Salinas Valley Health Medical Center Fiscal Years 2026–2028 CHNA Implementation Strategy

General Information

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Table of Contents

General Information 1

I. About Salinas Valley Health 3

COMMUNITY HEALTH INITIATIVES 3

II. Salinas Valley Health's Service Area 4

III. Purpose of Implementation Strategy 5

IV. List of Community Health Needs Identified in the 2025 CHNA 6

2025 COMMUNITY HEALTH NEEDS LIST 6

V. Those Involved in the Implementation Strategy (IS) Development 7

VI. Health Needs that Salinas Valley Health Plans to Address 7

A. PROCESS AND CRITERIA TO SELECT HEALTH NEEDS 7

B. DESCRIPTION OF HEALTH NEEDS THAT SALINAS VALLEY HEALTH PLANS TO ADDRESS 7

Access to Health Care Services

Cancer

Healthy Lifestyles

Heart Disease & Stroke

VII. Salinas Valley Health's Implementation Strategy 9

VIII. Evaluation Plans 18

IX. Health Needs that Salinas Valley Health Does Not Plan to Address 18

I. About Salinas Valley Health

Salinas Valley Memorial Healthcare System, a California Local Health Care District operating as Salinas Valley Health (SVH), is an integrated network of healthcare programs, services, and facilities that serves tens of thousands of people each year throughout Monterey County and surrounding areas. Opened in 1953, Salinas Valley Health Medical Center (SVHMC) anchors SVH's medical facilities. Licensed for 263 beds, this acute-care medical center features many medical specialties that enable people to advanced medical care without having to travel out of the area. The medical center employs approximately 2,200 people and has a medical staff of 300 board-certified physicians across a range of specialties.

Mission: To provide quality healthcare to our patients and to improve the health and wellbeing of our community.

Vision: A community where good health grows through every action, in every place, for every person.

COMMUNITY HEALTH INITIATIVES

Salinas Valley Health Mobile Clinic

Delivering free medical care directly where it is needed most, the SVH Mobile Clinic has improved access to quality medical services in Monterey County. In addition to primary and preventive care, community health advocates support the health and social needs of patients, helping them navigate services and provide supplies for those in financial need: blood pressure and glucose test kits; grocery and gas cards; stuffed animals and pajamas for children. Since launching in 2020, the Mobile Clinic recently surpassed 22,000 annual patient visits. The Mobile Clinic breaks through common barriers to healthcare, such as expense, travel and access. Its use of diverse resources is helping improve care-coordination, well-being and health outcomes for some of our most vulnerable populations. SVH collaborates with two Family Resource Centers, two local high schools and other entities in low income areas. It partners with the Food Bank for Monterey County to distribute food three days a week and in July 2025 met high standards to become an approved Vaccines for Children (VFC) provider.

Live Well Project

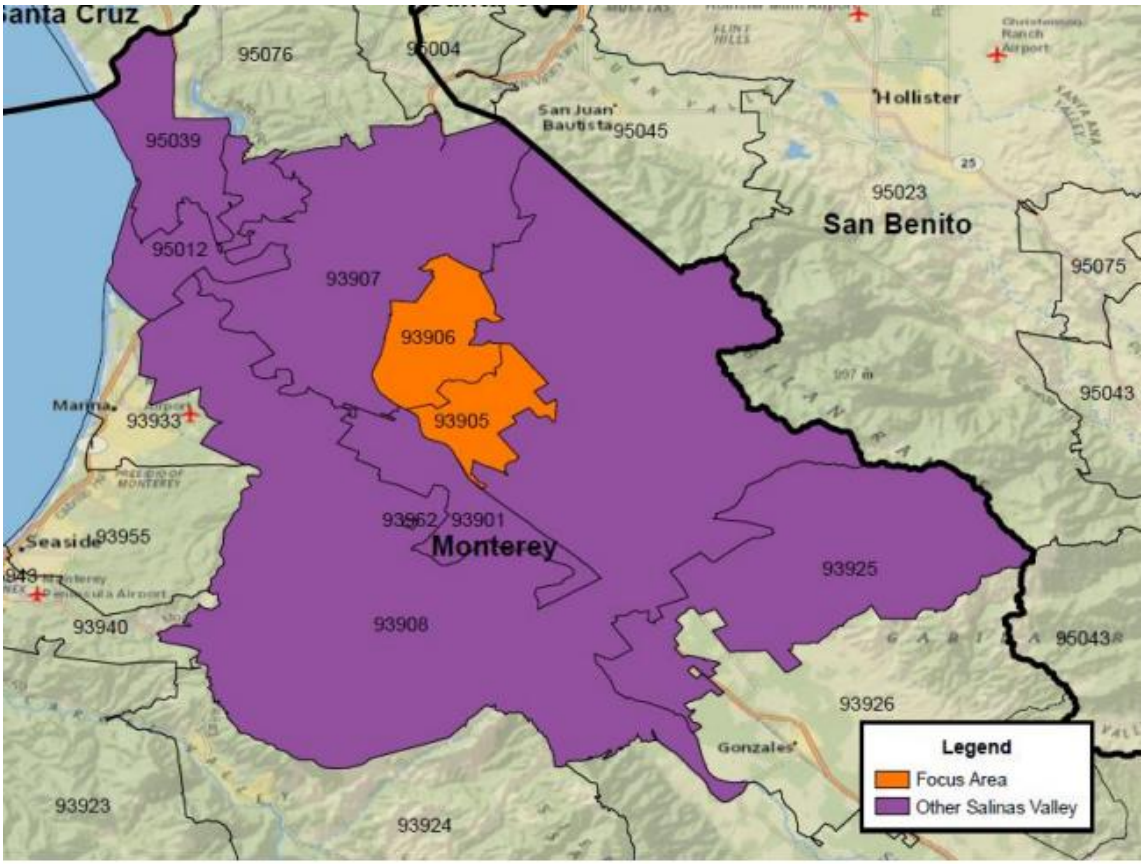
The SVH Live Well Project, formally known as Blue Zones Project Monterey County, builds changes in our community that make the healthy choice easy. The transformative health initiative engages a cross section of stakeholders including worksites, schools, faith-based organizations, restaurants, and grocery stores and takes a systemic approach to improved well-being through policy, design, and collaboration. Live Well Project has a designated team at SVH addressing goals and advancing the certification work done as Blue Zones Project Monterey County.

Health Education and Awareness Classes

Improving access to services and providing powerful opportunities for connection and support, our health education and awareness classes help our community rise in good health and well-being. In-person and virtual classes offer a wealth of resources – from preparing for a new baby to diabetes foot care, nutrition services for cancer survivors, support groups for cardiac patients, seminars on legal issues for life planning, meditation classes and more. Our medical providers have frank conversations community members during *Walk With a Doc* events. *Ask the Experts* presentations and podcasts share in-depth information on medical advances and common health concerns. Student programs ranging from fourth grade to post-secondary school inspire our future healthcare professionals. Outreach beyond the walls of our campus is fundamental in everything we do to support our community.

II. Salinas Valley Health's Service Area

The Internal Revenue Service defines the "community served" as individuals who live within the medical center's service area. This includes all residents in a defined geographic area and does not exclude low-income or underserved populations. According to its 2025 CHNA report, Salinas Valley Health's community is its service area, composed of ZIP Codes 93901, 93905, 93906, 93907, 93908, 93925, 93962, 95012, and 95039. The map below shows the service area in purple, as well as a more central "focus area" in orange, representing geographies of particular concern to SVH.



The population in the **SVHMC Service Area** is predominately Hispanic or Latino (74%) with 16% White and 10% diverse races represented by Asian/Pacific Islander, Black, American Native and Multiple races.[1]

The same census data indicates 42% of the population in the SVHMC Service Area is low income as defined by those living under 200% of the federal poverty level, based on guidelines established by the U.S. Department of Health and Human Service. Forty percent of survey respondents in the SVHMC service area reported they do not have cash on hand to cover a $400 emergency expense, a greater percentage than U.S. respondents (34%).[2]

SVH also works collaboratively with its community partners in Monterey County in the larger county-wide eco-system. While emphasis is placed on the SVHMC service area, it is important to understand regional data. Monterey County comprises 12 cities, eight census-designated places, and large areas of unincorporated rural land. In 2025, the Census Bureau estimates population at 436,000. The ethnic makeup of **Monterey County** is highly diverse—more than half (55%) of Monterey County residents are Hispanic or Latino. Diverse races including Asian/Pacific Islander, Black, American Native and multiple races make up 11% of the population; 37% are White. [3]

III. Purpose of Implementation Strategy

This Implementation Strategy (IS) Report describes Salinas Valley Health's planned response to the needs identified through the 2025 Community Health Needs Assessment (CHNA) process. It fulfills Section 1.501(r)-3 of the IRS regulations governing nonprofit hospitals, even though the SVH Medical Center is part of a publicly owned local health care district. SVH operates to deliver local, quality care to everyone in the region. Subsection (c) pertains to implementation strategy specifically, and its requirements include a description of the health needs that the hospital will and will not address. Pursuant to these requirements, the following descriptions of the actions (strategies) to take include the anticipated impact of the strategies, the resources SVH plans to commit to address the health needs, and any planned collaboration between the medical center and other facilities or organizations in addressing the health needs.

For information about SVH's 2025 CHNA process and for a copy of the 2025 CHNA report, visit salinasvalleyhealth.com/chna.

[1] US Census Bureau, 2016-2020 American Community Survey and 2025 PRC Community Health Survey, PRC, Inc.
[2] 2025 PRC Community Health Survey, PRC, Inc. and 2025 PRC National Health Survey
[3] US Census Bureau, 2016-2020 American Community Survey and 2025 PRC Community Health Survey, PRC, Inc.

IV. List of Community Health Needs Identified in the 2025 CHNA

The 2025 CHNA assessed community health needs by gathering input through online surveys from persons representing the broad interests of the community, including ratings of the degree to which various health issues were a problem in the community. In addition, quantitative (statistical) data were analyzed to identify poor health outcomes and health trends. The CHNA study team[4] compiled statistical data and provided comparisons against statewide averages and rates. The CHNA findings indicate that chronic disease, access to care, and social determinants of health continue to significantly impact health outcomes across the region.

Significant health needs, for the purposes of the 2025 CHNA, 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. The list of needs also takes into account those issues of greatest concern to the community leaders (key constituents) who provided input during the CHNA process.

The 2025 CHNA identified a total of 12 health needs[5]. In October 2025, a variety of community leaders totaling 116 evaluated, discussed, and prioritized the identified health needs, which are listed below in community prioritization order. The health need prioritization process is described in more detail in SVH's CHNA report. The SVH Executive Team at SVH then selected the health needs that Salinas Valley Health will address during FY2026–2028. The health need selection process is described in Section VI of this report and prioritized those focus areas in which Salinas Valley Health is uniquely positioned to have impact.

2025 COMMUNITY HEALTH NEEDS LIST

1. **Diabetes**
2. **Access to Healthcare 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**

[4] The study team was composed of Salinas Valley Health, Montage Health, County of Monterey Health Department, Mee Memorial Healthcare System, Natividad, California State University Monterey Bay, Central California Alliance for Health and United Way Monterey County.

[5] Monterey County CHNA page 15

11. **Respiratory Disease**
12. **Tobacco Use**

V. Those Involved in the Implementation Strategy (IS) Development

After extensive dialogue among the Executive Leadership Team along with input from elected members of the Board of Directors and clinical service line directors, SVH selected the health needs to address for 2026-2028 and developed the Implementation Strategy (IS).

VI. Health Needs that Salinas Valley Health Plans to Address

A. PROCESS AND CRITERIA USED TO SELECT HEALTH NEEDS

Key stakeholders from SVH met in November 2025 and January 2026 to review the 2025 SVH CHNA, assess results and discuss prioritization. At its February 9, 2026 meeting, the Leadership Working Group reviewed CHNA highlights and next steps. On February 18, 2026, a report was presented to the Community Advocacy Committee comprised of elected members of the Board of Directors, all of which contributed to the final IS. SVH, by consensus, selected four of the health needs that had been identified. The selected needs are listed below in alphabetical order.

1. **Access to Healthcare Services**
2. **Cancer**
3. **Healthy Lifestyles**
4. **Heart Disease & Stroke**

For the purposes of this IS, SVH merged Diabetes and Nutrition, Physical Activity, & Weight into one need named “Healthy Lifestyles” in order to better express the topics on which it will focus in addressing the needs.

B. DESCRIPTION OF HEALTH NEEDS THAT SALINAS VALLEY HEALTH PLANS TO ADDRESS

ACCESS TO HEALTHCARE SERVICES

Community survey data and key informant data continually rank healthcare access and delivery as a top concern, citing persistent barriers to care and the need for expanded primary care access. These barriers contribute to delayed care, lower utilization of preventive services, and increased reliance on emergency departments. The major topics of this feedback included:

- Lack of providers
- Primary care physician ratio

- Limited appointment availability
- Cost of care and insurance coverage gaps
- Geographic distance, transportation
- Low Health Literacy [Focus Area ZIP Codes]

While not addressed in the CHNA, the SVH Executive Team is concerned that the impact of HR 1 will result in increase in the number of uninsured community members, further reducing utilization of preventative care and a likely increase in the reliance on emergency room treatment.

CANCER

Cancer continues to be a leading cause of death in Monterey County and according to CDC data from July 2025, deaths attributed to cancer are statistically equal to deaths attributed to heart disease. While screening data is generally more favorable in SVH focus areas than in Monterey County as a whole, in the two cancer screening opportunities cited below, SVH and the County are below Healthy People 2030 targets. The CHNA identified ongoing gaps in:

- Breast cancer screening
- Cervical cancer screening
- Access to early detection services

Despite improvements in some areas, disparities persist in screening rates and outcomes, particularly among underserved populations. Increasing access to screening and early detection remains critical to reducing cancer related mortality. With major investments in creating a comprehensive cancer program to serve the community, SVH is in a unique position to address this leading cause of death.

HEALTHY LIFESTYLES

Survey data and key Informants identified overweight and obesity among adults and children as a major health concern contributing to diabetes and chronic disease. The major topics of their feedback on these needs included:

- Significant proportions of residents reporting inadequate physical activity
- Barriers to accessing fresh and healthy foods
- High consumption of sugar-sweetened beverages
- Prevalence of diabetes in the county
- Issues of health equity: BIPOC (Black, Indigenous People of Color) and south county residents identified as at increased risk for adverse health outcomes

Statistical data did not meet Healthy People 2030 benchmarks or had a declining trend in areas of diabetes, pre-diabetes and kidney disease deaths.

HEART DISEASE AND STROKE

The CHNA reveals heart disease and stroke remain among the leading cause of death in the region. The CHNA identified the high prevalence of associated risk factors, including:

- High blood pressure
- High cholesterol
- Poor nutrition
- Physical inactivity

These conditions are largely preventable through education, early detection, and lifestyle interventions. Increasing awareness and improving access to preventable care are critical to reducing cardiovascular disease burden.

VII. Salinas Valley Health's Implementation Strategy

The federal government requires nonprofit hospitals to complete an Implementation Strategy Report, or ISR. The ISR is a companion to the CHNA, in that it describes how hospitals will use community benefit and other resources to address priority health needs in their service areas. This ISR fulfills federal requirements. Specifically, the ISR must detail:

- Which of the priority health needs will be directly addressed by the hospital as part of its implementation strategy, and which top health needs will not be addressed (and justification)
- The actions, programs, and resources the hospital intends to commit to address the selected health needs
- The anticipated impact of these actions
- Any planned collaboration between the hospital and other hospitals or organizations

The goals and strategies proposed to address the chosen needs are described in the section below. SVH will implement these strategies through a combination of intentional resource allocation, program development or expansion of existing programs, grants, sponsorships, partnerships, and in-kind support to community-based organizations, community health centers, or clinics. Associated indicators of anticipated impact are listed for each goal.

SVH's definition of "community health" includes not only the physical health of both counties' residents, but also broader social and environmental determinants of health (such as access to and delivery of health care, affordable housing, child care, education, and employment). This more inclusive definition reflects the understanding that myriad factors impact community health. SVH is committed to supporting community health improvement through strategies that address both upstream (social determinants of health) and downstream (health condition) interventions.

HEALTH NEED 1: ACCESS TO HEALTHCARE SERVICES

Long-Term Goal: Improve Access to affordable, high quality healthcare services for our community members.

Goal	Strategies	Anticipated Impact
1.A Decrease barriers to accessing healthcare	i. Support health care clinics and related programs in close geographic proximity to populations of low socioeconomic status ii. Support Salinas Valley Health physicians serving in community clinics iii. Support education on appropriate utilization iv. Provide low cost alternatives to emergency or after-hours care access v. Support mobile health clinic program vi. Optimize Vaccines for Children (VFC) Program vii. Pursue Vaccines for Adults (VFA) opportunity viii. Support community health fairs, virtual health education sessions, and vaccination clinics ix. Pursue innovative technology that supports patient engagement strategies x. Develop strategy for MyChart enrollment and engagement xi. Leverage technology to improve care coordination	a. Increased number of community members served b. Increased access to preventative care c. Reduced unnecessary ED visits/hospitalizations d. Increased vaccination rates e. Increase school readiness in children f. Decreased outbreaks of vaccine-preventable diseases g. Number of patients served in urgent care, in person and Telehealth h. Increased awareness of patient engagement strategies for prevention of chronic disease i. Increase patient enrollment in MyChart j. Increase patient utilization and engagement in MyChart
1.B Ensure future supply of health care providers	i. Provide training to health care professionals (e.g., Hartnell College nursing program, CSUMB program) ii. Support pipeline programs for healthcare careers	a. Increased number of qualified providers in the community focused on community-based practices b. Standard of care raised

Goal	Strategies	Anticipated Impact
	iii. Support the recruitment of healthcare providers to the area	c. Reduction in wait time for patient appointments d. Expand specialty care access in underserved population
1.C Address financial barriers to access	i. Continue to provide uncompensated Medi-Cal care to Medi-Cal patients ii. Provide financial assistance to reduce health care cost barriers to care for low-income individuals iii. Support organizations or programs assisting with insurance enrollment, including community outreach about insurance iv. Continually evaluate opportunities for low-cost alternatives for care v. Support redetermination program for qualified patients vi. Expand access to lower cost alternatives for services, with a focus on outpatient options vii. Support and collaborate with organizations that provide transportation for healthcare needs, such as post discharge travel, and transit to/from preventative care appointments	a. Reduced health care cost barriers for vulnerable populations b. Improved health insurance rates (% of people with health insurance) c. Reduction in transportation barrier for medical appointments

HEALTH NEED 2: CANCER

Long-Term Goal: Increase community prevention awareness, access and early detection of cancer.

Goal	Strategies	Anticipated Impact
2.A Continue/expand access to programs and services that prevent and/or support early detection of cancer	i. Expand access to programs and services that raise awareness on chronic disease prevention, such as cancer (e.g., healthy eating, active living programs) ii. Expand access to programs and services that address early detection iii. Expand access to programs and services the support cancer screening iv. Explore a genetic screening campaign v. Continue to grow Oncology Health Coordinator role and community presence	a. Improved access to free community education and programs b. Increased number of early detection cancers c. Increase number of people screened for cancer d. Increase number of people who utilize genetic screening
2.B Continue/expand services for those diagnosed with cancer	i. Expand access to programs and services that support cancer patients (ex. Lipstick Angels) ii. Expand access to programs and services that support care givers of cancer patients	a. Improved access to cancer support services b. Increased number of participants in cancer support services

Goal	Strategies	Anticipated Impact
	iii. Expand access to programs and services that support cancer survivors, i.e. Survivorship Initiatives iv. Expand Community Partnerships for aligned patient support	c. Increase number of caregiver services utilized d. Increased awareness and utilization of community services

HEALTH NEED 3: HEALTHY LIFESTYLES

Long-Term Goal: Increase ability of community members to live healthy lifestyles, including a focus on prevention and treatment programs for diabetes.

Goal	Strategies	Anticipated Impact
3.A Increase access to high-quality, affordable, healthy foods for vulnerable populations	i. Expand capacity of existing food access programs, including those specifically addressing health care-related food access (e.g., Fresh Produce Rx, Food is Medicine) ii. Support additional, culturally relevant food access programs iii. Support implementation of healthy food policies in schools and the county at large iv. Support food education with healthy community cooking demonstrations	a. Improved access to high-quality, affordable, healthy foods b. Reduced proportion of individuals who are food insecure c. Improved associated health outcomes d. Increased knowledge related to healthy food preparation

Goal	Strategies	Anticipated Impact
	v. Support expanding partnerships with Community Based Organizations to expand free produce programming vi. Support ongoing implementation of Double Up Food Bucks in Monterey County	e. Increase enrollment on food incentive benefit programs
3.B Increase access to affordable exercise areas and options	i. Support/expand interventions and practices aimed at reducing recreational, sedentary screen time among community members (e.g., expand access to free/low-cost community exercise classes) ii. Advocate for the development and maintenance of trails, parks, bike paths, etc. especially in low-income/ rural communities iii. Support community awareness of Park Rx Program iv. Provide free outdoor community exercise programming	a. Improved access to exercise for low-income individuals b. Increased proportion of individuals who are physically fit c. Increased awareness and utilization of Monterey County parks d. Increased number of community members participating in Pathways programming e. Improved associated health outcomes
3.C Increase education and initiatives related to healthy lifestyles	i. Participate in health fairs and other opportunities for health screening and education (which include follow-up) ii. Support community health workers (CHAs) in health education, and as outreach, enrollment, and information agents to increase healthy behaviors iii. Support/expand community well-being initiatives promoting healthy lifestyles	a. Increased knowledge about healthy behaviors b. Increased participation in free community programming c. Improved health outcomes, particularly related to health disparities

Goal	Strategies	Anticipated Impact
	iv. Align with Community Schools to increase awareness of programming v. Support development and implementation of curriculum aligned nutrition curriculum in school districts	d. Increased participation in early childhood nutrition education
3.D Reduce uncontrolled chronic diseases such as prediabetes and diabetes	i. Support/expand initiatives and programs for diabetes and obesity prevention (e.g., screenings, diabetes and diabetes-prevention education, treatment) ii. Support/expand initiatives and programs that provide intervention strategies for chronic disease to include aligned diabetes prevention and education campaign iii. Expand free and low-cost access to diabetes service line prevention and education programming iv. Expand culturally relevant healthy food demonstrations, fun food experiences and recipe development throughout the Salinas Valley Health service area	a. Increased knowledge about healthy behaviors b. Increased number of screenings for diabetes c. Increased engagement in prevention education programming d. Improved health outcomes, particularly related to health disparities e. Improved knowledge and capacity for healthy food preparation

HEALTH NEED 4: HEART DISEASE & STROKE

Long-Term Goal: Increase community prevention awareness, access and early detection of heart disease & stroke.

Goal	Strategies	Anticipated Impact
4.A Increase awareness and education programming of healthy lifestyle interventions for preventable chronic disease	i. Support and expand healthy eating/healthy lifestyle community programming ii. Expand offerings in both English and Spanish for nutrition education iii. Participate in health fairs and other opportunities for health screening and education (which include follow-up) iv. Support community health workers (CHAs) in health education, and as outreach, enrollment, and information agents to increase healthy behaviors v. Expand locations of healthy lifestyle programming to increase access in underserved communities and throughout our service area vi. Implement patient engagement and education platforms, such as Mytonomy, to educate on risk factor modification, prevention and procedures	a. Improved patient engagement in preventative health b. Increased access as a result of additional programming c. Improved health outcomes, particularly related to health disparities d. Increased knowledge about healthy behaviors e. Increased participation in education and prevention programming f. Increased knowledge and engagement among patient population
4.B Increase access to affordable exercise areas and options	i. Support/expand interventions and practices aimed at reducing recreational and sedentary screen time among community members	a. Improved access to exercise for low-income individuals b. Increased proportion of individuals who are physically fit

Goal	Strategies	Anticipated Impact
	ii. Expand access to free/low-cost community exercise opportunities iii. Identify partners to support sustained physical activity upon completion of cardiac associated rehabilitation (Ex. YMCA partnership) iv. Advocate for the development and maintenance of trails, parks, bike paths, etc. especially in low-income/ rural communities v. Expand ParkRx partnerships to increase awareness and utilization by community members	c. Improved associated health outcomes d. Increased utilization of Monterey County parks
4.C Increase knowledge of risk factors and screening for heart disease, hypertension and stroke	i. Develop a bilingual and culturally relevant stroke awareness campaign ii. Develop a bilingual and culturally relevant campaign to increase awareness and screening for hypertension iii. Evaluate current cardiac related campaigns for bilingual comprehension and retention iv. Focus on cardiac related conditions and stroke in community outreach, with a strategic alignment in underserved areas	a. Increased awareness of stroke signs, symptoms b. Increased awareness of preventative options for stroke c. Increase awareness of prevention options for hypertension

VIII. Evaluation Plans

SVH will monitor and evaluate the strategies described above for the purpose of tracking the implementation of those strategies as well as to document the anticipated impact. When working with partners through our Community Benefit Funding, SVH will track the number of grants made, dollars spent, and number of people reached/served. In addition, SVH will require grantees to track and report outcomes/impact, including behavioral and physical health outcomes as appropriate.

Evaluation efforts will include both process and outcome measures aligned with the goals and anticipated impacts identified in Section VII. These measures may include:

- Utilization of primary and preventive care services
- Participation in community-based programs
- Preventive screening rates (e.g., cancer, hypertension)
- Patient engagement metrics, including use of digital tools
- Clinical indicators related to chronic disease management

Data sources will include internal program data, electronic health records, community partner reports, and publicly available health data. Where appropriate, SVH will compare results to state and national benchmarks.

Regular internal reviews will be conducted to assess program effectiveness, identify opportunities for improvement, and ensure alignment with organizational priorities and community needs. Strategies may be adjusted throughout the implementation period to improve outcomes and responsiveness.

SVH will also continue to collaborate with community partners to gather feedback and evaluate the impact of programs at the community level. Findings will inform future planning efforts, including subsequent CHNAs and Implementation Strategies.

IX. Health Needs that Salinas Valley Health Does Not Plan to Address

As described in Section VI(A) of this report, SVH will address the four health needs that met all of the selection criteria. SVH will not address the following identified health needs:

The 2025 CHNA identified a broad range of significant health needs within Monterey County, including mental health, substance use, housing, infant health and family planning, injury and violence, respiratory disease and tobacco use.

While these needs are critical to overall community health, Salinas Valley Health has chosen to focus its resources on four priority areas for Fiscal Years 2026–2028: Access to Healthcare Services, Cancer, Healthy Lifestyles, and Heart Disease & Stroke.

The decision to not prioritize the other needs within this IS is based on several factors, including:

- Alignment with organizational expertise and clinical capabilities
- Availability of resources
- Potential to achieve measurable impact within the three-year period
- Presence of other organizations and collaborative entities actively addressing these issues

SVH remains committed to supporting these broader needs through targeted programs currently in place, participation in community partnerships, collaboration with local agencies, and referral and care coordination efforts that connect individuals to appropriate services.

These needs will continue to be monitored and may be addressed in future Implementation Strategies as community conditions evolve.

Mental Health: While not prioritized in this IS, SVH has prioritized this health need in the past and remains active in addressing mental health needs in the community by securing and promoting telehealth mental health services for adults and children. SVH also promotes better mental health through our many healthy lifestyle programs, classes, and events and provides support for other community non-profits with expertise and resources focused on the topic.

Substance Use: SVH decided to focus on higher impact community health needs however SVH was an early adopter of the Prescribe Safe program and participates in the Quad County Coalition of Prescribe Safe; SVH is active in the California Bridge Collaborative; the Clinical Team is engaged in the Tri-County EMS Buprenorphine program; a SVH Magnet driven nursing practice council created a new 2025 protocol to update the ICU's alcohol withdrawal program supported by clinical evidence; and the work of SVH Case Management and Social Services teams have dedicated experts in substance use disorder to coordinate care and programs for patients in need of community based resources.

Housing: This topic is outside of SVH's core competencies or mission and the medical center feels it can have greater impact through partnerships of support where appropriate with those who have proven expertise in the housing and land use arena.

Infant Health & Family Planning: SVH is better positioned to address drivers of this need via healthcare access and delivery strategies. Additionally, this need was of lower priority to the community than the needs selected to be addressed by SVH. However, it is important to note the SVH Labor/Delivery and Mother/Baby units are very active in the community as it relates to maternal and infant health, every year leading a diaper collection campaign and community distribution of diapers to underserved communities.

Injury & Violence: This need was of lower priority to the community than the needs selected to be addressed by SVH. SVH, however, provides education materials on the leading cause of injuries - falls. Clinical teams especially counsel at risk patients and families on fall prevention strategies.

Respiratory Disease: While SVH chose to prioritize more community health needs impacting a greater percentage of residents, it is worth noting that SVH launched and hosts Monterey County's only Asthma Day Camp, a week long summer program started 40 years ago at SVH to help children better manage their asthma in a supportive, fun and supervised learning environment.

Tobacco Use: This health topic was viewed as the lowest priority by key stakeholders and survey results indicate the prevalence in the SVHMC Service area is very low with 94% of all respondents indicating they do not smoke at all and only 3% of respondents indicating they smoke cigarettes daily.