations. High-sugar, high-calorie, and filling foods are cheaper and more readily accessible than healthier food, which is more expensive and takes time to shop for and prepare.
> — Public Health Representative
>
> Physical activity, safe parks, and safe, walkable neighborhoods. — Community Leader
>
> Lack of places to get out and walk/exercise. — Community Leader

Lifestyle

> Cheap and easy to get processed foods, less physical activity, and more screen time. — Community Leader
>
> Soda and processed food intake (unregulated advertising, lack of available affordable fresh fruits and vegetables in low-income neighborhoods, lack of safe spaces for outdoor exercise in low-income neighborhoods; lack of after-school care for children). The biggest predictor of childhood obesity is working parents. Lack of nutrition education programs (as a primary care doctor in Salinas, there is nowhere I can refer children for nutrition counseling, and I can only refer adults when they qualify for bariatric surgery — BMI over 40). Also, no referrals available for diabetic nutrition. County needs to create more positions for nutritionists and diabetic educators.
> — Physician
>
> High intake of fast food and lack of exercise. Need to increase low-cost wellness programs and initiate community exercise programs. — Community Leader
>
> Nutrition — cheap, high-calorie, low-nutrition food readily available, especially in impoverished communities. Easy access to fast foods, which, again, are high-calorie and poor nutrition. Living in dense, crowded living spaces, high crime is not conducive to exercise and or physical activity. These two things result in weight gain.
> — Physician
>
> People aren't eating right, and they lack the motivation to exercise. — Community Leader

Access to Care/Services

> Lack of structured groups with regular meetings to teach and support lifestyle changes. The few I know of require a diagnosis of diabetes or payment to a weight loss clinic/program. There are wonderful sources for fresh fruits and veggies, including affordable ones, and many beautiful options for movement, but no regularly scheduled meetings or groups that integrate/utilize health care practitioners for people with ‘normal’ insurance. — Physician
>
> Our communities have limited or no access to community centers like the YMCA, gyms, or open areas for safe physical workouts. — Community Leader

> Resources in the community. — Health Care Provider

Awareness/Education

> No early education for parents from babies on up as to what they need to feed their children. We have gyms, but very few attend them. There is just nothing that reaches the people who need it the most. — Community Leader

> Awareness of available resources and access to resources. — Community Leader

Obesity

> Strategies to motivate or support weight loss, either through increased activity, improved nutrition, calorie reduction, or other appear to have largely failed. The community and nation as a whole are more overweight and obese now than at any time ever recorded in the past. Workplaces, schools, other tasks, and societal functions that capture people's attention Monday through Friday for the majority of their waking hours should incentivize more physical activity, more outdoor activity, and improved nutrition. — Community Leader

> Obesity. — Physician

Parental Influence

> Parents knowing how to set boundaries is what I see as the biggest challenge. In our city council meetings, many people speak up about how they do not feel safe in their neighborhoods, so they're not getting out to exercise. I have heard people talking about how rents are so high, they don't have money for food.
> — Social Services Provider

Nutrition

> I think we need to expose the community to better programs to help eat healthy, move more. More education. More programs like Blue Zones Project. — Physician

Technology

> Gamer culture, virtual reality, culture of unhealthy food consumption, and limited culturally-rooted healthy food options. — Community Leader

Affordable Care/Services

> Cost of services, finding resources, finding accessible options, having a safe space to exercise.
> — Social Services Provider

Employment

> Unemployment, education, access to transportation, access to professional caregivers. — Physician

Housing

> Cost of living driving individuals to work hard and work more hours, leading to limited activity, eating what is easily accessible. — Physician

Income/Poverty

> Low income often leads to an unhealthy, fast food, ultraprocessed food diet. — Physician

Substance Use

ABOUT DRUG & ALCOHOL USE

More than 20 million adults and adolescents in the United States have had a substance use disorder in the past year. …Substance use disorders can involve illicit drugs, prescription drugs, or alcohol. Opioid use disorders have become especially problematic in recent years. Substance use disorders are linked to many health problems, and overdoses can lead to emergency department visits and deaths.

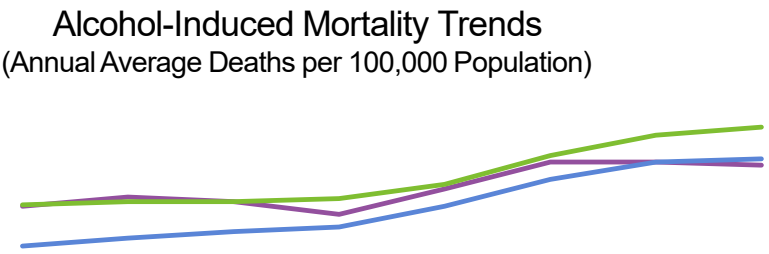
Effective treatments for substance use disorders are available, but very few people get the treatment they need. Strategies to prevent substance use — especially in adolescents — and help people get treatment can reduce drug and alcohol misuse, related health problems, and deaths.

– Healthy People 2030 (https://health.gov/healthypeople)

Alcohol

Alcohol-Induced Deaths

The following chart outlines alcohol-induced mortality in the area. [COUNTY-LEVEL DATA]



	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
Monterey County	12.7	13.3	13.0	12.2	13.8	15.5	15.5	15.3
CA	12.8	13.0	13.0	13.2	14.1	15.9	17.2	17.7
US	10.2	10.7	11.1	11.4	12.7	14.4	15.5	15.7

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2025.

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

Excessive Drinking

PRC SURVEY ► "During the past 30 days, on how many days did you have at least one drink of any alcoholic beverage such as beer, wine, a malt beverage, or liquor?"

PRC SURVEY ► "On the day(s) when you drank, about how many drinks did you have on average?"

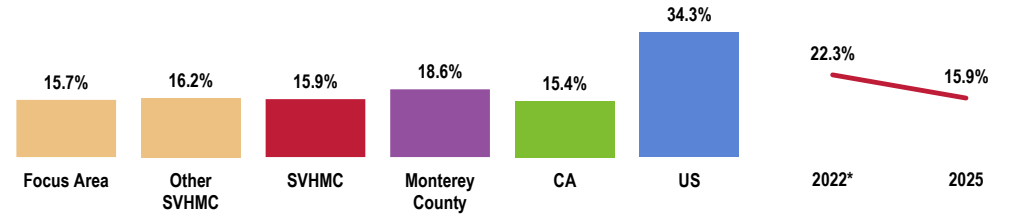
PRC SURVEY ► "Considering all types of alcoholic beverages, how many times during the past 30 days did you have 5 (if male)**/4** (if female) **or more drinks on an occasion?"**

Excessive drinking includes heavy and/or binge drinkers:

- HEAVY DRINKING ► men reporting 2+ alcoholic drinks per day or women reporting 1+ alcoholic drink per day in the month preceding the interview.
- BINGE DRINKING ► men reporting 5+ alcoholic drinks or women reporting 4+ alcoholic drinks on any single occasion during the past month.

Engage in Excessive Drinking

SVHMC Service Area



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 116]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 California data.
- 2023 PRC National Health Survey, PRC, Inc.

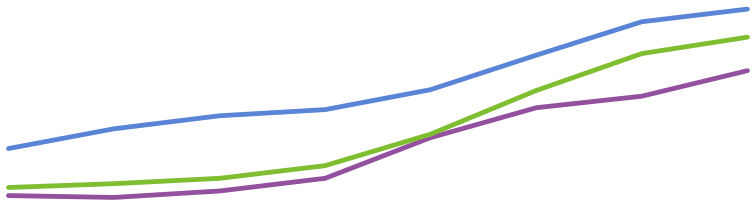
Notes:
- Asked of all respondents.
- Excessive drinking reflects the percentage of persons age 18 years and over who drank more than two drinks per day on average (for men) or more than one drink per day on average (for women) OR who drank 5 or more drinks during a single occasion (for men) or 4 or more drinks during a single occasion (for women) during the past 30 days.
- *2022 data does not include ZIP Codes 93926 and 93960.

Drugs

Unintentional Drug-Induced Deaths

Unintentional drug-induced deaths include all deaths, other than suicide, for which drugs are an underlying cause. A "drug" includes illicit or street drugs (e.g., heroin and cocaine), as well as legal prescription and over-the-counter drugs; alcohol is not included. The following chart outlines local mortality for unintentional drug-induced deaths. [COUNTY-LEVEL DATA]

Unintentional Drug-Induced Mortality Trends
(Annual Average Deaths per 100,000 Population)



	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
Monterey County	9.1	8.9	9.6	11.0	15.5	18.8	20.1	22.9
CA	10.0	10.4	11.0	12.4	15.9	20.7	24.8	26.6
US	14.3	16.5	17.9	18.6	20.8	24.6	28.3	29.7

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2025.

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

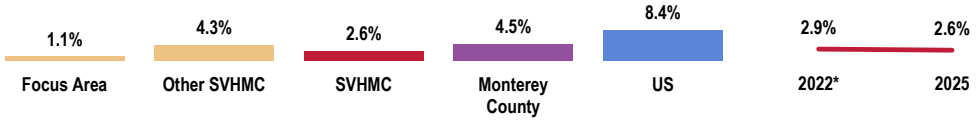
Illicit Drug Use

Note: As a self-reported measure – and because this indicator reflects potentially illegal behavior – it is reasonable to expect that it might be underreported, and that actual illicit drug use in the community is likely higher.

PRC SURVEY ► "During the past 30 days, have you used an illegal drug or taken a prescription drug that was not prescribed to you?"

Illicit Drug Use in the Past Month

SVHMC Service Area



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 40]
- 2023 PRC National Health Survey, PRC, Inc.

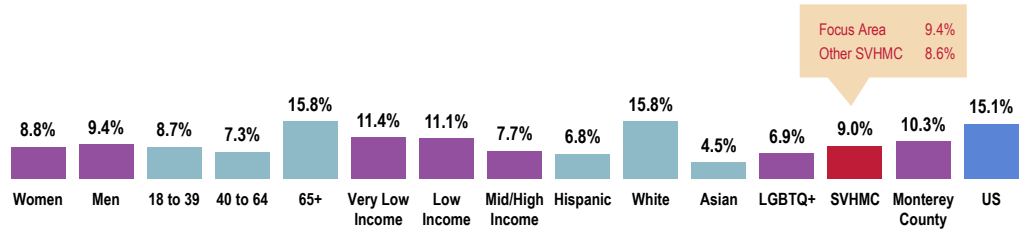
Notes:
- Asked of all respondents.
- *2022 data does not include ZIP Codes 93926 and 93960.

Use of Prescription Opioids

Opioids are a class of drugs used to treat pain. Examples presented to respondents include morphine, codeine, hydrocodone, oxycodone, methadone, and fentanyl. Common brand name opioids include Vicodin, Dilaudid, Percocet, OxyContin, and Demerol.

PRC SURVEY ► "Opiates or opioids are drugs that doctors prescribe to treat pain. Examples of prescription opiates include morphine, codeine, hydrocodone, oxycodone, methadone, and fentanyl. In the past year, have you used any of these prescription opiates?"

Used a Prescription Opioid in the Past Year
(SVHMC Service Area, 2025)



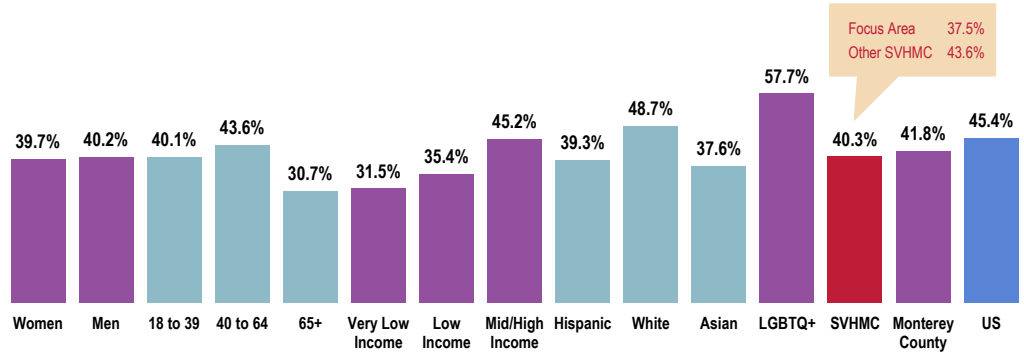
Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 41]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Personal Impact From Substance Use

PRC SURVEY ► "To what degree has your life been negatively affected by your own or someone else's substance use issues, including alcohol, prescription, and other drugs? Would you say: a great deal, somewhat, a little, or not at all?"

Life Has Been Negatively Affected by Substance Use (by Self or Someone Else)
(SVHMC Service Area, 2025)

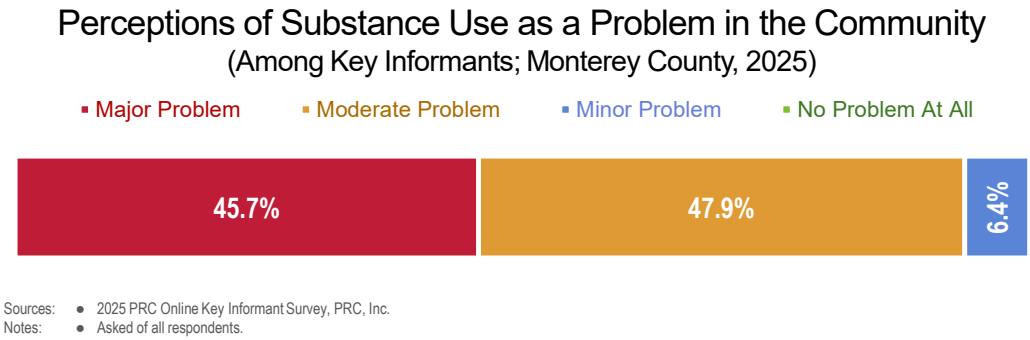


Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 43]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes response of "a great deal," "somewhat," or "a little."

Key Informant Input: Substance Use

The following chart outlines key informants' perceptions of the severity of *Substance Use* as a problem in the community:



Sources: • 2025 PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

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

Access to Care/Services

> Difficulty getting into a methadone clinic. Too few physicians prescribing buprenorphine for OUD and IM naltrexone, vivitrol for alcohol use disorder. — Physician
>
> Not enough treatment facilities in the county. — Health Care Provider
>
> Access and awareness of folks in need and of service providers. — Physician
>
> Not enough access to inpatient treatment programs covered by Medi-Cal. Not enough resources for minors in the community. Not enough beds or space for people in need of an inpatient stay. — Social Services Provider
>
> Lack of residential facilities in our area to address the substance use. Lack of money to afford treatment. Lack of funding to implement prevention programs in our community. Lack of consistent awareness of the resources and treatments available to families. — Community Leader
>
> Lack of available and timely services, especially for those who are uninsured, low-income, or don't speak English. Stigma is another major barrier. Many individuals and families avoid seeking help due to shame, fear of judgment, or lack of understanding around addiction as a health issue. — Social Services Provider
>
> Fancy mental health residential facilities built on the peninsula that have limited or no availably for kids on Medi-Cal or without insurance. — Public Health Representative
>
> Limited resources. Lots of patients with mental health issues, houselessness, chronic pain. — Physician
>
> Access to treatment that doesn't result in incarceration, fear of deportation due to immigration status result in not reaching out for access. — Community Leader
>
> No access, no resources. — Physician
>
> Insufficient availability of treatment programs. Lack of information to medical community about how/ where to refer. — Physician
>
> Lack of availability of services in county, inundated wait lists for people actively seeking services. — Social Services Provider
>
> Lack of intervention services. — Social Services Provider

Affordable Care/Services

> Easily accessible, affordable treatments. Transportation and cost are the biggest barriers. — Social Services Provider
>
> There is a dearth of affordable substance use treatment experts and facilities. — Community Leader
>
> Cost. — Physician
>
> SUD treatment is expensive, and most insurance does not cover inpatient treatment. Several for medical patients. Treatment access has lots of barriers, requires screenings, not enough employees available to get timely screenings. — Health Care Provider
>
> Cost and lack of insurance; stigma and shame; lack of local treatment facilities; transportation; and mental health. — Social Services Provider
>
> It is really hard to find affordable substance use treatment programs in our community. — Community Leader

Alcohol/Drug Use

> Fentanyl and opioid use/abuse. — Community Leader
>
> Increased availability of fentanyl, specifically. — Community Leader

> Fentanyl. — Community Leader
>
> More people who use substances are using at a higher rate and are developing addiction challenges that require high levels of care (residential, intensive outpatient) to address. However, the process to access these services is difficult to navigate and have a long wait period after assessment before being placed in the appropriate level of care. Substance use is also seen by some law enforcement personnel as a criminal matter and approached as such, with the result being punitive (incarceration) versus rehabilitative (seeking treatment). — Community Leader

Lack of Providers

> Connecting to a reputable provider. — Social Services Provider
>
> Lack of psychiatrists. Bias against people with addiction. Lack of long-term inpatient and outpatient treatment centers. — Social Services Provider
>
> Not enough providers of these services in our county. — Physician
>
> Limited number of providers for substance abuse disorder. Limited number of providers who can provide medically assisted treatment. — Community Leader

Denial/Stigma

> Feeling like truly judgement-free zones and accessible information exist, can be asked for/requested, and actually find programs that work for folks. — Social Services Provider
>
> Stigma. — Social Services Provider
>
> I am only aware of people not wanting treatment. — Community Leader
>
> Willingness to receive treatment. — Health Care Provider

Incidence/Prevalence

> I'm not sure, but one needs only go for a walk along the main street to see that it's a big problem. — Social Services Provider
>
> Of course, it is a problem. Opioid and methamphetamine use is at all-time high. Not many providers are trained or comfortable in the dispensing of suboxone, which only works well for opioid use. It is a big problem for our community. Meth is bigger, and there are no effective treatments as of yet for meth. Seems to be very easy to access, and it might be that we are on the 101 corridor and not landlocked with the Pacific on our left, allowing for delivery of drugs from Latin America and Asia. In addition, there are specialty stores where you can purchase medications such as tramadol and benzodiazepines, etc. This is not hearsay, as I along with another provider treated a patient who thought they were purchasing tramadol (which is illegal) from a store, and it turned out they were being sold benzos, resulting in a lot of problems. There are thousands of these stores (in this store the FBI seized 2,000 illegal pills after I reported it). — Physician

Access to Care for Uninsured/Underinsured

> Most people do not know the first steps. Even after they identify the problems, then what's next and who pays? — Social Services Provider
>
> Awareness of programming, costs and support systems. — Community Leader

Co-Occurrences

> Mental health. — Community Leader
>
> Substance abuse is associated with mental disease. Addiction is not curable. — Physician

Cultural/Personal Beliefs

> Barriers are cultural. Existing resources are not supported enough to meet the urgent needs visible on a daily basis on our streets and schools. — Community Leader

Easy Access

> Adults purchasing alcohol, weed for youngsters. Youngsters trying to avoid the pain in their lives. Social connection. — Social Services Provider

Language Barriers

> Language and social obstacles, but mostly the gang problems that haunt all of the county. — Community Leader

Law Enforcement

> Legal mandates to attend/seek treatment rather than criminal charges. — Social Services Provider

Opioid Dependence

> Opioid dependence and overutilization. — Public Health Representative

Tobacco Use

ABOUT TOBACCO USE

More than 16 million adults in the United States have a disease caused by smoking cigarettes, and smoking-related illnesses lead to half a million deaths each year.

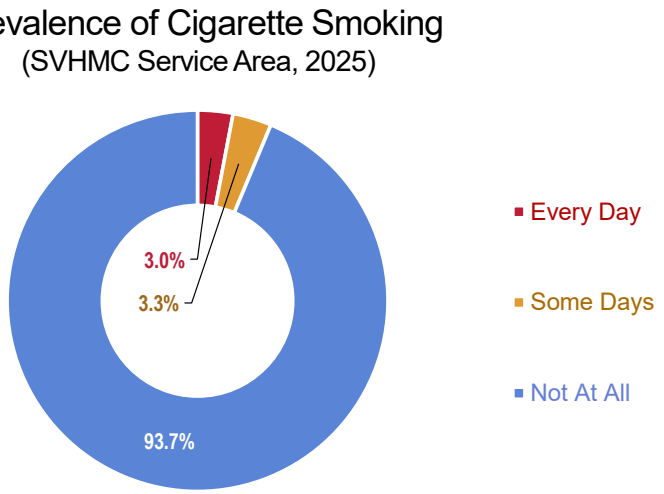
Most deaths and diseases from tobacco use in the United States are caused by cigarettes. Smoking harms nearly every organ in the body and increases the risk of heart disease, stroke, lung diseases, and many types of cancer. Although smoking is widespread, it's more common in certain groups, including men, American Indians/Alaska Natives, people with behavioral health conditions, LGBT people, and people with lower incomes and education levels.

Several evidence-based strategies can help prevent and reduce tobacco use and exposure to secondhand smoke. These include smoke-free policies, price increases, and health education campaigns that target large audiences. Methods like counseling and medication can also help people stop using tobacco.

– Healthy People 2030 (https://health.gov/healthypeople)

Cigarette Smoking

PRC SURVEY ► "Do you currently smoke cigarettes every day, some days, or not at all?"
("Currently Smoke Cigarettes" includes those smoking "every day" or on "some days.")

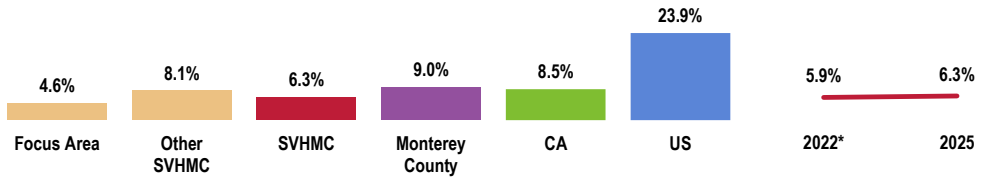


Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 34]
Notes: ● Asked of all respondents.

Currently Smoke Cigarettes

Healthy People 2030 = 6.1% or Lower

SVHMC Service Area



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 34]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 California data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Asked of all respondents.
- Includes those who smoke cigarettes every day or on some days.
- *2022 data does not include ZIP Codes 93926 and 93960.

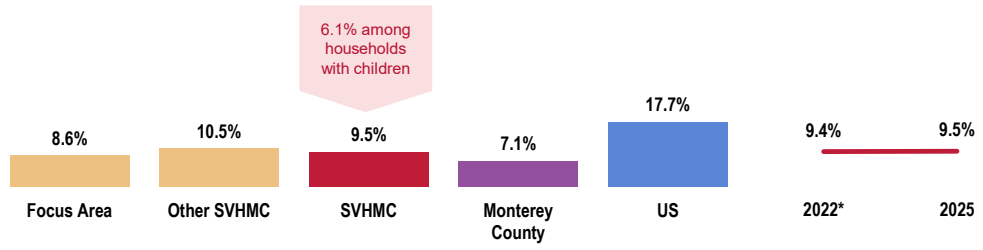
Environmental Tobacco Smoke

PRC SURVEY ► "In the past 30 days, has anyone, including yourself, smoked cigarettes, cigars, or pipes anywhere in your home on an average of four or more days per week?"

The following chart details these responses among the total sample of respondents, as well as among only households with children (age 0-17).

Member of Household Smokes at Home

SVHMC Service Area



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Items 35, 114]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- "Smokes at home" refers to someone smoking cigarettes, cigars, or a pipe in the home an average of four or more times per week in the past month.
- *2022 data does not include ZIP Codes 93926 and 93960.

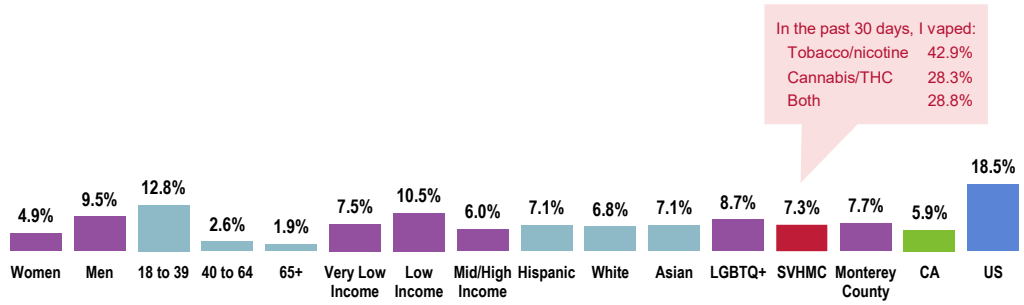
Use of Vaping Products

PRC SURVEY ► "Electronic vaping products, such as electronic cigarettes, are battery-operated devices that simulate traditional cigarette smoking but do not involve the burning of tobacco. Do you currently use electronic vaping products, such as electronic cigarettes, every day, some days, or not at all?"

("Currently Use Vaping Products" includes use "every day" or on "some days.")

PRC SURVEY ► [Those who currently use vaping products] **"During the past 30 days, when you used vaping products, did you use: tobacco or nicotine products; cannabis products; or both?"** (Excludes those who vape on some days, but not within the past 30 days.)

Currently Use Vaping Products
(SVHMC Service Area, 2025)

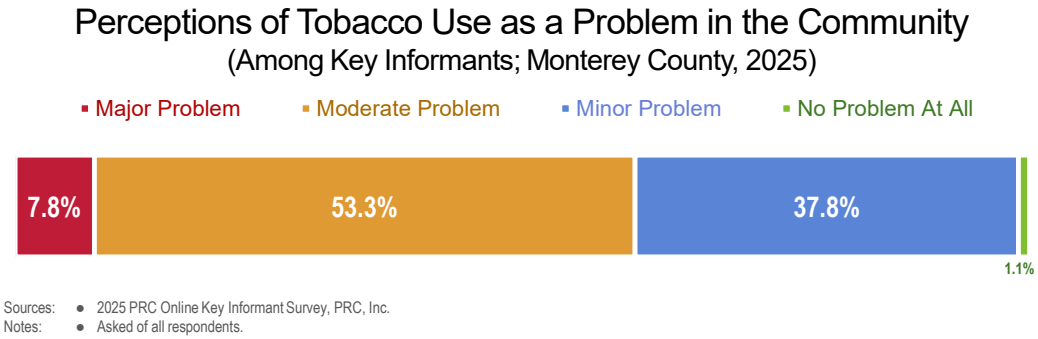


Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Items 36, 310]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 California data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes those who use vaping products every day or on some days.

Key Informant Input: Tobacco Use

The following chart outlines key informants' perceptions of the severity of *Tobacco Use* as a problem in the community:



Sources: • 2025 PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

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

Incidence/Prevalence

> It impacts not just the individual who smokes, but also the broader population. — Social Services Provider
>
> Incidence is not necessarily decreasing. Vaping is not helping, either. — Physician

E-Cigarettes

> Tobacco is a problem, but not as much as vaping. Although it is still an issue, campaigns against tobacco use have been effective, and I myself do not see as much tobacco use as I do vape use and marijuana use. The 60 and older population, from my own experience, seems to be the highest risk of TUD, perhaps coinciding with the time when tobacco companies were at their peak in targeting populations. — Physician

Social Norms/Community Attitude

> A lot of kids don't think it is a big deal. It is prevalent. Norm rather than exception. Entry to substance use. Stores selling to minors. — Social Services Provider

Sexual Health

ABOUT HIV & SEXUALLY TRANSMITTED INFECTIONS

Although many sexually transmitted infections (STIs) are preventable, there are more than 20 million estimated new cases in the United States each year — and rates are increasing. In addition, more than 1.2 million people in the United States are living with HIV (human immunodeficiency virus).

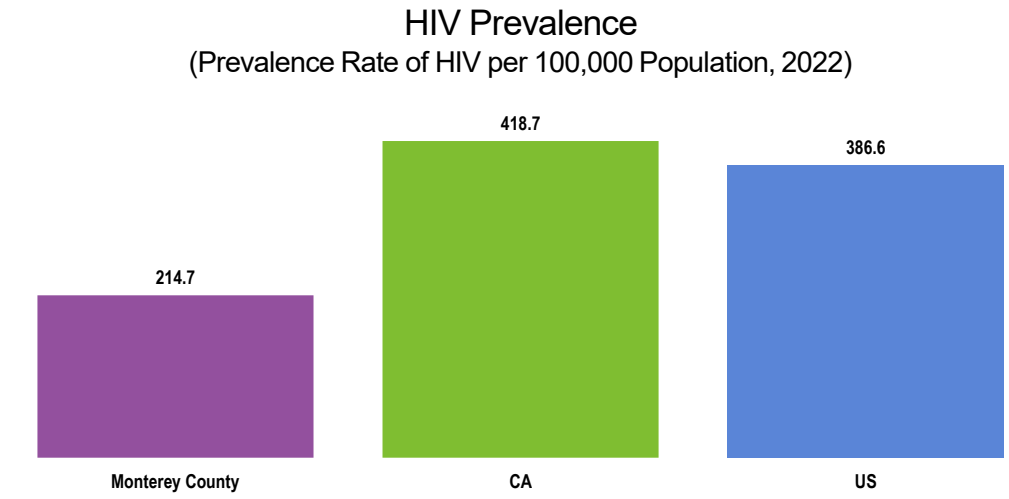
Adolescents, young adults, and men who have sex with men are at higher risk of getting STIs. And people who have an STI may be at higher risk of getting HIV. Promoting behaviors like condom use can help prevent STIs.

Strategies to increase screening and testing for STIs can assess people's risk of getting an STI and help people with STIs get treatment, improving their health and making it less likely that STIs will spread to others. Getting treated for an STI other than HIV can help prevent complications from the STI but doesn't prevent HIV from spreading.

– Healthy People 2030 (https://health.gov/healthypeople)

HIV

The following chart outlines prevalence (current cases, regardless of when they were diagnosed) of HIV per 100,000 population in the area. [COUNTY-LEVEL DATA]



Sources:
- Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved July 2025 via SparkMap (sparkmap.org).

Sexually Transmitted Infections (STIs)

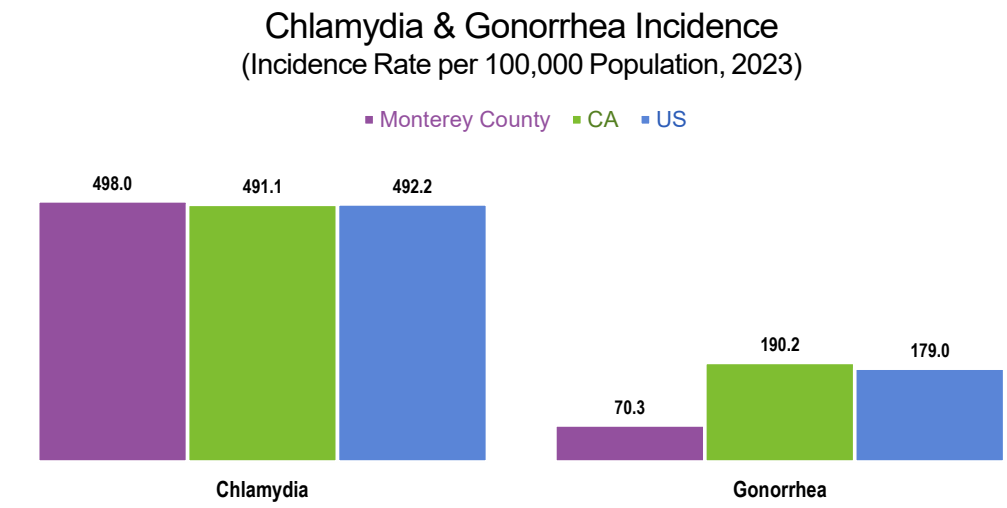
Chlamydia

Chlamydia is the most commonly reported STI in the United States; most people who have chlamydia are unaware, since the disease often has no symptoms.

Gonorrhea

Anyone who is sexually active can get gonorrhea. Gonorrhea can be cured with the right medication; left untreated, however, gonorrhea can cause serious health problems in both women and men.

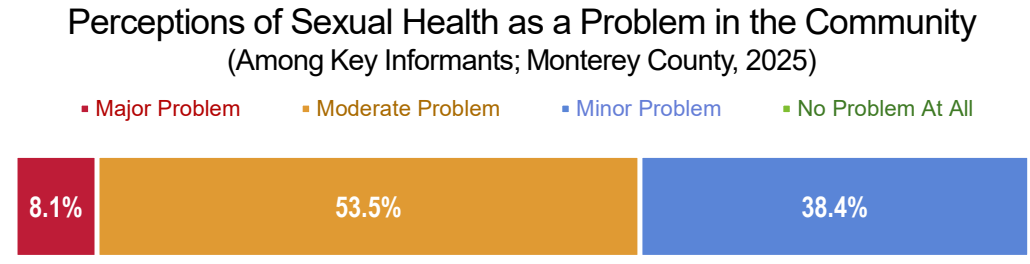
The following chart outlines local incidence for these STIs. [COUNTY-LEVEL DATA]



Sources:
- Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved July 2025 via SparkMap (sparkmap.org).

Key Informant Input: Sexual Health

The following chart outlines key informants' perceptions of the severity of *Sexual Health* as a problem in the community:



Sources: 2025 PRC Online Key Informant Survey, PRC, Inc.
Notes: Asked of all respondents.

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

Sexually Transmitted Infections

> I work in clinics and labor and delivery. In both those sectors, I have seen a rise in syphilis and chlamydia, and as a consequence, the sequelae, such as neurosyphilis and pelvic inflammatory disease. — Physician

> HIV transmission is ongoing; this is unconscionable in a community of our size. Other STIs are common, high syphilis rate, potential birth defects when occurring in pregnancy, and chlamydia causing infertility. — Physician

> The numbers of reported cases of STIs have increased year over year, including syphilis, which may also lead to preventable congenital syphilis cases. This increase in STI cases may not be the whole picture, as individuals may, for different reasons, not seek treatment. Lack of uptake of PrEP, for, again, multiple reasons, including embarrassment and cultural norms. Mis- or disinformation aimed at the public, discouraging support for the needed services. I also worry about the future of this type of funding and services with the current administration. — Public Health Representative

Access to Care/Services

> There is unfortunately a lack of access to regular STI testing in our area. Lots of gay men and men who have sex with men report challenges in getting prescriptions for PrEP and other medications that could reduce the spread of HIV/other STDs. — Community Leader

Denial/Stigma

> There is still a lot of stigma surrounding the topic and uncomfortable young parents entering parenthood, unsure of what to do and if they wanted their now-existent children. — Social Services Provider

Parental Supervision

> There are a lot of unsupervised kids after school whose parents are working, and there are no Planned Parenthood offices anywhere nearby that I have ever heard of. — Community Leader

ACCESS TO HEALTH CARE

ABOUT HEALTH CARE ACCESS

Many people in the United States don't get the health care services they need. …About 1 in 10 people in the United States don't have health insurance. People without insurance are less likely to have a primary care provider, and they may not be able to afford the health care services and medications they need. Strategies to increase insurance coverage rates are critical for making sure more people get important health care services, like preventive care and treatment for chronic illnesses.

Sometimes people don't get recommended health care services, like cancer screenings, because they don't have a primary care provider. Other times, it's because they live too far away from health care providers who offer them. Interventions to increase access to health care professionals and improve communication — in person or remotely — can help more people get the care they need.

– Healthy People 2030 (https://health.gov/healthypeople)

Lack of Health Insurance Coverage

Here, lack of health insurance coverage reflects respondents age 18 to 64 (thus, excluding the Medicare population) who have no type of insurance coverage for health care services – neither private insurance nor government-sponsored plans.

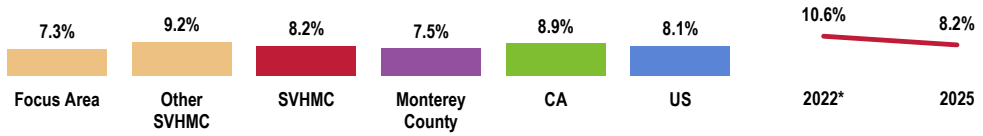
Survey respondents were asked a series of questions to determine their health care insurance coverage, if any, from either private or government-sponsored sources.

PRC SURVEY ► "Do you have any government-assisted health care coverage, such as Medicare, Medi-Cal, or VA/military benefits?"

PRC SURVEY ► "Do you currently have: health insurance you get through your own or someone else's employer or union; health insurance you purchase yourself or get through a health insurance exchange website; or, you do not have health insurance and pay entirely on your own?"

Lack of Health Care Insurance Coverage
(Adults 18-64)
Healthy People 2030 = 7.6% or Lower

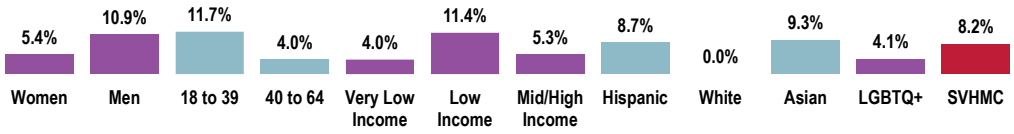
SVHMC Service Area



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 117]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 California data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Reflects respondents age 18 to 64.
- *2022 data does not include ZIP Codes 93926 and 93960.

Lack of Health Care Insurance Coverage
(Adults 18-64; SVHMC Service Area, 2025)
Healthy People 2030 = 7.6% or Lower



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 117]
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Reflects respondents age 18 to 64.

Difficulties Accessing Health Care

Barriers to Health Care Access

To better understand health care access barriers, survey participants were asked whether any of the following barriers to access prevented them from seeing a physician or obtaining a needed prescription in the past year.

PRC SURVEY ► "Was there a time in the past 12 months when you needed medical care but had difficulty finding a doctor?"

PRC SURVEY ► "Was there a time in the past 12 months when you had difficulty getting an appointment to see a doctor?"

PRC SURVEY ► "Was there a time in the past 12 months when you needed to see a doctor but could not because of the cost?"

PRC SURVEY ► "Was there a time in the past 12 months when a lack of transportation made it difficult or prevented you from seeing a doctor or making a medical appointment?"

PRC SURVEY ► "Was there a time in the past 12 months when you were not able to see a doctor because the office hours were not convenient?"

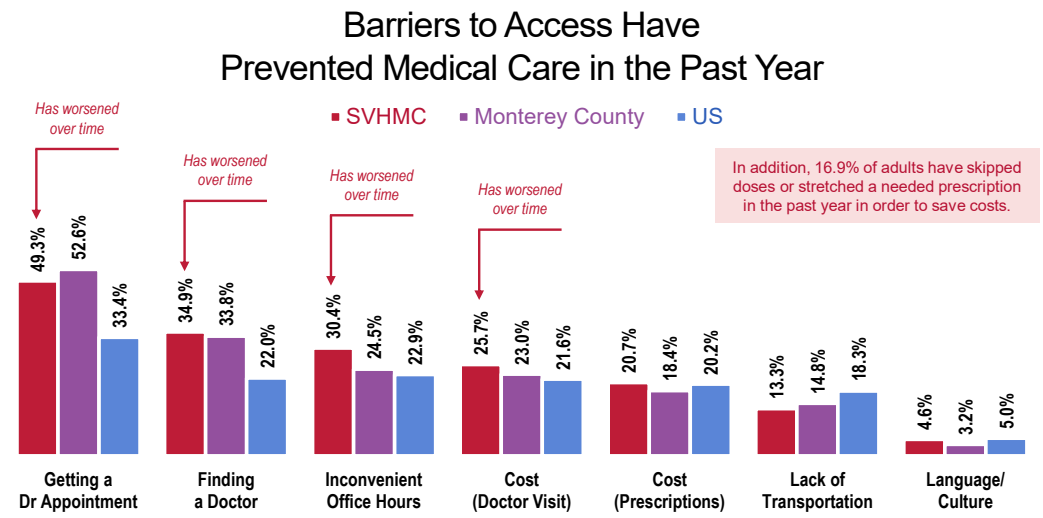
PRC SURVEY ► "Was there a time in the past 12 months when you needed a prescription medicine but did not get it because you could not afford it?"

PRC SURVEY ► "Was there a time in the past 12 months when you were not able to see a doctor due to language or cultural differences?"

Also:

PRC SURVEY ► "Was there a time in the past 12 months when you skipped doses or took smaller doses in order to make your prescriptions last longer and save costs?"

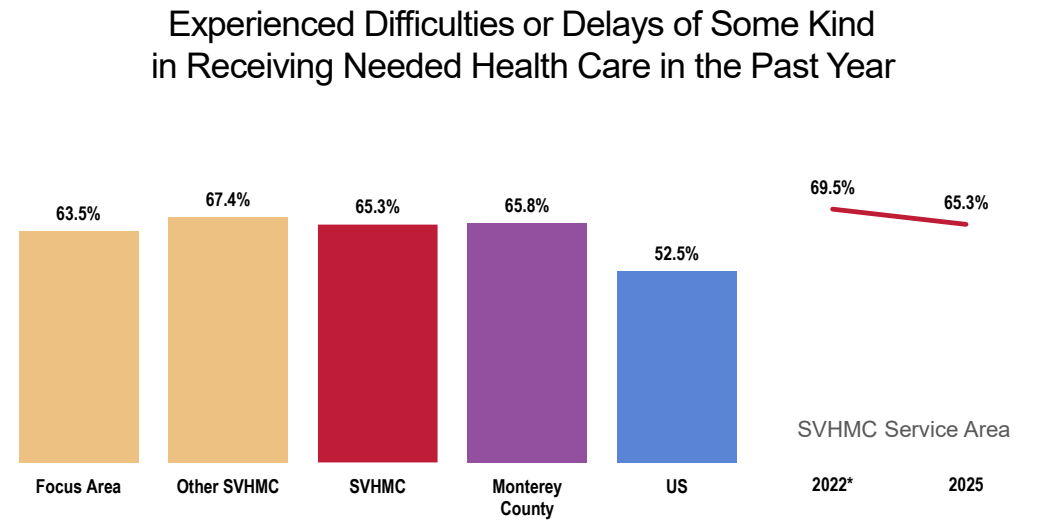
The percentages shown in the following chart reflect the total population, regardless of whether medical care was needed or sought.



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Items 6-13]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

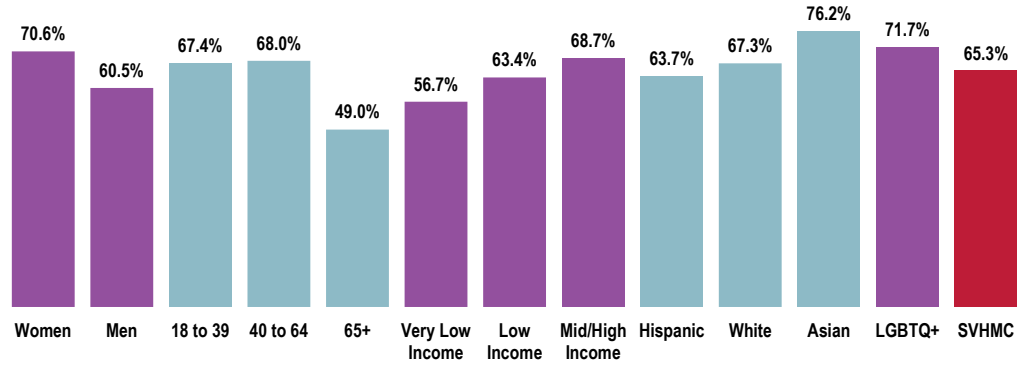
The following charts reflect the composite percentage of the total population experiencing problems accessing health care in the past year (indicating one or more of the aforementioned barriers), again regardless of whether they needed or sought care.



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 119]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Percentage represents the proportion of respondents experiencing one or more barriers to accessing health care in the past 12 months.
- *2022 data does not include ZIP Codes 93926 and 93960.

Experienced Difficulties or Delays of Some Kind in Receiving Needed Health Care in the Past Year
(SVH Service Area, 2025)



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 119]

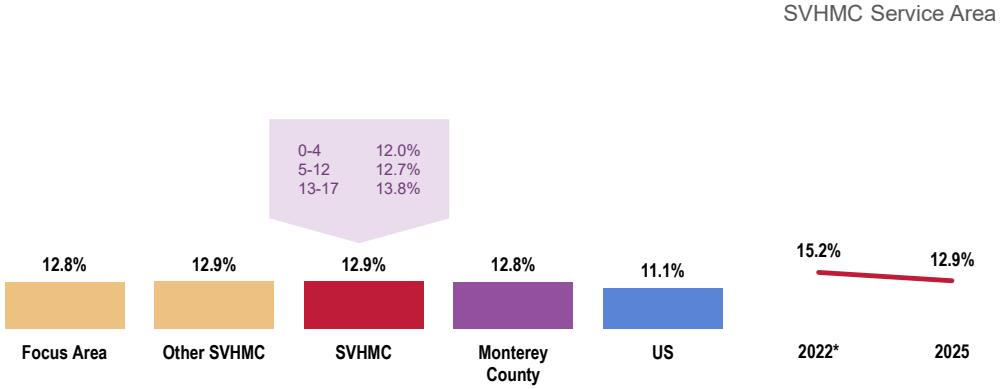
Notes:
- Asked of all respondents.
- Percentage represents the proportion of respondents experiencing one or more barriers to accessing health care in the past 12 months.

Accessing Health Care for Children

Surveyed parents were also asked if, within the past year, they experienced any trouble receiving medical care for a randomly selected child in their household.

PRC SURVEY ▶ [Among parents of children age 0-17] **"Was there a time in the past 12 months when you needed medical care for this child but could not get it?"**

Had Trouble Obtaining Medical Care for Child in the Past Year
(Children 0-17)

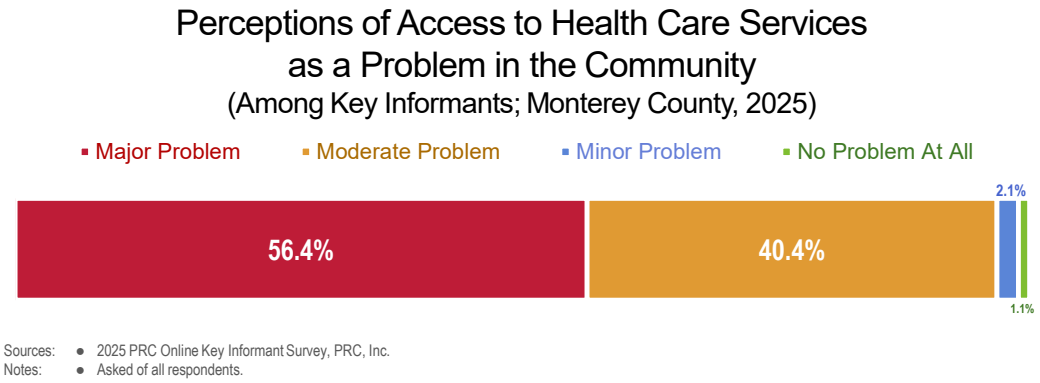


Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 90]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents with children age 0 to 17 in the household.
- *2022 data does not include ZIP Codes 93926 and 93960.

Key Informant Input: Access to Health Care Services

The following chart outlines key informants' perceptions of the severity of *Access to Health Care Services* as a problem in the community:



Sources: ● 2025 PRC Online Key Informant Survey, PRC, Inc.
Notes: ● Asked of all respondents.

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

Access to Care/Services

Access to primary care. Costs. — Community Leader

South County residents continue to have major access to care issues, especially for PCP and specialized care. — Public Health Representative

Having health insurances accepted locally and that so few doctors are accepting new patients. For many services, people have to travel to receive care, and that is not always possible. — Social Services Provider

The length of time patients must wait for an appointment, often two to three months. — Social Services Provider

Availability of physicians in our area for all services. Appointment times can take up to four months. In addition, many physicians do not take a variety of health care insurances, resulting in fewer physicians to be seen by patients. This includes patients with good insurance. — Public Health Representative

Timely access for clinically urgent needs and access to establishing with primary care and specialists involved in chronic care like neurology, endocrinology, and rheumatology; access to primary care physicians; mismatch of expectations between where/how to access care and level of care needed. — Physician

Long wait times to get scheduled for new patient appointments. Long wait times to get scheduled for follow-up appointments. — Public Health Representative

In general: Wait times for appointments. Lack of same-day or after-hours primary and urgent care for Medicaid members. Few services offered in Spanish. Limited resources for behavioral health and substance use disorders. Lack of local access to specialty care. Lack of care coordination Impacts of SDOHs on patient. — Physician

There is limited access to health care services in our county, especially in South County. Dental is also an issue for our families in our county, especially for our families that rely on Medicare. Salinas Valley Health has been a great support with their mobile clinic by serving rural communities at no cost. We need more mobile clinics and also mobile dental clinics. — Community Leader

We desperately need a new medical clinic. The existing one is very old and antiquated. We need more diagnostic equipment and specialists to treat major health problems. — Community Leader

For-profit health care institutions are expanding issues in the industry and are continually increasing barriers folks have when they want to see a doctor. — Social Services Provider

Availability of timely appointments. Appointments that work with hours of our patients who are not eligible for PTO — missed work equals lost wages. Providers who have a cultural understanding, or willingness to learn, of many of our immigrant population, especially in the current political climate. This encompasses many aspects of this particular sector, advocacy of the immigrant population, work conditions, mental health issues as of result of many factors stemming from trauma, domestic violence, substance use disorder, not being a legal resident, being unhoused/or foregoing necessities due to the high cost of living in this area. Accessing care that is not fragmented and disruptive. We need to provide comprehensive care, especially for major chronic issues, such as mental health (including psychiatrist and therapists that speak patients languages), diabetes care and all that comes with it in comprehensive fashion, to be able to make an impact. — Physician

Wait times and physician shortages. — Social Services Provider

I focus on North Monterey County, especially the Pajaro area. Access to all services in Monterey County is challenging and difficult for residents. — Community Leader

There are not enough appointments available for patients who need them, and insurance coverage is variable, making it difficult for some to afford care when it's needed. — Health Care Provider

Monterey County is a very large county with many disparities in certain areas of the county and for certain populations, especially low-income and Hispanic communities. Health care is often hard to obtain because of these disparities. Another issue is the lack of specialists, which leads to excessively long waits to be seen by one. — Social Services Provider

Access to mental health services and addiction recovery services, fear of deportation due to immigration status results in not reaching out for access. — Community Leader

Lack of Providers

Not enough providers, long wait times to see a provider, recruiting providers due to cost of housing. — Social Services Provider

The primary health care workforce needs to be expanded. At this moment, the system needs greater capacity of community health workers and a program for them to be successful. — Physician

Insufficient number of primary care doctors, very long waits for individuals to get a first appointment. Cost of living is a deterrent for doctors and other health care professionals to move to this community. — Physician

Inadequate number of primary health providers. — Physician

More doctors are moving into medical groups, which tends to limit options in local neighborhoods. Also, lack of new doctors locating to Monterey County due to costs of living, office space, and insurance costs. — Community Leader

Difficult to get an appointment, particularly with subspecialists such as neurology. — Health Care Provider

Access to doctors, general practitioners for prevention and early detection, as well as specialists and mental health support that is culturally appropriate. — Social Services Provider

Lack of access to physicians. We need more physicians in Monterey County. — Physician

Shortage and availability of physicians with long waits time for appointments. Distance to services. — Social Services Provider

Lack of providers across the board for family medicine and some specialties. Major service deserts in South and North counties, especially for mental health and substance use disorders treatment. — Social Services Provider

Lack of primary care and specialty providers in the region because of the high cost of living. — Social Services Provider

There is still a deficit in the number of primary care providers (MD/DO/NP/PA) available to care for uninsured and underinsured patients in Monterey County. — Physician

Fewer primary care providers and not enough alternatives being introduced, particularly for seniors. — Social Services Provider

The number of quality providers in the area, which are hard to find because of cost of living and reimbursement in the area. — Physician

We do not have enough physicians. It can take six to 12 months to get a new patient appointment with a primary care provider. After-hours and weekend care are limited, and patients end up in the emergency room at a much higher cost for basic care. Some specialty care, like neurology, sleep medicine, dermatology, and in-person behavioral health care can take six to 12 months or even longer to get in to. Access for MRIs and sleep studies can be six weeks to three months to get an appointment, which delays treatment. — Health Care Provider

Not enough primary care providers, lack of insurance options that allow local residents to see local providers. — Physician

Affordable Care/Services

The biggest challenges related to accessing health care services are costs associated with receiving treatment, filling prescriptions, etc. — Social Services Provider

The biggest challenges in our community related to accessing health care services are affordable health care coverage, lack of insurance coverage, long waiting periods for access to appointments, especially specialty care for families with Medi-Cal appointments with providers are sometimes a few months out. — Community Leader

Access to affordable care. Transportation barriers. Having to leave the county for specialist and major medical provider shortfalls, especially for youth and older adults. — Social Services Provider

The biggest problem with health care in Monterey County is the excessive costs hospitals charge. These excessive costs drive health care premiums for both government and commercial payors, creating an unsustainable cost for employers who provide health care to their employees. These excessive hospital charges impact the overall cost of providing affordable health care to residents of Monterey County and are a roadblock to economic development, driving up insurance premiums, cost of doing business for employers, and maintaining low salaries for hospitality and agricultural workers. In addition, access to health care services for indigenous-speaking residents is limited due to the lack of interpreters in health care facilities and readily available information to financial/charitable support for low-wage workers. — Community Leader

> Health care is not only expensive, it is also hard to access for many residents. Access is limited due to transportation limitations or issues and the need for more health care clinics, labs, providers.
> — Social Services Provider

Access for Medicare/Medicaid Patients

> Many residents in Monterey County are qualifying for or are dependent on Medicaid (Medi-Cal), and there are expressed concerns regarding cuts to funding, a reduction in services that qualify under this health insurance. Additionally, there have been reports that health care services are mostly about treating symptoms in the moment rather than fully healing and not addressing the underlying causes for prevention of chronic conditions.
> — Community Leader

> Availability of providers that will take Medi-Cal, TRICARE, and Medicare. — Public Health Representative

> Difficulty for Medicare recipients finding appropriate doctors and therapists. Insufficient resources providing mental health services. Too many general practitioners and specialists not able to accept new patients. Exceedingly long wait times for scheduling appointments. Increasing concierge services further limit availability and capacity. — Community Leader

> Insurance, not able to accept Medicare so we can have our students be a part of Ohana. One young man in middle school is in Juvenile Hall instead of getting mental help for his abandonment, sexual abuse, and anger problems. — Social Services Provider

Access to Care for Uninsured

> The biggest challenge to accessing health care services is lack of insurance for undocumented community members who, right now, are most likely afraid to sign up for medical services. The other issue is that it is difficult to get into a doctor quickly, so many individuals go to the hospital for help, and it drives the insurance costs up. When insurance costs are too high, employees tend to go for a less expensive plan with less choice of physicians in network or health care facilities that are outside of our county. — Community Leader

> Providing access to everyone, regardless of insurance status. — Health Care Provider

> Lack of coverage for the uninsured. — Health Care Provider

Housing

> The high cost of living. — Social Services Provider

> The very high cost of housing makes it hard to attract and retain health care providers. — Physician

> Housing for the most vulnerable, who are more likely to die from preventable diseases. Easy access for the homeless — the need for clinics or mobile units. The need for regular health screenings like Pap smears, mammograms, and other tests, as well as treatment for preventable illness such as high blood pressure, diabetes, etc. Also, access to mental wellness providers. — Social Services Provider

Income/Poverty

> Cost of living in the county may leave some residents in a bracket where they might not be able to qualify for full-scope Medi-Cal but also might not have employment where affordable insurance is available. This leaves some of our community underinsured or uninsured. Additionally, the high cost of ER and hospital stays can be a contributing factor to not accessing care, as our three largest hospitals are the most expensive in the state (per OHCA data). The cost of living may also have an impact on availability of providers and specialists, limiting the amount of physicians available to provide care for those who might have insurance. — Health Care Provider

> Finances/affordability, lack of knowledge of what exists in the community, lack of trust, and lack of transportation.
> — Social Services Provider

Language Barriers

> Language access is not as consistent in all health care settings. There needs to be more emphasis on being more readily available with interpreters and not waiting for the request. There is also a backlog of mental health services for residents. There needs to be an increase in services throughout the county. The lack of a consistent welcoming environment also adds to the inability to access proper health services.
> — Public Health Representative

> There are monolingual Spanish and Mexican indigenous speakers whose needs are not met, nor are they evaluated authentically/effectively enough to assure residents that there are services designed to meet their needs, regardless of cultural/language barriers and economic constraints. — Community Leader

Transportation

> Transportation, expansion of services. More clinics provide the services and specialists.
> — Social Services Provider

> The following are barriers for access to health care services. 1. Access to transportation, as we still have residents who do not own cars. 2. Obtaining health care in a culturally sensitive manner. South County has a large percentage of Spanish speakers and multiple indigenous dialects. 3. Access to specialty doctors. We lack pediatric doctors or specialists in women's health care. Most services are located in Salinas. 4. Financial burdens. Many residents do not schedule preventive appointments, as typically this means they need to miss a day of work, as we have limited clinics that accommodate for people who work in the agricultural industry (farmworkers). Families defer care, as it can be costly and they can't afford to miss work. This is further impacted by the use of emergency care due to lack of preventive care. — Community Leader

Lack of Coordinated Care

> Lack of communication between health systems (siloed electronic health records without interoperability). Shortage of primary care physicians, institutional lack of engagement with/support for primary care physicians, salaries not sufficient for high cost of living, administrative burdens, and managerial restrictions on practice. High cost of health insurance and low quality of coverage suggest that the county could offer a health plan and provide care for enrollees at Natividad and Health Department clinics. Poor access to mental health services for those with mild to moderate mental illness. — Physician

Lack of Supportive Gender-Affirming Care

> As an LGBTQ+ and Latin-serving organization, our community routinely struggles to find primary care support that is affirming of our identities and accessible in terms of costs. — Community Leader

Government/Politics

> Currently, the fears about federal immigration enforcement are a huge barrier preventing people from accessing care. — Social Services Provider

Violence Against Health Care Providers

> Increased anger and threats of and actual violence against health care providers. — Physician

Senior Health

> Senior health. — Community Leader

Primary Care Services

ABOUT PREVENTIVE CARE

Getting preventive care reduces the risk for diseases, disabilities, and death — yet millions of people in the United States don't get recommended preventive health care services.

Children need regular well-child and dental visits to track their development and find health problems early, when they're usually easier to treat. Services like screenings, dental check-ups, and vaccinations are key to keeping people of all ages healthy. But for a variety of reasons, many people don't get the preventive care they need. Barriers include cost, not having a primary care provider, living too far from providers, and lack of awareness about recommended preventive services.

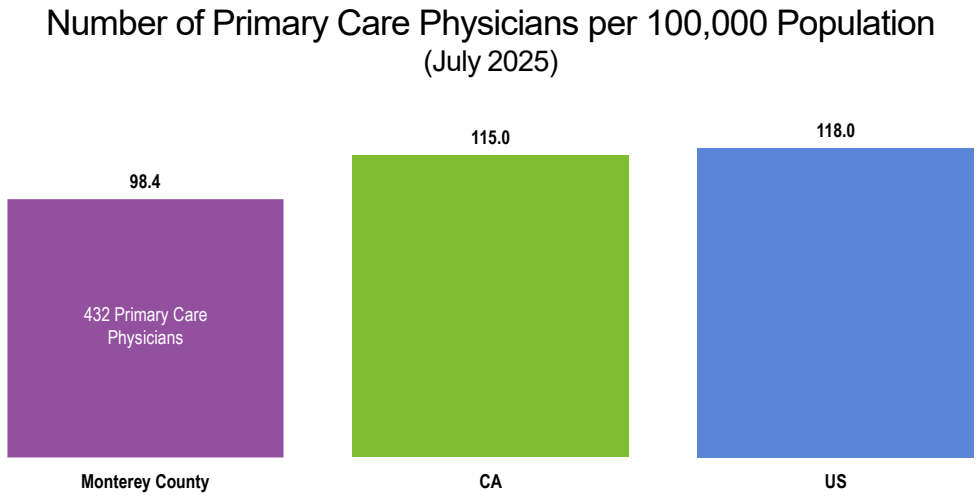
Teaching people about the importance of preventive care is key to making sure more people get recommended services. Law and policy changes can also help more people access these critical services.

– Healthy People 2030 (https://health.gov/healthypeople)

Access to Primary Care

Note that this indicator takes into account *only* primary care physicians. It does not reflect primary care access available through advanced practice providers, such as physician assistants or nurse practitioners.

The following chart shows the number of active primary care physicians per 100,000 population. This indicator is relevant because a shortage of health professionals contributes to access and health status issues. [COUNTY-LEVEL DATA]

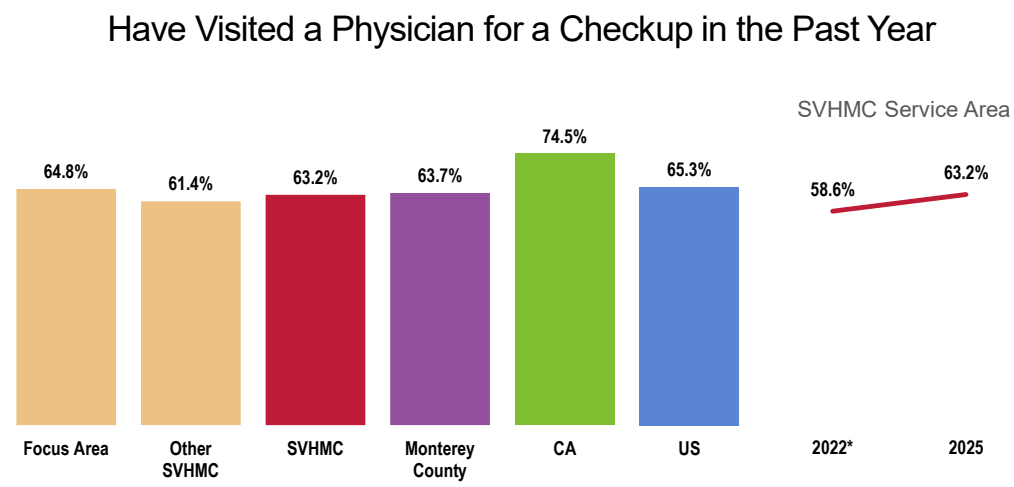


Sources:
- Centers for Medicare and Medicaid Services, National Plan and Provider Enumeration System (NPPES).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved July 2025 via SparkMap (sparkmap.org).

Notes:
- Doctors classified as "primary care physicians" by the AMA include general family medicine MDs and DOs, general practice MDs and DOs, general internal medicine MDs, and general pediatrics MDs. Physicians age 75 and over and physicians practicing sub-specialties within the listed specialties are excluded.

Utilization of Primary Care Services

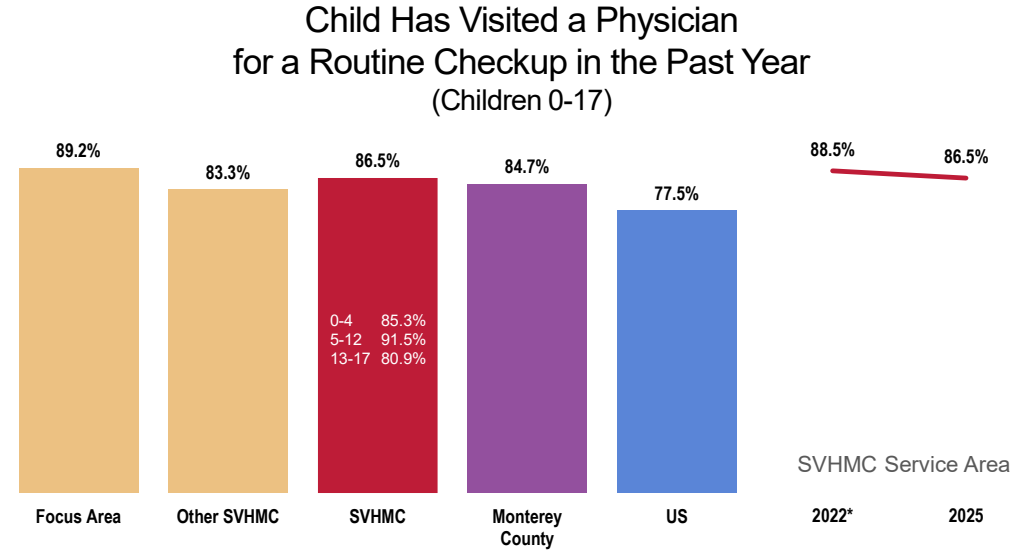
PRC SURVEY ► "A routine checkup is a general physical exam, not an exam for a specific injury, illness, or condition. About how long has it been since you last visited a doctor for a routine checkup?"



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 16]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 California data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- *2022 data does not include ZIP Codes 93926 and 93960.

PRC SURVEY ► [Among parents of children age 0-17] "About how long has it been since this child visited a doctor for a routine checkup or general physical exam, not counting visits for a specific injury, illness, or condition?"



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 91]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents with children age 0 to 17 in the household.
- *2022 data does not include ZIP Codes 93926 and 93960.

Oral Health

ABOUT ORAL HEALTH

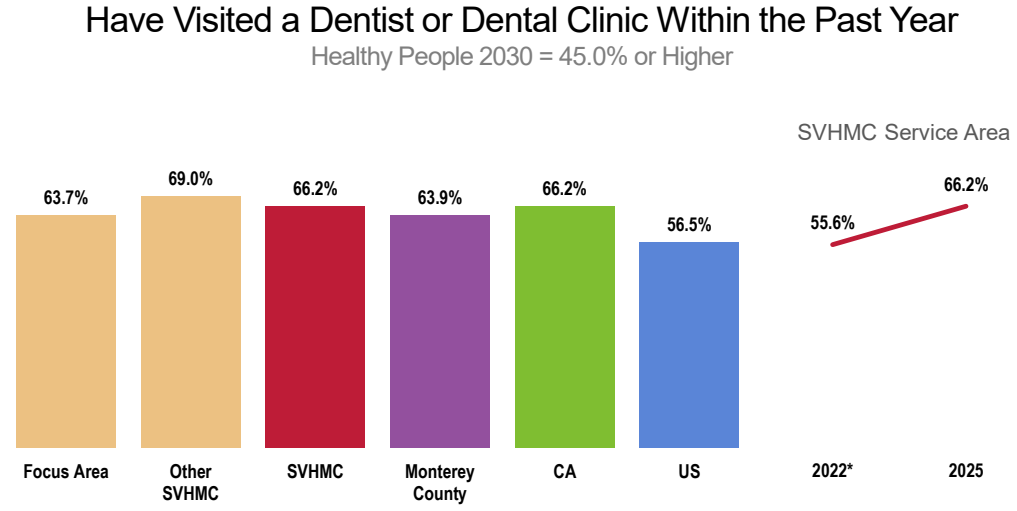
Tooth decay is the most common chronic disease in children and adults in the United States. …Regular preventive dental care can catch problems early, when they're usually easier to treat. But many people don't get the care they need, often because they can't afford it. Untreated oral health problems can cause pain and disability and are linked to other diseases.

Strategies to help people access dental services can help prevent problems like tooth decay, gum disease, and tooth loss. Individual-level interventions like topical fluorides and community-level interventions like community water fluoridation can also help improve oral health. In addition, teaching people how to take care of their teeth and gums can help prevent oral health problems.

– Healthy People 2030 (https://health.gov/healthypeople)

Dental Care

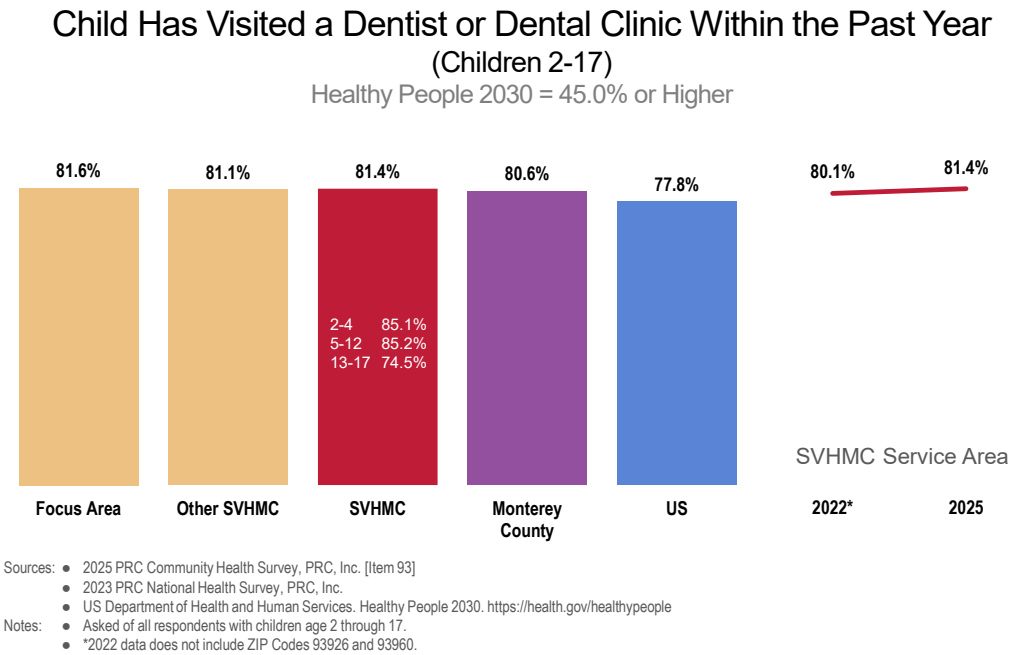
PRC SURVEY ► "About how long has it been since you last visited a dentist or a dental clinic for any reason?"



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 17]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 California data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

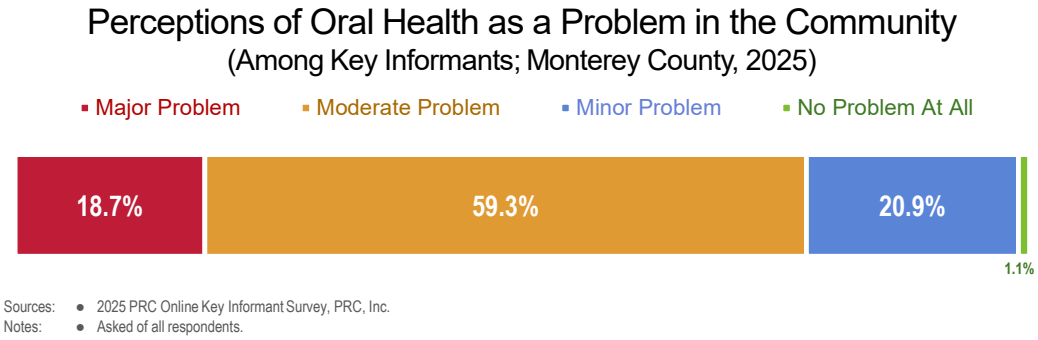
Notes:
- Asked of all respondents.
- *2022 data does not include ZIP Codes 93926 and 93960.

PRC SURVEY ▶ [Among parents of children age 2-17] **"About how long has it been since this child visited a dentist or dental clinic?"**



Key Informant Input: Oral Health

The following chart outlines key informants' perceptions of the severity of *Oral Health* as a problem in the community:



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

Access to Care/Services

> So many dentists are not taking new patients or have very, very specific insurance requirements. — Social Services Provider
>
> Limited access to dental care, cost, transportation, and lack of education. — Social Services Provider
>
> Limited access to dentists. — Physician
>
> There are not a lot of oral doctors, and there is a ton of poverty and kids eating candy for breakfast, lunch, and dinner. Kids are eating donuts in the morning and hitting the snack truck or 7-Eleven after school, drinking soda and energy drinks throughout the school day. It's an epidemic we don't know how to deal with. — Community Leader
>
> There aren't many options for our rural communities. A mobile dental clinic would be beneficial. — Community Leader
>
> Lack of access to dental care for underserved communities. — Social Services Provider

Affordable Care/Services

> Lack of affordable dental care. — Community Leader
>
> There is a lack of access to affordable dental care. In South County, there are not many dentists, and a limited number of one that will take Medi-Cal. Diets in general are higher in sugar, which may lead to cavities in children and adults. Even for those in the middle-income bracket, dental care is often not affordable, as dental insurance usually has limited coverage and costs are high. — Public Health Representative
>
> Many children complain about teeth/oral problems to their peers but fear telling their parents due to their perception of an unnecessary cost. — Social Services Provider
>
> Toothpaste and brushes are non-basic needs costs. — Social Services Provider
>
> Affordability of dental care in general. Affordability of restorative dental care as opposed to just removal of teeth. Uncontrolled access to sugary beverages and food by children. — Physician

Access to Care for Uninsured/Underinsured

> A lot of young adults in our community engage in the gig economy and are often un/underinsured, resulting in infrequent visits, if any, to dentists. — Community Leader
>
> Poor people and Medi-Cal recipients are unable to find competent providers. — Physician
>
> Lack of dental insurance coverage. — Community Leader

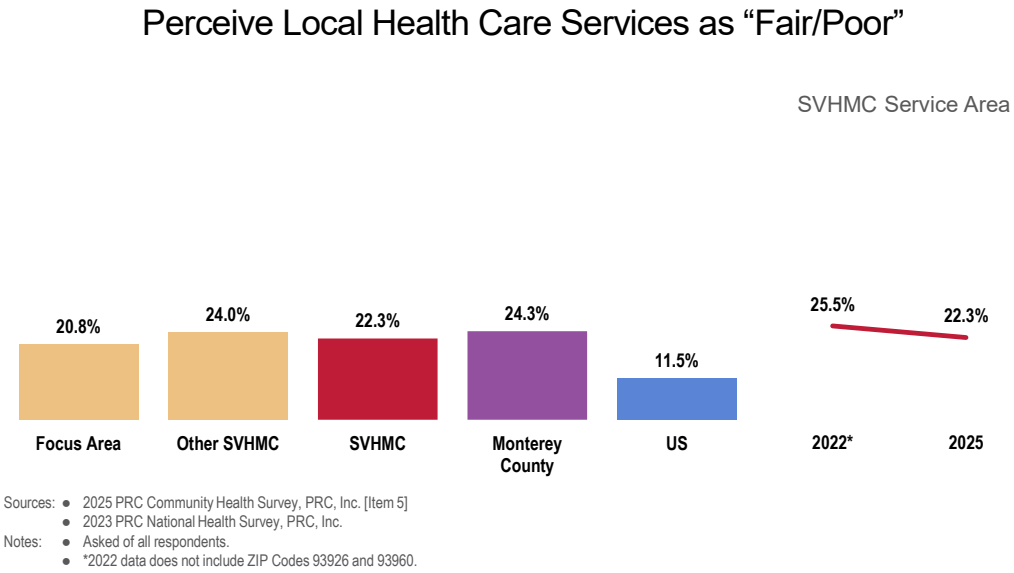
Diagnosis/Treatment

> Many patients have not been to the dentist in many years. — Community Leader

LOCAL RESOURCES

Perceptions of Local Health Care Services

PRC SURVEY ► "How would you rate the overall health care services available to you? Would you say: excellent, very good, good, fair, or poor?"



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 5]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- *2022 data does not include ZIP Codes 93926 and 93960.

Resources Available to Address Significant Health Needs

The following represent potential measures and resources (such as programs, organizations, and facilities in the community) identified by key informants as available to address the significant health needs identified in this report. This list only reflects input from participants in the Online Key Informant Survey and should not be considered to be exhaustive nor an all-inclusive list of available resources.

Access to Health Care Services

- Access Support Network
- Affordable Housing
- Alisal Health Center
- Alliance on Aging
- Boys and Girls Club
- California Alliance for Health
- California State University Monterey Bay
- Casa de La Cultura
- Catholic Charities
- Central California Alliance for Health
- Central Coast Alliance for Health
- Central Coast Center for Independent Living
- Centro Binacional para el Desarrollo Indígena Oaxaqueño
- Churches
- Clinica de Salud del Valle de Salinas
- Community Action Board
- Community Bridges
- Community Health Services
- Community Hospital of the Monterey Peninsula
- Community Human Services
- Dental Offices
- Diagnostic Testing
- Doctors' Offices
- Doctors on Duty
- Door to Hope
- Eden Valley Care Center
- Family Resource Centers
- Federally Qualified Health Centers
- First Five
- Food Banks/Pantries
- Health Department
- Health Systems
- Hospitals
- Intra-Agency Collaboration
- ITNMontereyCounty
- Kaiser Permanente
- Know Your Rights Campaigns
- Laurel Family Practice Clinic
- Media Information Sources
- Medi-Cal
- Mee Memorial Healthcare System
- Memorial Hospital
- Mental Health Bureau
- MILPA
- Mobile Clinics
- MoGo Urgent Care
- Montage Health
- Montage Medical Group
- Monterey County Behavioral Health
- Monterey County Clinic
- Monterey County Health Department
- Monterey County Social Services Office
- Monterey-Salinas Transit (MST)
- Mood Health
- Natividad
- Natividad Mental Health
- Ohana Center for Child and Adolescent Behavioral Health
- Office of Health Care Affordability
- Orthopedic Urgent Care
- Pajaro Valley Prevention and Student Assistance Program
- Partnership for Children
- Peer to Peer Mental Health Support Groups
- Pharmacies
- Planned Parenthood
- Primecare
- Rural Health Clinics
- Salinas Valley Funded Medical Group
- Salinas Valley Health
- Salud Para La Gente
- Seaside Clinic
- Sleep Medicine Equipment Access
- Soledad Medical Clinic
- Soledad Medical Healthcare District
- Stanford
- Sun Street Centers
- Taylor Farms
- Telemedicine
- University of California San Francisco
- Urgent Care Centers
- VA Services
- Women, Infant, and Children Program
- Women's Health Center

Cancer

- Ag Commissioner
- American Cancer Society
- Blue Zones Project
- Cancer Alliance
- Cancer Care Center
- Cancer Screenings
- Cancer Support Groups
- Clinic Services Bureau
- Community Hospital of the Monterey Peninsula
- Farmworker Education
- Food Banks/Pantries
- Health Department
- Jacob's Heart
- Mee Memorial Healthcare System
- Montage Health
- Natividad
- Pacific Cancer Care Medical Group
- Palliative Care Services
- Salinas Valley Health
- Soledad Mission Healthcare
- Susan Bacon Cancer Resource Center

Diabetes

- 211
- Aspire Diabetes Program
- Aspire Health
- Blue Zones Project
- Brighter Bites
- CalFresh
- California State University Monterey Bay
- Catholic Charities
- Central California Alliance for Health
- Clinic Services Bureau
- Clinica de Salud del Valle de Salinas
- Community Health Educators
- Community Hospital of the Monterey Peninsula
- Community Human Services
- Community Programs
- Cooking Classes
- County Programs
- Day Care
- Diabetes Center
- Diabetes Education Classes
- Diabetes Events
- Diabetic Educators
- Doctors' Offices
- Doctors on Duty
- Emeline Building K
- Everyone's Harvest Farmers Markets
- Farmers' Markets
- Federally Qualified Health Centers
- Food Banks/Pantries
- Food Bucks
- Food Programs
- GoodRx
- Hartnell College
- Health Department
- Homeless Persons Health Project
- Hospitals
- Kids Eat Right
- MC Diabetes Collaborative
- Meals on Wheels
- Mee Memorial Healthcare System
- Memorial Hospital
- Mobile Clinics
- Montage Health
- Montage Medical Group
- Monterey County Health Department
- Monterey Endocrine and Diabetes
- Natividad
- Natividad Diabetes Care Center
- Nutrition and Fitness Collaborative of Central Coast
- Nutrition Education
- Parks and Recreation
- Pharmacy Discount Cards
- Primecare
- Primetime
- Project Food Box
- Public Transportation
- RotaCare Monterey Clinic
- Safe Routes to School
- Salinas Valley Health
- Salud Para La Gente
- Seaside Clinic
- Supplemental Nutrition Assistance Program
- Soledad Mission Healthcare
- United Way
- University of California San Francisco
- VA Services
- Wellness Events
- Women, Infant, and Children Program

Disabling Conditions

- Aging and Disability Resource Connection
- Alliance on Aging
- Alzheimer's Association
- American Heart Association
- AOA Memory Cafe
- Blind and Visually Impaired Center
- Center Stage Theatrical Productions
- Central Coast Audiology

- Central Coast Center for Independent Living
- City of Seaside Family and Community Support Program
- Deaf and Hard of Hearing Center
- Doctors' Offices
- Eden Valley Care Center
- Emeline Building K
- First Tee
- Gateway Center of Monterey County
- Health Department
- Health Projects Center
- Homeless Persons Health Project
- Hospitals
- IHSS Services
- Interim Inc
- Kasey's Fitness
- Kearnes Therapy Pool
- Meals on Wheels
- Memorial Hospital
- Mental Health Bureau
- Mental Health Client Action Network
- Mental Health Professionals
- Montage Health
- Monterey County Aging Disability Resource Connection
- Monterey County Free Libraries
- Monterey County Homeless Services
- Monterey Sports Center
- MST Rides Program
- Natividad
- Nonprofits
- Pacific Acute
- Parks and Recreation
- Rainbow Connections
- Rehabilitation
- San Andreas Regional Center
- Seniors Helping Seniors
- Skilled Nursing Facilities
- Small Companies Providing Caregiving
- Sol Treasures
- Soledad Medical Clinic
- Special Kids Connect
- The Village Project
- Transport-Assist Organizations
- VA Services
- Violence Prevention Programs
- Vision Center

Heart Disease & Stroke

- Ambulatory Health Service Clinics
- American Heart Association
- Aspire Health
- Blue Zones Project
- California Department of Health Care Services
- Cardiac Wellness Program
- Central California Alliance for Health
- Community Hospital of the Monterey Peninsula
- Diagnostic Testing
- Doctors' Offices
- Healthy Lifestyle Promotion
- Hospitals
- Media Information Sources
- Million Hearts
- Montage Health
- Montage Medical Group
- Montage Wellness Centers
- Monterey County Clinic
- Monterey County Leadership
- Natividad
- Nonprofits
- Parks and Recreation
- Salinas Valley Health
- School System
- Support Groups
- Tyler Heart Institute

Infant Health & Family Planning

- Birth Network of Monterey County
- Boys and Girls Club
- Bright Beginnings
- Children's Council
- Clinica de Salud del Valle de Salinas
- Community Health Services
- Door to Hope
- Doula Care
- Federally Qualified Health Centers
- First Five
- Hartnell Child Development Center
- MCAH Home Visiting Program
- Mentors at Community Partnership for Youth
- Natividad
- Nurse-Family Partnership Program
- Perinatal Services Program
- Planned Parenthood
- Salinas Adult School
- Salinas Adult School - Preschool
- Salinas Valley Health
- Seaside Clinic
- Women, Infant, and Children Program

Injury & Violence

- Big Brothers and Sisters
- Boys and Girls Club
- City of Soledad Victim Services Advocate
- City Programs to Combat Gang Violence
- Communities Advocating for Safety and Peace
- Door to Hope
- Education Department
- Emeline Building K
- First Responders
- Health Department
- Homeless Persons Health Project
- Hospitals
- Juvenile Justice System
- Law Enforcement
- Lideres Campesinas
- MCRCC
- Mental Health Bureau
- MILPA
- Monarch Services
- Monterey County Behavioral Health
- Monterey County Probation
- Monterey County Sheriff's Department
- Monterey District Attorney's Office
- Natividad
- Nonprofits
- Partners for Peace
- Planned Parenthood
- Probation Department
- Rancho Cielo
- Safe Routes to School
- Salinas Valley Health
- School System
- Soledad Shopping Center
- Stuff the Bus
- Sun Street Centers
- Sweetwater Union High School District
- YMCA/YWCA
- Youth Sports Leagues

Mental Health

- AIM
- Alisal Union School District
- Alliance on Aging
- Behavioral Health Department
- BienEstar Clinics
- Boys and Girls Club
- Building Healthy Communities
- Cal State Monterey Bay Masters of Social Work Program
- Central California Alliance For Health
- Central Coast Alliance for Health
- Central Coast Center for Independent Living
- Centro Binacional para el Desarrollo Indígena Oaxaqueño
- Churches
- City of Seaside Family and Community Support Program
- Clinica de Salud del Valle de Salinas
- Community Bridges
- Community Hospital of the Monterey Peninsula
- Community Human Services
- Community Programs
- Connections
- County Children and Adult Mental Health
- County Mental Health Services
- County Programs
- Daybreak
- Del Mar Caregiver Resource Center
- Doctors' Offices
- Door to Hope
- Dorothy's Place
- EAP Programs
- Emeline Building K
- Employee Assistance Program
- Epicenter
- Equine Therapy
- Family Service Agency of the Central Coast
- First Five
- Harmony at Home
- Harmony Place Monterey
- Hartnell College
- Health Department
- Health Systems
- Homeless Persons Health Project
- Interim Inc
- MC Hopes
- Mental Health Client Action Network
- Mental Health Professionals
- Mentors
- MILPA
- Montage Health
- Montage Medical Group
- Monterey County
- Monterey County Behavioral Health
- Monterey County Health Department
- Mood Health
- National Alliance on Mental Illness
- National Association of Minority Contractors
- Natividad
- Natividad Mental Health
- Nonprofits
- Ohana Center for Child and Adolescent Behavioral Health
- Outreach Programs

- Pajaro Valley Prevention and Student Assistance Program
- Partners for Peace
- Personal Growth and Counseling Center
- Prescribe Safe
- School System
- Soledad Mission Healthcare
- Soledad Shopping Center
- Substance Abuse Facilities
- Suicide Prevention Service of the Central Coast
- Sun Street Centers
- Sunrise House
- Telemedicine
- The Pavilion
- The Village Project
- Therapify
- Trained Therapists
- United Way
- VA Services
- YMCA/YWCA

Nutrition, Physical Activity & Weight

- Alliance on Aging
- Aspire Health
- BKM
- Blue Zones Project
- Boys and Girls Club
- Brighter Bites
- CalFresh
- Center for Community Advocacy
- City Community Centers
- Diabetes Education Classes
- Doctors' Offices
- Education Department
- Everyone's Harvest Farmers Markets
- Farm to Fork
- Farmers' Markets
- Fitness Centers/Gyms
- Food Banks/Pantries
- Food Bucks
- Free Lunch Program
- Girls Health in Girls Hands
- Grocery Stores
- Health Department
- Health Programs
- Health Systems
- Healthy Together
- Hospitals
- Kids Eat Right
- Lifestyle Classes
- Memorial Hospital
- Montage Health
- Montage Wellness Centers
- Monterey Bay JumpstartMD
- Monterey County Health Department
- Monterey Sports Center
- Natividad
- Nonprofits
- Parks and Recreation
- ParkRx
- Physical Activity Programs
- Safe Routes to School
- Salinas Regional Soccer Complex
- Salinas Valley Health
- School System
- Second Harvest Food Bank
- Supplemental Nutrition Assistance Program
- Soledad Community Center
- Tatum's Garden
- Team Villa Boxing Club
- United Way
- Women, Infant, and Children Program
- YMCA/YWCA
- Youth Sports Leagues

Oral Health

- 211
- Ambulatory Health Service Clinics
- California Department of Health Care Services
- Clinica de Salud del Valle de Salinas
- Community Health Services
- Dental Offices
- Medi-Cal
- Monterey Bay Dental Society
- Monterey County Health Department
- Monterey County Oral Health Program
- Salud Para La Gente
- School System
- Seaside Clinic
- WOW! Smiles

Respiratory Diseases

- Ambulatory Health Service Clinics
- Athena
- Central Coast Breath Cal
- Communicable Disease Unit
- Community Hospital of the Monterey Peninsula
- Memorial Hospital
- Montage Health
- Monterey County Health Department
- Natividad

Pulmonary Rehabilitation Program
Seaside Clinic

Sexual Health

Access Support Network
Community Health Services
Doctors' Offices
Health Department
Montage Health
Monterey County Health Department
Natividad
Needle Exchange Clinic
Planned Parenthood
School System

Social Determinants of Health

211
Affordable Housing
Alliance on Aging
Aspire Health
Blue Zones Project
Bright Futures
Building Healthy Communities
Cal Works Program
California Construction Authority
California Department of Corrections and Rehabilitation
California Rural Legal Assistance
Catholic Charities
Center for Community Advocacy
Central California Alliance For Health
Central Coast Alliance for Health
Centro Binacional para el Desarrollo Indígena Oaxaqueño
CHISPA
City of Monterey Housing Fund
City of Seaside Family and Community Support Program
Clinica de Salud del Valle de Salinas
Coalition of Homeless Services Providers
Community Action Board
Community Alliance for Safety and Peace
Community Bridges
Community Foundation
Community Health Services
Community Human Services
Council on Aging
County Health in All Policies
Department of Social Services
Doctors' Offices
Door to Hope
Dorothy's Place
Faith-Based Organizations
Farmers' Markets
Financial Institutions
First Five
Food Banks/Pantries
Food Bucks
Food Programs
Food Shelters
Gathering for Women
Government-Built Low Cost Housing
Habitat for Humanity
Hartnell College
Health Department
Hospitals
Housing Authority
Housing Coalition
Housing Resource Center
Libraries
Loaves and Fishes
Local Government Programs
Medication Resource Program
MILPA
Montage Health
Monterey Bay Economic Partnership
Monterey County Health Department
Monterey County Housing Authority
Monterey County School Districts
Monterey County Social Services Office
Monterey County Works
Monterey Peninsula College
MST Rides Program
Natividad
Pajaro Valley Prevention and Student Assistance Program
Parenting Connection
Parks and Recreation
Rancho Cielo
Salinas Valley Health
Salud Para La Gente
Salvation Army
School System
Seaside Community Services
Section 8
Smart Referral Network
Sun Street Centers
The Village Project
United Way
Women, Infant, and Children Program
Workforce Housing

Substance Use

211
Beacon House
Behavioral Health Department
Bridge Program
Bright Futures
City of Seaside Family and Community Support Program
Clinica de Salud del Valle de Salinas
Community Hospital of the Monterey Peninsula
Community Human Services
County Programs
Doctors' Offices
Door to Hope
Dorothy's Place
Family Resource Centers
Genesis
Interim Inc
Janus
King City Residential Center
Mee Memorial Healthcare System
Mental Health Professionals
Mentors at Community Partnership for Youth
MILPA
Monterey County Behavioral Health
Monterey County Health Department
Monterey County Social Services Office
Natividad
Needle Exchange Clinic
Ohana Center for Child and Adolescent Behavioral Health
Partners for Peace
Prescribe Safe
Seaside Clinic
Shelters
Sober Living Environments
Soledad Street Services
Substance Abuse Facilities
Sun Street Centers
Sunrise House
Valley Health Associates
YMCA/YWCA

Tobacco Use

California Smokers Hotline
Center for Disease Control
Kick It California
Montage Health
Salinas Valley Health
School System
Substance Abuse and Mental Health Services Administration
Sun Street Centers