2023 COMMUNITY HEALTH NEEDS ASSESSMENT

Watsonville Community Hospital Service Area
Pajaro Valley Healthcare District

Sponsored by

WATSONVILLE COMMUNITY HOSPITAL

2023-0413-02

Prepared by
www.PRCCustomResearch.com

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Project Goals

This Community Health Needs Assessment is a systematic, data-driven approach to determining the health status, behaviors, and needs of residents in the service area of Watsonville Community Hospital in Watsonville, California. 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.

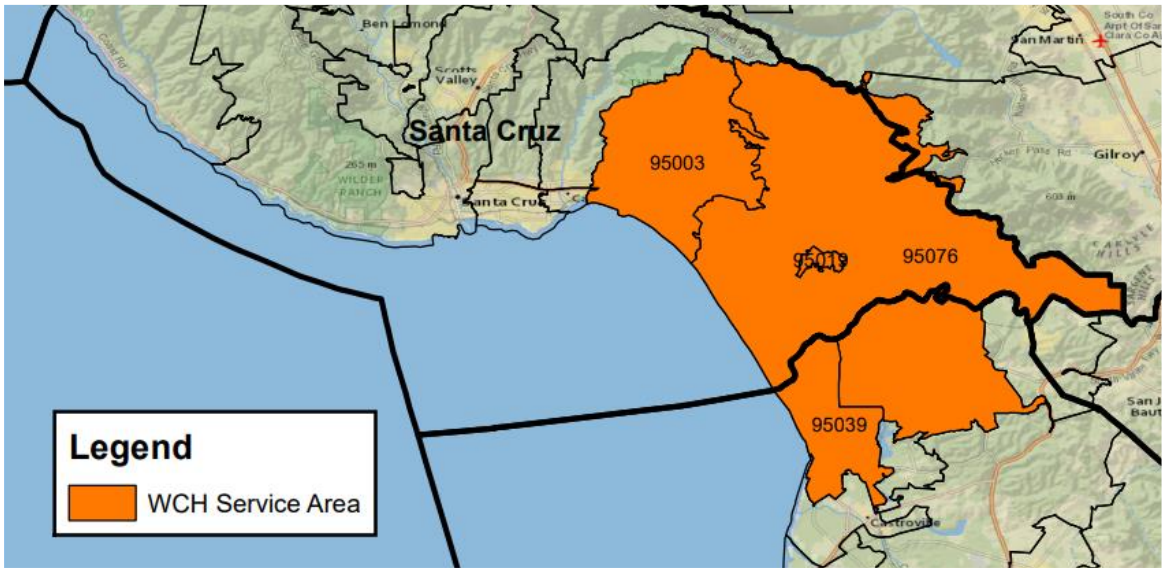
This assessment was conducted on behalf of Watsonville Community Hospital by PRC, Inc., a nationally recognized health care consulting firm with extensive experience conducting Community Health Needs Assessments in hundreds of communities across the United States since 1994.

Methodology

Quantitative data input for this assessment includes secondary research (vital statistics and other existing health-related data) that allows for comparison to benchmark data at the state and national levels. Qualitative data input includes primary research among community leaders gathered through an Online Key Informant Survey.

Community Defined for This Assessment

The study area for this effort (referred to as the "WCH Service Area" in this report) is the Pajaro Valley Healthcare District, which includes ZIP Codes 95003, 95019, 95039, and 95076 in southern Santa Cruz County and northern Monterey County in California. This community definition, determined based on the residences of most recent patients of Watsonville Community Hospital, is illustrated in the following map.



Online Key Informant Survey

To solicit input from community key informants, those individuals who have a broad interest in the health of the community, an Online Key Informant Survey also was implemented as part of this process. A list of recommended participants was provided by Watsonville Community Hospital; 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, 41 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	7
Public Health Representatives	5
Other Health Providers	10
Social Services Providers	2
Other Community Leaders	17

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.

- Central California Alliance for Health
- City of Watsonville
- Coastal Health Partners
- Community Action Board
- Community Bridges
- Community Bridges WIC Program
- Community Health Trust of Pajaro Valley
- County of Santa Cruz
- Dientes Community Dental Care
- Doctors on Duty
- Elderday Adult Day Health Care
- Hospice of Santa Cruz County
- Kaiser Permanente
- Meals on Wheels, Santa Cruz
- Monterey County Public Health
- Monterey County Supervisor
- Pajaro Valley Health Care District
- Pajaro Valley Prevention and Student Assistance
- Salud Para La Gente
- Santa Cruz Community Health Centers
- Santa Cruz County Health Services Agency
- Santa Cruz County Office of Education
- Santa Cruz County Public Health
- Santa Cruz Health Information Organization
- Second Harvest Food Bank
- United Way of Santa Cruz County
- Watsonville Community Hospital
- Watsonville Health Center

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 for the Watsonville Community Hospital Service Area 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 ZIP Code-level data are not available for all measures; for these indicators, data is taken from Santa Cruz County as a whole. Throughout this report, chart labels signify whether the data presented are ZIP Code-level based (WCH Service Area) or county-level based (Santa Cruz County).

Benchmark Data

California and National Data

Where possible, state and national data are provided as an additional benchmark against which to compare local findings.

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

For the purpose of this report, “significance” of secondary data indicators (which 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. 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.

Public Comment

Watsonville Community Hospital will use its website as a tool to solicit public comments and ensure that these comments are considered in the development of future CHNAs.

IRS FORM 990, SCHEDULE H COMPLIANCE

For nonprofit hospitals, a Community Health Needs Assessment (CHNA) also serves to satisfy certain requirements of tax reporting, pursuant to provisions of the Patient Protection & Affordable Care Act of 2010. To understand which elements of this report relate to those requested as part of hospitals' reporting on IRS Schedule H (Form 990), the following table cross-references related sections.

IRS FORM 990, SCHEDULE H (2022)	See Report Page
Part V Section B Line 3a A definition of the community served by the hospital facility	6
Part V Section B Line 3b Demographics of the community	21
Part V Section B Line 3c Existing health care facilities and resources within the community that are available to respond to the health needs of the community	92
Part V Section B Line 3d How data was obtained	6
Part V Section B Line 3e The significant health needs of the community	11
Part V Section B Line 3f Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups	Addressed Throughout
Part V Section B Line 3g The process for identifying and prioritizing community health needs and services to meet the community health needs	12
Part V Section B Line 3h The process for consulting with persons representing the community's interests	6
Part V Section B Line 3i The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)	98

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 Watsonville Community Hospital Service 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; 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 community key informants giving input to this process.

AREAS OF OPPORTUNITY IDENTIFIED THROUGH THIS ASSESSMENT	
ACCESS TO HEALTH CARE SERVICES	▪ Primary Care Visits ▪ Uninsured Children
CANCER	▪ Leading Cause of Death ▪ Colorectal Cancer Screening ▪ Prostate Cancer Incidence
DIABETES	▪ Key Informants: *Diabetes* ranked as a top concern.
HEART DISEASE & STROKE	▪ Leading Cause of Death
INJURY & VIOLENCE	▪ Unintentional Injury Deaths
MENTAL HEALTH	▪ Suicide Deaths ▪ Key Informants: *Mental Health* ranked as a top concern.
NUTRITION, PHYSICAL ACTIVITY & WEIGHT	▪ Low Food Access ▪ Key Informants: *Nutrition, Physical Activity & Weight* ranked as a top concern.
ORAL HEALTH	▪ Access to Dentists
SOCIAL DETERMINANTS OF HEALTH	▪ Housing Burden ▪ Unemployment ▪ Education Levels ▪ Key Informants: *Social Determinants of Health* ranked as a top concern.
SUBSTANCE USE	▪ Excessive Drinking ▪ Drug Overdose Deaths
TOBACCO USE	▪ Cigarette Smoking

Community Feedback on Prioritization of Health Needs

Prioritization of the health needs identified in this assessment ("Areas of Opportunity" above) was determined based on a prioritization exercise conducted among providers and other community leaders (representing a cross-section of community-based agencies and organizations) as part of the Online Key Informant Survey.

In this process, these key informants were asked to rate the severity of a variety of health issues in the community. Insofar as these health issues were identified through the data above and/or were identified as top concerns among key informants, their ranking of these issues informed the following priorities:

1. Social Determinants of Health
2. Diabetes
3. Mental Health
4. Nutrition, Physical Activity & Weight
5. Substance Use
6. Oral Health
7. Access to Health Care Services
8. Heart Disease & Stroke
9. Injury & Violence
10. Tobacco Use
11. Cancer

Hospital Implementation Strategy

Watsonville Community Hospital will use the information from this Community Health Needs Assessment to develop an Implementation Strategy to address the significant health needs in the community. While the hospital will likely not implement strategies for all of the health issues listed above, the results of this prioritization exercise will be used to inform the development of the hospital's action plan to guide community health improvement efforts in the coming years.

Summary Tables:
Comparisons With Benchmark Data

The following tables provide an overview of indicators in the WCH Service Area, grouped by health topic.

Reading the Summary Tables

Note that blank table cells in the tables that follow signify that data are not available for that indicator.

In the following tables, WCH Service Area results are shown in the larger, gray column. *For indicators where ZIP-level based data results are not available, county-level based data (Santa Cruz County) results are shown (marked as [COUNTY-LEVEL]).*

The columns to the right of the WCH Service Area column provide comparisons between local data and any available state and national findings, and Healthy People 2030 objectives. Symbols indicate whether the WCH Service Area (or Santa Cruz County) compares favorably (), unfavorably (), or comparably () to these external data.

SOCIAL DETERMINANTS	WCH Service Area	WCH SERVICE AREA vs. BENCHMARKS		
		vs. CA	vs. US	vs. HP2030
Linguistically Isolated Population (Percent)	10.8	7.4	4.0	
Population in Poverty (Percent)	9.8	12.3	12.6	8.0
Children in Poverty (Percent)	12.7	16.2	17.1	8.0
No High School Diploma (Age 25+, Percent)	25.0	15.8	11.1	
Unemployment Rate (Age 16+, Percent)	5.0 [COUNTY-LEVEL]	3.9	3.3	
Housing Exceeds 30% of Income (Percent)	41.9	40.0	30.3	25.5
		better	similar	worse

OVERALL HEALTH	WCH Service Area	WCH SERVICE AREA vs. BENCHMARKS		
		vs. CA	vs. US	vs. HP2030
"Fair/Poor" Overall Health (Percent)	20.3	17.3	16.1	
		better	similar	worse

ACCESS TO HEALTH CARE	WCH Service Area	WCH SERVICE AREA vs. BENCHMARKS		
		vs. CA	vs. US	vs. HP2030
Uninsured (Adults 18-64, Percent)	9.8	9.8	12.1	7.6
Uninsured (Children 0-18, Percent)	4.1	3.4	5.3	7.6
Routine Checkup in Past Year (Percent)	60.5	63.1	73.6	
Primary Care Doctors per 100,000	104.1 [COUNTY-LEVEL]	81.1	76.4	
		better	similar	worse

CANCER	WCH Service Area	WCH SERVICE AREA vs. BENCHMARKS		
		vs. CA	vs. US	vs. HP2030
Cancer Deaths per 100,000 (Age-Adjusted)	**124.9** [COUNTY-LEVEL]	134.5	149.4	122.7
Cancer Incidence per 100,000 (Age-Adjusted)	**444.8** [COUNTY-LEVEL]	394.7	442.3	
Female Breast Cancer Incidence per 100,000 (Age-Adjusted)	**139.1** [COUNTY-LEVEL]	121.0	127.0	
Prostate Cancer Incidence per 100,000 (Age-Adjusted)	**118.5** [COUNTY-LEVEL]	95.4	110.5	
Colorectal Cancer Incidence per 100,000 (Age-Adjusted)	**34.9** [COUNTY-LEVEL]	33.5	36.5	
Lung Cancer Incidence per 100,000 (Age-Adjusted)	**34.7** [COUNTY-LEVEL]	37.6	54.0	
Breast Cancer Screening in Past 2 Years (Women 50-74, Percent)	**71.5**	69.6	78.2	80.5
Cervical Cancer Screening in Past 3 Years (Women 21-65, Percent)	**81.2**	80.7	82.8	84.3
Colorectal Cancer Screening (Age 50-75, Percent)	**54.8**	61.0	72.4	74.4
		better	similar	worse

DIABETES	WCH Service Area	WCH SERVICE AREA vs. BENCHMARKS		
		vs. CA	vs. US	vs. HP2030
Diabetes Prevalence (Percent)	**8.4**	9.3	10.1	
		better	similar	worse

DISABLING CONDITIONS	WCH Service Area	WCH SERVICE AREA vs. BENCHMARKS		
		vs. CA	vs. US	vs. HP2030
Disability Prevalence (Percent)	**11.9**	10.6	12.6	
		better	similar	worse

HEART DISEASE & STROKE	WCH Service Area	WCH SERVICE AREA vs. BENCHMARKS vs. CA	vs. US	vs. HP2030
Heart Disease Deaths per 100,000 (Age-Adjusted)	**53.7** [COUNTY-LEVEL]	84.6	91.5	127.4
Stroke Deaths per 100,000 (Age-Adjusted)	**30.6** [COUNTY-LEVEL]	37.6	37.6	33.4
High Blood Pressure Prevalence (Percent)	**27.6**	28.5	32.7	42.6
High Blood Cholesterol Prevalence (Percent)	**33.7**	35.3	36.4	
		better	similar	worse

INFANT HEALTH & FAMILY PLANNING	WCH Service Area	WCH SERVICE AREA vs. BENCHMARKS vs. CA	vs. US	vs. HP2030
No Prenatal Care in First 6 Months (Percent of Births)	**3.1** [COUNTY-LEVEL]	3.7	6.1	
Low Birthweight (Percent of Births)	**5.8** [COUNTY-LEVEL]	6.9	8.2	
Infant Deaths per 1,000 Live Births	**4.0** [COUNTY-LEVEL]	4.0	5.6	5.0
Teen Births per 1,000 Females 15-19	**9.9** [COUNTY-LEVEL]	15.6	19.3	
		better	similar	worse

INJURY & VIOLENCE	WCH Service Area	WCH SERVICE AREA vs. BENCHMARKS vs. CA	vs. US	vs. HP2030
Unintentional Injury Deaths per 100,000 (Age-Adjusted)	**45.1** [COUNTY-LEVEL]	35.8	50.4	43.2
Motor Vehicle Crash Deaths per 100,000 (Age-Adjusted)	**8.5** [COUNTY-LEVEL]	9.9	11.5	10.1

INJURY & VIOLENCE (continued)	WCH Service Area	WCH SERVICE AREA vs. BENCHMARKS vs. CA	vs. US	vs. HP2030
Homicide Deaths per 100,000 (Age-Adjusted)	3.2 [COUNTY-LEVEL]	5.1	6.4	5.5
Violent Crimes per 100,000	403.6 [COUNTY-LEVEL]	440.5	416.0	
		better	similar	worse

MENTAL HEALTH	WCH Service Area	WCH SERVICE AREA vs. BENCHMARKS vs. CA	vs. US	vs. HP2030
Suicide Deaths per 100,000 (Age-Adjusted)	13.9 [COUNTY-LEVEL]	10.5	13.8	12.8
Mental Health Providers per 100,000	171.0	174.7	155.8	
		better	similar	worse

NUTRITION, PHYSICAL ACTIVITY & WEIGHT	WCH Service Area	WCH SERVICE AREA vs. BENCHMARKS vs. CA	vs. US	vs. HP2030
Fast Food Restaurants per 100,000	69.4 [COUNTY-LEVEL]	80.4	75.9	
Population With Low Food Access (Percent)	26.9	13.3	22.2	
No Leisure-Time Physical Activity (Percent)	15.6	19.2	22.0	21.8
Recreation/Fitness Facilities per 100,000	17.7	13.0	11.9	
Obese (Percent)	26.1	26.0	29.0	36.0
		better	similar	worse

ORAL HEALTH	WCH Service Area	WCH SERVICE AREA vs. BENCHMARKS		
		vs. CA	vs. US	vs. HP2030
Dental Visit in Past Year (Percent)	57.5	62.3	64.8	45.0
Dentists per 100,000	32.3	46.7	37.3	
		better	similar	worse

RESPIRATORY DISEASE	WCH Service Area	WCH SERVICE AREA vs. BENCHMARKS		
		vs. CA	vs. US	vs. HP2030
Lung Disease Deaths per 100,000 (Age-Adjusted)	20.8 [COUNTY-LEVEL]	30.5	39.1	
COVID-19 Deaths per 100,000	100.6 [COUNTY-LEVEL]	255.7	337.9	
Asthma Prevalence (Percent)	9.8	9.2	9.7	
COPD Prevalence (Percent)	5.7	5.3	6.4	
		better	similar	worse

SEXUAL HEALTH	WCH Service Area	WCH SERVICE AREA vs. BENCHMARKS		
		vs. CA	vs. US	vs. HP2030
HIV Prevalence per 100,000	214.6 [COUNTY-LEVEL]	406.0	379.7	
Chlamydia Incidence per 100,000	275.2 [COUNTY-LEVEL]	452.2	481.3	
Gonorrhea Incidence per 100,000	78.0 [COUNTY-LEVEL]	198.5	206.5	
		better	similar	worse

SUBSTANCE ABUSE	WCH Service Area	WCH SERVICE AREA vs. BENCHMARKS		
		vs. CA	vs. US	vs. HP2030
Excessive Drinking (Percent)	**22.4** [COUNTY-LEVEL]	18.4	19.0	
Drug Overdose Deaths per 100,000 (Age-Adjusted)	**17.2** [COUNTY-LEVEL]	14.5	22.4	
		better	similar	worse

TOBACCO USE	WCH Service Area	WCH SERVICE AREA vs. BENCHMARKS		
		vs. CA	vs. US	vs. HP2030
Cigarette Smoking (Percent)	**13.1**	11.1	13.5	6.1
		better	similar	worse

COMMUNITY DESCRIPTION

POPULATION CHARACTERISTICS

Total Population

Data from the US Census Bureau reveal the following statistics for our community relative to size, population, and density.

Total Population
(Estimated Population, 2020)

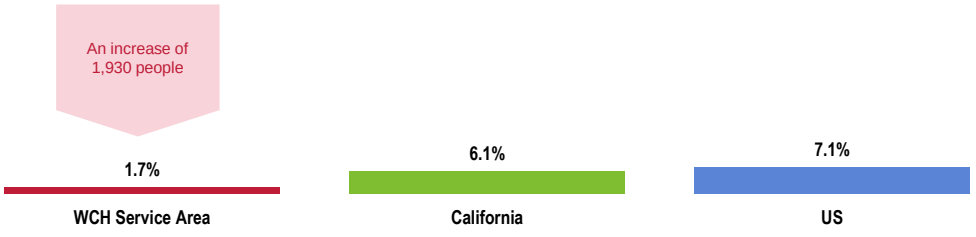
	TOTAL POPULATION	TOTAL LAND AREA (SQUARE MILES)	POPULATION DENSITY (PER SQUARE MILE)
WCH Service Area	117,575	178.16	660
California	39,538,223	155,857.45	254
United States	331,449,281	3,533,018.38	94

Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2023 via SparkMap (sparkmap.org).

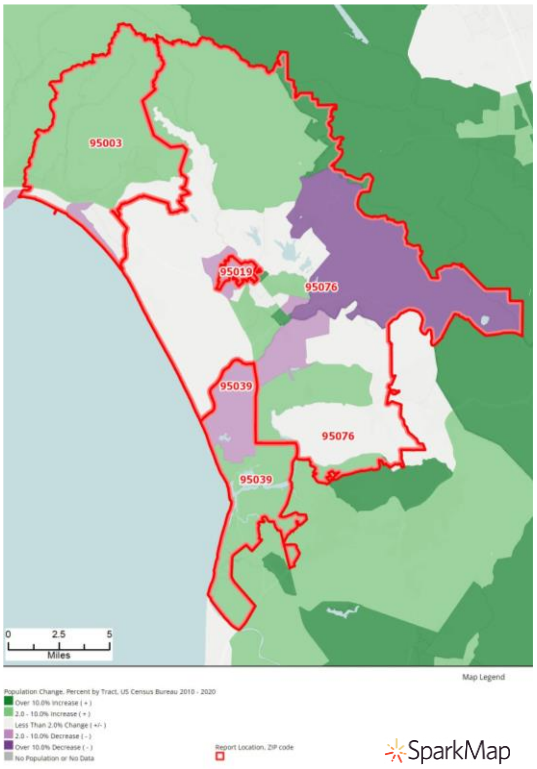
Population Change

A significant positive or negative shift in total population over time impacts health care providers and the utilization of community resources. The following chart and map illustrate the changes that have occurred in the WCH Service Area between the 2010 and 2020 US Censuses.

Change in Total Population
(Percentage Change Between 2010 and 2020)

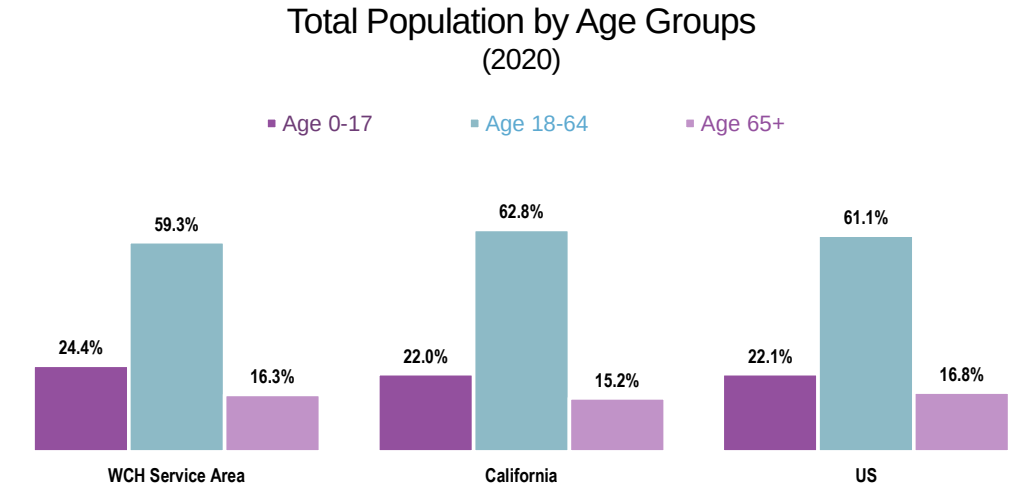


Sources:
- US Census Bureau Decennial Census (2010-2020).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2023 via SparkMap (sparkmap.org).



Age

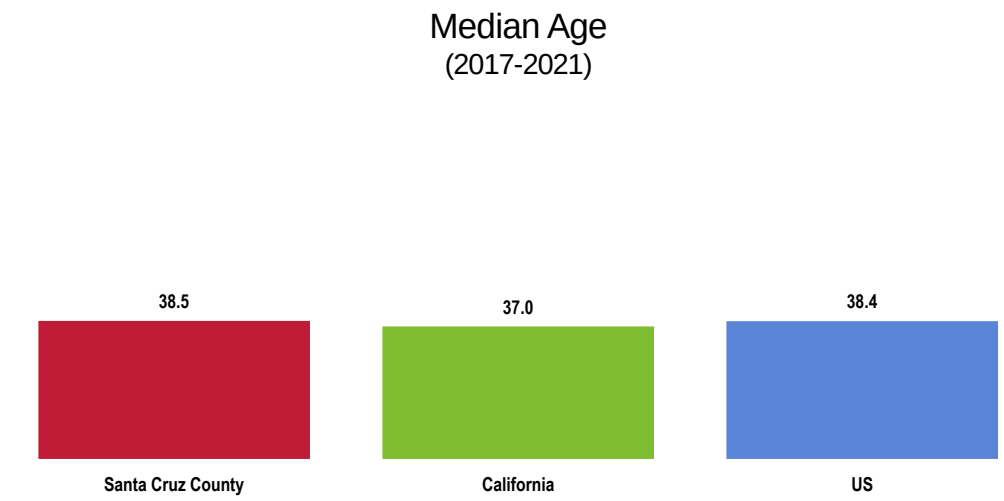
It is important to understand the age distribution of the population, as different age groups have unique health needs that should be considered separately from others along the age spectrum.



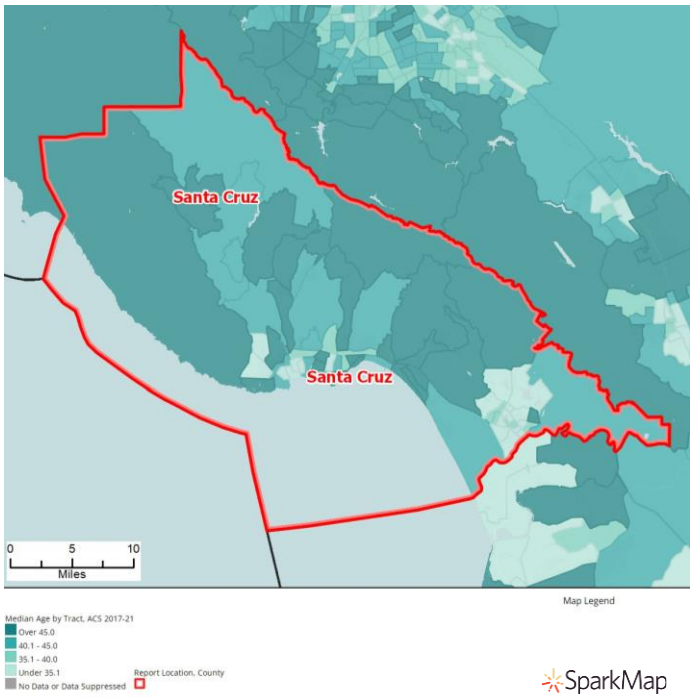
Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2023 via SparkMap (sparkmap.org).

Median Age

Note the median age of the Santa Cruz County population, relative to state and national medians.

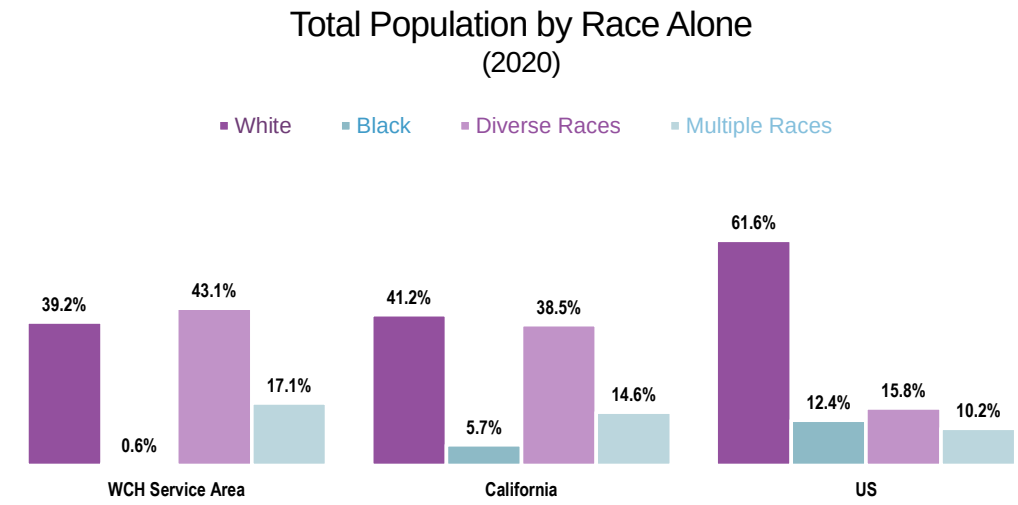


Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2023 via SparkMap (sparkmap.org).

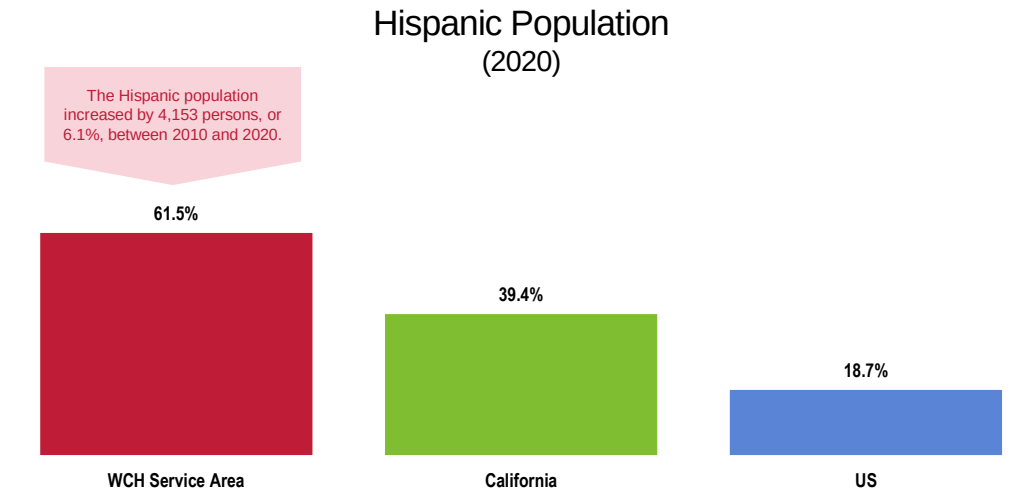


Race & Ethnicity

The following charts illustrate the racial and ethnic makeup of our community. “Race Alone” reflects those who identify with a single race category — people who identify their origin as Hispanic, Latino, or Spanish may be of any race.



Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2023 via SparkMap (sparkmap.org).



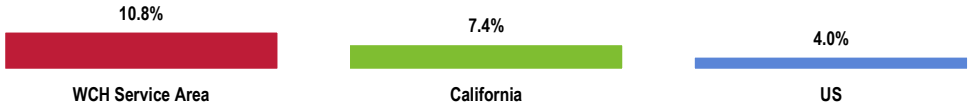
Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2023 via SparkMap (sparkmap.org).

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

Linguistic Isolation

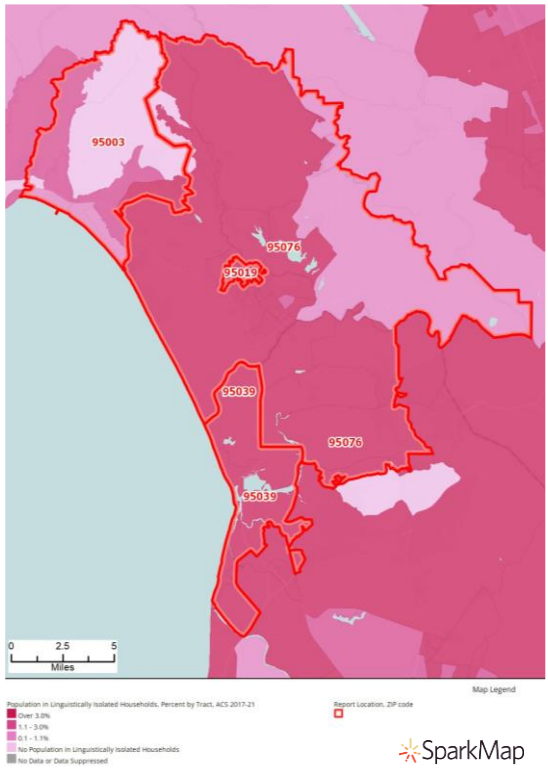
This indicator reports the percentage of the population age 5 years and older who live in a home in which: 1) no person age 14 years or older speaks only English; or 2) no person age 14 years or older speaks a non-English language but also speaks English "very well."

Linguistically Isolated Population
(2017-2021)



Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2023 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the percentage of the population age 5+ who live in a home in which no person age 14+ speaks only English, or in which no person age 14+ speak a non-English language and speak English "very well."



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)

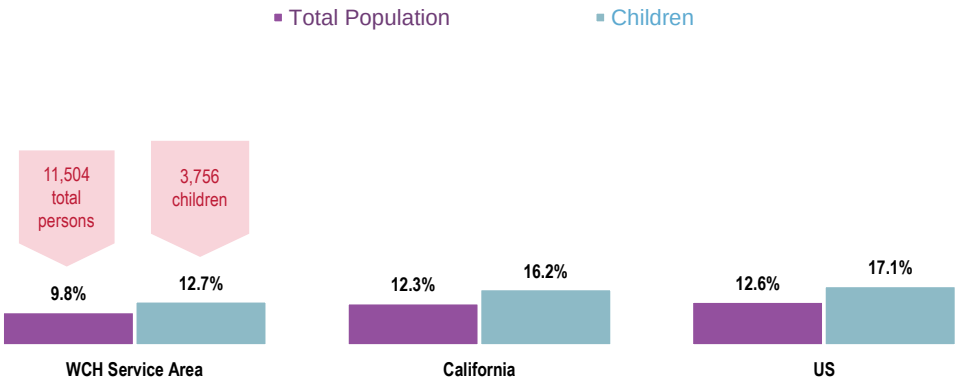
Poverty

Poverty is considered a key driver of health status. This indicator is relevant because poverty creates barriers to accessing health services, healthy food, and other necessities that contribute to health status. The following chart and maps outline the proportion of our population below the federal poverty threshold, as well as the percentage of children in the WCH Service Area living in poverty, in comparison to state and national proportions.

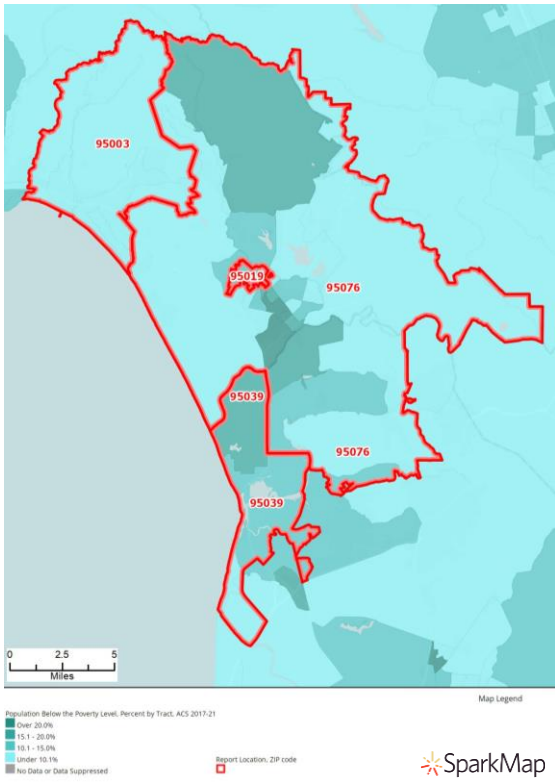
Percent of Population in Poverty

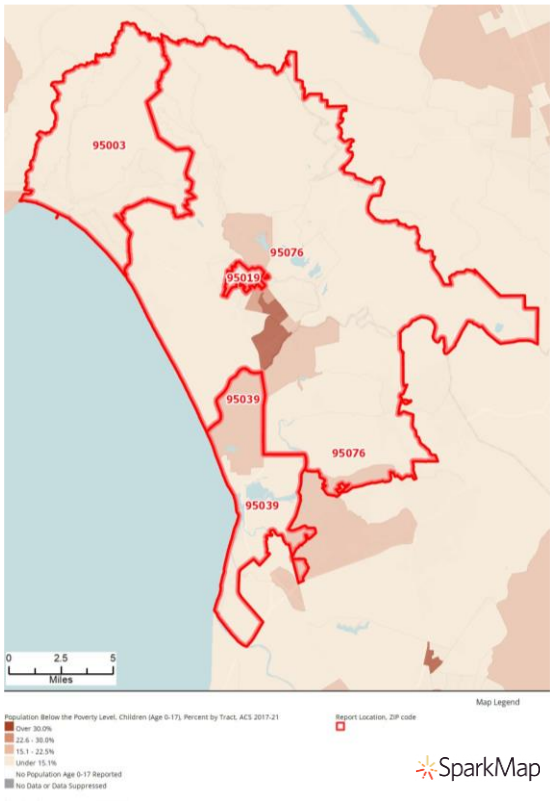
(2017-2021)

Healthy People 2030 = 8.0% or Lower



Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2023 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

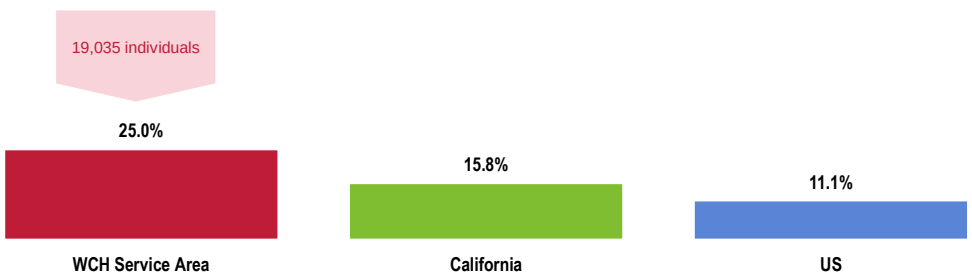




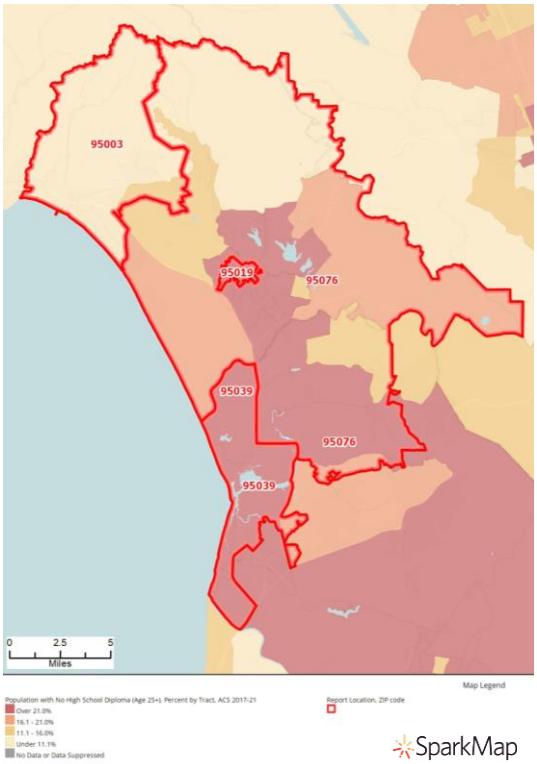
Education

Education levels are reflected in the proportion of our population age 25 and older without a high school diploma. This indicator is relevant because educational attainment is linked to positive health outcomes.

Population With No High School Diploma
(Adults Age 25 and Older, 2017-2021)

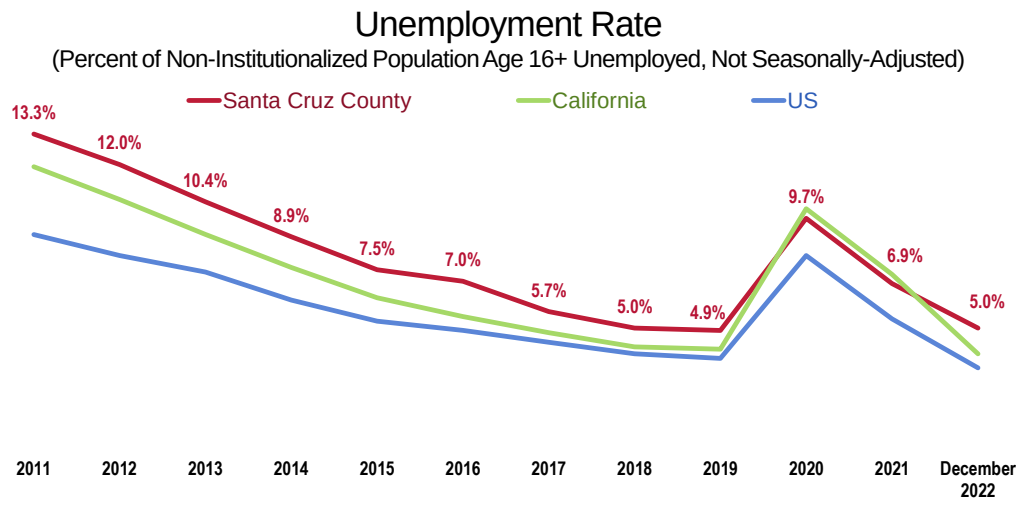


Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2023 via SparkMap (sparkmap.org).



Employment

Changes in unemployment rates in Santa Cruz County over the past several years are outlined in the following chart. This indicator is relevant because unemployment creates financial instability and barriers to accessing insurance coverage, health services, healthy food, and other necessities that contribute to health status.

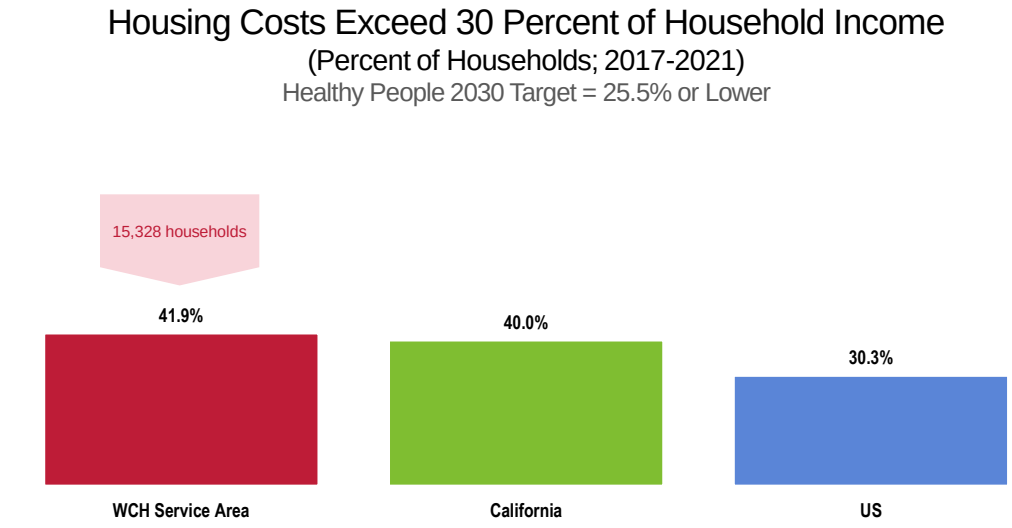


Sources:
- US Department of Labor, Bureau of Labor Statistics.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2023 via SparkMap (sparkmap.org).

Housing Burden

"Housing burden" reports the percentage of the households where housing costs (rent or mortgage costs) exceed 30% of total household income.

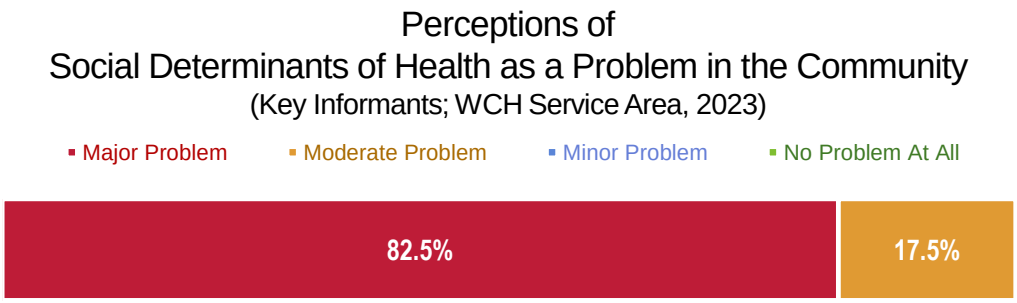
The following chart shows the housing burden in the WCH Service Area. This serves as a measure of housing affordability and excessive shelter costs. The data also serve to aid in the development of housing programs to meet the needs of people at different economic levels.



Sources:
- US Census Bureau, American Community Survey, 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2023 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Key Informant Input: Social Determinants of Health

Key informants' ratings of the severity of *Social Determinants of Health* as a concern in the WCH Service Area are outlined below.



Sources: 2023 PRC Online Key Informant Survey, PRC, Inc.
Notes: Asked of all respondents.

Top Concerns

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

Housing

> Housing and income disparities. – Social Services Provider
>
> Lack of housing for homeless population, lack of support from community leaders, TOO MUCH STIGMA. – Other Health Provider
>
> Housing costs, homelessness, poverty. – Other Health Provider
>
> Not enough housing or shelter beds for individuals who are without. – Other Health Provider
>
> Housing is a big problem in CA but especially for South County. If you do not have a home, how do you have health. Education services are limited at Cabrillo, and UCSC does not provide services in South County. – Community Leader
>
> High cost of housing in our area, storm damage in Watsonville and Pajaro, fears of accessing services due to immigration status. – Community Leader
>
> Massive lack of affordable housing. Very low wages in the ag industry. Systemic racism. – Community Leader
>
> There is little affordable housing options, which leads multiple families living in households together. – Social Services Provider
>
> High cost of living in economy driven by ag with seasonal work. – Other Health Provider
>
> There is serious inequity between socioeconomic groups in our community. It is clear that people cannot attend to their health properly if they are unhoused, hungry, facing eviction, have inadequate transportation, or live in an environment filled with toxic chemicals. I am optimistic that CalAIM/Enhanced Care Management may be able to address some of these issues for people in the Medi-Cal system with the most complex medical situations, but the general inequity is a much more stubborn issue, especially related to housing costs and severely limited affordable housing. – Community Leader
>
> Housing costs (from the generations of political refusal to prioritize building housing and the re-use of entry level housing stock for 2nd homes and vacation rentals), the federal designation that 95076 and surrounding zips are rural (thereby lowering federal reimbursement rates), the reduction of services over two decades within the Watsonville Community Hospital from corporate for-profit leadership. – Community Leader

Income/Poverty

> Income and work drive a lot of our patients’ decisions when seeking treatments that may cost more money or will require them to miss work for a period of time. – Physician
>
> Low-income population. – Community Leader
>
> Residents in South County tend to be of lower income, live in overcrowded housing, and don't have equitable access to green space and recreation facilities. – Public Health Representative
>
> Majority of patients I see are living in poverty and experience some type of SDOH. – Physician

Impact on Health

> According to all of these metrics, Watsonville has been identified as one of the least "healthiest" communities in the state of California. These social determinants of health have a massive impact on the success of people in South Santa Cruz County and the progress in our community because our residents cannot focus on anything else other than surviving. – Community Leader
>
> SDH are the main determinant of morbidity, mortality and quality of life in our under-served communities. Elected officials need to take responsibility for addressing the SDH, which when properly addressed, can improve the health and well-being of our HPI quartile 1 and 2 communities. – Public Health Representative
>
> South County is disproportionately impacted by social determinants. – Physician

Homelessness

> Huge issue here. Homelessness. Food desert. Poor health literacy. Pesticides. – Physician
>
> Health disparities are worse in Watsonville. Homelessness is a big issue statewide, and Watsonville is no exception. We faired poorer in the pandemic with COVID-19 deaths (the number one cause of death in South County), and eviction increased. South County also suffered through the floods, which were devasting. – Public Health Representative Access to Care/Services
>
> Accessing care, specialist care can take months to access. – Other Health Provider

Built Environment

> The Social Determinants are predictors of health. The built environment contributes and/or limits to the health of the community. As an example, we don't have enough housing, and there is no real focus on building wealth anymore. We keep talking about rental housing but not wealth building. Educational and certificated outcomes post-high school need improvement. – Community Leader
>
> Safe infrastructure. The recent Pajaro flood, with the levees breaking, is a prime example. Everyone has known for years that those levees were in imminent danger of collapsing. But nobody took action to prevent the disaster. This would have never happened with the levees in Los Gatos, for example. The lives of the poor brown people are not valued the way those of wealthy white people in other areas of the county. There's systemic racism in this country, and our county is sadly a heightened example of this injustices of our nation. We rely on farmworkers for the food we need to survive. They are truly essential workers. But we have a system in place that allows their continued exploitation by agricultural companies, landlords, and other elites in the area. Our county government doesn't invest in the areas where these communities live. It's disgraceful. – Community Leader

Racism

> Systemic racism and underinvestment in South County because it breeds inequity and lack of opportunity for our young people. – Other Health Provider
>
> The underlying historical racism plays a major factor in ZIP codes determining life span, adverse childhood experiences, and social determinants of health. Lack of quality resources (i.e. it is vital for the local hospital to have efficient technology and equipment). – Community Leader

Vulnerable Populations

> Because this region is a major food production area, with a large population of migrant farmworker families, where there are significant levels of exploitation, limited services, and limited investment in health and other services. Many migrant families have limited knowledge of their rights and awareness of the limited social services available to them. They live in fear of having their families separated and being deported. And powerful agricultural companies have significant influence over elected officials and legislation. – Community Leader

Access to Care/Services

> Accessing care, specialist care can take months to access – Other Health Provider

HEALTH STATUS

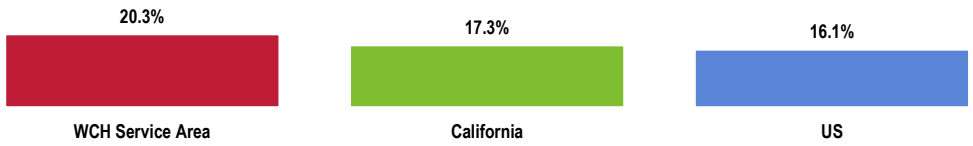
OVERALL HEALTH STATUS

The CDC's Behavioral Risk Factor Survey, from which these data are derived, asked respondents:

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

The following indicator provides a relevant measure of overall health status in the WCH Service Area, noting the prevalence of residents' "fair" or "poor" health evaluations. While this measure is self-reported and a subjective evaluation, it is an indicator which has proven to be highly predictive of health needs.

Adults With "Fair" or "Poor" Overall Health
(2021)



Sources:
- Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2023 via SparkMap (sparkmap.org).

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.

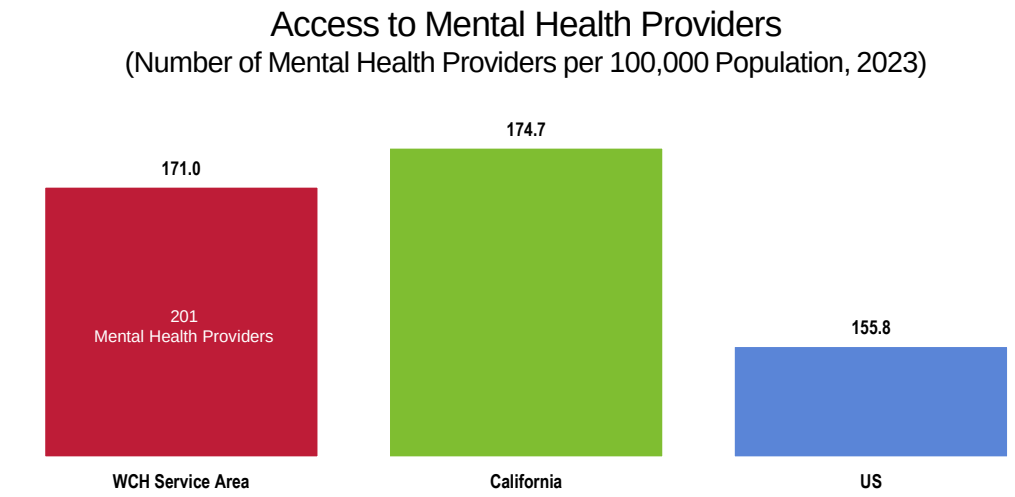
– Healthy People 2030 (https://health.gov/healthypeople)

Mental Health Providers

Here, "mental health providers" includes psychiatrists, psychologists, clinical social workers, and counselors who specialize in mental health care.

Note that this indicator only reflects providers practicing in the WCH Service Area and residents in the WCH Service 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 data below show the number of mental health care providers in the WCH Service Area relative to the WCH Service Area population size (per 100,000 residents). This is compared to the rates found statewide and nationally.

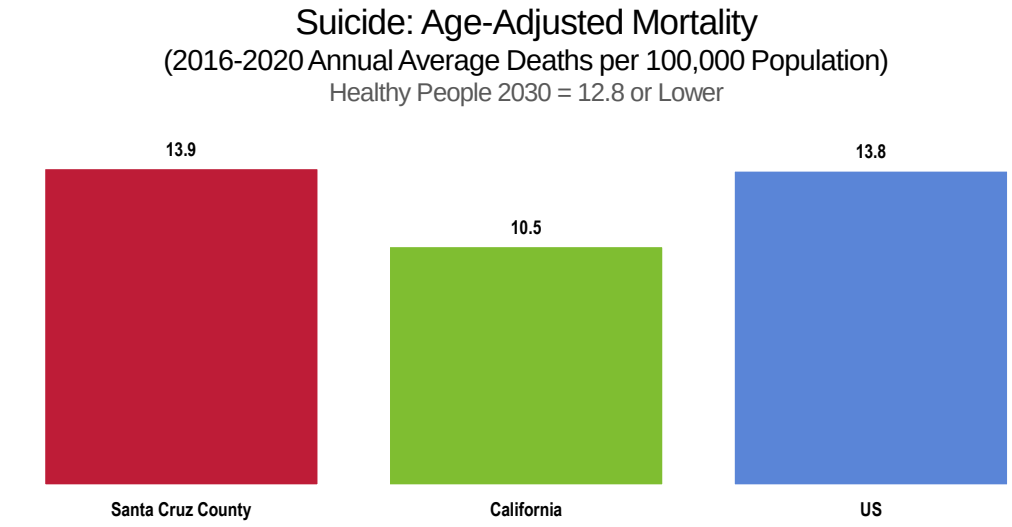


Sources:
- Centers for Medicare and Medicaid Services, National Plan and Provider Enumeration System (NPPES).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2023 via SparkMap (sparkmap.org).

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

Suicide

The following reports the rate of death in Santa Cruz County due to intentional self-harm (suicide) in comparison to statewide and national rates. Here, these rates are age-adjusted to account for age differences among populations in this comparison. This measure is relevant as an indicator of poor mental health.



Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2023 via SparkMap (sparkmap.org).
- 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, age-adjusted to the 2000 US Standard Population.

AGE-ADJUSTED DEATH RATES

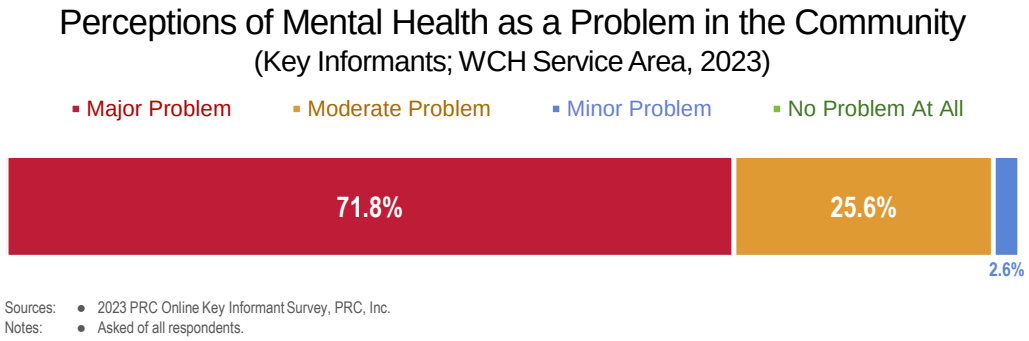
In order to compare mortality in the region with other localities (in this case, California and the United States), it is necessary to look at rates of death — these are figures which represent the number of deaths in relation to the population size (such as deaths per 100,000 population, as is used here).

Furthermore, in order to compare localities without undue bias toward younger or older populations, the common convention is to adjust the data to some common baseline age distribution. Use of these “age-adjusted” rates provides the most valuable means of gauging mortality against benchmark data, as well as Healthy People 2030 objectives.

Note that 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, age-adjusted to the 2000 US Standard Population.

Key Informant Input: Mental Health

Key informants' ratings of the severity of *Mental Health* as a concern in the WCH Service Area are outlined below.



Sources: 2023 PRC Online Key Informant Survey, PRC, Inc.
Notes: Asked of all respondents.

Top Concerns

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

Access to Care/Services

> No mild to moderate mental health services. No long-term mental health location for patients, except in San Jose or San Francisco. – Community Leader
>
> Although more providers are screening for mental health disorders, autism and developmental delay, individuals that are referred for further evaluation, diagnosis and treatment can wait months or years before being seen, even when health care providers contact mental health services providers and the managed care plans repeatedly regarding the referral. – Public Health Representative
>
> Lack of services and stigma that comes with it. – Other Health Provider
>
> Access to psychiatrists, access to counseling. Also, there is a great amount of stress in the patients I see related to basic needs like food, housing, employment that impact mental health by worsening or exacerbating existing conditions. I also see many kids who are not succeeding in school academically and have no normal outlets for fun like sports or other after-school activities because families can't afford or don't have time to get kids there; as a result, I see kids come home from school or spend entire summer/winter vacations lying around their house instead of doing developmentally appropriate activities to engage and provide fun. This also can worsen/exacerbate existing or predisposing conditions. finally, there is also a lot of familial strife that i see- divorce, substance abuse, immigration issues, teen pregnancies, etc. that also contribute to mental health concerns. – Physician
>
> Lack of available resources such as outpatient and inpatient programs. – Other Health Provider
>
> Psychiatric inpatients beds, children's crisis stabilization unit, housing and substance use. – Other Health Provider
>
> Access to care in a timely manner. – Other Health Provider
>
> Not enough of anything, physical centers for adults and youth in crises. Providers trained to support mental health within schools, community and within health care systems. Changing societal interaction and social media. – Community Leader
>
> Significantly limited availability of resources. – Physician
>
> It is often difficult to access mental health services – not enough providers in the community. Many people with mental health issues are unhoused and difficult to engage precisely because of their mental health issues, further contributing to homelessness issues. Also, mental health issues of older adults are often undiagnosed, misdiagnosed, and untreated. – Community Leader

Incidence/Prevalence

> Increased volume. – Community Leader
>
> Mental health has been declining since even before the pandemic. Loneliness and depression are big factors and social media is contributing. – Public Health Representative
>
> High rates of anxiety and depression. – Physician

Lack of Providers

> Lack of physicians. – Other Health Provider
>
> Not enough providers with clinical training and expertise. – Social Services Provider

Culturally Relevant Information

> Culturally relevant information that de-stigmatizes mental health; lack of value in cultural best practices to address mental health; ignoring the toll that financial hardships and fear that people are dealing with; responding to those that speak up about mental health with "pull yourself up by the boot straps"; lack of empathy and concern the depth that racism has with mental health. – Community Leader

Disease Management

> It doesn't exist. People are self-treating. – Physician

Follow Up/Support

> Lack of ongoing continuum of care to support individuals on a recovery path. The county has only 38 residential mental health beds that are not locked/inpatient units. There are extremely limited partial hospitalization or intensive outpatient services to support people in the community. There is insufficient appropriate housing for people experiencing homelessness and mental illness, and stigma and NIMBYism prevent development of more, even if funds are available. And there is a workforce challenge that adversely impacts the services that do exist. – Public Health Representative

Income/Poverty

> I think the biggest challenges are multi-faceted and tie into low income, and lack of time to model well-being and overall health. – Community Leader

Language Barrier

> Depression and anxiety. Lack of bilingual behavioral health providers. – Other Health Provider

Prevention/Screenings

> Prevention services and lack of licensed staff to serve their needs. – Public Health Representative

Social Norms/Community Attitude

> The cultural norms in our largely Latino community discourage asking for help and knowing what depression and other mental health issues feel like and are. Also, the availability of service providers for older adults and other vulnerable populations. – Community Leader

DEATH, DISEASE & CHRONIC CONDITIONS

CARDIOVASCULAR DISEASE

ABOUT HEART DISEASE & STROKE

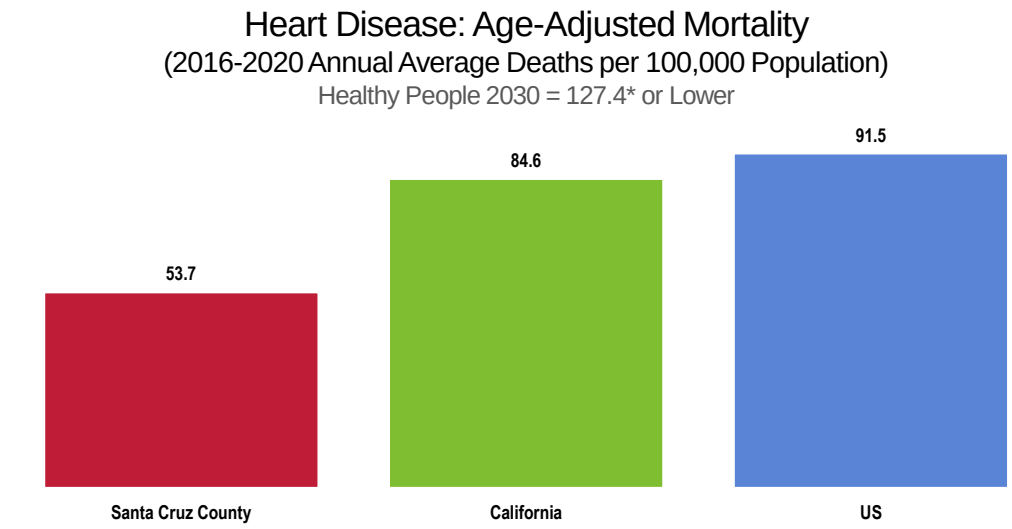
Heart disease and stroke can result in poor quality of life, disability, and death. Though both diseases are common, they can often be prevented by controlling risk factors like high blood pressure and high cholesterol through treatment.

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 Deaths

Heart disease is a leading cause of death in Santa Cruz County and throughout the United States. The chart that follows illustrates how our (age-adjusted) mortality rate compares to rates in California and the US.



Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2023 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
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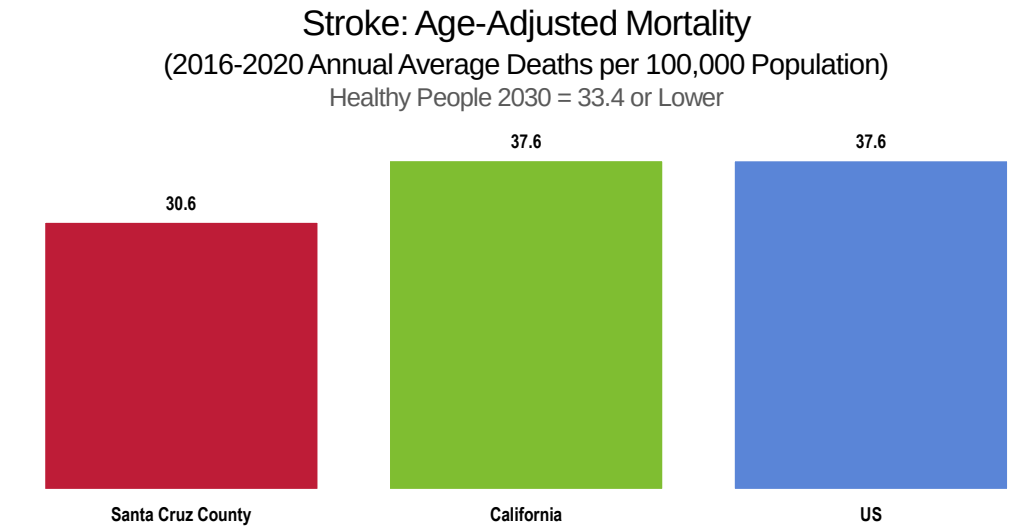
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
- *The Healthy People 2030 objective for coronary heart disease has been adjusted here to account for all diseases of the heart.

Stroke Deaths

Stroke, a leading cause of death in Santa Cruz County and throughout the nation, shares many of the same risk factors as heart disease. Outlined in the following chart is a comparison of stroke mortality locally, statewide, and nationally.



Sources:
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- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2023 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
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- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

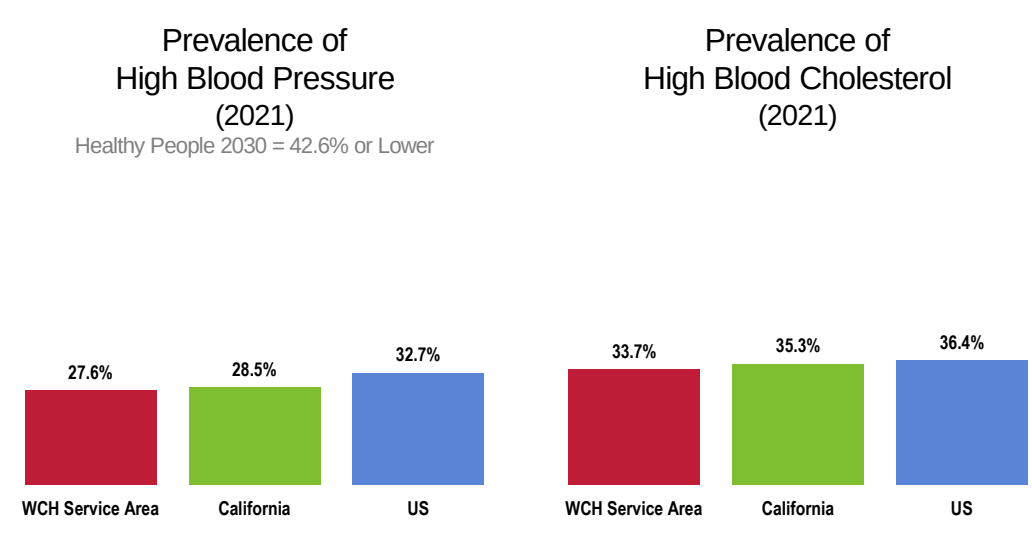
Blood Pressure & Cholesterol

The following chart illustrates the percentages of WCH Service Area adults who have been told that they have high blood pressure or high cholesterol, known risk factors for cardiovascular disease.

The CDC's Behavioral Risk Factor Survey asked:

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

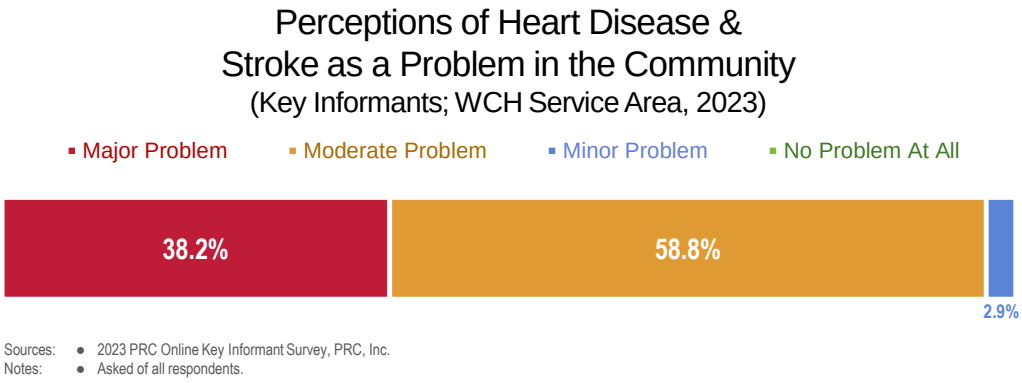
"Have you ever been told by a doctor, nurse, or other health professional that your cholesterol is high?"



Sources:
- Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2023 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Key Informant Input: Heart Disease & Stroke

Outlined below are key informants' levels of concern for *Heart Disease & Stroke* as an issue in the WCH Service Area.



Top Concerns

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

Lifestyle

> Eating and exercise absence. – Community Leader
>
> Poor diet, lack of exercise, alcohol and unsafe neighborhoods. – Other Health Provider
>
> Poor nutrition, low activity levels, smoking and alcohol and drug use. – Other Health Provider

Access to Care/Services

> Complex heart and medical, access to specialty care and services. – Social Services Provider
>
> No cardiology service at WCH, yet you're planning a cath lab. We can't even get a consultation. – Physician
>
> There is no STEMI center in Watsonville. Need specialists like cardiologist and interventional cardiologist. Also need Latino doctors to treat the community. – Public Health Representative

Incidence/Prevalence

> The majority of people who attend our program have some kind of heart disease and/or have experienced strokes. The prevalence of heart disease appears to be very high locally. – Community Leader
>
> Population health assessment. – Other Health Provider

Aging Population

> We have an aging community that is susceptible to heart disease and stroke because of cultural norms around exercise and nutrition. – Community Leader

Co-Occurrences

> Diabetes raises the risk for cardiovascular disease and stroke. – Community Leader

Disease Management

> Although health care providers at FQHCs provide evidence based, best practice treatment recommendations to patients to control blood pressure, cholesterol and prediabetes/diabetes, there is still reluctance among some patients at increased risk for heart disease and stroke to follow health care provider recommendations for treatment, even when Medi-Cal covers the cost of these treatments. Communities in the 1st and 2nd HPI quartiles lack the time, money and immediate access to safe places to be physically active, resulting in sedentary lifestyles and increased risk of heart disease and stress. – Public Health Representative

Lack of Providers

> Fewer cardiologists and neurologists in the area affect access. Lower income or rural geography affect access to healthier food, transportation, and assistance at home. – Physician

CANCER

ABOUT CANCER

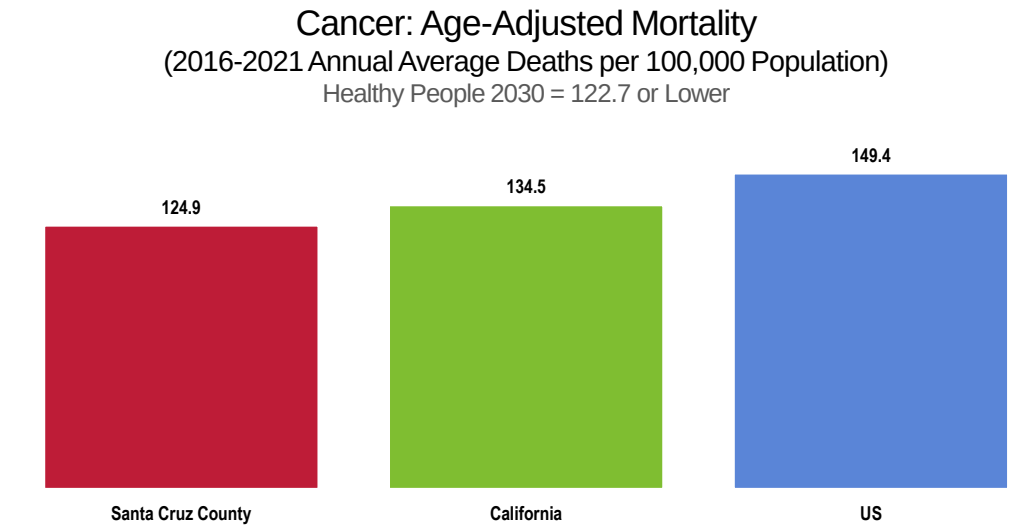
Cancer is the second leading cause of death in the United States. …The cancer death rate has declined in recent decades, but over 600,000 people still die from cancer each year in the United States. Death rates are higher for some cancers and in some racial/ethnic minority groups. These disparities are 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)

Age-Adjusted Cancer Deaths

Cancer is a leading cause of death in Santa Cruz County and throughout the United States. Age-adjusted cancer mortality rates are outlined below.



Sources:
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- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2023 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
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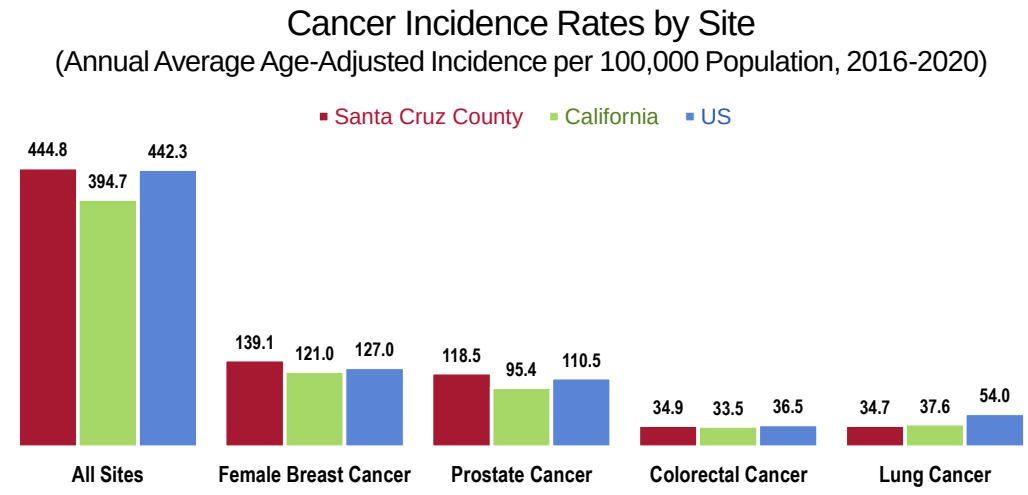
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

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. These rates are also age-adjusted. It is usually expressed as cases per 100,000 population per year.

It is important to identify leading cancers by site in order to better address them through targeted intervention. The following chart illustrates Santa Cruz County incidence rates for leading cancer sites.



Sources:
- State Cancer Profiles.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2023 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the age adjusted incidence rate (cases per 100,000 population per year) of cancers, adjusted to 2000 US standard population age groups (under age 1, 1-4, 5-9, ..., 80-84, 85 and older).

Cancer Screenings

FEMALE BREAST CANCER

The US Preventive Services Task Force (USPSTF) recommends biennial screening mammography for women age 50 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.

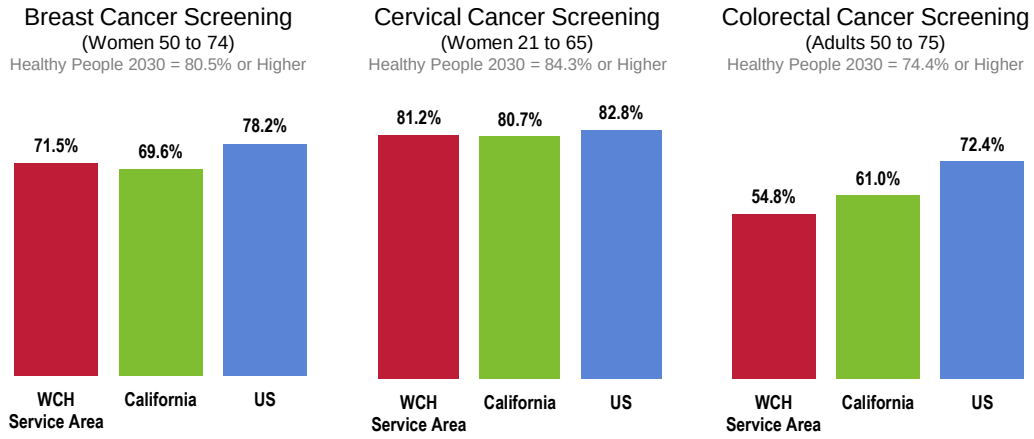
COLORECTAL CANCER

The US Preventive Services Task Force (USPSTF) recommends screening for colorectal cancer starting at age 50 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.

The following outlines the percentages of residents receiving these age-appropriate cancer screenings. These are important preventive behaviors for early detection and treatment of health problems. Low screening levels can highlight a lack of access to preventive care, a lack of health knowledge, or other barriers.

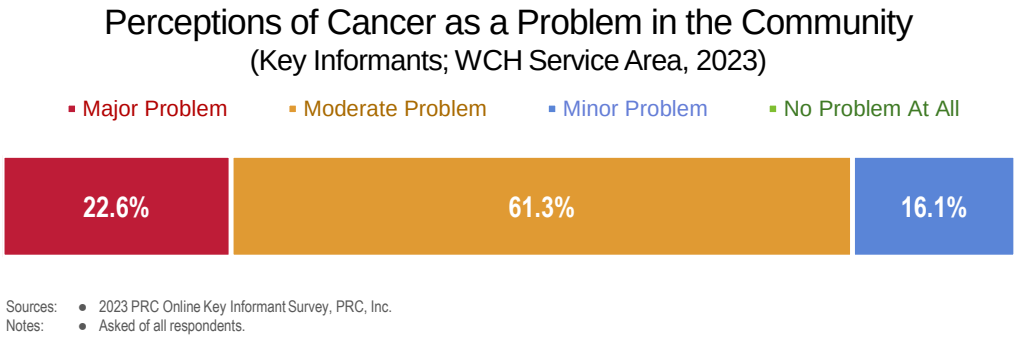


Sources:
- Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2023 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Each indicator is shown among the age group specified. Breast cancer screenings are mammograms among females age 50-74 in the past 2 years. Cervical cancer screenings are Pap smears among women 21-65 in the past 3 years. Colorectal cancer screenings include the percentage of population age 50-75 years who report having had 1) a fecal occult blood test (FOBT) within the past year, 2) a sigmoidoscopy within the past 5 years and a FOBT within the past 3 years, or 3) a colonoscopy within the past 10 years.

Key Informant Input: Cancer

Key informants' perceptions of *Cancer* as a local health concern are outlined below.



Sources: 2023 PRC Online Key Informant Survey, PRC, Inc.
Notes: Asked of all respondents.

Top Concerns

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

Access to Care/Services

> Only access is in North County, which is already very impacted. – Other Health Provider
>
> No availability in South County. – Physician
>
> No hematology oncology access at all at Watsonville. Yet asked to admit these patients. – Physician
>
> Most oncology services are not readily available in South County. – Other Health Provider

Environmental Contributors

> We are surrounded by agriculture and pesticides are used. – Social Services Provider
>
> Cancer rates in the Pajaro Valley, especially among youth, are disproportionately high because of various reasons, including the use of harmful pesticides in the agriculture industry that is very prevalent in the region. – Community Leader

Vulnerable Populations

> The exploitation of migrant farmworkers is a significant issue in South County. Among this meta-issue, farmworkers and their families are regularly exposed to high levels of dangerous pesticides, and as a result cancer rates in the area are far higher than national averages, particularly among infants and children. Many infants are born with health conditions and defects due to the contaminated environment they live in, including cancer and conditions that develop into cancer. This is further exacerbated by the poorer levels of health care many immigrant farmworker families have access to. This is one of the biggest, dirty secrets to the agricultural sector, and because south Santa Cruz County and north Monterey County produce a significant amount of the nation's food, this issue, including the resultant cancer rates and less than adequate treatment options and quality of care available to the farmworkers in the area, deserves a lot of attention. The status quo is downright shameful. – Community Leader

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.

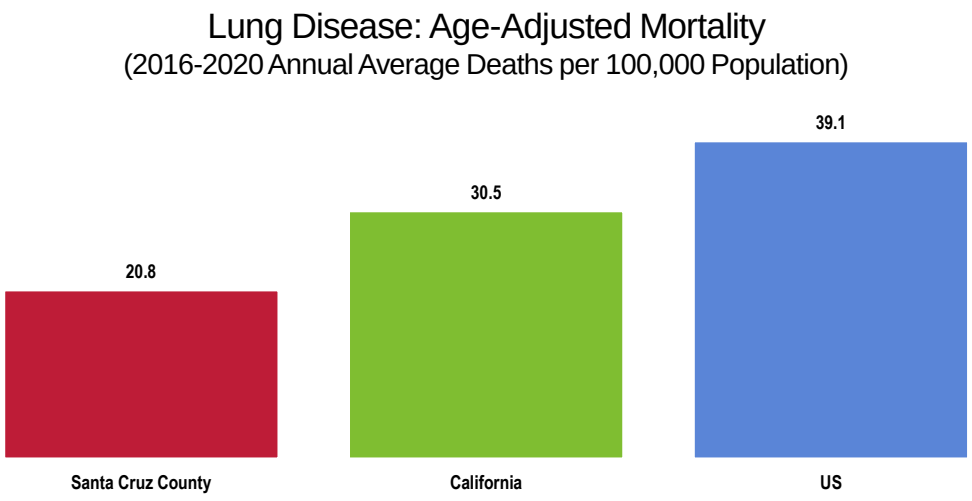
– Healthy People 2030 (https://health.gov/healthypeople)

Note that this section also includes data relative to COVID-19 (coronavirus disease).

Lung Disease Deaths

Note: Here, lung disease reflects chronic lower respiratory disease deaths and includes conditions such as emphysema, chronic bronchitis, and asthma.

The mortality rate for lung disease in Santa Cruz County is summarized below, in comparison with California and national rates.

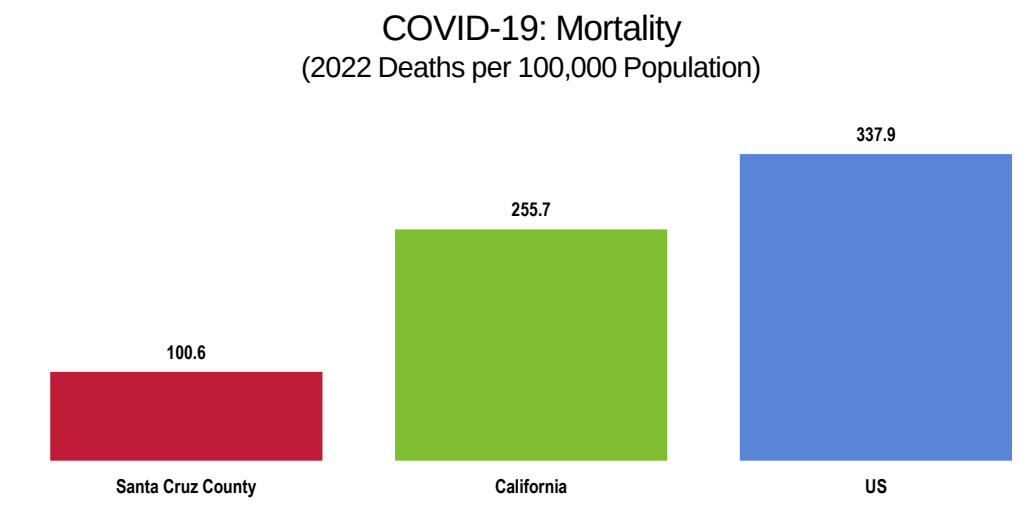


Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2023 via SparkMap (sparkmap.org).

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, age-adjusted to the 2000 US Standard Population.

COVID-19 (Coronavirus Disease) Deaths

The age-adjusted mortality rate for COVID-19 in Santa Cruz County is summarized below, in comparison with California and national rates.



Sources:
- Johns Hopkins University. Accessed via ESRI. Additional data analysis by CARES. 2022.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2023 via SparkMap (sparkmap.org).

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.

Asthma Prevalence

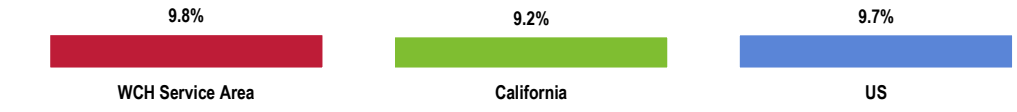
The following chart shows the prevalence of asthma among WCH Service Area adults.

The CDC Behavioral Risk Factor Surveillance Survey asked respondents:

"Has a doctor, nurse, or other health professional ever told you that you had asthma?"

"Do you still have asthma?"

Prevalence includes those responding "yes" to both.



Sources:
- Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2023 via SparkMap (sparkmap.org).

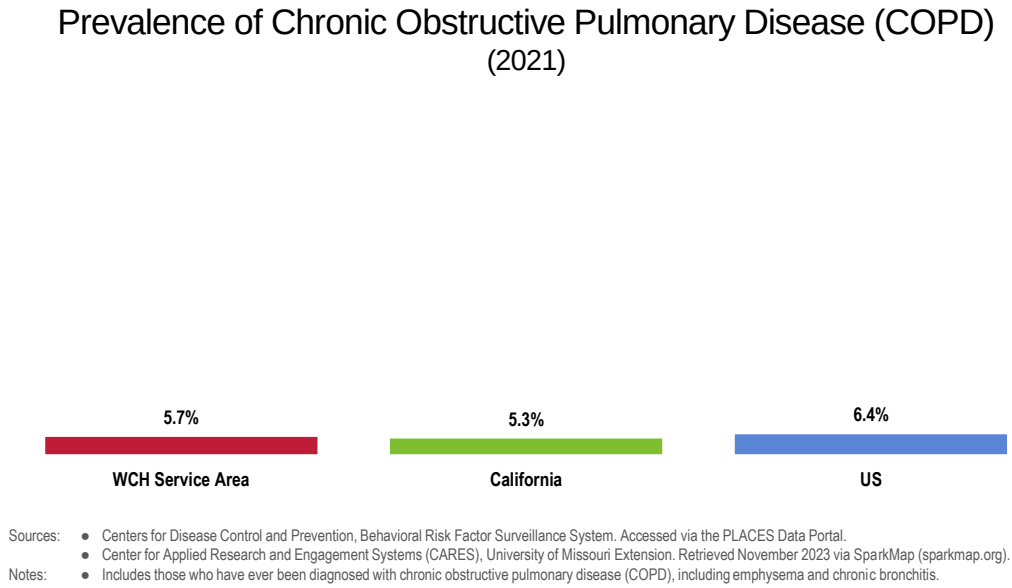
Notes:
- Includes those who have ever been diagnosed with asthma and report that they still have asthma.

COPD Prevalence

The following chart shows the prevalence of chronic obstructive pulmonary disease (COPD) among WCH Service Area adults.

The CDC Behavioral Risk Factor Surveillance Survey asked respondents:

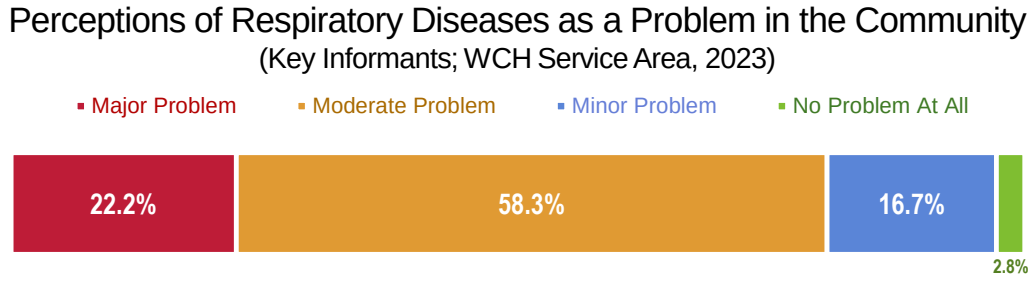
"Has a doctor, nurse, or other health professional ever told you that you had COPD (chronic obstructive pulmonary disease), emphysema, or chronic bronchitis?"



Sources: ● Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal.
● Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2023 via SparkMap (sparkmap.org).
Notes: ● Includes those who have ever been diagnosed with chronic obstructive pulmonary disease (COPD), including emphysema and chronic bronchitis.

Key Informant Input: Respiratory Disease

The following outlines key informants' perceptions of *Respiratory Disease* in our community.



Sources: ● 2023 PRC Online Key Informant Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Top Concerns

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

Housing

> Families live in crowded houses or attend day care and are exposed to a lot. Many parents don't/cant take off work, so kids with mild illness go to school and day care and spread it to others. Families not always knowledgeable on what to look out for, so mild illness can worsen before they decide to seek medical care. – Physician
>
> High rates due to multifamily housing, insufficient housing. – Physician

Access to Vaccines

> COVID, RSV and flu are rising. We need to increase community's vaccination rate and access to COVID and flu therapeutics. – Public Health Representative

Environmental Contributors

> I am not positive, but it seems that we may have some contamination due to pesticides. – Social Services Provider

Incidence/Prevalence

> Death and illness. – Other Health Provider

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.

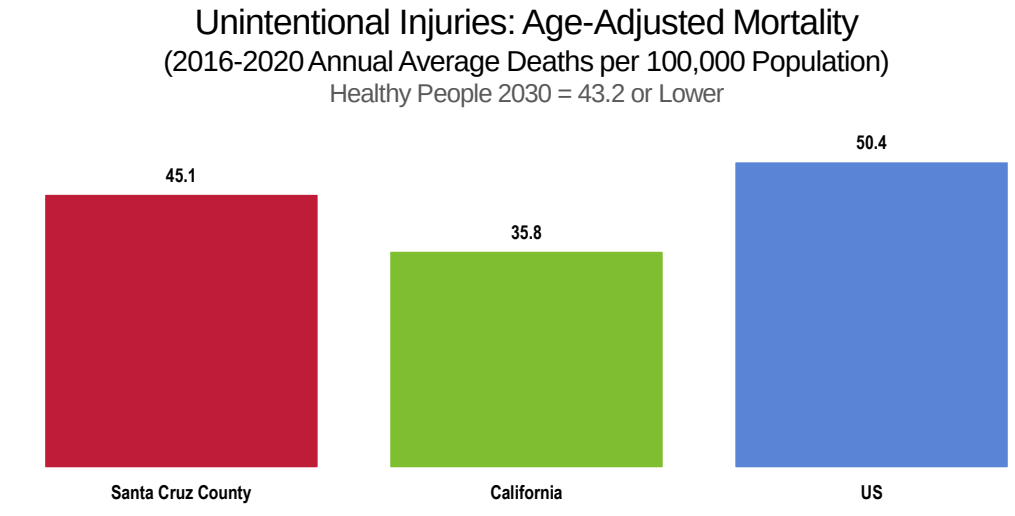
Children who experience violence are at risk for long-term physical, behavioral, and mental health problems. Strategies to protect children from violence can help improve their health and well-being later in life.

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

Unintentional Injury

Age-Adjusted Unintentional Injury Deaths

Unintentional injury is a leading cause of death. The chart that follows illustrates unintentional injury death rates for Santa Cruz County, California, and the US.



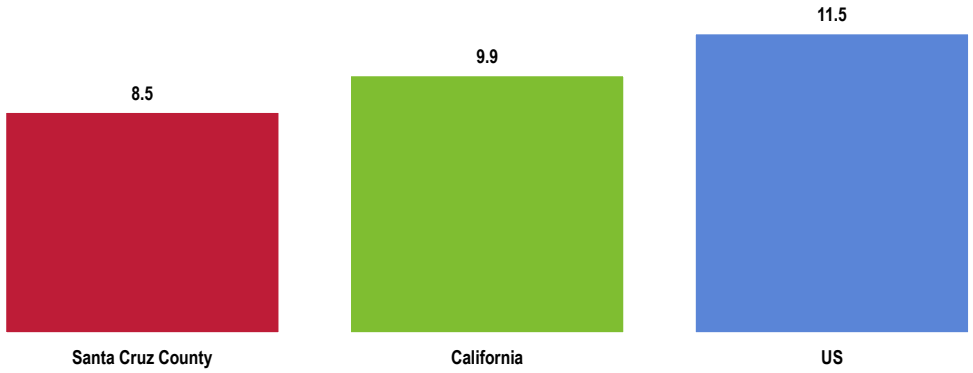
Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2023 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. 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, age-adjusted to the 2000 US Standard Population.

Age-Adjusted Motor Vehicle Crash Deaths

Motor vehicle crash deaths are preventable and are a cause of premature death. Mortality rates for motor vehicle crash deaths are outlined below.

Motor Vehicle Crashes: Age-Adjusted Mortality
(2016-2020 Annual Average Deaths per 100,000 Population)
Healthy People 2030 = 10.1 or Lower



Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2023 via SparkMap (sparkmap.org).
- 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, age-adjusted to the 2000 US Standard Population.

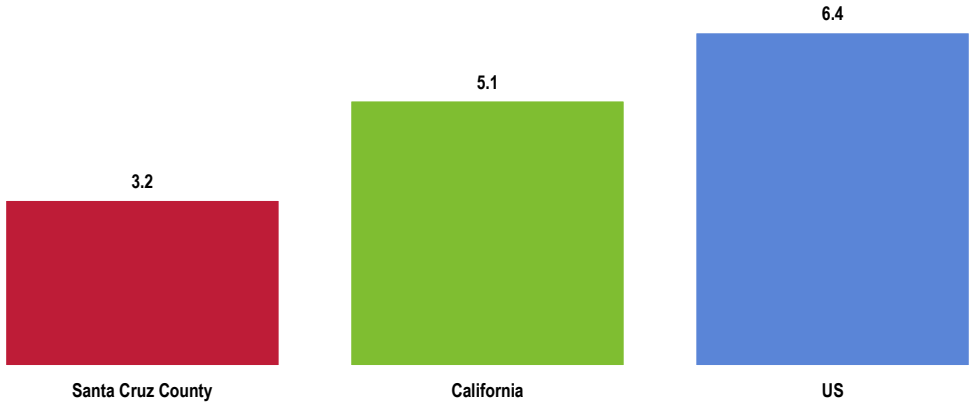
Intentional Injury (Violence)

Age-Adjusted Homicide Deaths

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

Homicide is a measure of community safety and a leading contributor to years of potential life lost. Homicide mortality rates for Santa Cruz County, California, and the US are shown in the following chart.

Homicide: Age-Adjusted Mortality
(2016-2020 Annual Average Deaths per 100,000 Population)
Healthy People 2030 = 5.5 or Lower



Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2023 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

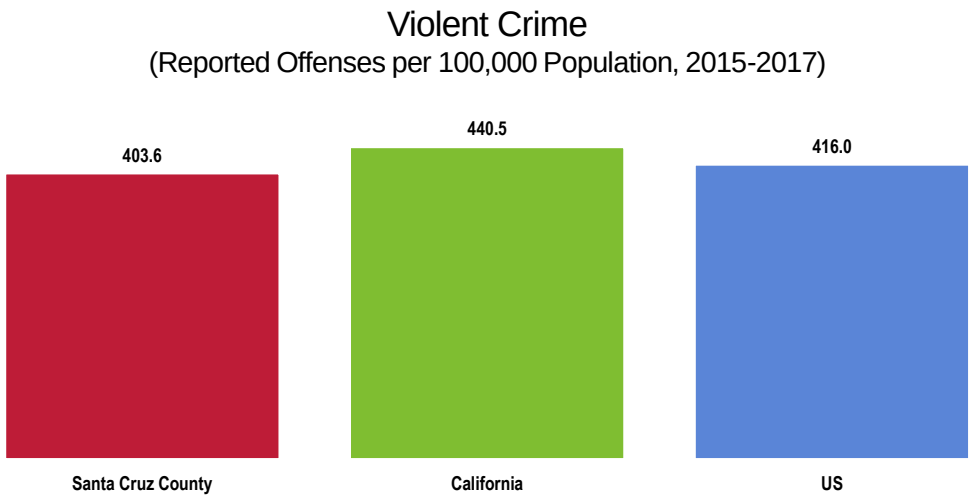
Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Violent Crime Rate

Violent crime is composed of four offenses (FBI Index offenses): murder and non-negligent manslaughter; forcible rape; robbery; and aggravated assault.

Note that the quality of crime data can vary widely from location to location, depending on the consistency and completeness of reporting among various jurisdictions.

The following chart shows the rate of violent crime per 100,000 population in Santa Cruz County, California, and the US.

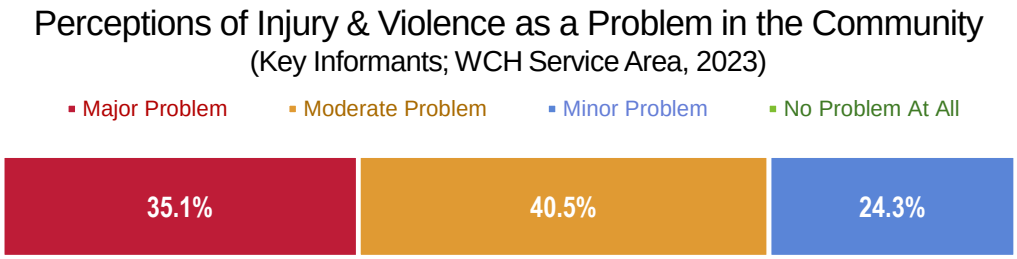


Sources:
- Federal Bureau of Investigation, FBI Uniform Crime Reports (UCR).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2023 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the rate of violent crime offenses reported by the sheriff's office or county police department per 100,000 residents. Violent crime includes homicide, forcible rape, robbery, and aggravated assault.
- Participation by law enforcement agencies in the UCR program is voluntary. Sub-state data do not necessarily represent an exhaustive list of crimes due to gaps in reporting. Also, some institutions of higher education have their own police departments, which handle offenses occurring within campus grounds; these offenses are not included in the violent crime statistics but can be obtained from the Uniform Crime Reports Universities and Colleges data tables.

Key Informant Input: Injury & Violence

Key informants' perceptions of *Injury & Violence* in our community:



Sources:
- 2023 PRC Online Key Informant Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Top Concerns

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

Incidence/Prevalence

> We have many traffic-related deaths, and we have a lot of violence that is upticking in our community. – Social Services Provider
>
> We have a prevalence of pedestrian/cyclist injuries, domestic violence, and youth violence is on the rise. – Community Leader

> I see a lot of patients complain to me that their child is being bullied at school or there is concern for gang violence. At Aptos High, there was a homicide a couple years ago, and a recent threat at the football game for violence. In talking with colleagues at the county office of education, there have been increases in fights and dangerous behaviors across the county. Often when I look at the local newspaper, there is a headline of a stabbing or a hit-and-run or some other type of violent event. Also, a lot of homeless people walking around downtown. – Physician

Behavioral Health

> Suicide and youth mental health is important. We need to reduce the stigma and support our youth. – Public Health Representative
>
> Just no behavioral health to speak of. – Physician

Gang Violence

> Gangs. Social pressures. Availability of guns. – Community Leader
>
> Gangs and domestic violence continue to plague our community. I believe root causes include economic hardships and lack of safe spaces for children and youth, recreational activities and family space for activities. – Community Leader

Denial/Stigma

> People are getting injured and not seeking services for whatever reasons, such as fear and stigma. – Other Health Provider

Social Norms/Community Attitude

> Injury and violence are significant issues in our community because of social norms that have been solidified from decades of disinvestment and exclusion that have made finding success more difficult for some in our community. This has created social issues that lead to violence and injuries happening more regularly than in other communities. – Community Leader

Vulnerable Populations

> Farmworkers experience sexual violence in fields. Also, violence and gang involvement is too high. Farmworkers experience injuries from physical labor. – Physician

DIABETES

ABOUT DIABETES

More than 30 million people in the United States have diabetes. …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)

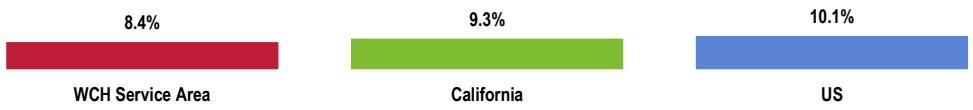
Prevalence of Diabetes

The CDC Behavioral Risk Factor Surveillance Survey asked respondents:

"Has a doctor, nurse, or other health professional ever told you that you had diabetes?"

Diabetes is a prevalent and long-lasting (chronic) health condition with a number of adverse health effects, and it may indicate an unhealthy lifestyle. The prevalence of diabetes among WCH Service Area adults age 20 and older is outlined below, compared to state and national prevalence levels.

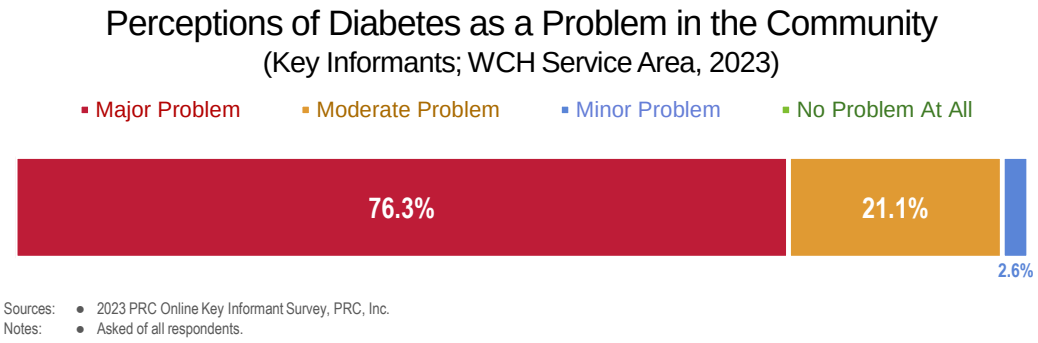
Prevalence of Diabetes
(Adults Age 20 and Older; 2019)



Sources:
- Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2023 via SparkMap (sparkmap.org).

Key Informant Input: Diabetes

The following are key informants' ratings of *Diabetes* as a health concern in the WCH Service Area.



Sources: 2023 PRC Online Key Informant Survey, PRC, Inc.
Notes: Asked of all respondents.

Top Concerns

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

Awareness/Education

> Need for more education and prevention. – Community Leader
>
> The biggest challenges are education and access to healthy foods and preventative measures they can take to reduce the chances of becoming diabetic, as well as receiving care. – Community Leader
>
> Accessible information, medication, safe exercise, and culturally appropriate nutrition education. – Physician
>
> Lack of knowledge, lack of access to testing and medication, cost barriers, poor nutrition, food deserts and low activity rates. – Other Health Provider
>
> Education and access to affordable medication. – Other Health Provider
>
> Education, supporting a healthy lifestyle and eating habit changes. Individuals cannot afford some of the healthier foods and are not educated on the long-term damages of their choices. – Other Health Provider
>
> Poor understanding by community leaders of the root causes of overweight, obesity and diabetes, and insufficient commitment by leaders to take responsibility for the root causes. Poorer communities lack money, time and immediate access to safe spaces to be active compared to wealthy communities, thus contributing to the root causes and inequities in morbidity and mortality when it comes to diabetes. – Public Health Representative
>
> Education regarding disease progression, diet. Income related access or lack of healthier foods. – Physician
>
> Since diabetes is a significant problem in the Latino population, there doesn't appear to be enough information in the community about diabetes care and cultural issues, e.g., how to prepare and eat healthy Mexican/Latino foods, in general, and on a limited income, in particular. The long-term effects of DMII are great and cause a huge amount of disability, trauma, and expense. A more culturally appropriate and motivating education is needed in the whole community. – Community Leader

Access to Affordable Healthy Food

> The lack of access to healthy foods and safe places to recreate. Long working hours prevent individuals from accessing healthcare services during traditional business hours. Lack of health insurance or limited coverage to purchase necessary medications and testing supplies. – Public Health Representative
>
> Access to healthy foods at low costs, cultural diet high in carbs, knowledge of and willingness to make early lifestyle changes and obesity. – Other Health Provider
>
> Access to nutritious food, education, and support. – Other Health Provider
>
> Options for healthy eating and outdoor access for physical movement. – Social Services Provider
>
> Lack of healthy options and routine checkups. Prices in medications. – Other Health Provider
>
> Access to affordable healthy foods and knowing how to prepare cultural foods. – Public Health Representative
>
> Healthy food desserts in neighborhoods, access to low-cost healthy nourishment, motivation for physical and active lifestyles. – Community Leader

Access to Care/Services

> The lack of an effective diabetes health center. The lack of public health approach to the prevention diagnosis and treatment of diabetes. – Community Leader

> Timely access to care and regular follow-up. – Other Health Provider
>
> Access to diagnosis. – Community Leader

Affordable Medications/Supplies

> Being able to afford/access medications. Having time and resources to shop for healthy food and exercise, understanding recommendations of the doctors, not enough primary care doctors to care for these patients. – Physician
>
> Access to testing supplies at a reasonable price. Access to healthy food choices. Time for physical activity and support for weight loss. – Physician

Disease Management

> Not prioritizing their own care, not following treatment protocols and social determinants. – Other Health Provider
>
> Management, health literacy and access to preventive care. – Physician

Built Environment

> Access to safe physical activity, reliance on cheap, convenience foods and obesity. – Community Leader

Culturally Relevant Information

> Culturally relevant information on remedies to prevent or mitigate diabetes. – Community Leader

Housing

> Housing costs deplete all available income for farmworkers and low-wage earners that are unable to afford the "time" to cook their own food and fall to low cost, high-sugar and fat options, soda, chips, fast food, etc. – Community Leader

DISABLING CONDITIONS

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.

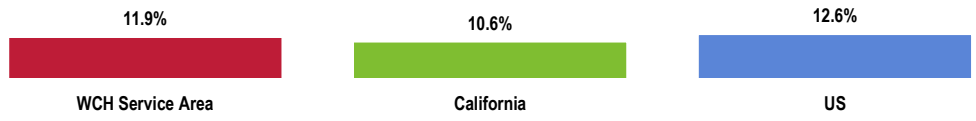
– Healthy People 2030 (https://health.gov/healthypeople)

Disability

The following represents the percentage of the total civilian, non-institutionalized population in the WCH Service Area with a disability. This indicator is relevant because disabled individuals may comprise a vulnerable population that requires targeted services and outreach.

Disability data come from the US Census Bureau's American Community Survey (ACS), Survey of Income and Program Participation (SIPP), and Current Population Survey (CPS). All three surveys ask about six disability types: hearing difficulty, vision difficulty, cognitive difficulty, ambulatory difficulty, self-care difficulty, and independent-living difficulty.

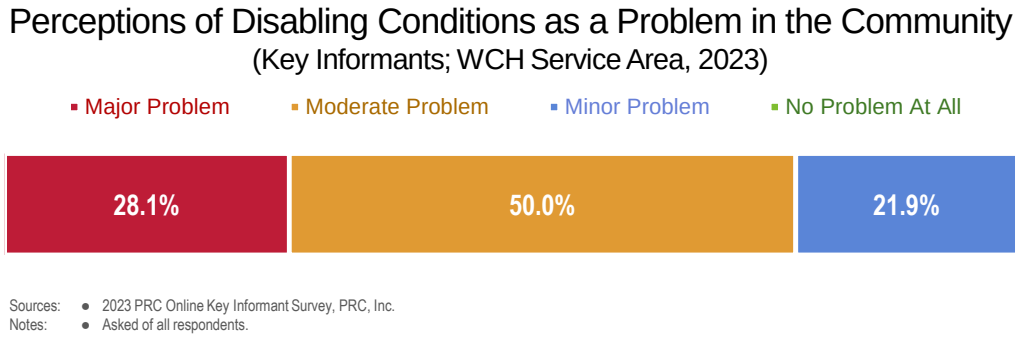
Respondents who report any one of the six disability types are considered to have a disability.



Sources:
- US Census Bureau, American Community Survey.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2023 via SparkMap (sparkmap.org).

Key Informant Input: Disabling Conditions

Key informants' perceptions of *Disabling Conditions* are outlined below.



Top Concerns

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

Access to Care/Services

> They exist, with few resources to support. – Physician
>
> Not enough supports for those who are physically disabled, sidewalks and infrastructure limitations for those in wheelchairs. – Social Services Provider
>
> Santa Cruz County has very limited access to care, especially for those who require home, or residential/board and care support. As our population ages, we are seeing more people experiencing a nexus of cognitive decline, medical complications, behavioral health complications, and homelessness, and they are cycling through the emergency room or crisis unit because the appropriate level/type of care does not exist. – Public Health Representative

Vulnerable Populations

> Undocumented, indigenous language speakers, newly arrived immigrants, homeless youth, and adults cannot navigate systems to access services. – Community Leader
>
> They are significant issues because the majority of residents in the region are blue-collar workers who are constantly dealing with chronic pain and loss of vision and hearing. At the same time, they do not make enough money to seek or afford care to address these issues and take simple steps to correct them. – Community Leader

Affordable Care/Services

> Many of the individuals residing in the community cannot afford vision and dental services. Left unmanaged, both vision and dental lead to other health issues or are an indicator of health issues. The other issue within the community is lack of mobility due to sedentary lifestyles. – Other Health Provider

Awareness/Education

> Level of education affects what people know about resources available, treatment options and a degree of assertiveness in requesting evaluation or assistance. – Physician

Co-Occurrences

> Many folks experience chronic pain, contributes to mental health issues, disruption in work and economic instability. – Physician

Aging Population

> Caring for our senior community, more needs to be done to ensure our senior community are engaged and active. – Community Leader

Impact on Caregivers/Families

> Poor health affects the family as a whole. – Other Health Provider

BIRTHS

BIRTH OUTCOMES & RISKS

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.

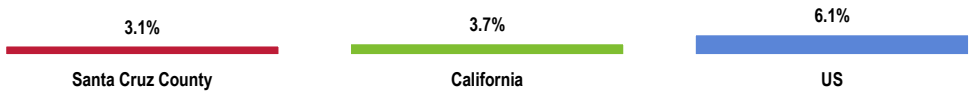
– Healthy People 2030 (https://health.gov/healthypeople)

Prenatal Care

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

This indicator reports the percentage of Santa Cruz County women who did not receive prenatal care during the first six months of pregnancy. This indicator can signify a lack of access to preventive care, a lack of health knowledge, or other barriers to services.

Lack of Prenatal Care in the First Six Months of Pregnancy
(Percentage of Live Births, 2017-2019)



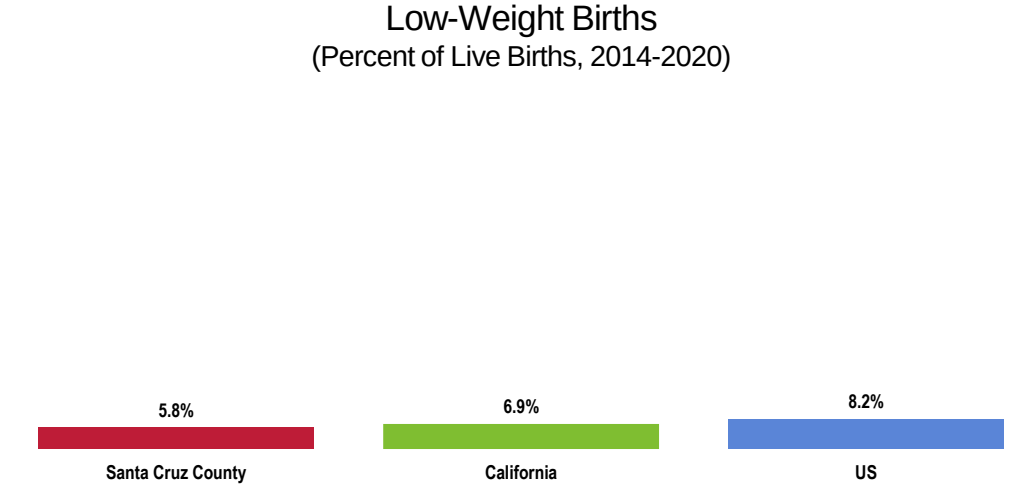
Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. Centers for Disease Control and Prevention, Wide-Ranging Online Data for Epidemiologic Research.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2023 via SparkMap (sparkmap.org).

Note:
- This indicator reports the percentage of women who did not obtain prenatal care before their seventh month of pregnancy (if at all).

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. The following chart illustrates the percent of total births that are low birth weight.

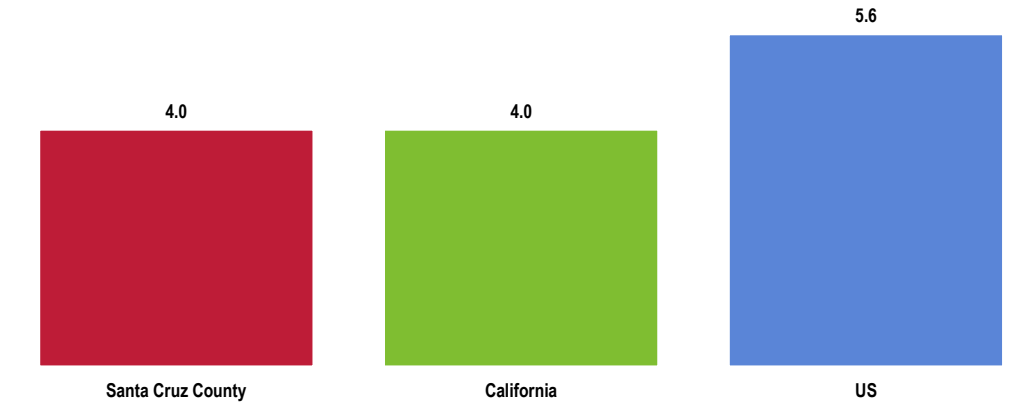


Sources: ● University of Wisconsin Population Health Institute, County Health Rankings.
Note: ● This indicator reports the percentage of total births that are low birth weight (Under 2500g).

Infant Mortality

Infant mortality includes the death of a child before his/her first birthday, expressed as the number of such deaths per 1,000 live births.

The following chart shows the number of infant deaths per 1,000 live births in Santa Cruz County. High infant mortality can highlight broader issues relating to health care access and maternal/child health.



Sources: ● Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER.
● Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2023 via SparkMap (sparkmap.org).
● US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople
Notes: ● Infant deaths include deaths of children under 1 year old.

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.

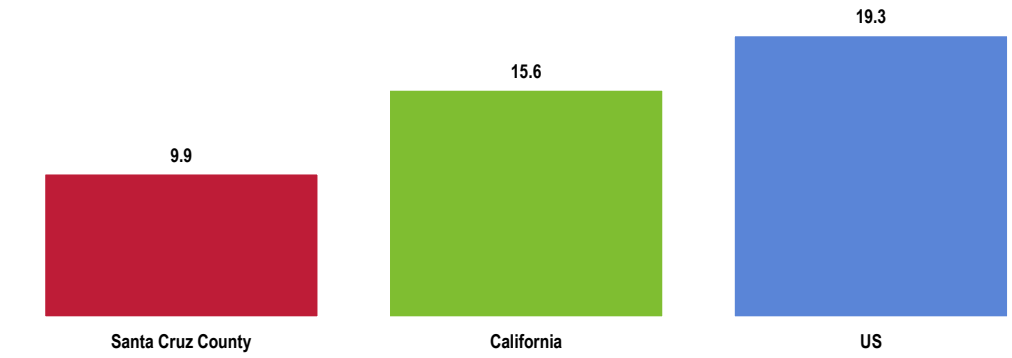
Adolescents are at especially high risk for unintended pregnancy. Although teen pregnancy and birth rates have gone down in recent years, close to 200,000 babies are born to teen mothers every year in the United States. Linking adolescents to youth-friendly health care services can help prevent pregnancy 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 ages 15 to 19 years old, expressed as a rate per 1,000 female population in this age cohort.

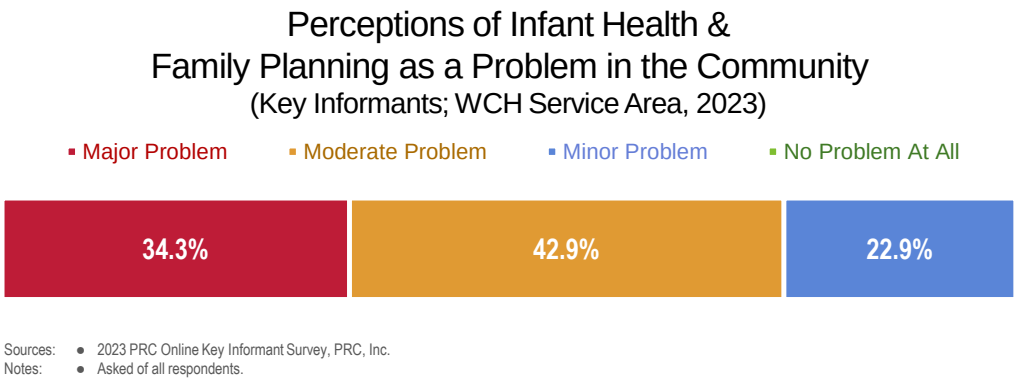
The following chart outlines the teen birth rate in Santa Cruz County, compared to rates statewide and nationally. In many cases, teen parents have unique health and social needs. High rates of teen pregnancy might also indicate a prevalence of unsafe sexual behavior.



Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2023 via SparkMap (sparkmap.org).

Key Informant Input: Infant Health & Family Planning

Key informants' perceptions of *Infant Health & Family Planning* as a community health issue are outlined below.



Top Concerns

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

Awareness/Education

> Education. Social and family influences. – Community Leader

Culturally Relevant Information

> Culturally relevant information and continued support from prenatal to birth. – Community Leader

Cost of Housing

> The majority of child-bearing adults now reside in and around the 95076 ZIP code, as the 95060 and surrounding ZIP codes are now one of the highest cost/least affordable housing in the United States. Due to the systematically under-invested health care systems in the 95076 and surrounding areas, there are not adequate resources and care options to even match what is in the 95060 ZIP codes. Those 95060 resources are now (like Sutter Maternity Center and Dominican) turning into boutique service providers, as traffic patterns can make for a 50-minute commute from the South Santa Cruz County. – Community Leader

High Birth Rate

> The birth rate is now again rising in South County. – Public Health Representative

Income/Poverty

> Because of low wages and high cost of living, many families are not able to afford the prenatal care or family planning care and services that is needed to get their kids on the right path to health. – Community Leader

Lack of Family Planning

> Family planning is not done with planning at all. There is no wraparound health planning for pregnant women. – Community Leader

Vulnerable Populations

> Because this region is a major food production area, with a large population of migrant farmworker families, where there are significant levels of exploitation, limited services, and limited investment in health and other services. Many migrant families have limited knowledge of their rights and awareness of the limited social services available to them. They live in fear of having their families separated and being deported. And powerful agricultural companies have significant influence over elected officials and legislation. – Community Leader

Prenatal Care

> Prenatal care. – Community Leader

Female Reproductive Care

> Female reproductive health access. – Community Leader

Early Childhood Development

> Lack of quality, affordable and accessible early childhood development for all communities. What we see are the consequences of lack of ECD, including poor and delayed academic performance and achievement among our students, up to and including high school students, which impacts their opportunities for higher education and lifelong earning potential. – Public Health Representative

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.

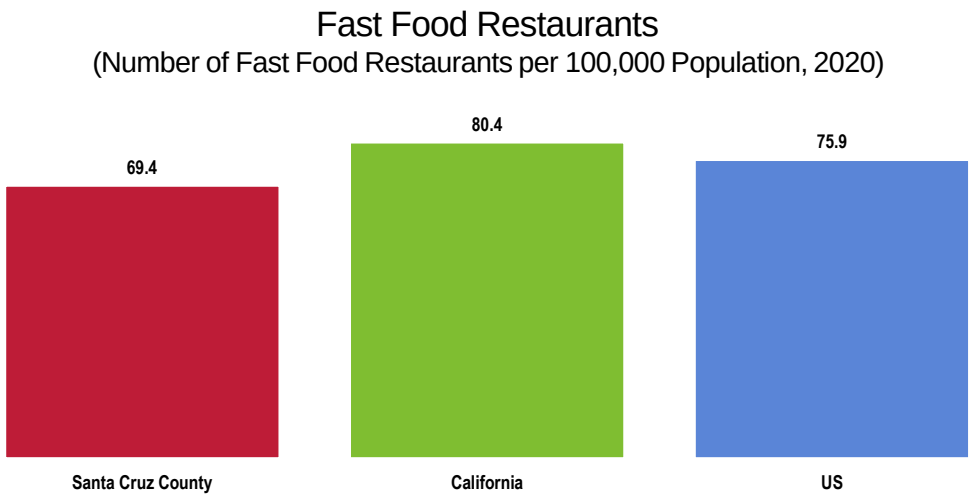
Some people don't have the information they need to choose healthy foods. Other people don't have access to healthy foods or can't afford to buy enough food. Public health interventions that focus on helping everyone get healthy foods are key to reducing food insecurity and hunger and improving health.

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

Food Environment: Fast Food

Here, fast food restaurants are defined as limited-service establishments primarily engaged in providing food services (except snack and nonalcoholic beverage bars) where patrons generally order or select items and pay before eating.

The following shows the prevalence of fast food restaurants in Santa Cruz County, expressed as a number per 100,000 residents. This indicator provides a measure of healthy food access and environmental influences on dietary behavior.



Sources:
- US Census Bureau, County Business Patterns. Additional data analysis by CARES.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2023 via SparkMap (sparkmap.org).

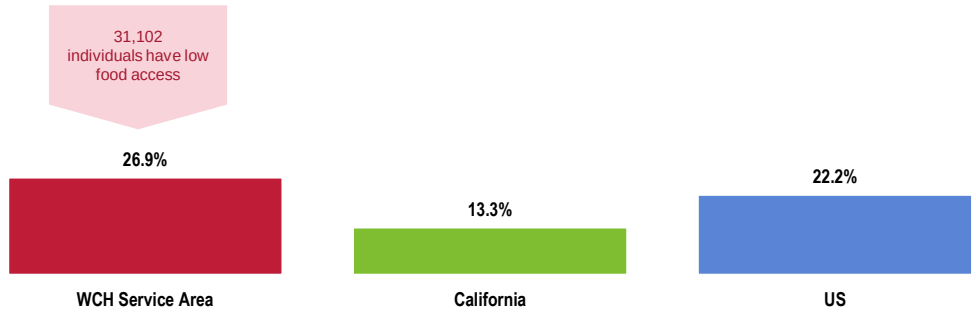
Low Food Access

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

The following chart shows US Department of Agriculture data determining the percentage of WCH Service Area residents found to have low food access, meaning that they do not live near a supermarket or large grocery store.

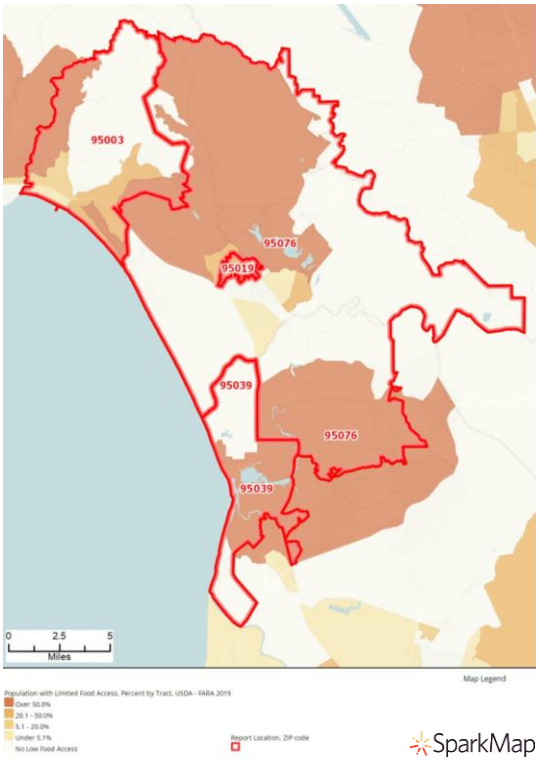
Population With Low Food Access

(Percent of Population Far From a Supermarket or Large Grocery Store, 2019)



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 November 2023 via SparkMap (sparkmap.org).

Notes:
- Low food access is defined as living more than 1 mile from the nearest supermarket, supercenter, or large grocery store for urban census tracts, and 10 miles for rural ones.



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.

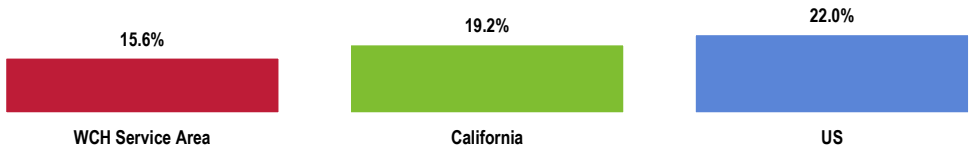
– Healthy People 2030 (https://health.gov/healthypeople)

Leisure-Time Physical Activity

Leisure-time physical activity includes any physical activities or exercises (such as running, calisthenics, golf, gardening, walking, etc.) which take place outside of one's line of work.

Below is the percentage of WCH Service Area adults age 20 and older who report no leisure-time physical activity in the past month. This measure is important as an indicator of risk for significant health issues such as obesity or poor cardiovascular health.

No Leisure-Time Physical Activity in the Past Month
(Adults Age 20 and Older, 2019)
Healthy People 2030 = 21.8% or Lower



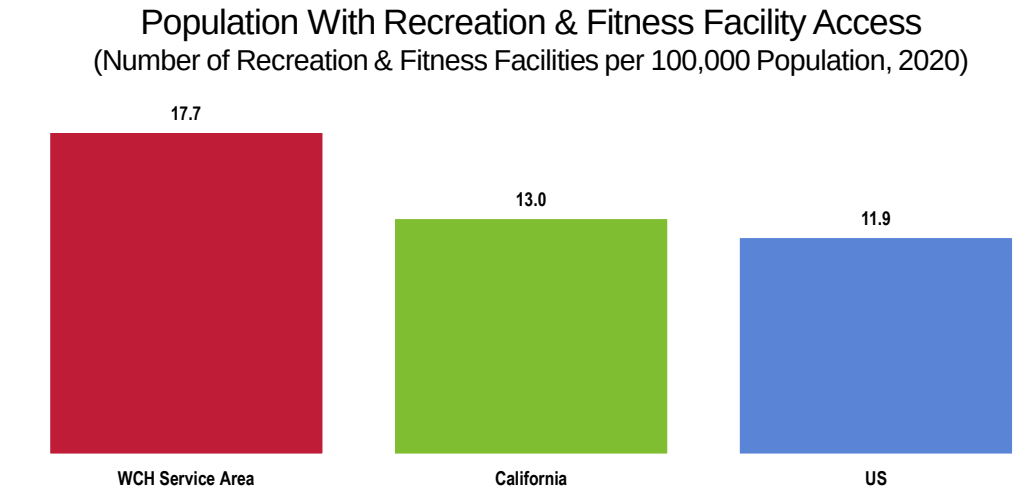
Sources:
- Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2023 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Access to Physical Activity

Here, recreation/fitness facilities include establishments engaged in operating facilities which offer "exercise and other active physical fitness conditioning or recreational sports activities."

Examples include athletic clubs, gymnasiums, dance centers, tennis clubs, and swimming pools.

The following chart shows the number of recreation/fitness facilities for every 100,000 population in the WCH Service Area. This is relevant as an indicator of the built environment's support for physical activity and other healthy behaviors.



Sources:
- US Census Bureau, County Business Patterns. Additional data analysis by CARES.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2023 via SparkMap (sparkmap.org).

Notes:
- Recreation and fitness facilities include establishments engaged in operating facilities which offer "exercise and other active physical fitness conditioning or recreational sports activities." Examples include athletic clubs, gymnasiums, dance centers, tennis clubs, and swimming pools.

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.

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

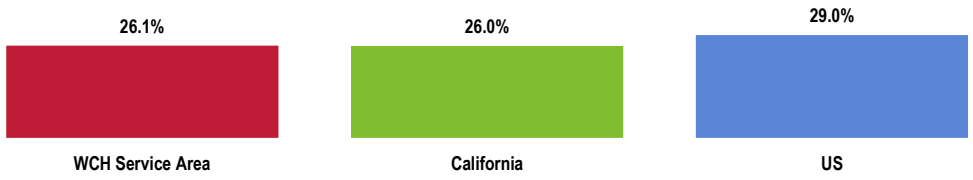
Source: Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. National Institutes of Health. National Heart, Lung, and Blood Institute in Cooperation With The National Institute of Diabetes and Digestive and Kidney Diseases. September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

Obesity

"Obese" includes respondents with a BMI value ≥30.0.

Outlined below is the percentage of WCH Service Area adults age 20 and older who are obese, indicating that they might lead an unhealthy lifestyle and be at risk for adverse health issues.

Prevalence of Obesity
(Adults Age 20 and Older With a Body Mass Index ≥ 30.0, 2019)
Healthy People 2030 = 36.0% or Lower



Sources:
- Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2023 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- 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.

Key Informant Input: Nutrition, Physical Activity & Weight

Key informants' ratings of *Nutrition, Physical Activity & Weight* as a community health issue are illustrated below.

Perceptions of Nutrition, Physical Activity & Weight as a Problem in the Community
(Key Informants; WCH Service Area, 2023)

Sources:
- 2023 PRC Online Key Informant Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Top Concerns

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

Awareness/Education

> There is a lack of education about nutrition, physical activity, and weight and a lack of open and public recreation facilities. There are also societal norms that make obtaining this education and engaging in physical activity extremely challenging for younger generations. – Community Leader
>
> There is a huge divide in health literacy between socioeconomic groups. A great deal more community education is needed to change the culture around health promotion. We should look at some of the health promotion strategies used in the UK for educating the general population – simple, easy-to-understand messages that are repeated everywhere (Eat your five a day, Every Mind Matters, Scroll Free September, etc.). – Community Leader
>
> Consistent, reliable and accessible education. More time on working for income for basic needs, less discretionary income or time for exercise and community activities. – Physician
>
> Knowledge about healthy foods, knowing how to prepare, being able to afford healthy foods, having time/money to join gym or sign kids up for sports, knowledge about early childhood nutrition related to excess bottle use and early introduction of junk foods. – Physician
>
> Lack of early education about nutrition. Consumption of cheap/fast food. Gyms being too expensive for low-income residents. – Other Health Provider

Built Environment

> Incomplete streets. Lack of grocery stores. Transportation. – Public Health Representative
>
> We need more open spaces for the community to access physical activity. We need to do better as a community to motivate the community to practice healthy behaviors. – Community Leader
>
> Lack of safe places to play and be active, stress due to poor living conditions and high cost of living, reliance on high-calorie and inexpensive foods. – Community Leader
>
> Not enough outdoor locations for exercise. Food is expensive, and there are not enough healthy food options. Too many fast food restaurants. – Social Services Provider
>
> Lack of safe spaces, culturally relevant information in these areas, and lack of sensitivity to cultural lens when it comes to viewing the meaning of "healthy." – Community Leader

Nutrition

> Poor food choices due to food prices. – Other Health Provider
>
> Communities continue to have easy access to unhealthy foods, including fast food restaurants and highly processed foods in retail grocery stores. HPI quartile 1 and 2 communities with highest risk of overweight and chronic disease have the fewest resources to live physically active lives. – Public Health Representative

Obesity

> There is a stark equity gap between the children in South County and their counterparts in Santa Cruz cities with regards to BMI in our K-12th grade students. – Community Leader
>
> Nonexistent, wild obesity rates and poverty. – Physician

Access to Affordable Healthy Food

> Access to healthy food that is affordable and safe space for physical activity. – Physician

Income/Poverty

> In a low-income and low-education community, people often have to work multiple jobs in order to maintain a living income. This leads to very little time dedicated to focusing on personal well-being, such as time to exercise, cook fresh meals, and learn about better choices. On a more systemic level, the food supply system in this country sets most people up for failure when trying to maintain a healthy weight. – Physician

Lifestyle

> Screen time, food deserts, lack of information about healthy habits. – Other Health Provider

SUBSTANCE USE

ABOUT DRUG & ALCOHOL USE

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)

Excessive Alcohol Use

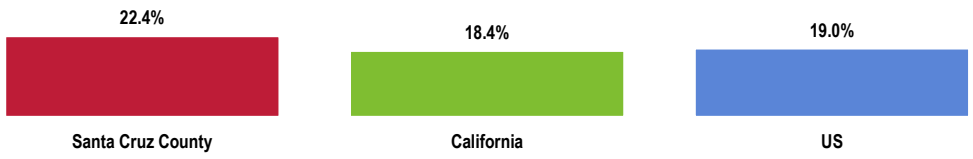
Excessive drinking includes heavy and/or binge drinking:

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.

The following illustrates the prevalence of excessive drinking in Santa Cruz County, as well as statewide and nationally. Excessive drinking is linked to significant health issues, such as cirrhosis, certain cancers, and untreated mental/behavioral health issues.

Engage in Excessive Drinking
(2020)

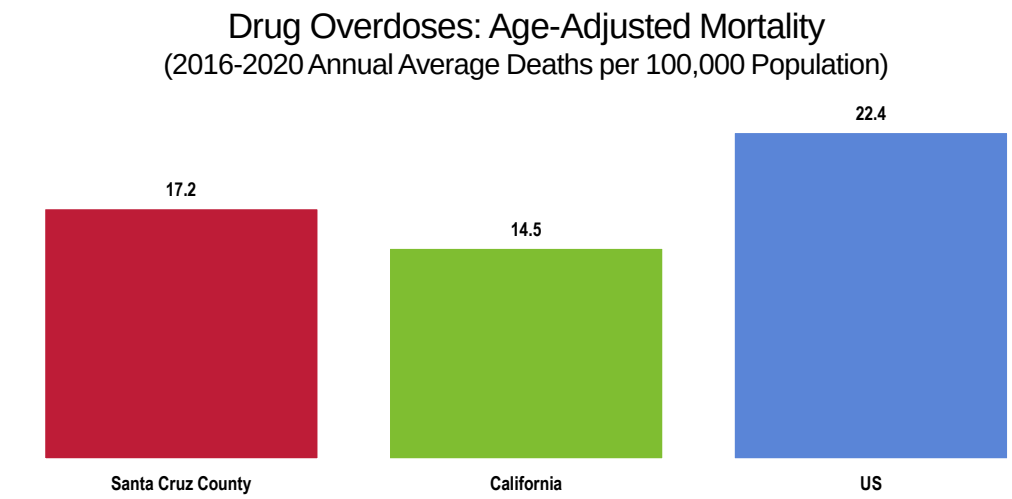


Sources:
- Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via County Health Rankings.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2023 via SparkMap (sparkmap.org).

Notes:
- Excessive drinking is defined as the percentage of the population who report at least one binge drinking episode involving five or more drinks for men and four or more for women over the past 30 days, or heavy drinking involving more than two drinks per day for men and more than one per day for women, over the same time period.

Drug Overdose Deaths

The chart that follows illustrates age-adjusted death rates attributed to drug overdoses (all substances, excluding alcohol) for Santa Cruz County, California, and the US.

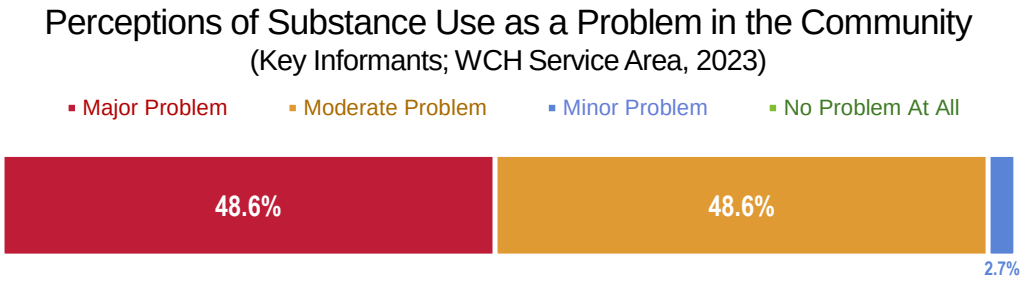


Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2023 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. 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, age-adjusted to the 2000 US Standard Population.

Key Informant Input: Substance Use

Note the following perceptions regarding *Substance Use* in the community among key informants taking part in an online survey.



Sources:
- 2023 PRC Online Key Informant Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Top Concerns

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

Access to Care/Services

> There needs to be a wider variety of substance use treatment options in the community. The available resources don't fit the needs of many people, especially younger people of high school or college age. – Community Leader
>
> Don't know. Maybe safe injection sites. Poverty. Racism. – Community Leader
>
> Lack of available and affordable programs. – Other Health Provider
>
> Access to treatment. – Other Health Provider

Incidence/Prevalence

> I don't think anyone can solve this one. Why does it seem that most of my patients use methamphetamines? – Physician
>
> Substance use, fentanyl crisis. – Public Health Representative

Awareness/Education

> I think the greatest barrier is residents are unaware what the problems are and where they can access services. – Community Leader

Denial/Stigma

> The stigma that comes with asking for help and admitting that someone might have an issue. – Community Leader

Disease Management

> Patients do not seek out treatment, limited ability in primary care to provide these services. – Physician

Funding

> Limitations with funding streams, stigma, asking for help and peer pressure to continue to use. Limited programs/services. – Social Services Provider

Most Problematic Substances

Note below which substances key informants (who rated this as a “major problem”) identified as causing the most problems in the WCH Service Area.

SUBSTANCES VIEWED AS MOST PROBLEMATIC IN THE COMMUNITY (Among Key Informants Rating Substance Use as a “Major Problem”)	
ALCOHOL	36.4%
METHAMPHETAMINE OR OTHER AMPHETAMINES	27.3%
HEROIN OR OTHER OPIOIDS	27.3%
PRESCRIPTION MEDICATIONS	6.0%
MARIJUANA	3.0%

TOBACCO USE

ABOUT TOBACCO USE

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 Prevalence

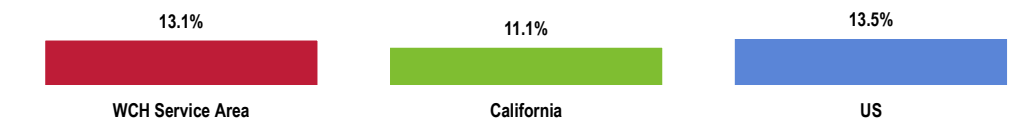
Tobacco use is linked to the two major leading causes of death: cancer and cardiovascular disease. Note below the prevalence of cigarette smoking in our community.

The CDC Behavioral Risk Factor Surveillance Survey asked respondents:

"Have you smoked at least 100 cigarettes in your entire life?"

"Do you now smoke cigarettes every day, some days, or not at all?"

Cigarette smoking prevalence includes those who report having smoked at least 100 cigarettes in their lifetime and who currently smoke every day or on some days.

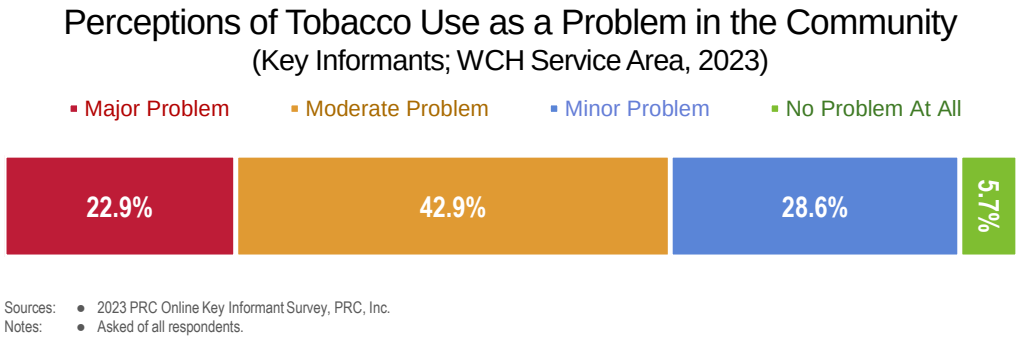


Sources:
- Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2023 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Includes those who report having smoked at least 100 cigarettes in their lifetime and currently smoke cigarettes every day or on some days.

Key Informant Input: Tobacco Use

Below are key informants' ratings of *Tobacco Use* as a community health concern.



Sources: 2023 PRC Online Key Informant Survey, PRC, Inc.
Notes: Asked of all respondents.

Top Concerns

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

E-Cigarettes

> Vaping has become an epidemic. – Other Health Provider

Incidence/Prevalence

> Perhaps I should have selected "moderate problem" instead. – Community Leader

Social Norms/Community Attitude

> Socially accepted. – Other Health Provider

Teen/Young Adult Usage

> With vaping, it seems that more youth are using tobacco. – 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).

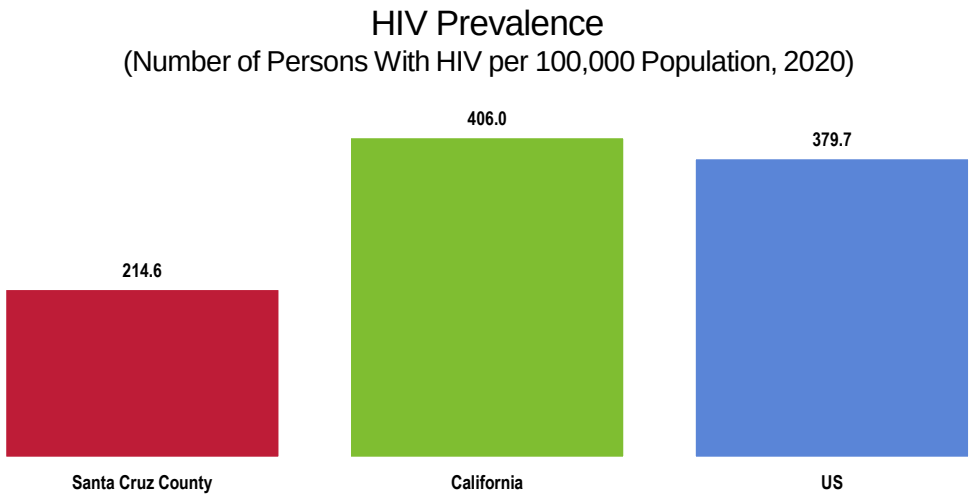
Adolescents, young adults, and men who have sex with men are at higher risk of getting STIs. And people who have an STI may be at higher risk of getting HIV. Promoting behaviors like condom use can help prevent STIs.

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 the prevalence of HIV in our county, expressed as a rate per 100,000 population. This indicator is relevant because HIV is a life-threatening communicable disease that disproportionately affects minority populations and may also indicate the prevalence of unsafe sex practices.

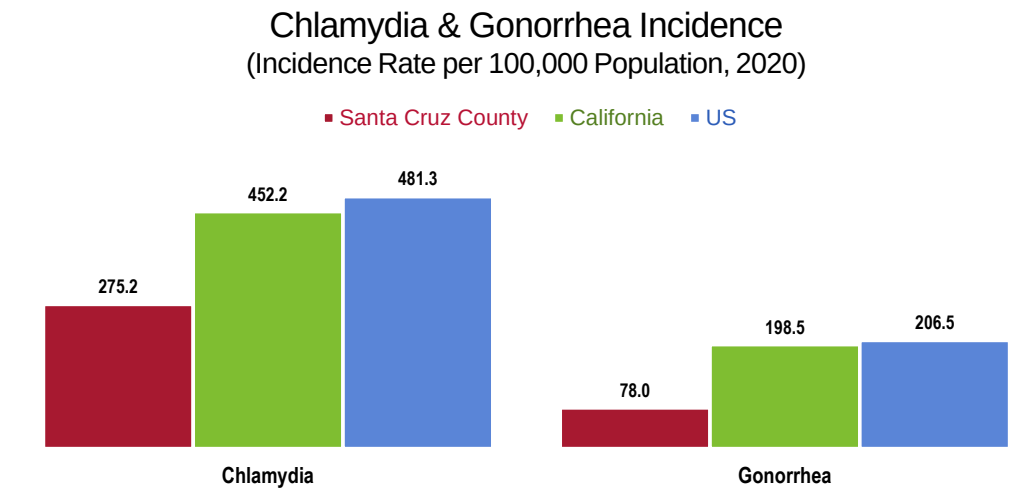


Sources:
- Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2023 via SparkMap (sparkmap.org).

Sexually Transmitted Infections (STIs)

Chlamydia & Gonorrhea

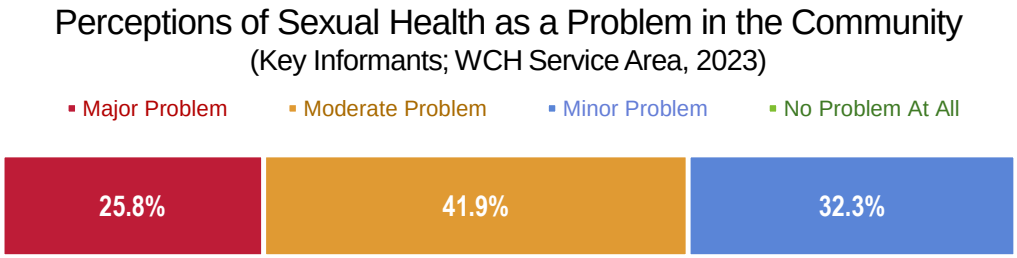
Chlamydia and gonorrhea are reportable health conditions that might indicate unsafe sexual practices in the community. Incidence rates for these sexually transmitted diseases are shown in the following chart.



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 November 2023 via SparkMap (sparkmap.org).

Key Informant Input: Sexual Health

Key informants' ratings of *Sexual Health* as a community health concern are shown in the following chart.



Sources: 2023 PRC Online Key Informant Survey, PRC, Inc.
Notes: Asked of all respondents.

Top Concerns

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

Incidence/Prevalence

> We recently learned that chlamydia in school-age children was on the rise in South County from Co. Santa Cruz Communicable Disease Unit. – Community Leader
>
> Higher rates of STIs. – Physician
>
> We are experiencing rising rates of sexually transmitted infections, particularly syphilis and congenital syphilis, and recurring Mpox infections. As a nation, women's reproductive rights have been reduced. – Public Health Representative

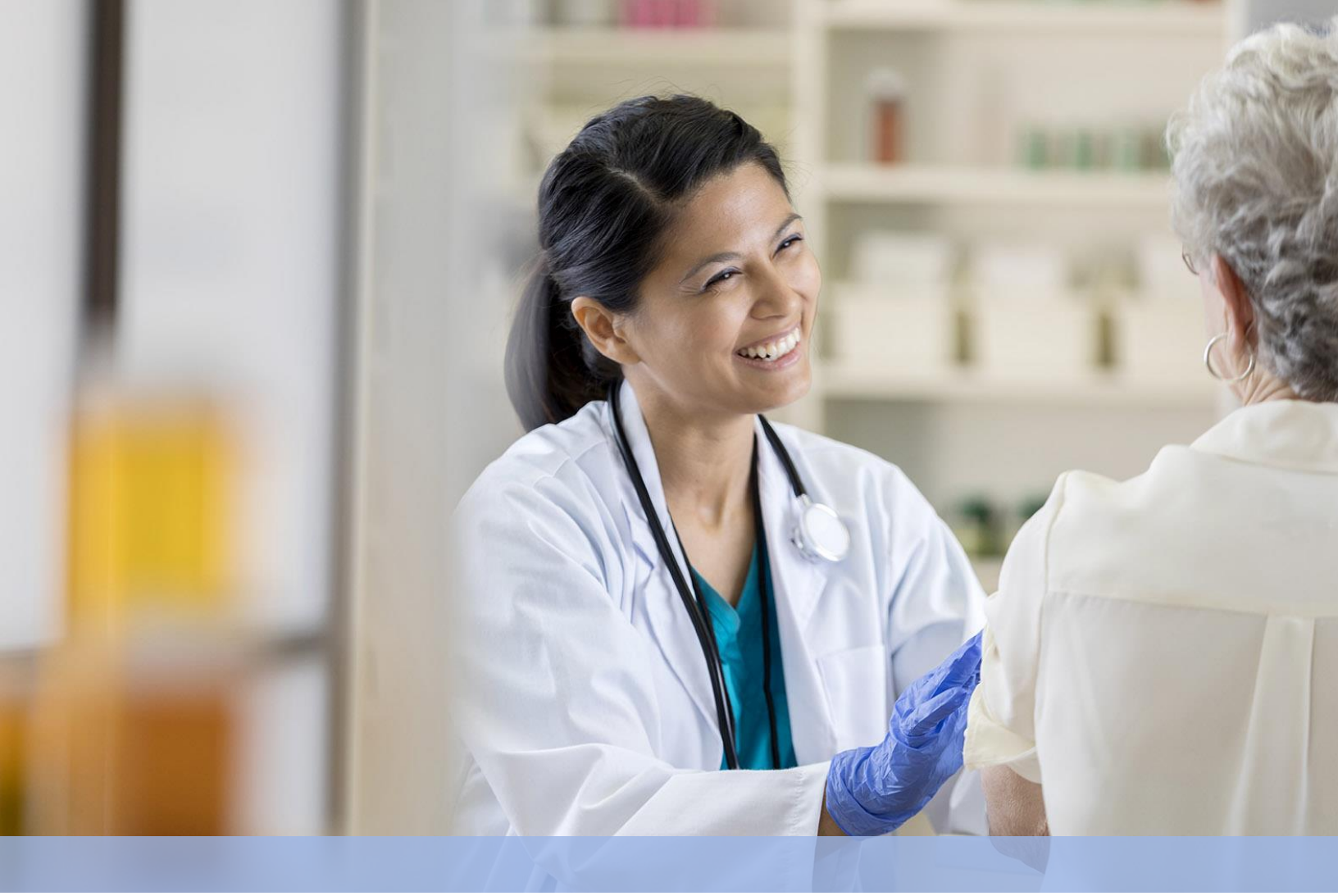
> Syphilis and Mpox are rising. – Public Health Representative

Awareness/Education

> We need to promote better sexual health choices and education. – Social Services Provider
>
> Lack of education. – Other Health Provider

Social Norms/Community Attitude

> Societal norms and lack of education. – Community Leader



ACCESS TO HEALTH CARE

BARRIERS TO HEALTH CARE ACCESS

ABOUT HEALTH CARE ACCESS

Many people in the United States don't get the health care services they need. …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.

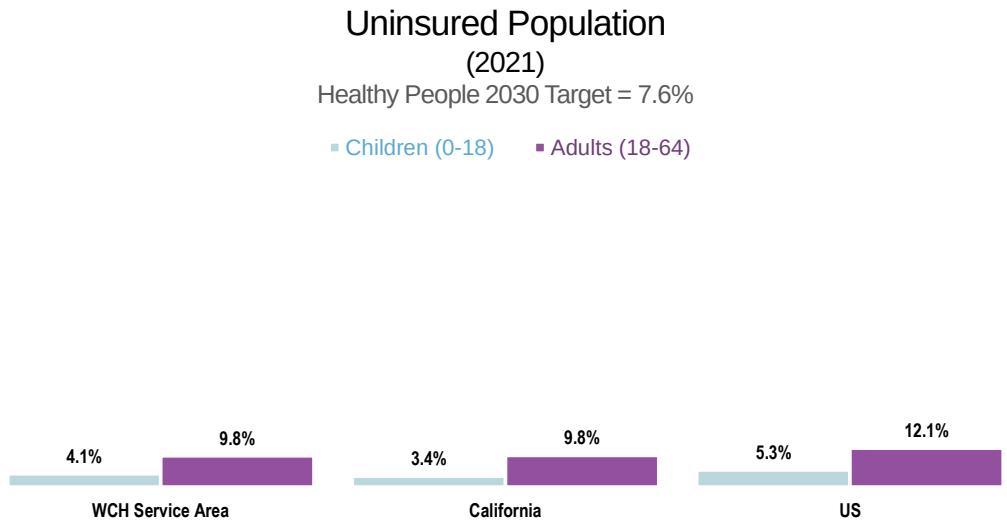
Sometimes people don't get recommended health care services, like cancer screenings, because they don't have a primary care provider. Other times, it's because they live too far away from health care providers who offer them. Interventions to increase access to health care professionals and improve communication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

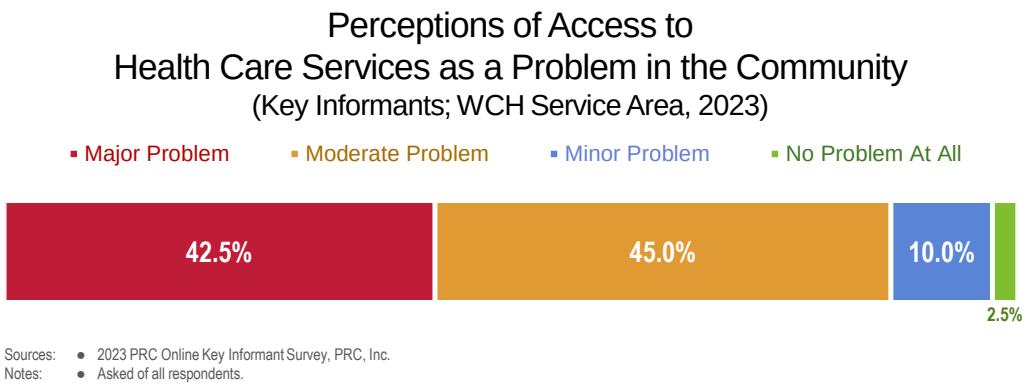
Health insurance coverage is a critical component of health care access and a key driver of health status. The following chart shows the latest figures for the prevalence of uninsured adults (age 18 to 64 years) and of uninsured children (under the age of 19) in the WCH Service Area.



Sources:
- US Census Bureau, Small Area Health Insurance Estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2023 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Key Informant Input: Access to Health Care Services

Key informants' ratings of *Access to Health Care Services* as a problem in the WCH Service Area is outlined below.



Sources: 2023 PRC Online Key Informant Survey, PRC, Inc.
Notes: Asked of all respondents.

Top Concerns

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

Access to Care/Services

> The majority of residents in South Santa Cruz County have to leave the area to get most services. – Community Leader
>
> Not enough services available for the community and some restrictions in regard to medical coverage. – Other Health Provider
>
> The biggest issue is the safety and well-being of community members if they access care at WCH. Services are woefully inadequate – no in-person cardiology; critical care weekdays only; no in-person GI a majority of the time; limited access to PCPs and specialists in the community to support these services; and massive pressure from the ER to admit patients who are too sick to be there or who have issues thar cannot be managed there (which can lead to, and has led to, unnecessary DEATHS). – Physician
>
> Better access to SDOH, behavioral health, and enhanced care management and community support. – Other Health Provider

Lack of Providers

> A significant issue is the limited access to health care services, particularly for residents in rural and underserved areas. The shortage of health care professionals, including primary care physicians and specialists, is exacerbated by doctors' hesitancy to work in this region. The high cost of living in California and lower reimbursement rates for services in South Santa Cruz County make it less attractive, leading to staffing shortages. These challenges underscore the urgent need for innovative solutions, improved infrastructure, and increased incentives to attract health care professionals and ensure access to health care. Solutions can include direct or indirect employment of physicians by the health care district, student loan forgiveness, working with lenders to assist physicians with home purchases, and including physicians in discussions about strategic plans and heeding their advice since they are, in fact, the most likely to understand the needs of the community they serve. – Physician
>
> Patient safety at WCH given lack of access to specialty care. – Physician
>
> Not enough primary care doctors. Not enough specialty care doctors. Not enough psychiatrists. – Community Leader
>
> Limited specialty medical providers available in health insurance networks. No dental care or dental specialty care is available to majority of low income Medi-Cal recipients. – Other Health Provider
>
> Need more specialists, especially those willing to see Medi-Cal recipients. – Other Health Provider

Vulnerable Populations

> Hesitancy around accessing services due to immigration status; ability to access services due to language barriers, transportation. Also, few primary care providers, long wait times for appointments. Difficult to recruit doctors. High rates of uninsured and underinsured. – Physician

> Chronic systematic barriers that over decades created barriers that limit largely Latino populations in the south Santa Cruz and northern Monterey County's from having basic access to primary care and specialty care services. The investments in health care have typically been in and around the 95060 ZIP code by private and county health agencies. The "Santa Cruz County Health Improvement Partnership" had been led largely by northern Santa Cruz area health providers, and due to the "corporate ownership" of the Watsonville Community Hospital and their decision NOT to be a part of this partnership nor the Santa Cruz County emergency management council. As recently as during COVID-19, even the progressive leadership within the Santa Cruz County Health Agency through implicit bias redirected health outreach efforts and marketing to be targeted to and tailored for English-speaking populations and to the unhoused (even through the unhoused are less than 1% of county's population). – Community Leader
>
> Existing systems are not accessible to the most vulnerable, including undocumented, indigenous language speakers, homeless adults and youth and newly arrived immigrants. – Community Leader

Access to Care for Uninsured/Underinsured

> Many are uninsured and make low wages. – Community Leader

Access to Vaccines

> So COVID-19 emergency ended, there is less access to vaccines, especially for those that are homebound. People also do not feel vaccines are important – need a trusted person in the community to share importance. Also, a lot of people did not go to the doctor during the COVID-19 pandemic, so there are a lot of people who have delayed care for routine health maintenance. – Public Health Representative

Income/Poverty

> The biggest challenge in accessing health care services in our community is due to economic burdens, language barriers, historical racism, which has deepened mistrust in receiving adequate healthcare and lack of quality health care services. – Community Leader

Behavioral Health

> Access to mental health. – Community Leader

Transportation

> Transportation to/from clinics/health care settings. – Social Services Provider

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.

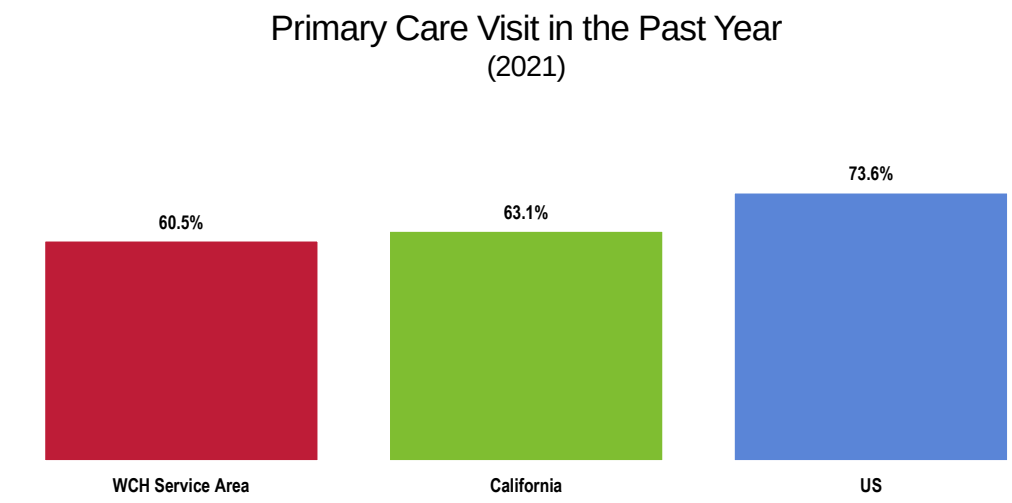
Children need regular well-child and dental visits to track their development and find health problems early, when they're usually easier to treat. Services like screenings, dental check-ups, and vaccinations are key to keeping people of all ages healthy. But for a variety of reasons, many people don't 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)

Primary Care Visits

The following chart reports the percentage of WCH Service Area adults who visited a doctor for a routine checkup in the past year.



Sources:
- Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2023 via SparkMap (sparkmap.org).

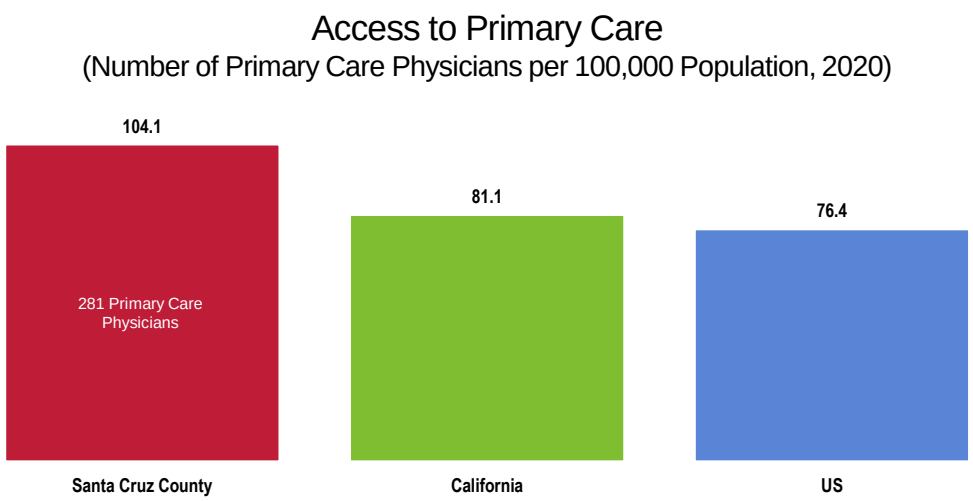
Notes:
- This indicator reports the number and percentage of adults age 18 and older with one or more visits to a doctor for routine checkup within the past one year.

Access to Primary Care

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 subspecialties within the listed specialties are excluded.

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 indicator outlines the number of primary care physicians per 100,000 population in Santa Cruz County. Having adequate primary care practitioners contributes to access to preventive care.



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 November 2023 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.

ORAL HEALTH

ABOUT ORAL HEALTH

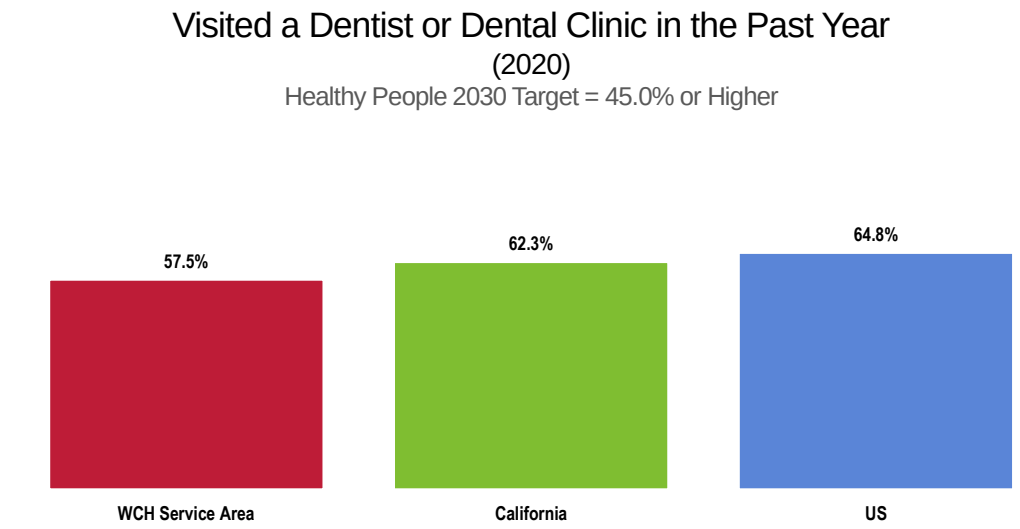
Tooth decay is the most common chronic disease in children and adults in the United States. …Regular preventive dental care can catch problems early, when they're usually easier to treat. But many people don't get the care they need, often because they can't afford it. Untreated oral health problems 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 Visits

The following chart shows the percentage of WCH Service Area adults age 18 and older who have visited a dentist or dental clinic in the past year.

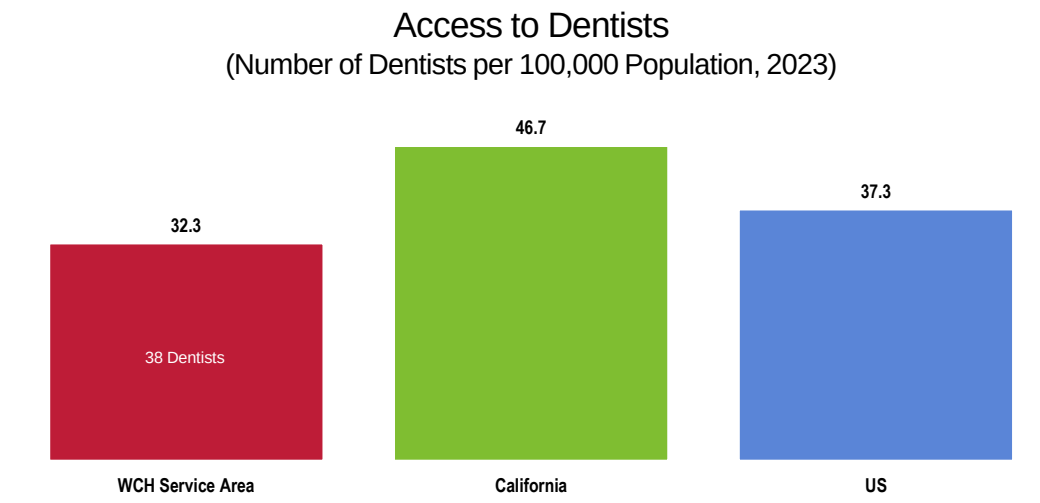


Sources:
- Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2023 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Access to Dentists

This indicator includes all dentists — qualified as having a doctorate in dental surgery (DDS) or dental medicine (DMD), who are licensed by the state to practice dentistry and who are practicing within the scope of that license.

The following chart outlines the number of dentists for every 100,000 residents in the WCH Service Area.

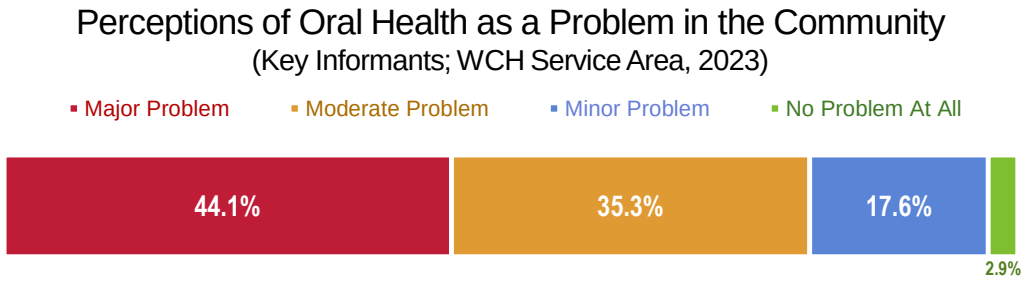


Sources:
- Centers for Medicare and Medicaid Services, National Plan and Provider Enumeration System (NPPES).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2023 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the number of dentists per 100,000 population. This indicator includes all dentists — qualified as having a doctorate in dental surgery (DDS) or dental medicine (DMD) — who are licensed by the state to practice dentistry and who are practicing within the scope of that license.

Key Informant Input: Oral Health

Key informants' perceptions of *Oral Health* are outlined below.



Sources:
- 2023 PRC Online Key Informant Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Top Concerns

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

Access to Care/Services

> Only one of three Medi-Cal patients in SC County are able to access the dentist. There are no specialty providers offering services to Medi-Cal patients outside of Dientes. Sugar-sweetened beverages are too available, especially to youth. – Other Health Provider
>
> Many of the older adults in our program have serious oral health issues that have not been treated for many years. Many of them are missing all or most of their teeth, leading us to believe that they have not had good oral health care most of their lives. The care they can receive through Medi-Cal at Western Dental appears to be substandard much of the time. – Community Leader

> I believe it is a major problem because children drop off from seeing their dental providers around the age of 9, and adult teeth may come into a compromised mouth or, worse, start out with untreated decay. – Community Leader
>
> Many folks need access to dental care, and there aren't enough facilities/providers. – Physician

Incidence/Prevalence

> There are a lot of cavities in the children I see, many kids have been traumatized by painful dental work, many parents are concerned about needing sedation or even general anesthesia to complete dental work for their child, many lost days of work and school. – Physician
>
> Poor hygiene. – Other Health Provider

Nutrition

> Bottle use, high consumption of sugar-sweetened beverages. – Community Leader
>
> Children with high level of decay on primary teeth. Sugary sweets at a young age. – Other Health Provider

Affordable Care/Services

> Oral health is not highly prioritized when it's not included in primary health benefits and out-of-pocket expenses. – Community Leader

Awareness/Education

> A lack of education about the importance of good oral health and a lack of resources to obtain the care. – Community Leader

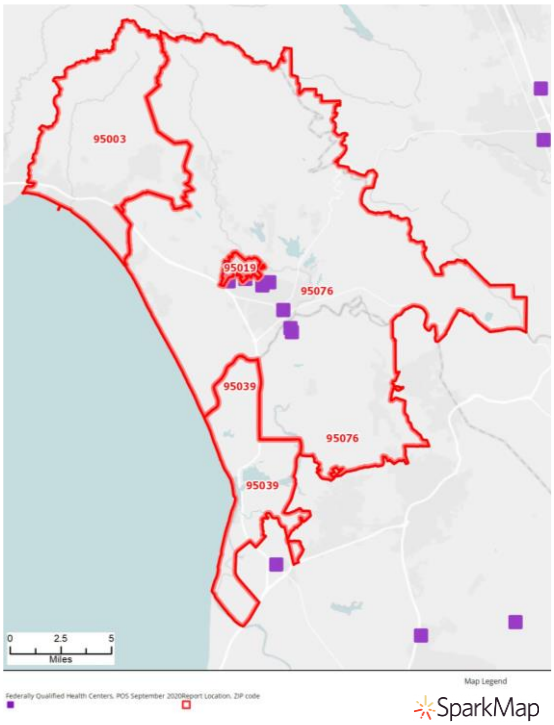
LOCAL RESOURCES

HEALTH CARE RESOURCES & FACILITIES

Federally Qualified Health Centers (FQHCs)

FQHCs are community assets that provide health care to vulnerable populations; they receive federal funding to promote access to ambulatory care in areas designated as medically underserved.

The following map details Federally Qualified Health Centers (FQHCs) within the WCH Service Area.



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

- 211 Santa Cruz County
- CAB
- Carelon
- Central Coast Alliance Managed Medical
- Chief of Staff
- City of Watsonville
- Clinica Del Valle Del Pajaro
- Coastal Health Partners
- Community Health Trust
- County Behavioral Health
- County Clinics
- County HSA Watsonville Clinic
- County of Santa Cruz
- County Public Health Nurse
- Dientes
- Doctor's Offices
- Elderday Adult Day Health Care
- Encompass Community Services
- Enhance Care Management
- Faith-Based Networks
- Food Bank
- Homeless Network
- Homeless Persons Health Project
- Hospitals
- Insurance
- Kaiser
- Loaves and Fishes
- Lucile Packard
- Pajaro Valley Healthcare District
- Pajaro Valley Prevention and Student Assistance
- Pajaro Valley Unified School District
- PAMF/Sutter
- Salud Para La Gente
- Santa Cruz Community Health
- Second Harvest Food Bank
- South County Non-Profit Health Coalition
- Watsonville Community Hospital
- Watsonville Health Center
- WIC

Cancer

- Brown Berets
- Center for Farmworker Families
- Community Bridges
- Esperanza Community Farms
- Jacob's Heart
- Kaiser
- PAMF/Sutter
- Salud Para La Gente
- United Farm Workers
- Watsonville Community Hospital

Diabetes

- CalAIM
- Central California Alliance for Health
- City and County Health Department
- Clinica de Salud
- Community Bridges
- Community Gardens
- Community Health Trust
- Community Health Workers
- County of Santa Cruz Health Services
- County Public Health Nutrition Services
- Diabetes Health Center
- Diabetic Support Groups
- Dietitians
- Doctor's Offices
- Enhance Care Management
- Farmer's Market
- Federally Qualified Health Centers
- Food Bank
- Health Trust Diabetes Center
- Homeless Persons Health Project
- Hospitals
- Kaiser
- LPCH Endocrinology
- Pajaro Valley Health Trust
- Pajaro Valley Unified School District
- PAMF/Sutter
- ParkRx
- Public TV and Radio

- Salud Para La Gente
- Santa Cruz Community Health
- School System
- Second Harvest Food Bank
- Stanford
- Watsonville Community Hospital
- Watsonville Health Center
- WIC

Disabling Conditions

- Community Action Board
- Community Bridges
- County Clinics
- Montecito Manor
- Recuperative Care Center
- Salud Para La Gente
- Watsonville Community Hospital

Heart Disease & Stroke

- American Heart Association
- CalAIM
- Community Health Workers
- Community Health Trust of Pajaro Valley
- County Nutrition Case Management Program
- Dientes
- Doctor's Offices
- Dominican's Acute Rehab Unit
- Dominican Hospital
- Encompass Community Services
- Enhance Care Management
- Federally Qualified Health Centers
- Loaves and Fishes
- PAMF/Sutter
- Parks and Recreation
- Public TV and Radio
- Salud Para La Gente
- Santa Cruz Community Health
- Stroke Center - Cabrillo College
- Watsonville Community Hospital
- WIC

Infant Health & Family Planning

- Community Bridges
- County HSA Watsonville Clinic
- Doctor's Offices
- Family Resource Collective
- First 5 of Santa Cruz County
- Hospitals
- Infant/Planning Services
- La Manzana
- Salud Para La Gente
- Santa Cruz Community Foundation
- United Way
- Watsonville Community Hospital
- Watsonville Health Center
- WIC

Injury & Violence

- Churches
- City of Watsonville
- Community Bridges
- County Office of Education
- Digital NEST
- Food Bank
- Hospitals
- Jovenes SANOS
- Monarch Services
- Outreach Counselors
- Pajaro Valley Prevention and Student Assistance
- Pajaro Valley Unified School District
- Police Activities League
- Police Department
- School System
- Watsonville Community Hospital
- Watsonville Police Department
- Youth Center

Mental Health

- Central California Alliance for Health
- Community Action Board
- Community Bridges
- Community Health Trust
- County Behavioral Health
- County Clinics
- County Mental Health Services
- County Outpatient Services
- Doctor's Offices
- Early Head Start
- Encompass Community Services
- Head Start
- HSA County Behavioral Health Services
- Jovenes SANOS
- Kaiser
- Mobile Emergency Response Team
- National Alliance on Mental Illness
- Pajaro Valley Prevention and Student Assistance
- Pajaro Valley Unified School District
- ParkRx

- Salud Para La Gente
- Santa Cruz County Behavioral Health
- Santa Cruz County Mental Health Resources
- Santa Cruz County Office of Education
- Santa Cruz County Soquel
- School System
- Second Harvest Food Bank
- Telecare
- Watsonville Community Hospital

Nutrition, Physical Activity, & Weight

- City and County Health Department
- City of Watsonville
- Community Health Trust of Pajaro Valley
- County Health Services Agency
- County Nutrition Case Management Program
- Diabetes Health Center
- Doctor's Offices
- Doctors on Duty
- Food Bank
- Friends of Santa Cruz Parks
- Friends of Watsonville Parks
- Health Centers
- Life Lab
- Loaves and Fishes
- Pajaro Valley Unified School District
- ParkRx
- Parks and Recreation
- Safe Routes to Schools Program
- Salud Para La Gente
- Salud Y Carino
- School System
- Second Harvest Food Bank
- Stanford
- Teen Kitchen Project
- Watsonville Community Hospital
- Watsonville Parks and Community Services
- WIC
- YMCA
- Youth Sports Leagues

Oral Health

- Big Smile
- Central California Alliance for Health
- County Clinics
- Dental Offices
- Diabetes Health Center
- Dientes
- Oral Health Access Coalition
- Salud Para La Gente
- Second Harvest Food Bank
- Western Dental
- WIC

Respiratory Diseases

- Community Providers
- County Clinics
- County Health Services Agency
- Doctor's Offices
- Dominican Hospital
- Hospitals
- Kaiser
- Salud Para La Gente
- Vaccines
- Watsonville Community Hospital

Sexual Health

- Access Support Network
- Care Teams
- Community Providers
- County Clinics
- County Office of Education
- County Public Health
- County-Sponsored Sexual Health Education
- Doctors on Duty
- Dominican Hospital
- Federally Qualified Health Centers
- Pajaro Valley Prevention and Student Assistance
- Pajaro Valley Unified School District
- Planned Parenthood
- Salud Para La Gente
- School System
- Watsonville Community Hospital

Social Determinants of Health

- CAB
- Cabrillo
- Catholic Charities
- Center for Farmworker Health
- CHISPA
- City of Watsonville
- Community Action Board
- Community Action Network
- Community Based Organizations
- Community Bridges
- Community Health Trust of Pajaro Valley
- County Health Services Agency
- County Human Services Department

- County of Santa Cruz
- Doctor's Offices
- Encompass Community Services
- Family Resource Collective
- Food Bank
- Health and Human Services
- Housing Element
- Housing Matters
- La Manzana
- Loaves and Fishes
- National Alliance on Mental Illness
- Non-Profits and Faith-Based Groups
- Pajaro Rescue Mission
- Pajaro Valley Prevention and Student Assistance
- Pajaro Valley Shelter Services
- Pajaro Valley Unified School District
- Public Health Department
- Raices Y Carino
- Salud Para La Gente
- Salvation Army
- Santa Cruz County Health Department
- Second Harvest Food Bank
- South County Triage Group
- UCSC
- United Way
- Watsonville Community Hospital
- Watsonville Law Center
- WIC

Substance Use

- County Clinics
- County of Santa Cruz
- Elevate Addiction Services
- Encompass Community Services
- Janus
- Pajaro Valley Prevention and Student Assistance
- Salud Para La Gente
- Santa Cruz County Behavioral Health

Tobacco Use

- County Clinics
- Pajaro Valley Prevention and Student Assistance

APPENDIX

EVALUATION OF PAST ACTIVITIES

Watsonville Community Hospital gained not-for-profit status in 2022; as such, this is the first Community Health Needs Assessment completed pursuant to IRS regulations. Watsonville Community Hospital will evaluate actions taken to address the needs identified in this assessment from this point forward.