MORE
COMMUNITY VOICES

Adventist Health
Twin Cities

Living God's love by **inspiring health**, **wholeness** and hope.

IRS Section 501(r)(3) CHNA Compliance Checklist

1) A definition of the community served by the hospital facility and description of how the community was defined.	Page 8	4) A prioritized description of the significant health needs of the community identified through the CHNA, along with a description of the criteria and process used in identifying certain health needs as significant as well as prioritizing and selecting those significant health needs.	Section IV. and V.
2) A description of the process and methods used to conduct the CHNA, including identification of information gaps that limit the hospital facility's ability to assess the community's health needs.	Section V.	5) A description of the resources potentially available to address the significant health needs identified through the CHNA.	Section IV. A
3) A description of how the hospital facility solicited and took into account input received from persons who represent the broad interests of the community it serves.	Section IV. B	6) An evaluation of the impact of any actions that were taken, since the hospital facility finished conducting its immediately preceding CHNA to address the significant health needs identified in the hospital facility's prior CHNA(s).	Page 11

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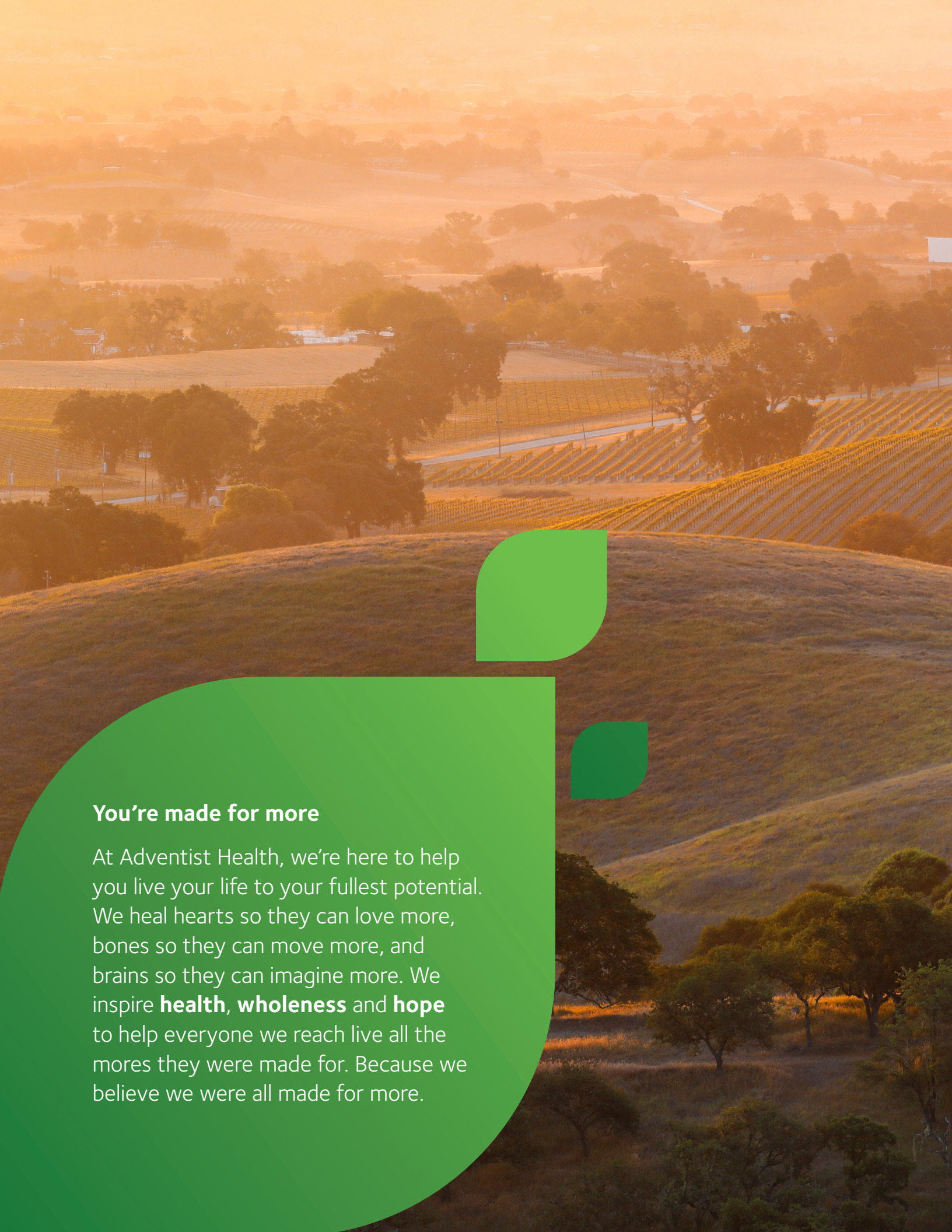


You’re made for more

At Adventist Health, we’re here to help you live your life to your fullest potential. We heal hearts so they can love more, bones so they can move more, and brains so they can imagine more. We inspire **health**, **wholeness** and **hope** to help everyone we reach live all the mores they were made for. Because we believe we were all made for more.

Executive Summary

Non-profit health systems, community-based organizations and public health agencies across the country all share a similar calling: to provide public services to help improve the lives of the community members they serve. The Community Health Needs Assessment (CHNA) is conducted every three years to support this calling by helping nonprofit hospitals understand the health needs of the community. The CHNA is a public document and represents the collaborative work between community stakeholders and the local hospital(s), partnering to identify the health needs of their community. The CHNA process engages communities in identifying high priority health needs, and in aligning the resources of community-based organizations, public health services and Adventist Health to achieve improved health for all. Through this collective effort, communities collect data and identify resources to maximize their focus on meeting the most significant community health needs over the next three years.

For 2025, Adventist Health Sierra Vista and Adventist Health Twin Cities collaborated with community partners to create a concise report that the entire community could contribute to and access, regardless of public health context or reading ability. Input was gathered from focus groups and key informants representing the broad interests of the community served by our hospital, and collaborative organizations. We intentionally prioritized gathering insights from local health officials with knowledge and expertise about community health needs, community-based organizations, medical providers, and members of medically underserved, low-income and minority populations.

Our assessment used a combination of primary and secondary data, providing the greatest understanding of community needs from the broadest range of perspectives. Primary data was collected from focus groups and key informant interviews conducted between August 2024 and March 2025. Seven significant health needs, which focused on the social determinants of health, were identified through in-depth analysis.

The local CHNA Steering Committee reviewed significant health needs, along with corresponding data, and prioritized needs based on severity, prevalence, alignment around common goals, feasibility of potential interventions and opportunities to maximize available resources over a three-year period. This collaborative effort resulted in the identification of the following high priority health needs:

Access to Care

Housing

Mental Health

The following pages share opportunities where you, your family and your community can drive change for improved well-being. We hope this report is leveraged by all local partners and community members, empowering them to own the potential of healthy living for all. In addition to our comprehensive written CHNA report, please explore our living CHNA dashboard below. The entire report is published online and available in print form free of charge by contacting community.benefit@ah.org.

Scan QR Code to explore the full live data report or visit: cares.page.link/RJmJ

Transforming the health experience of our **communities** by **improving** physical, mental and spiritual **health**.

Identity of Steering Committee Hospital & Partner Organizations

To all that partnered with us, we say THANK YOU. To those now joining, we welcome you. Let's work together to inspire health, wholeness and hope in our community.

We thank the Twin Cities CHNA Steering Committee, who collaborated and partnered to create the 2025 CHNA. Through a series of three collaborative meetings, engagement of community members, and data review, each committee member brought their unique perspective as seen through their job and the work they performed during the CHNA process.

Jill Bolster-White
Transitions-Mental Health Association,
Executive Director

Susan Funk, FACHE
City of Atascadero, Mayor Pro Tem

Maria Elena Garcia
Hispanic Business Association, Founder

Nicole Johnson, RN
Cuesta College, Director, Student Health Services

Molly Kern
SLO Food Bank, CEO

Trey Lauderdale
Atomic Canyon, CEO

Wendy Lewis
El Camino Homeless Organization, CEO

Elizabeth Merson, MPP
Public Health, Planning, Evaluation & Policy
Division Manager

Cecilia Montalvo
Cambria Community Healthcare District, President

Aydin Nazmi, PhD
Cal Poly University, Professor

Leo Ontiveros
Public Health, Health Equity Program Manager

Bridget Ready
Jack's Helping Hands, Founder

Jonathan Stornetta
Paso Robles City, Fire Chief

Todd Tuggle
SLO City Fire, Fire Chief

Ron Yukelsonson
Carmel & Naccasha Law Firm, Community Outreach

A. CHNA Community Defined

Getting to Know Our Community

Located halfway between San Francisco and Los Angeles on California's picturesque Central Coast is a one-of-a-kind wine region with over 200 tasting rooms and rolling lush vineyards. The area is also home to a vibrant community of rural farm workers who play a crucial role in the agricultural sector, providing fresh produce and maintaining the region's rich farming heritage. We recognize the challenges of being a remote community and are optimistic about finding opportunities to improve our community's vitality so we can live our best possible life.

Research suggests that up to 80% of health outcomes can be traced back to social determinants of health (SDoH), the conditions where people are born, live, learn, work and play. For additional community context, below are a few SDoH data points:

- 7.75% of the population is aged 75 or older.
- High school graduation rate of 90.3%
- 38.75% of the population lives within 0.5 miles of public transit, compared to 62.31% in California.
- Based on the Area Median Income, residents spend 50.89% percent of their income on housing and transportation alone.

For the purposes of our CHNA, we refer to the following geographic areas throughout the report:

- **Twin Cities CHNA** as the full geographic area represented in this report (defined by specific zip codes listed on the following page and in the CARES secondary data reports).
- **San Luis Obispo County** as defined by county boundaries.
- **Adventist Health Twin Cities** as the hospital facility conducting this CHNA report.

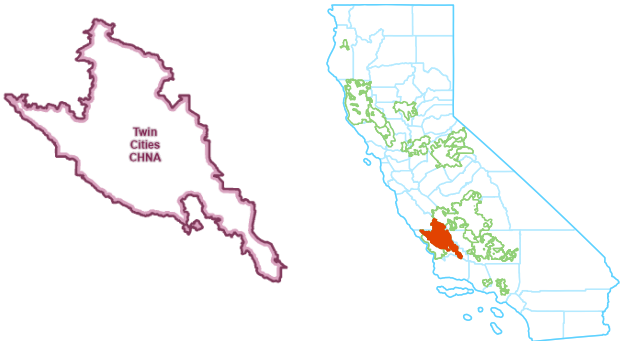
These terms are used for different purposes throughout this report, with the report data being reflective of the most exhaustive "Twin Cities CHNA" service area. We gathered data and heard voices spanning across all corners of San Luis Obispo County.

In the following pages, we'll review lessons learned and accomplishments from the past three years. We'll dive deeper into the high priority needs, community voices, and data that guided the Community Health Needs Assessment selection process.

Defining the Community We Serve

To define our community, we used the hospital's primary service area and vetted the zip codes with Steering Committee members. We also invited our Steering Committee members to expand the CHNA service area to include zip codes based on the constituents they serve.

The report area is located in the state of California and includes a total population of 99,678 (based on the 2020 Decennial Census). The largest city in the report area is El Paso de Robles (Paso Robles) city, with a population of 31,490. The report area is comprised of the following ZIP codes: 93422, 93432, 93446, 93451, 93453, 93461, 93465.

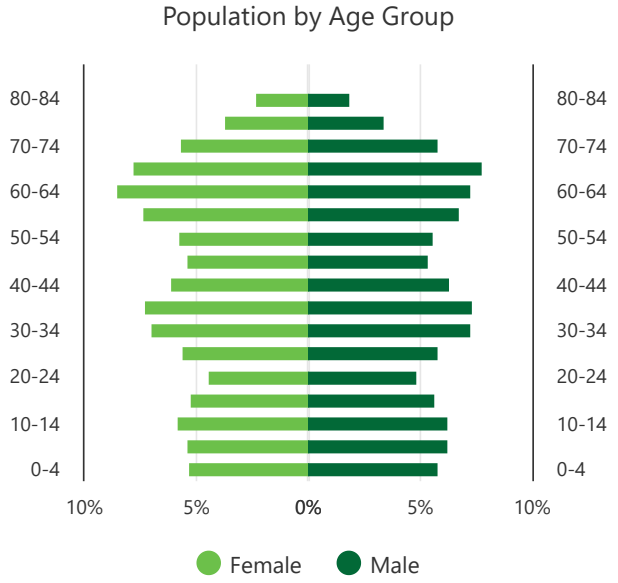


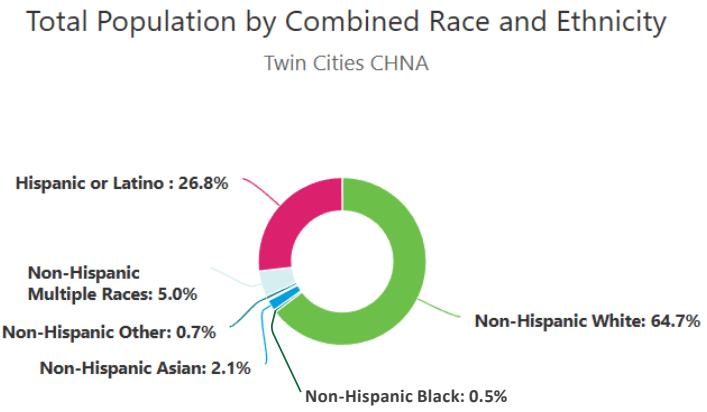
Total Population
99,678

The largest city in the service area is
El Paso de Robles (Paso Robles) city
with a population of

31,490

Demographic Profile





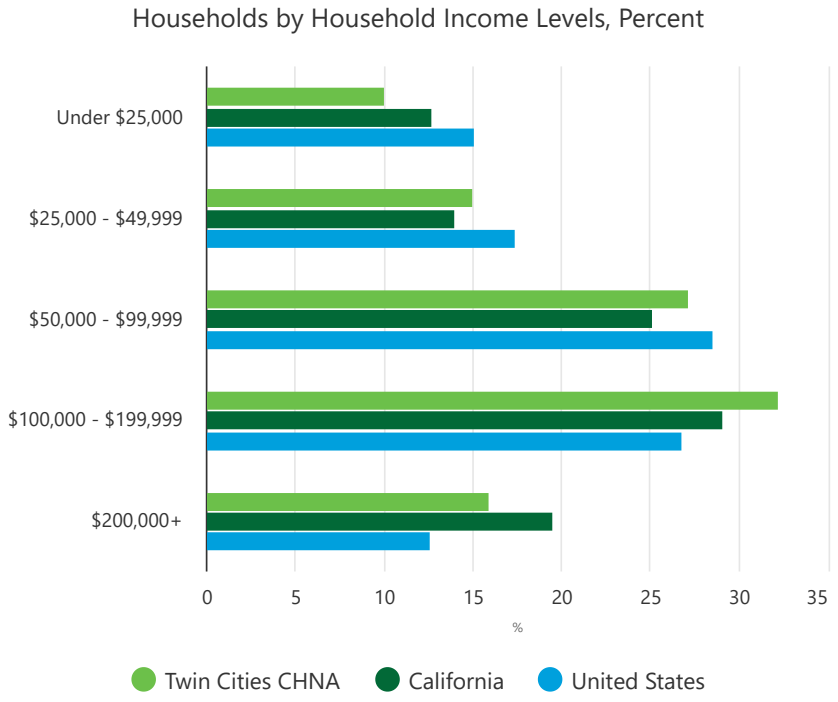
Students Experiencing Homelessness, Percent
4.67%
California: 3.96%

Associate's Degree or Higher
44.25%
California: 44.42%

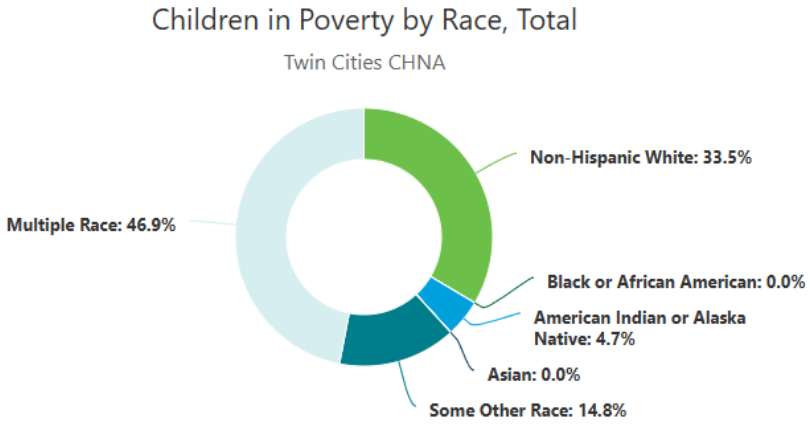
Labor Force Participation Rate
61.63%
California: 63.86%

67.93%
California: 55.79%
of the population **owns** their home

32.07%
California: 44.21%
of the population **rents** their home



Data Source: US Census Bureau, American Community Survey. 2019-23.



Childhood Poverty Rate
13.78%
California: 15.15%

II. About Us

Adventist Health

Adventist Health is a faith-based, nonprofit, integrated health system serving more than 100 communities on the West Coast and Hawai'i, with over 440 sites of care, including 27 acute care facilities. Founded on Adventist heritage and values, Adventist Health provides care in hospitals, clinics, home care agencies, hospice agencies and joint-venture retirement centers in both rural and urban communities. Our compassionate and talented team of more than 38,000 includes employees, physicians, allied health professionals and volunteers driven in pursuit of one mission: living God's love by inspiring health, wholeness and hope. Guided by our mission, Adventist Health supports purposeful work to address the social drivers of health, with a special focus on underserved members of the communities in which we operate. Together, we are transforming the healthcare experience of our communities with a whole-person focus on physical, mental, spiritual and social healing to support well-being.

Adventist Health Twin Cities

Adventist Health Twin Cities is a 122-bed hospital that has served Northern San Luis Obispo County since 1977. Our hospital offers whole-person care for a wide variety of illnesses and injuries, and is committed to delivering medical excellence, emergency care, outpatient services and wellness programs to all individuals regardless of insurance or ability to pay. Our vast network of healthcare resources and expertise allows us to provide patients with seamless coordination and access to specialized services.

Specialties Brought to our Community

- Diagnostic Imaging
- Gastroenterology
- General Surgery
- Obstetrics
- Orthopedics
- Wound Care

A Look Back: Activities Since 2022 CHNA

CHNA Successes

In March 2024, Adventist Health acquired Twin Cities Community Hospital from Tenet Health. Now doing business as Adventist Health Twin Cities, it is part of the larger Adventist Health non-profit health care system and will be completing its first CHNA report for publication in December 2025. In the interim, Adventist Health Twin Cities leveraged several resources to identify significant priority health needs, crucial for the annual reporting of community benefits ensuring compliance with state and federal regulations. In collaboration with the community, we implemented solutions to improve community health and well-being.

One of the ways Adventist Health Twin Cities uniquely addressed community health needs is by collaborating with Cal Poly to provide 10 students with the opportunity to advance healthcare through innovation and participation in patient care improvement. Made possible by a five-year grant from the National Institutes of Health, Adventist Health Twin Cities, Adventist Health Sierra Vista and Cal Poly has brought together biomedical engineering students, faculty, physicians and hospital leaders to provide space for clinical training, licensing and certification of health professionals. The goal is to integrate technologies and innovations into practical, everyday healthcare and make a lasting impact on patient care. The program provides participants with hands-on experience and the opportunity to complete rotations in Obstetrics, surgery, medical surgical nursing and intensive care unit, neonatal intensive care unit/pediatrics, emergency department, radiology and lab, learning directly from our team members and clinicians. The program teaches students about the daily operations of a hospital and challenges them to recognize gaps in care and develop ways to improve patient outcomes.

In 2024, Adventist Health Twin Cities hosted a free community health education program called “Stop the Bleed” for 204 attendees, which taught community members how to identify life-threatening bleeding, intervene and complement bleeding controls such as compression techniques including tourniquet application, direct pressure and packing. The health education program hosted speakers such as Hope for Stroke Survivors, community mental health workers and other healthcare professionals to provide education around strokes, recovery, self-care and various adaptive devices. Adventist Health Twin Cities also hosted three blood drives to increase the number of blood donors and save lives.

A Look Forward: After the CHNA Report

The next step in our CHNA process is to complete a CHIS. The goal of the CHIS is to strategically implement programs using evidence-informed solutions that address the high priority needs identified in our 2025 CHNA. Together, Adventist Health Twin Cities and Adventist Health Sierra Vista, local public health officials, community-based organizations, medical providers, students, parents, and members of underserved, low-income and minority populations will develop a three-year strategic plan to work towards addressing the needs of our community.

We believe the power of community transformation lies in the hands of the community. We’re calling for more collaboration to create intentional strategies that improve health needs for all. Everyone’s voice matters, so we want to hear more of your ideas and partner closely with those who want to drive meaningful change. If you would like to learn more, share ideas or stay connected, please contact us at community.benefit@ah.org.

RALF
SURGERY
RN

The following pages **reflect high priority needs** for our community, as identified by our **diverse** CHNA Steering Committee.

III. High Priority Health Needs

Access to Care

Access to care refers to the timely use of personal health services to achieve the best health outcomes. This concept encompasses the availability, affordability and appropriateness of healthcare services, and accessibility for all individuals, regardless of income, location or social standing. Access to care directly affects population health, influencing rates of preventable diseases, overall mortality and quality of life. Ensuring equitable access to healthcare is a central public health goal, particularly in reducing health disparities among underserved populations.

In the United States, three in ten people do not have access to a reliable source of primary care (National Association of Community Health Centers), and the American Medical Association projects a shortage of 17,000 - 45,000 primary care doctors over the next decade. Additionally, factors such as being uninsured, lacking access to transportation, limited English proficiency and insufficient provider availability prevent people from receiving the services they need at the right time and place. Community members in the Adventist Health Twin Cities service area face similar limiting factors, often to a greater extent, making access to care a priority need.

One of the many challenges in accessing health care is ensuring that people can reach a service provider. When asked about what makes it hard to live and be well, a community survey showed 19.4% of respondents selected not being able to get medical care as a top reason. The secondary data reveals that 38.75% of the population lives within a half mile of public transportation compared to more than 60% across California, making it harder to access care. Additionally, 33% of respondents indicated they did not receive the medical care they needed to live a healthy life. Key informants described how “not everybody has health insurance” but there are opportunities to “engage in public relations [...] campaigns” to educate people about Medi-Cal eligibility and enrollment. Almost 7% of the Adventist Health Twin Cities service area is uninsured, which is a barrier to health services and contributes to poor health status.

Given that many community residents live in underserved areas, increasing access and reducing barriers to healthcare in our community can improve health outcomes and reduce disparities. For additional data, see the following pages.

Scan QR Code to explore the full live data report on Access to Care or visit: cares.page.link/A4Z7

Data Highlights

Community Voices: *exploring local perceptions, thoughts & beliefs*

"Too many people need the [medical] services and not enough people to provide [the medical services]."

"I mean there's a lot of challenges. I think lack of healthcare is a huge one."

"...there's a hesitancy to seek out services and care partially because there's a language barrier, but also there's a lack of understanding of their culture and what would make them feel comfortable in a medical setting."

"[I] call to make an appointment but [am told] we can see you in four weeks to three weeks...so I rely on cancellations..."

"My father had an ear infection for a month, couldn't find an ENT that would see him within six months and he ended up going to the urgent care five times and then ended up at the ER."

"So in that [dental] screening we find kids with major decay and then we try to connect them with someone."

"...we have come to understand that during covid there [were] people able to stay on Medi-Cal and then once the time ended we dumped a lot of people off and...what our data is telling us...is that there are a lot of families that... don't know how to re-enroll."

"...we don't have enough doctors, we don't have enough medical professionals."

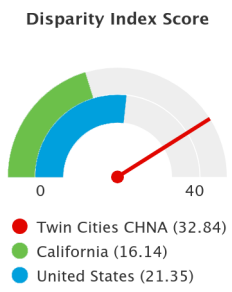
"Not everybody [has] health insurance."

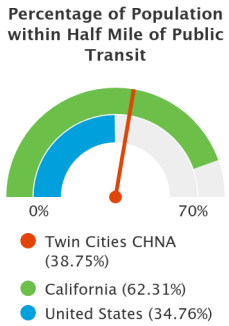
"About 70% of our fire calls are medical aid calls...that's just indicative of the healthcare system in general. People need insulin shots...they fell out of bed and they live alone and we have to help them."

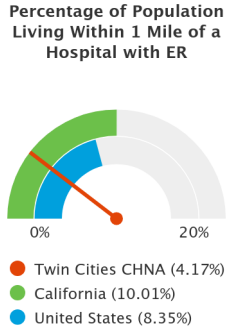
"In northern San Luis Obispo County...we have very few pediatricians."

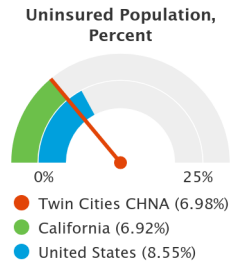
"...certainly the access to care is more challenged. So when someone's diagnosed, it's harder to get into care, and so you get worse...early prevention work is not available."

"We also have a bit of an OB crisis in that we don't have OB coverage."









Community Resources

Healthcare Enrollment Services
coveredca.com
800-300-1506

United Way of San Luis Obispo County
unitedwayslo.org/community-strengthening/211-helpline/
805-541-1234

Community Health Needs Assessment Full Report

Location

Twin Cities CHNA

Health Needs: Access to Care

Availability - Mental Health Care - Mental Health Professional Shortage Areas

A **Health Professional Shortage Area (HPSA)** is a designation given by the Health Resources and Services Administration (HRSA) in the United States to identify geographic areas, populations, or facilities that lack sufficient health care professionals to meet the health needs of the community. HPSAs are categorized into three main types based on the specific type of health professional shortage:

Types of HPSA

- **Primary Care HPSA**: Areas with a shortage of primary care physicians, including family medicine, internal medicine, pediatrics, obstetrics, and gynecology.
- **Dental Health HPSA**: Areas with a shortage of dental health professionals, such as general and pediatric dentists.
- **Mental Health HPSA**: Areas with a shortage of mental health providers, including psychiatrists, clinical psychologists, clinical social workers, psychiatric nurse specialists, and marriage and family therapists.

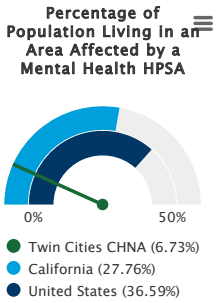
This indicator reports the total population in the report area that is living in a mental health care Health Professional Shortage Area, regardless of the degree of shortage, or whether the HPSA covers the entire geographic area or a population subgroup. Indicator data are based on the following calculation:

Percentage = [HPSA Population] / [Report Area Population] * 100

The population figures used in this calculation are from the 2019 American Community Survey 5-year Estimates. This indicator is relevant because a shortage of health professionals contributes to access and health status issues.

Within the report area, there are 6,712 people living in a mental health care Health Professional Shortage Area. This represents 6.73% of the total population.

Report Area	Total Population (ACS 2023 5-Year Estimates)	Population Living in an Area Affected by a HPSA	Percentage of Population Living in an Area Affected by a Mental Health HPSA	Percentage of HPSA Population Underserved
Twin Cities CHNA	99,683	6,712	6.73%	23.90%
Monterey County, CA	433,410	172,208	39.73%	69.34%
San Luis Obispo County, CA	282,165	139,458	49.42%	13.95%
California	39,283,497	10,907,014	27.76%	69.55%
United States	324,697,795	118,818,005	36.59%	62.78%



Note: This indicator is compared to the state average.
Data Source: US Department of Health & Human Services, Health Resources and Services Administration, HRSA - Health Professional Shortage Areas Database. 2024.

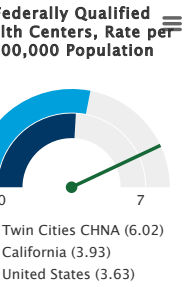
Availability - Hospitals & Clinics - FQHCs, Rate Per Low-Income Population

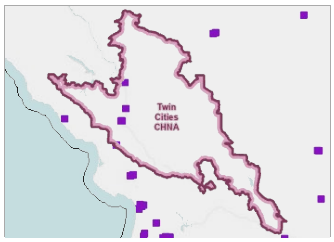
This indicator reports the number of Federally Qualified Health Centers (FQHCs) in the community. This indicator is relevant because FQHCs are community assets that provide health care to vulnerable populations; they receive extra funding from the federal government to promote access to ambulatory care in areas designated as medically underserved.

Within the report area, there are 6 Federally Qualified Heath Centers. This means there is a rate of 6.02 Federally Qualified Health Centers per 100,000 total population.

Report Area	Total Population (2020)	Number of Federally Qualified Health Centers	Rate of Federally Qualified Health Centers per 100,000 Population
Twin Cities CHNA	99,683	6	**6.02**
Monterey County, CA	439,035	21	4.78
San Luis Obispo County, CA	282,424	18	6.37
California	39,538,223	1,554	3.93
United States	334,735,155	12,138	3.63

Note: This indicator is compared to the state average.
Data Source: US Department of Health & Human Services, Center for Medicare & Medicaid Services, Provider of Services File. 2024.





Federally Qualified Health Centers, POS December 2024

Federally Qualified Health Centers, POS December 2024
Twin Cities CHNA

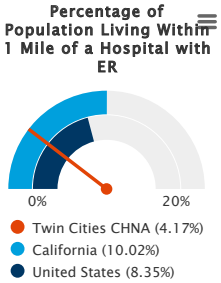
Availability - Hospitals & Clinics - Proximity to Hospitals with ER

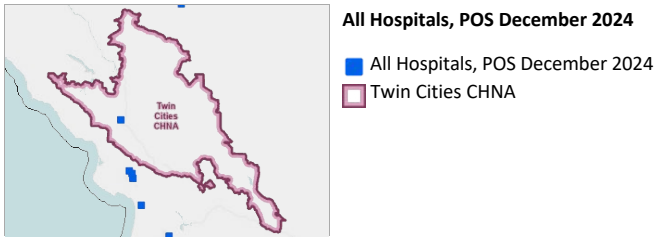
This indicator reports the percentage of the total population living within 1 mile of a hospital with an emergency room. Having good access to hospitals with an emergency room is important for community health because these hospitals play an important role in rapid and serious medical conditions.

As of 2023, of the report area's 99,683 total population, 4,153 or 4.17% live within 1 mile of a hospital with an emergency room. This is less than the state's reported rate of 10.02%.

Report Area	Total Population	Population Within 1 Mile of a Hospital with ER	Percent Within 1 Mile of a Hospital with ER
Twin Cities CHNA	99,683	4,153	**4.17%**
Monterey County, CA	439,035	37,878	8.63%
San Luis Obispo County, CA	282,424	34,440	12.19%
California	39,538,223	3,961,644	10.02%
United States	334,735,155	27,942,571	8.35%

Note: This indicator is compared to the state average.
Data Source: US Department of Health & Human Services, Center for Medicare & Medicaid Services, Provider of Services File. 2023.

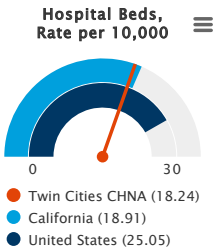




Availability - Hospitals & Clinics - Hospital Beds Per Capita

This indicator reports hospital bed availability by estimating the number of hospital beds per 10,000 population. This calculation allocates the number of hospital beds at a given hospital (location) and assigns them to ZIP codes in the hospital service area based on the proportion of patients coming from each ZIP code. This provides an estimation of how hospital capacity (beds) affects the population in ZIP codes served by the hospital.

Report Area	Hospital Beds, Total	Total Population (2020)	Hospital Beds, Rate per 10,000
Twin Cities CHNA	181	99,687	**18.24**
Monterey County, CA	756	439,035	17.22
San Luis Obispo County, CA	530	282,424	18.77
California	74,762	39,538,223	18.91
United States	830,171	331,449,281	25.05



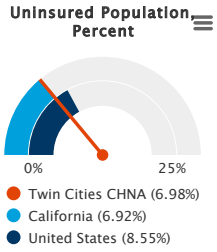
Note: This indicator is compared to the state average.
Data Source: Centers for Medicare & Medicaid Services, Hospital Service Area. 2023.

Barriers - Medical Insurance - Population without Medical Insurance

The lack of health insurance is considered a *key driver* of health status.

In the report area 6.98% of the total civilian non-institutionalized population are without health insurance coverage. The rate of uninsured persons in the report area is greater than the state average of 6.92%. This indicator is relevant because lack of insurance is a primary barrier to healthcare access including regular primary care, specialty care, and other health services that contributes to poor health status.

Report Area	Total Population (For Whom Insurance Status is Determined)	Uninsured Population	Uninsured Population, Percent
Twin Cities CHNA	98,347	6,862	**6.98%**
Monterey County, CA	420,702	41,838	9.94%
San Luis Obispo County, CA	276,628	16,050	5.80%
California	38,761,738	2,682,732	6.92%
United States	327,425,278	28,000,876	8.55%



Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2019-23.

Uninsured Population, Percent by Tract, ACS 2019-23

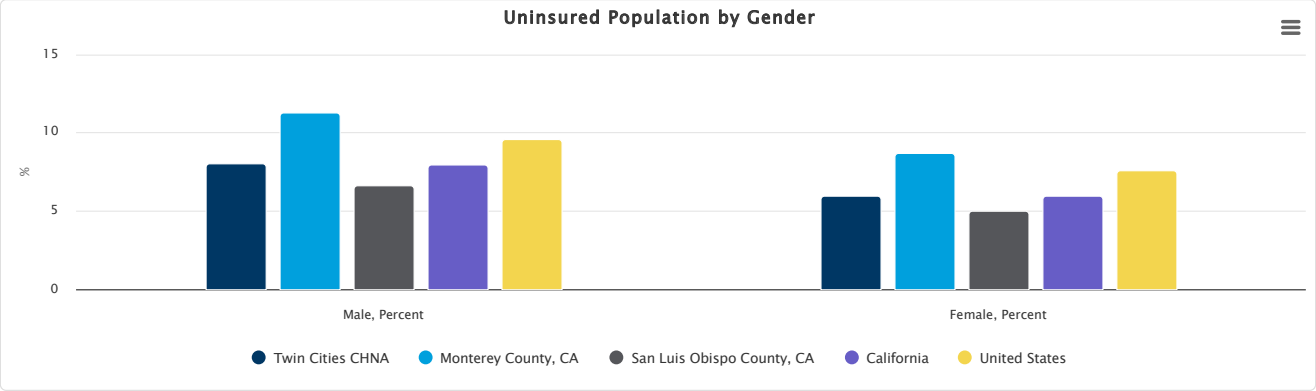
- Over 20.0%
- 15.1 - 20.0%
- 10.1 - 15.0%
- Under 10.1%
- No Data or Data Suppressed
- Twin Cities CHNA

Uninsured Population by Gender

This indicator reports the uninsured population by gender.
The percentage values could be interpreted as, for example, *"Of all the male population within the report area, the proportion without health insurance coverage is (value)."*

Report Area	Male	Female	Male, Percent	Female, Percent
Twin Cities CHNA	3,902	2,958	7.99%	5.98%
Monterey County, CA	23,421	18,417	11.24%	8.68%
San Luis Obispo County, CA	9,135	6,915	6.63%	4.98%
California	1,526,004	1,156,728	7.93%	5.92%
United States	15,443,840	12,557,036	9.59%	7.55%

Data Source: US Census Bureau, American Community Survey. 2019-23.

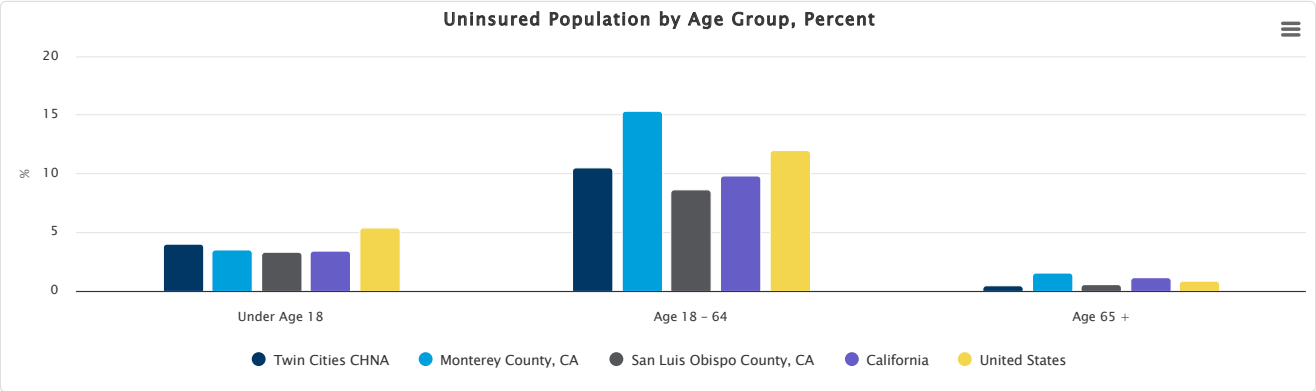


Uninsured Population by Age Group, Percent

This indicator reports the percentage of uninsured population by age group.
The percentage values could be interpreted as, for example, *"Of all the population under age 18 within the report area, the proportion without health insurance coverage is (value)."*

Report Area	Under Age 18	Age 18 - 64	Age 65 +
Twin Cities CHNA	3.95%	10.54%	0.42%
Monterey County, CA	3.50%	15.34%	1.52%
San Luis Obispo County, CA	3.30%	8.61%	0.57%
California	3.35%	9.77%	1.09%
United States	5.39%	11.98%	0.83%

Data Source: US Census Bureau, American Community Survey. 2019-23.

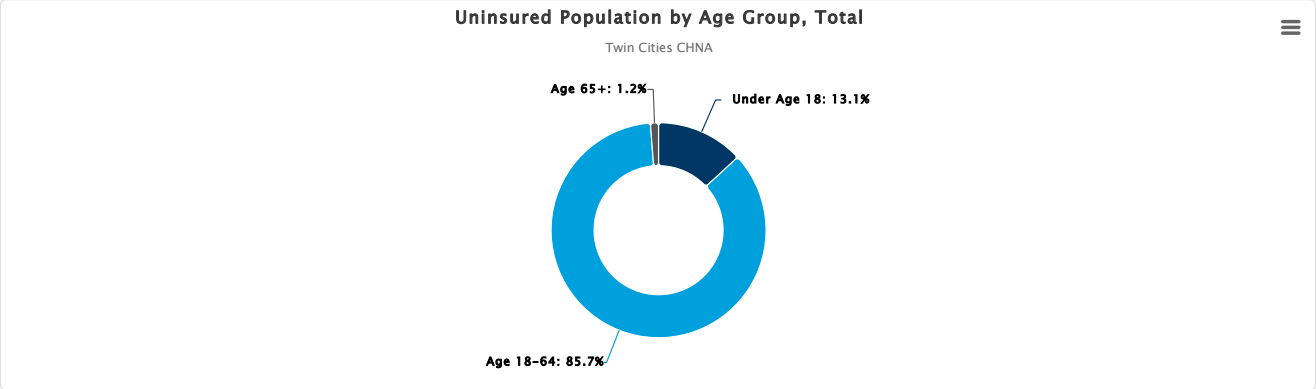


Uninsured Population by Age Group, Total

This indicator reports the total uninsured population by age group.

Report Area	Under Age 18	Age 18-64	Age 65+
Twin Cities CHNA	901	5,875	83
Monterey County, CA	4,176	36,718	944
San Luis Obispo County, CA	1,845	13,863	342
California	310,351	2,307,944	64,437
United States	4,208,983	23,338,717	453,176

Data Source: US Census Bureau, American Community Survey. 2019-23.

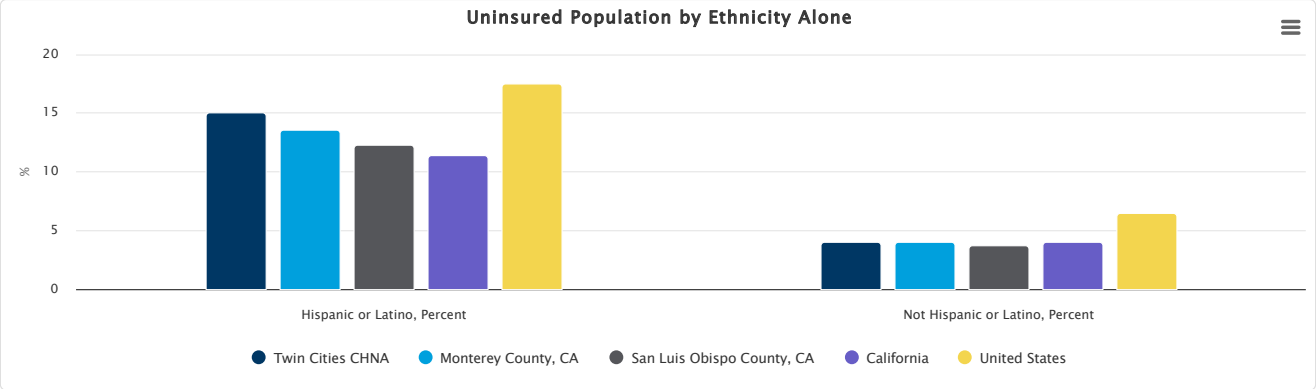


Uninsured Population by Ethnicity Alone

This indicator reports the uninsured population by ethnicity alone.
The percentage values could be interpreted as, for example, *"Of all the Hispanic population within the report area, the proportion without health insurance coverage is (value)."*

Report Area	Hispanic or Latino	Not Hispanic or Latino	Hispanic or Latino, Percent	Not Hispanic or Latino, Percent
Twin Cities CHNA	4,005	2,855	15.07%	3.98%
Monterey County, CA	35,505	6,333	13.59%	3.97%
San Luis Obispo County, CA	8,276	7,774	12.23%	3.72%
California	1,760,029	922,703	11.37%	3.96%
United States	10,900,185	17,100,691	17.47%	6.45%

Data Source: US Census Bureau, American Community Survey. 2019-23.

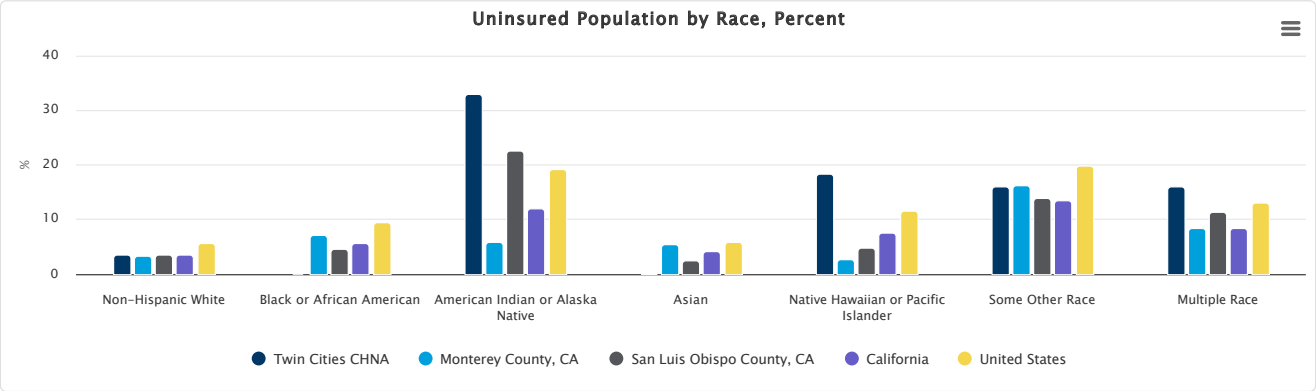


Uninsured Population by Race, Percent

This indicator reports the percentage of uninsured population by race alone.
The percentage values could be interpreted as, for example, *"Of all the non-Hispanic white population within the report area, the proportion without health insurance coverage is (value)."*

Report Area	Non-Hispanic White	Black or African American	American Indian or Alaska Native	Asian	Native Hawaiian or Pacific Islander	Some Other Race	Multiple Race
Twin Cities CHNA	3.48%	0.00%	32.97%	0.14%	18.29%	15.99%	16.04%
Monterey County, CA	3.37%	7.17%	5.90%	5.39%	2.74%	16.26%	8.44%
San Luis Obispo County, CA	3.54%	4.46%	22.61%	2.35%	4.85%	13.96%	11.24%
California	3.52%	5.65%	11.90%	4.06%	7.56%	13.37%	8.27%
United States	5.71%	9.46%	19.22%	5.89%	11.59%	19.70%	12.98%

Data Source: US Census Bureau, American Community Survey. 2019-23.

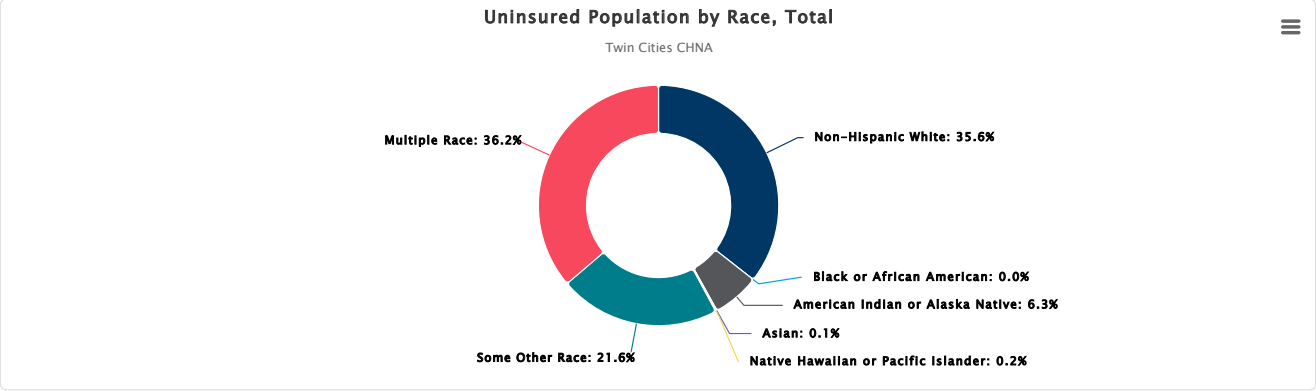


Uninsured Population by Race, Total

This indicator reports the total uninsured population by race alone.

Report Area	Non-Hispanic White	Black or African American	American Indian or Alaska Native	Asian	Native Hawaiian or Pacific Islander	Some Other Race	Multiple Race
Twin Cities CHNA	2,202	0	393	4	10	1,338	2,244
Monterey County, CA	3,820	521	195	1,321	58	28,387	4,847
San Luis Obispo County, CA	6,439	95	582	243	23	2,590	4,617
California	471,187	118,238	52,186	242,128	10,982	903,127	524,941
United States	10,876,176	3,775,959	549,575	1,134,010	71,131	4,280,782	4,567,337

Data Source: US Census Bureau, American Community Survey. 2019-23.

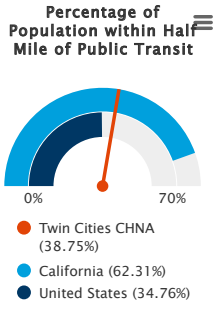


Barriers - Transportation - Distance to Public Transit

This indicator measures the proportion of the population living within 0.5 miles of a GTFS or fixed-guideway transit stop. Transit data is available from over 200 transit agencies across the United States, as well as all existing fixed-guideway transit service in the U.S. This includes rail, streetcars, ferries, trolleys, and some bus rapid transit systems.

Report Area	Total Population	Population Within 0.5 Miles of Public Transit	Percentage of Population within Half Mile of Public Transit
Twin Cities CHNA	41,610	16,125	**38.75%**
Monterey County, CA	433,212	302,737	69.88%
San Luis Obispo County, CA	281,455	137,139	48.73%
California	39,148,760	24,391,714	62.31%
United States	322,903,030	112,239,342	34.76%

Note: This indicator is compared to the state average.
Data Source: Environmental Protection Agency, EPA - Smart Location Database. 2021.



Distance to Nearest Transit Stop, (Meters) by Block Group, EPA SLD 2021

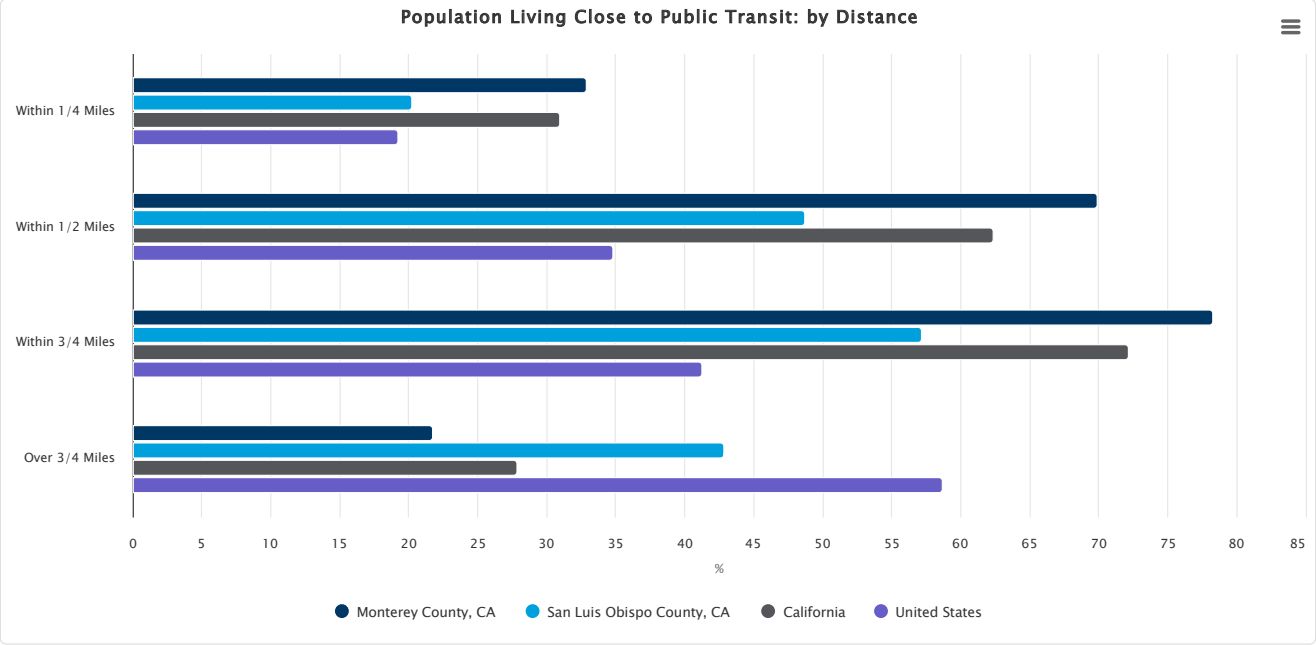
- 800 - 1200 Meters (0.5 - 0.75 Miles)
- 400 - 800 Meters (0.25 - 0.5 Miles)
- 200 - 400 Meters (0.125 - 0.25 Miles)
- Closer than 200 Meters (< 0.125 Miles)
- Further than 1200 Meters (> 0.75 Miles)
- Twin Cities CHNA

Population Living Close to Public Transit: by Distance

This indicator reports the percentages of population living within 1/4, 1/2, 3/4, and over 3/4 miles from the nearest transit stop.

Report Area	Within 1/4 Miles	Within 1/2 Miles	Within 3/4 Miles	Over 3/4 Miles
Monterey County, CA	32.86%	69.88%	78.27%	21.73%
San Luis Obispo County, CA	20.2%	48.73%	57.14%	42.86%
California	30.95%	62.31%	72.11%	27.83%
United States	19.25%	34.76%	41.26%	58.64%

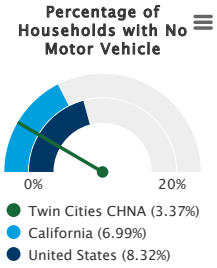
Data Source: Environmental Protection Agency, EPA - Smart Location Database. 2021.



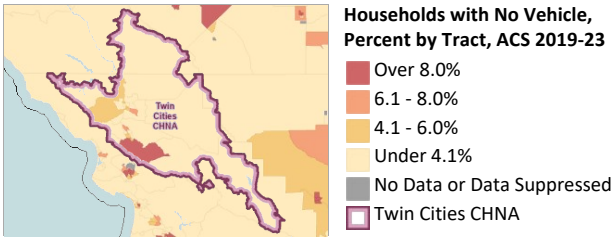
Barriers - Transportation - Households with No Vehicle

This indicator reports the number and percentage of households with no motor vehicle based on the latest 5-year American Community Survey estimates. Of the 37,907 total households in the report area, 1,278 or 3.37% are without a motor vehicle.

Report Area	Total Occupied Households	Households with No Motor Vehicle	Households with No Motor Vehicle, Percent
Twin Cities CHNA	37,907	1,278	3.37%
Monterey County, CA	132,046	6,041	4.57%
San Luis Obispo County, CA	108,897	4,366	4.01%
California	13,434,847	939,021	6.99%
United States	127,482,865	10,602,826	8.32%



Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2019-23.

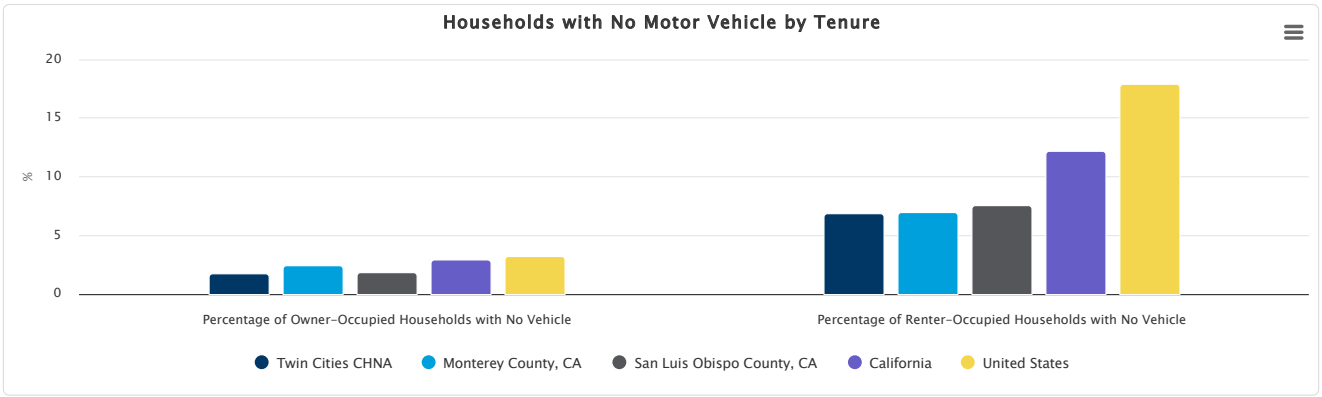


Households with No Motor Vehicle by Tenure

This indicator reports the total and percentage of households with no vehicle by tenure.
These numbers in the following table could be interpreted as (take the first two columns as an example), *"Within the report area, there are a total of (value) owner-occupied households with no vehicle. This accounts for (value) of all the owner-occupied households."*

Report Area	Owner-Occupied Households	Owner-Occupied Households, Percent	Renter-Occupied Households	Renter-Occupied Households, Percent
Twin Cities CHNA	444	1.72%	834	6.86%
Monterey County, CA	1,690	2.45%	4,351	6.90%
San Luis Obispo County, CA	1,245	1.85%	3,121	7.52%
California	216,828	2.89%	722,193	12.16%
United States	2,636,344	3.18%	7,966,482	17.87%

Data Source: US Census Bureau, American Community Survey. 2019-23.

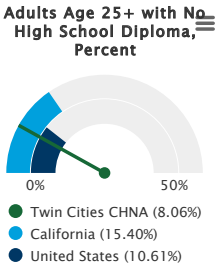


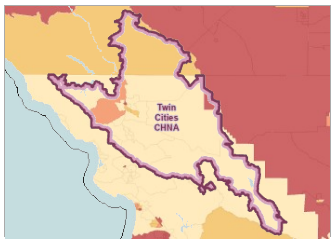
Barriers - Health Literacy - Educational Attainment

Within the report area there are 5,615 persons aged 25 and older without a high school diploma (or equivalency) or higher. This represents 8.06% of the total population aged 25 and older. This indicator is relevant because educational attainment is linked to positive health outcomes (Freudenberg & Ruglis, 2007).

Report Area	Total Population Age 25+	Adults Age 25+ with No High School Diploma	Adults Age 25+ with No High School Diploma, Percent
Twin Cities CHNA	69,630	5,615	8.06%
Monterey County, CA	279,274	74,469	26.67%
San Luis Obispo County, CA	190,233	15,656	8.23%
California	26,941,198	4,149,146	15.40%
United States	228,434,661	24,230,217	10.61%

Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2019-23.





Population with No High School Diploma (Age 25+), Percent by Tract, ACS 2019-23

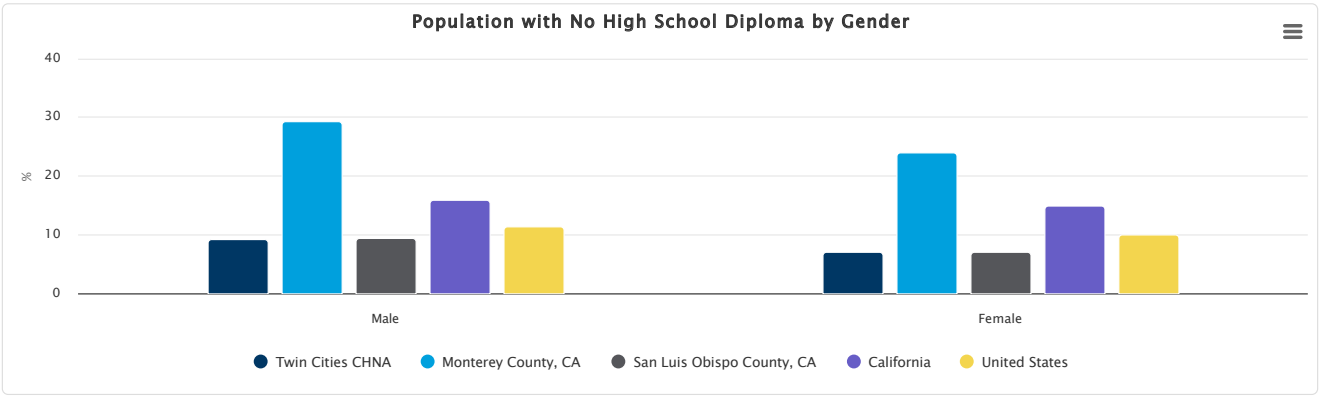
- Over 21.0%
- 16.1 - 21.0%
- 11.1 - 16.0%
- Under 11.1%
- No Data or Data Suppressed
- Twin Cities CHNA

Population with No High School Diploma by Gender

This indicator reports the population age 25+ with no high school diploma by gender.
The percentage values could be interpreted as, of all the males age 25+ within the report area, the percentage without a high school diploma is 9.26%; of all the females age 25+ within the report area, the percentage without a high school diploma is 6.91%.

Report Area	Male	Female	Male, Percent	Female, Percent
Twin Cities CHNA	3,163	2,451	9.26%	6.91%
Monterey County, CA	41,591	32,878	29.35%	23.90%
San Luis Obispo County, CA	8,925	6,731	9.44%	7.03%
California	2,111,415	2,037,731	15.87%	14.94%
United States	12,672,705	11,557,512	11.38%	9.87%

Data Source: US Census Bureau, American Community Survey. 2019-23.

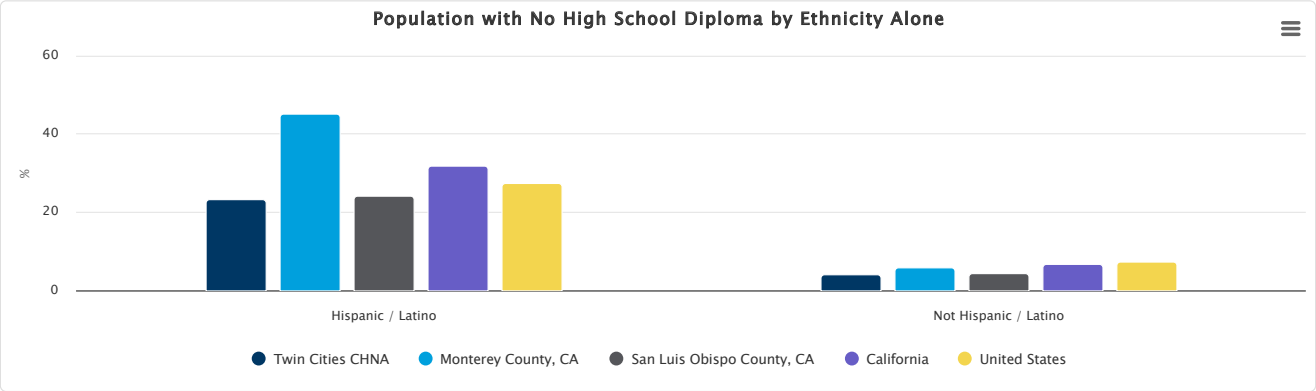


Population with No High School Diploma by Ethnicity Alone

This indicator reports the population age 25+ with no high school diploma by ethnicity alone.
The percentage values could be interpreted as, of all the Hispanic population age 25+ within the report area, the percentage without a high school diploma is 23.15%; of all the non-Hispanic population age 25+ within the report area, the percentage without a high school diploma is 4.01%.

Report Area	Hispanic or Latino	Not Hispanic or Latino	Hispanic or Latino, Percent	Not Hispanic or Latino, Percent
Twin Cities CHNA	3,418	2,198	23.15%	4.01%
Monterey County, CA	66,924	7,545	45.19%	5.75%
San Luis Obispo County, CA	9,261	6,395	24.06%	4.21%
California	2,963,752	1,185,394	31.69%	6.74%
United States	10,132,918	14,097,299	27.46%	7.36%

Data Source: US Census Bureau, American Community Survey. 2019-23.

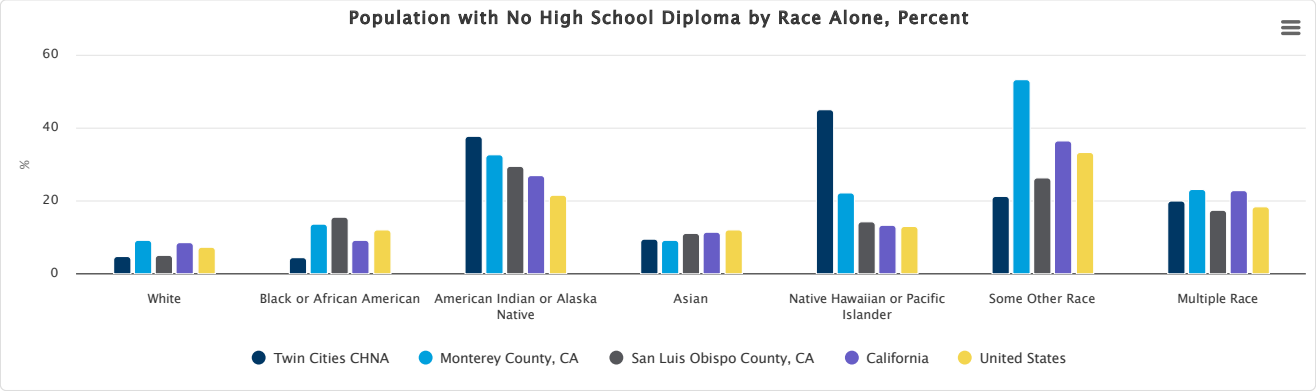


Population with No High School Diploma by Race Alone, Percent

This indicator reports the percentage of population age 25+ with no high school diploma by race alone in the report area. The percentage values could be interpreted as, for example, *"Of all the white population age 25+ in the report area, the percentage with no high school diploma is (value)."*

Report Area	White	Black or African American	American Indian or Alaska Native	Asian	Native Hawaiian or Pacific Islander	Some Other Race	Multiple Race
Twin Cities CHNA	4.63%	4.35%	37.54%	9.32%	44.97%	21.21%	19.93%
Monterey County, CA	8.90%	13.48%	32.42%	8.89%	22.08%	53.15%	22.86%
San Luis Obispo County, CA	4.88%	15.54%	29.39%	10.97%	14.14%	26.33%	17.32%
California	8.28%	9.18%	26.94%	11.14%	13.33%	36.28%	22.77%
United States	7.12%	11.94%	21.51%	11.97%	12.73%	33.21%	18.36%

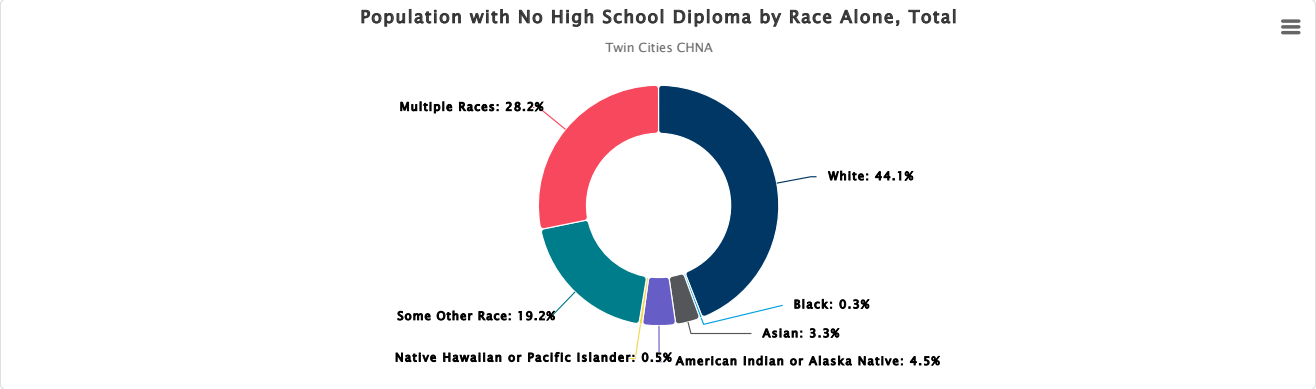
Data Source: US Census Bureau, American Community Survey. 2019-23.



Population with No High School Diploma by Race Alone, Total

Report Area	White	Black	Asian	American Indian or Alaska Native	Native Hawaiian or Pacific Islander	Some Other Race	Multiple Races
Twin Cities CHNA	2,473	19	186	250	26	1,076	1,582
Monterey County, CA	10,296	965	1,712	813	340	52,459	7,884
San Luis Obispo County, CA	7,089	389	697	500	54	3,014	3,913
California	1,050,186	139,805	495,148	79,473	13,685	1,538,790	832,059
United States	10,836,488	3,217,325	1,664,267	393,606	51,272	4,453,551	3,613,708

Data Source: US Census Bureau, American Community Survey. 2019-23.

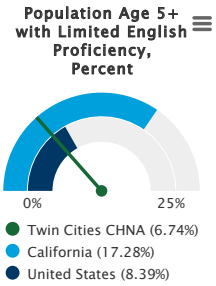


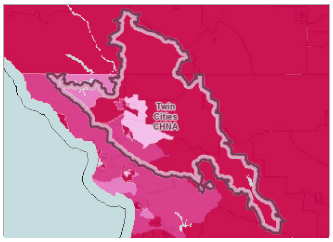
Barriers - Health Literacy - Limited English Proficiency

This indicator reports the percentage of the population aged 5 and older who speak a language other than English at home and speak English less than "very well". This indicator is relevant because an inability to speak English well creates barriers to healthcare access, provider communications, and health literacy/education. Of the 94,173 total population aged 5 and older in the report area, 6,345 or 6.74% have limited English proficiency.

Report Area	Population Age 5+	Population Age 5+ with Limited English Proficiency	Population Age 5+ with Limited English Proficiency, Percent
Twin Cities CHNA	94,173	6,345	6.74%
Monterey County, CA	406,954	100,871	24.79%
San Luis Obispo County, CA	269,109	15,590	5.79%
California	37,028,644	6,400,397	17.28%
United States	313,447,641	26,299,012	8.39%

Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2019-23.





Population with Limited English Proficiency, Percent by Tract, ACS 2019-23

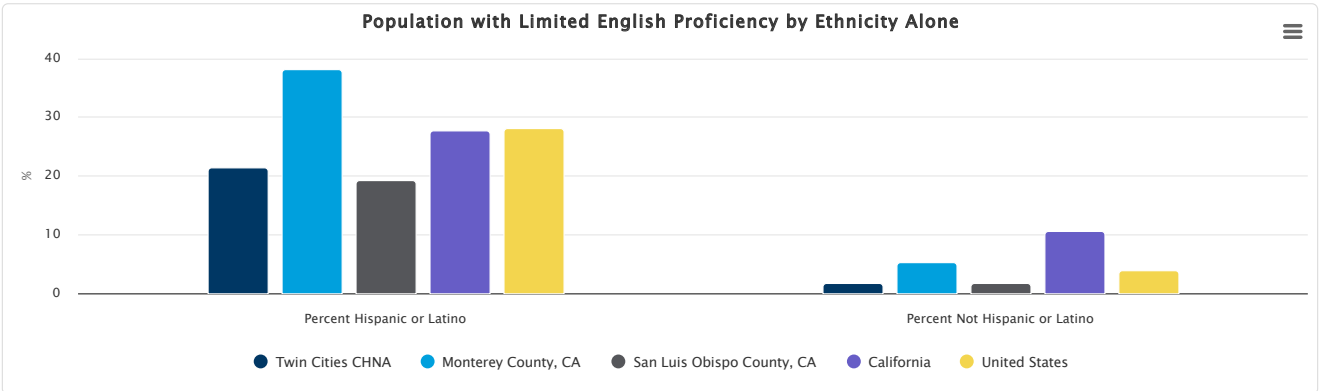
- Over 4.0%
- 2.1 - 4.0%
- 1.1 - 2.0%
- Under 1.1%
- No Data or Data Suppressed
- Twin Cities CHNA

Population with Limited English Proficiency by Ethnicity Alone

This indicator reports the total and percentage of population aged 5 and older who speak a language other than English at home and speak English less than "very well" by ethnicity alone in the report area. The percentage values could be interpreted as, for example, *"Among the Hispanic population in the report area, the percentage of the population with limited English proficiency is (value)."*

Report Area	Total Hispanic or Latino	Total Not Hispanic or Latino	Percent Hispanic or Latino	Percent Not Hispanic or Latino
Twin Cities CHNA	5,249	1,096	21.33%	1.58%
Monterey County, CA	92,413	8,458	38.04%	5.16%
San Luis Obispo County, CA	12,251	3,339	19.22%	1.63%
California	4,008,878	2,391,519	27.61%	10.62%
United States	16,290,980	10,008,032	28.02%	3.92%

Data Source: US Census Bureau, American Community Survey. 2019-23.

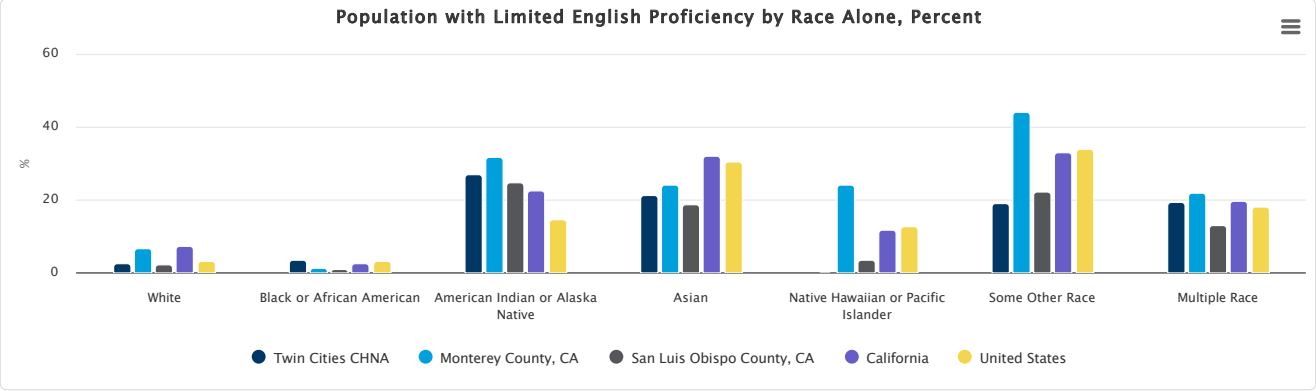


Population with Limited English Proficiency by Race Alone, Percent

This indicator reports the percentage of the population aged 5 and older who speak a language other than English at home and speak English less than "very well" by race alone in the report area.
The percentage values could be interpreted as, for example, *"Of all the white population in the report area, the percentage of population with limited English proficiency is (value)."*

Report Area	White	Black or African American	American Indian or Alaska Native	Asian	Native Hawaiian or Pacific Islander	Some Other Race	Multiple Race
Twin Cities CHNA	2.27%	3.29%	26.88%	21.09%	0.00%	18.97%	19.15%
Monterey County, CA	6.46%	1.17%	31.49%	24.12%	24.10%	44.10%	21.88%
San Luis Obispo County, CA	2.13%	0.66%	24.67%	18.54%	3.36%	22.06%	12.95%
California	7.13%	2.23%	22.24%	32.04%	11.45%	32.77%	19.53%
United States	3.13%	3.11%	14.39%	30.47%	12.50%	33.93%	18.06%

Data Source: US Census Bureau, American Community Survey. 2019-23.

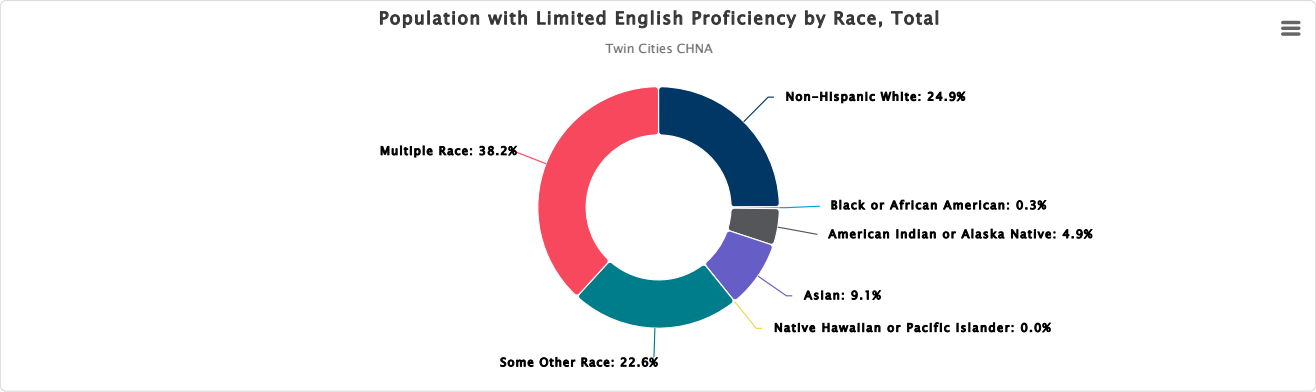


Population with Limited English Proficiency by Race, Total

This indicator reports the total population aged 5 and older who speak a language other than English at home and speak English less than "very well" by race alone in the report area.

Report Area	Non-Hispanic White	Black or African American	American Indian or Alaska Native	Asian	Native Hawaiian or Pacific Islander	Some Other Race	Multiple Race
Twin Cities CHNA	1,579	17	311	578	0	1,434	2,423
Monterey County, CA	9,768	108	1,084	5,842	534	71,746	11,789
San Luis Obispo County, CA	4,187	21	604	1,921	14	3,808	5,035
California	1,171,612	46,021	93,958	1,831,952	16,068	2,097,665	1,143,121
United States	6,268,072	1,198,675	395,358	5,604,715	73,488	6,939,133	5,819,571

Data Source: US Census Bureau, American Community Survey. 2019-23.

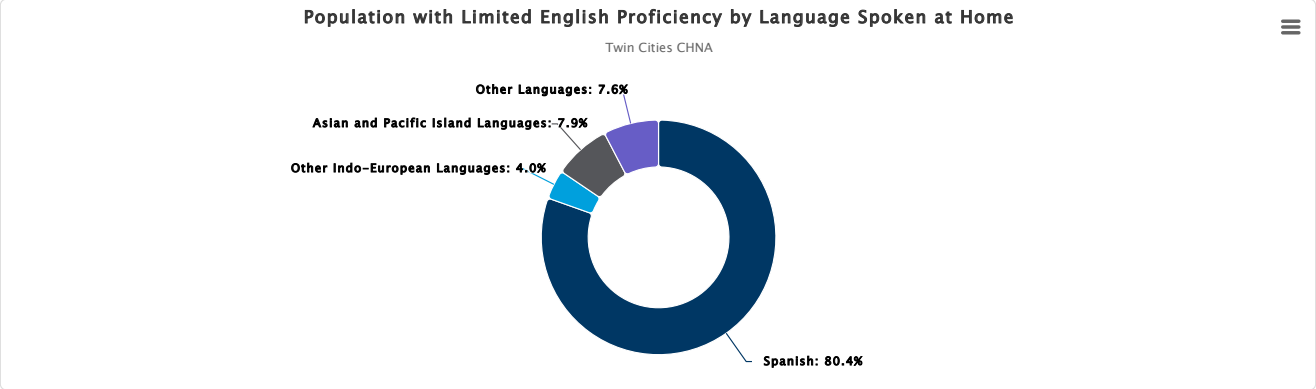


Population with Limited English Proficiency by Language Spoken at Home

This indicator reports the total population aged 5 and older who speak a language other than English at home and speak English less than "very well" by language spoken at home in the report area.

Report Area	Spanish	Other Indo-European Languages	Asian and Pacific Island Languages	Other Languages
Twin Cities CHNA	5,104	256	500	485
Monterey County, CA	92,597	1,947	5,439	888
San Luis Obispo County, CA	12,421	783	1,740	646
California	4,043,207	518,139	1,705,745	133,306
United States	16,642,933	3,637,966	4,890,240	1,127,873

Data Source: US Census Bureau, American Community Survey. 2019-23.

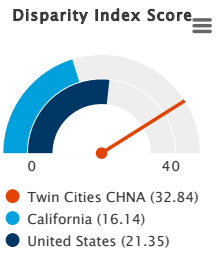


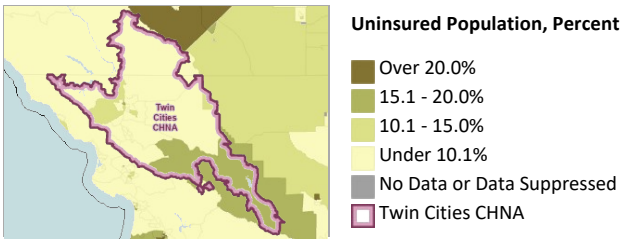
Barriers - Medical Insurance - Health Insurance Disparities

This indicator reports the percentage of the report area population that is uninsured by population race and ethnicity. The disparity index score is a relative measure which expresses the magnitude of disparity across population groups, with a score of 0 representing perfect equality, and a score of 100 representing perfect disparity.

Report Area	Non-Hispanic White	Hispanic or Latino	Non-Hispanic Black	Non-Hispanic Other Race	Disparity Index Score
Twin Cities CHNA	3.48%	15.07%	No data	15.13%	**32.84**
Monterey County, CA	3.37%	13.59%	7.17%	13.29%	12.94
San Luis Obispo County, CA	3.54%	12.23%	4.46%	11.03%	28.11
California	3.52%	11.37%	5.65%	8.82%	16.14
United States	5.71%	17.47%	9.47%	13.32%	21.35

Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2019-23.



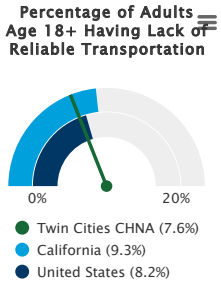


Barriers - Transportation - Lack of Reliable Transportation

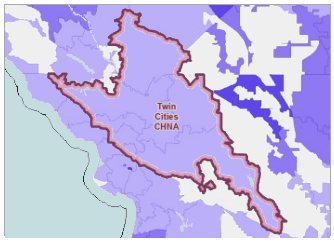
This indicator reports the percentage of adults age 18 and older who report having a lack of reliable transportation in the past 12 months.

Within the report area, there were 7.6% of adults 18 and older who rreport having a lack of reliable transportation in the past 12 months of the total population age 18 and older.

Report Area	Total Population	Adults Age 18+ Having Lack of Reliable Transportation (Crude)	Adults Age 18+ Having Lack of Reliable Transportation (Age-Adjusted)
Twin Cities CHNA	99,679	7.6%	No data
Monterey County, CA	432,858	11.2%	11.4%
San Luis Obispo County, CA	282,013	7.9%	8.3%
California	39,029,342	9.3%	9.5%
United States	333,287,557	8.2%	8.7%



Note: This indicator is compared to the state average.
Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal. 2022.



Lack of Reliable Transportation, Prevalence Among Adults Age 18+ by ZCTA, CDC BRFSS PLACES Project 2022

- Over 29.1%
- 22.1% - 29.0%
- 15.1% - 22.0%
- Under 15.1%
- No Data or Data Suppressed
- Twin Cities CHNA

Housing

Housing refers to the availability, affordability, quality and stability of living environments, which directly influences health outcomes. Housing has become an increasingly significant challenge, particularly as housing costs continue to outpace wage growth. A high housing costs and limited housing supply can significantly hinder the ability to recruit and retain care providers. According to the U.S. Census Bureau, nearly half (49.7%) of renter households are considered cost-burdened, spending more than 30% of their income on housing, which leaves limited funds for other essentials such as healthy food, healthcare and savings. Available and affordable housing is an important need for healthcare providers to create place attachment and thrive alongside the entire community.

The American Public Health Association (APHA) reports that housing instability is linked to higher rates of chronic health conditions such as asthma and hypertension, as well as increased mental health issues like anxiety and depression. When families struggle to afford their homes, they face a higher risk of displacement, poor housing conditions or homelessness and increased stress which affects community life. Stable housing can enable healthcare professionals to establish long-term roots in their community and result in better health outcomes by lowering the risk of related health issues.

In the Adventist Health Twin Cities service area, a family earning the Area Median Income (AMI) spends 50.89% of their income on housing and transportation alone, as modeled by the U.S. Department of Housing and Urban Development (HUD). Focus group participants noted that "one of [the] greatest issues [is] finding affordable housing or housing in general," which has led to "a lot of people [moving] out of the community or have struggled to move into the community because the price of living." When asked about what makes it hard to live and be well, a community survey showed 24.4% of respondents selected a high cost of living and 19.7% selected a lack of affordable housing as their top concerns.

Available, affordable and stable housing that meets our community's needs can improve health outcomes and reduce disparities. For additional data points, see the following pages.

Scan QR Code to explore the full live data report on Housing or visit: cares.page.link/XbBD

Data Highlights

Community Voices: *exploring local perceptions, thoughts & beliefs*

"We do live in an expensive area for housing relative to income."

"It's a problem for the community because many of the clients that I deal with, that is one of their greatest issues...finding affordable housing or housing in general."

"Single parents are affected a lot by it because...in order to get a two-bedroom unit...it's anywhere from $2,000-$2,7000 for a two-bedroom unit. Sometimes even approaching that $3,000 mark."

"The big, big barrier [that we] have is affordable living."

"...low-income housing. I know one of the wait lists I saw was two years to be even given a chance to live there, [and then] you're not guaranteed that space. You have to wait two years to get the chance to see."

"I wanted to say is some of our unhoused clients have pets and so they don't want to leave their pet alone."

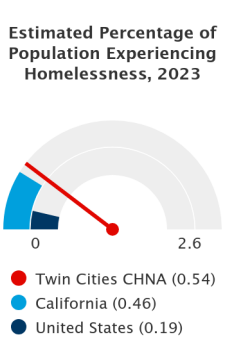
"...the last number I heard was over 3,000 unduplicated counted people that are unhoused, that's not counting those that have never been entered into the system."

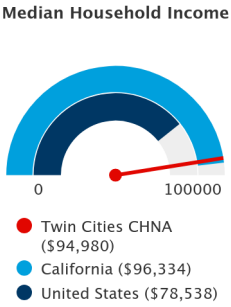
"...when I was in Bakersfield, I could buy a big home and now here I have to rent a small box."

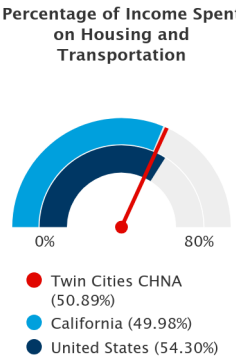
"...for our population, we have...those experiencing homelessness as a cohort of patients...these are your ER patients, you know that are the high utilizers coming in and out and in and out."

"It's the behavioral health and substance use in addition to the homelessness."

"But it's [housing] still really expensive, especially if someone's moving from another state...they love the organization and then they go on a tour to figure out what they can afford and where they can live and the spouse pulls the plug."







Community Resources

County of San Luis Obispo Social Services
slocounty.ca.gov/departments/social-services/homeless-services-division
805-781-1600

County of San Luis Obispo Housing Hub
slocounty.ca.gov/departments/planning-building/department-services/housing-hub/housing-hub#gsc.tab=0
805-781-5600

40 Prado
capslo.org/40-prado

ECHO Shelter
echoshelter.org

HASLO
haslo.org

People's Self-Help Housing
pshhc.org

TMHA Housing
t-mha.org/housing.php

Community Health Needs Assessment Full Report

Location

Twin Cities CHNA

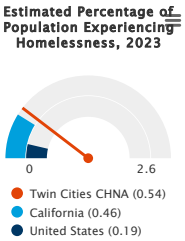
Basic Needs: Housing

Homelessness - Population Experiencing Homelessness

This indicator reports the estimated number of individuals experiencing homelessness as estimated from the Point-in-Time (PIT) count in January, 2023. Data are obtained from HUD's Annual Homeless Assessment Report (AHAR).

In January, 2023, there were an estimated 540 persons experiencing homelessness in CoCs in Twin Cities CHNA. This represents 0.54 per 100 total population.

Report Area	Total Population 2020	Population Experiencing Homelessness, 2023	Population Experiencing Homelessness, Rate per 100 Pop.
Twin Cities CHNA	99,633	540	**0.54**
Monterey County, CA	503,174	2,212	0.44
San Luis Obispo County, CA	282,420	1,532	0.54
California	39,538,223	181,399	0.46
United States	334,735,155	651,777	0.19



Note: This indicator is compared to the state average.
Data Source: U.S. Department of Housing and Urban Development, HUD Annual Homeless Assessment Report (AHAR). 2023.

Population Change 2020-2023: Total Population Experiencing Homelessness

This indicator reports the estimates of people experiencing homelessness in 2020 and 2023. Total and percentage change are also shown.

Report Area	Total Experiencing Homelessness 2020	Total Experiencing Homelessness 2023	Difference	% Difference
Twin Cities CHNA	1,016	1,080	64	6.3%
Monterey County, CA	2,683	2,212	-471	-17.6%
San Luis Obispo County, CA	1,423	1,532	109	7.7%
California	161,548	181,399	19,851	12.3%
United States	1,160,932	1,306,208	145,276	12.5%

Data Source: U.S. Department of Housing and Urban Development, HUD Annual Homeless Assessment Report (AHAR). 2023.

Population Change 2020-2023: Chronic Homelessness

This indicator reports the estimates of individuals experiencing chronic homelessness in 2020 and 2023. Total and percentage change are also shown.

Report Area	Total Experiencing Chronic Homelessness 2020	Total Experiencing Chronic Homelessness 2023	Difference	% Difference
Twin Cities CHNA	236	231	-5	-2.0%
Monterey County, CA	603	615	12	2.0%
San Luis Obispo County, CA	331	328	-3	-0.9%
California	51,785	71,150	19,365	37.4%
United States	240,646	308,626	67,980	28.2%

Data Source: U.S. Department of Housing and Urban Development, HUD Annual Homeless Assessment Report (AHAR). 2023.

Population Change 2020-2023: Individuals (Living Alone) Experiencing Homelessness

This indicator reports the estimates of individuals experiencing homelessness in 2020 and 2023. Total and percentage change are also shown.

Report Area	Individuals Experiencing Homelessness 2020	Individuals Experiencing Homelessness 2023	Difference	% Difference
Twin Cities CHNA	884	781	-103	-11.7%
Monterey County, CA	2,012	2,016	4	0.2%
San Luis Obispo County, CA	1,240	1,107	-133	-10.7%
California	135,771	155,916	20,145	14.8%
United States	817,782	934,040	116,258	14.2%

Data Source: U.S. Department of Housing and Urban Development, HUD Annual Homeless Assessment Report (AHAR). 2023.

Population Change 2020-2023: Population in Families Experiencing Homelessness

This indicator reports the estimates of people in families with children experiencing homelessness in 2020 and 2023. Total and percentage change are also shown.

Report Area	People in Families Experiencing Homelessness 2020	People in Families Experiencing Homelessness 2023	Difference	% Difference
Twin Cities CHNA	131	299	167	127.6%
Monterey County, CA	671	196	-475	-70.8%
San Luis Obispo County, CA	183	425	242	132.2%
California	25,777	25,483	-294	-1.1%
United States	343,150	372,168	29,018	8.5%

Data Source: U.S. Department of Housing and Urban Development, HUD Annual Homeless Assessment Report (AHAR). 2023.

Population Change 2020-2023: Veterans Experiencing Homelessness

This indicator reports the estimates of veterans experiencing homelessness in 2020 and 2023. Total and percentage change are also shown.

Report Area	Veterans Experiencing Homelessness 2020	Veterans Experiencing Homelessness 2023	Difference	% Difference
Twin Cities CHNA	103	15	-88	-85.5%
Monterey County, CA	199	143	-56	-28.1%
San Luis Obispo County, CA	145	21	-124	-85.5%
California	11,401	10,589	-812	-7.1%
United States	74,504	71,148	-3,356	-4.5%

Data Source: U.S. Department of Housing and Urban Development, HUD Annual Homeless Assessment Report (AHAR). 2023.

Population Change 2020-2023: Unsheltered Homeless

This indicator reports the estimates of unsheltered people in 2020 and 2023. Total and percentage change are also shown.

Report Area	Total Unsheltered Persons 2020	Total Unsheltered Persons 2023	Difference	% Difference
Twin Cities CHNA	836	815	-21	-2.6%
Monterey County, CA	1,998	1,625	-373	-18.7%
San Luis Obispo County, CA	1,172	1,156	-16	-1.4%
California	113,660	123,423	9,763	8.6%
United States	452,160	513,220	61,060	13.5%

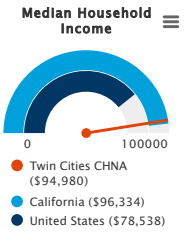
Data Source: U.S. Department of Housing and Urban Development, HUD Annual Homeless Assessment Report (AHAR). 2023.

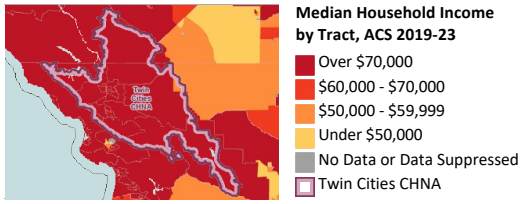
Housing Costs - Median Household Income

This indicator reports median household income based on the latest 5-year American Community Survey estimates. This includes the income of the householder and all other individuals 15 years old and over in the household, whether they are related to the householder or not. Because many households consist of only one person, average household income is usually less than average family income. There are 37,906 households in the report area, with an average income of $135,374 and a median income of $94,980.

Report Area	Total Households	Average Household Income	Median Household Income
Twin Cities CHNA	37,906	$135,374	**$94,980**
Monterey County, CA	132,046	$128,334.16	$94,486
San Luis Obispo County, CA	108,897	$126,121.55	$93,398
California	13,434,847	$136,729.66	$96,334
United States	127,482,865	$110,490.58	$78,538

Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2019-23.



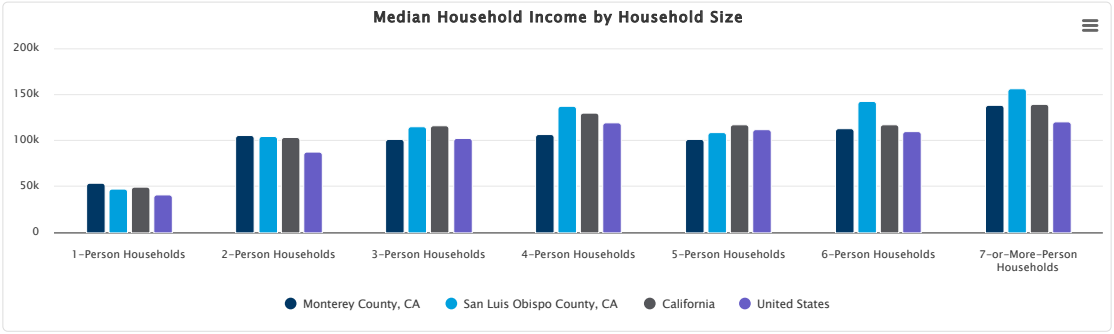


Median Household Income by Household Size

This indicator reports the median household income of the report area by household size.

Report Area	1-Person Households	2-Person Households	3-Person Households	4-Person Households	5-Person Households	6-Person Households	7-or-More-Person Households
Monterey County, CA	$53,400	$104,987	$101,318	$106,438	$100,963	$112,523	$137,696
San Luis Obispo County, CA	$46,914	$103,761	$114,516	$136,862	$108,548	$142,298	$156,436
California	$49,595	$102,789	$115,509	$129,753	$117,386	$116,568	$138,755
United States	$40,456	$86,971	$102,372	$118,913	$111,952	$109,893	$120,082

Data Source: US Census Bureau, American Community Survey. 2019-23.

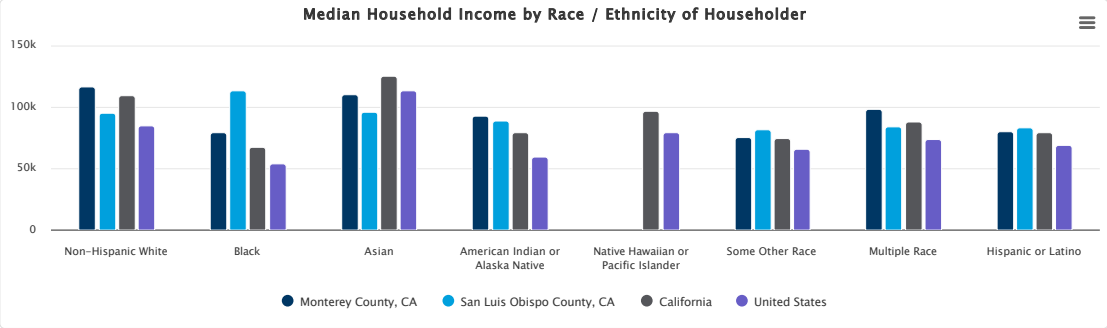


Median Household Income by Race / Ethnicity of Householder

This indicator reports the median household income of the report area by race / ethnicity of householder.

Report Area	Non-Hispanic White	Black	Asian	American Indian or Alaska Native	Native Hawaiian or Pacific Islander	Some Other Race	Multiple Race	Hispanic or Latino
Monterey County, CA	$116,317	$78,750	$109,731	$92,361	No data	$74,717	$98,204	$79,579
San Luis Obispo County, CA	$95,232	$113,125	$95,366	$88,850	No data	$81,097	$83,368	$82,575
California	$109,049	$67,365	$125,149	$78,909	$96,758	$74,377	$87,968	$78,763
United States	$84,745	$53,444	$113,106	$59,393	$78,640	$65,558	$73,412	$68,890

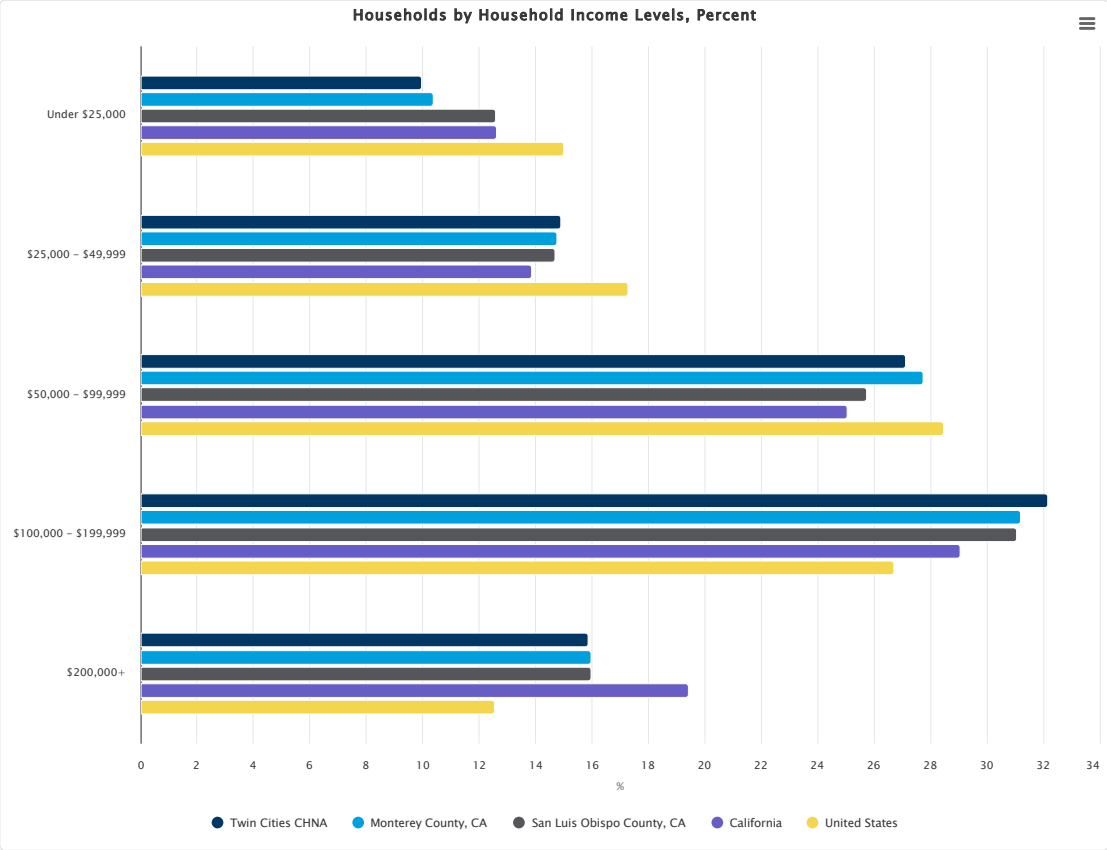
Data Source: US Census Bureau, American Community Survey. 2019-23.



Households by Household Income Levels, Percent

Report Area	Under $25,000	$25,000 - $49,999	$50,000 - $99,999	$100,000 - $199,999	$200,000+
Twin Cities CHNA	9.97%	14.91%	27.10%	32.16%	15.87%
Monterey County, CA	10.38%	14.74%	27.72%	31.19%	15.97%
San Luis Obispo County, CA	12.58%	14.69%	25.73%	31.05%	15.96%
California	12.62%	13.87%	25.05%	29.03%	19.43%
United States	15.00%	17.28%	28.46%	26.70%	12.56%

Data Source: US Census Bureau, American Community Survey. 2019-23.

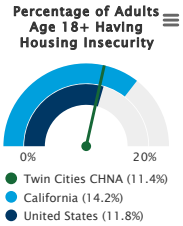


Homelessness - Housing Insecurity

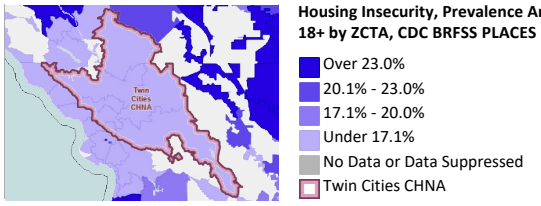
This indicator reports the percentage of adults age 18 and older who report having housing insecurity in the past 12 months.

Within the report area, there were 11.4% of adults 18 and older who report having housing insecurity in the past 12 months of the total population age 18 and older.

Report Area	Total Population	Adults Age 18+ Having Housing Insecurity (Crude)	Adults Age 18+ Having Housing Insecurity (Age-Adjusted)
Twin Cities CHNA	99,679	11.4%	No data
Monterey County, CA	432,858	17.1%	17.9%
San Luis Obispo County, CA	282,013	10.5%	12.4%
California	39,029,342	14.2%	14.8%
United States	333,287,557	11.8%	12.9%



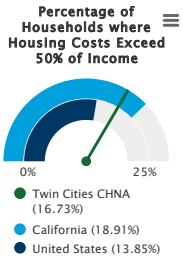
Note: This indicator is compared to the state average.
Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal. 2022.



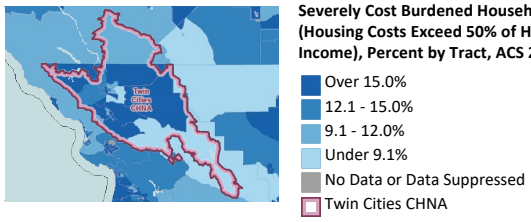
Housing Costs - Severe Housing Cost Burden (50%)

This indicator reports the percentage of the households where housing costs are 50% or more total household income. This indicator provides information on the cost of monthly housing expenses for owners and renters. The information offers 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.

Report Area	Total Households	Severely Burdened Households	Severely Burdened Households, Percent
Twin Cities CHNA	37,907	6,343	16.73%
Monterey County, CA	132,046	23,840	18.05%
San Luis Obispo County, CA	108,897	21,146	19.42%
California	13,434,847	2,541,076	18.91%
United States	127,482,865	17,661,218	13.85%



Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2019-23.



Severely Cost-Burdened Households by Tenure, Total

This data shows the number of households that spend more than 50% of the household income on housing costs. In the report area, there were 6,343 severely cost burdened households according to the U.S. Census Bureau American Community Survey (ACS) 2019-2023 5-year estimates. The data for this indicator is only reported for households where household housing costs and income earned was identified in the American Community Survey.

Report Area	Severely Burdened Households	Severely Burdened Rental Households	Severely Burdened Owner-Occupied Households w/ Mortgage	Severely Burdened Owner-Occupied Households w/o Mortgage
Twin Cities CHNA	6,343	2,752	2,859	840
Monterey County, CA	23,840	15,891	6,805	1,755
San Luis Obispo County, CA	21,146	11,977	7,272	2,273
California	2,541,076	1,594,285	821,496	201,494
United States	17,661,218	10,516,877	5,576,596	2,107,768

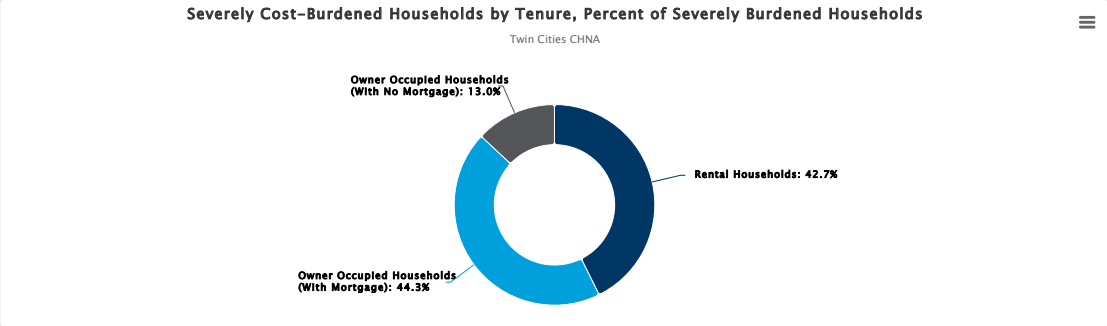
Data Source: US Census Bureau, American Community Survey. 2019-23.

Severely Cost-Burdened Households by Tenure, Percent of Severely Burdened Households

This data shows the percentage of severely cost burdened households that each tenure type represented. Rental households that spent more than 50% of the household income on rental costs represented 43.39% of all of the severely cost burdened households in the report area, according to the U.S. Census Bureau American Community Survey (ACS) 2019-2023 5-year estimates. The data for this indicator is only reported for households where tenure, household housing costs, and income earned was identified in the American Community Survey.

Report Area	Severely Burdened Households	Rental Households, Percent	Owner-Occupied Households w/ Mortgage, Percent	Owner-Occupied Households w/o Mortgage, Percent
Twin Cities CHNA	6,343	43.39%	45.07%	13.24%
Monterey County, CA	23,840	66.66%	28.54%	7.36%
San Luis Obispo County, CA	21,146	56.64%	34.39%	10.75%
California	2,541,076	62.74%	32.33%	7.93%
United States	17,661,218	59.55%	31.58%	11.93%

Data Source: US Census Bureau, American Community Survey. 2019-23.

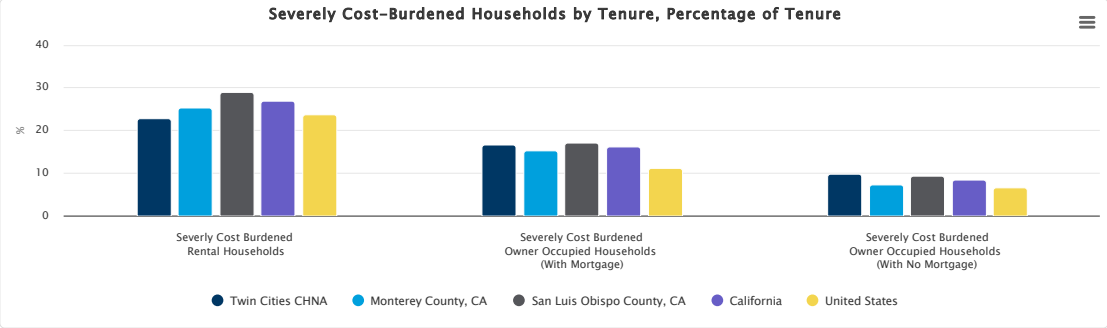


Severely Cost-Burdened Households by Tenure, Percentage of Tenure

This data shows the percentage of each tenure type that represented severely cost burdened households. Severely cost burdened rental households (those that spent more than 50% of the household income on rental costs) represented 22.64% of all of the rental households in the report area, according to the U.S. Census Bureau American Community Survey (ACS) 2019-2023 5-year estimates. The data for this indicator is only reported for households where tenure, household housing costs, and income earned was identified in the American Community Survey.

Report Area	Rental Households	Rental Households Severely Burdened, Percent	Owner-Occupied Households w/ Mortgage	Owner-Occupied Households w/ Mortgage Severely Burdened, Percent	Owner-Occupied Households w/o Mortgage	Owner-Occupied Households w/o Mortgage Severely Burdened, Percent
Twin Cities CHNA	12,157	22.64%	17,162	16.66%	8,588	9.78%
Monterey County, CA	63,013	25.22%	44,509	15.29%	24,524	7.16%
San Luis Obispo County, CA	41,494	28.86%	42,699	17.03%	24,704	9.20%
California	5,940,036	26.84%	5,095,484	16.12%	2,399,327	8.40%
United States	44,590,828	23.59%	50,718,449	11.00%	32,173,588	6.55%

Data Source: US Census Bureau, American Community Survey. 2019-23.



Housing Costs - Affordable Housing

This indicator reports the number and percentage of housing units affordable at various income levels. Affordability is defined by assuming that housing costs should not exceed 30% of total household income. Income levels are expressed as a percentage of each county's area median household income (AMI).

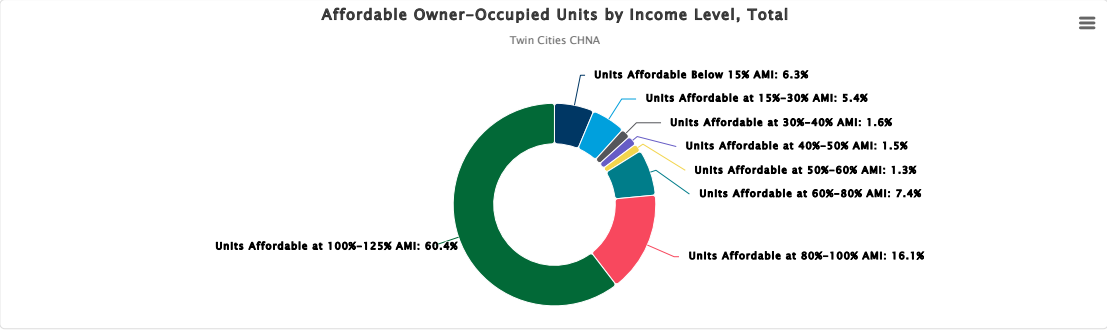
Report Area	Units Affordable at 15% AMI	Units Affordable at 30% AMI	Units Affordable at 40% AMI	Units Affordable at 50% AMI	Units Affordable at 60% AMI	Units Affordable at 80% AMI	Units Affordable at 100% AMI	Units Affordable at 125% AMI
Twin Cities CHNA	1.99%	4.12%	5.52%	7.88%	11.17%	20.73%	**38.29%**	50.57%
Monterey County, CA	1.74%	4.06%	6.30%	9.64%	13.67%	25.33%	52.91%	55.42%
San Luis Obispo County, CA	1.69%	3.86%	5.29%	8.23%	12.07%	22.13%	43.11%	45.77%
California	2.30%	5.07%	7.58%	11.35%	15.87%	27.35%	52.50%	56.50%
United States	3.72%	8.55%	13.51%	20.23%	27.66%	43.24%	58.33%	68.13%

Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2019-23.

Affordable Owner-Occupied Units by Income Level, Total

Report Area	Units Affordable Below 15% AMI	Units Affordable at 15%-30% AMI	Units Affordable at 30%-40% AMI	Units Affordable at 40%-50% AMI	Units Affordable at 50%-60% AMI	Units Affordable at 60%-80% AMI	Units Affordable at 80%-100% AMI	Units Affordable at 100%-125% AMI
Twin Cities CHNA	483.13	415.66	119.03	116.46	99.99	566.17	1,230.65	4,628.09
Monterey County, CA	1,439.98	1,109.52	666.45	666.53	665.61	1,647.87	2,658.45	3,323.17
San Luis Obispo County, CA	1,188.49	1,051.29	463.47	463.07	463.07	1,305.42	2,315.77	2,894.71
California	189,482.30	127,647.49	76,939.59	76,931.60	84,709.98	318,552.14	430,684.36	538,361.04
United States	3,672,061.44	3,687,305.27	3,452,143.81	3,879,584.44	3,946,921.16	8,855,616.96	8,957,253.34	8,465,449.03

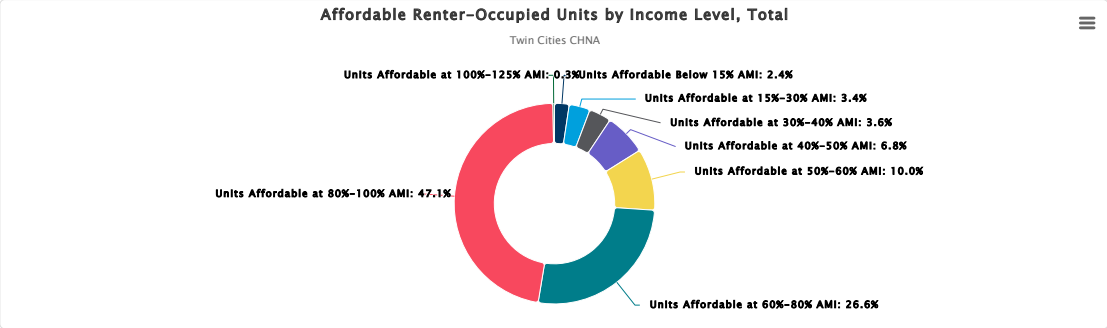
Data Source: US Census Bureau, American Community Survey. 2019-23.



Affordable Renter-Occupied Units by Income Level, Total

Report Area	Units Affordable Below 15% AMI	Units Affordable at 15%-30% AMI	Units Affordable at 30%-40% AMI	Units Affordable at 40%-50% AMI	Units Affordable at 50%-60% AMI	Units Affordable at 60%-80% AMI	Units Affordable at 80%-100% AMI	Units Affordable at 100%-125% AMI
Twin Cities CHNA	273.04	389.51	412.55	778.06	1,145.80	3,057.42	5,426.60	29.02
Monterey County, CA	853.79	1,963.97	2,289.39	3,734.73	4,655.06	13,752.96	33,758.10	0
San Luis Obispo County, CA	646.66	1,316.16	1,090.07	2,744.09	3,718.58	9,652.71	20,524.73	0
California	120,120.36	243,763.84	260,523.03	428,791.40	523,855.82	1,222,535.15	2,948,193.41	0
United States	1,100,771.25	2,504,587.06	2,907,484.71	4,739,835.94	5,582,353.44	11,106,926.08	10,344,775.33	3,982,905.30

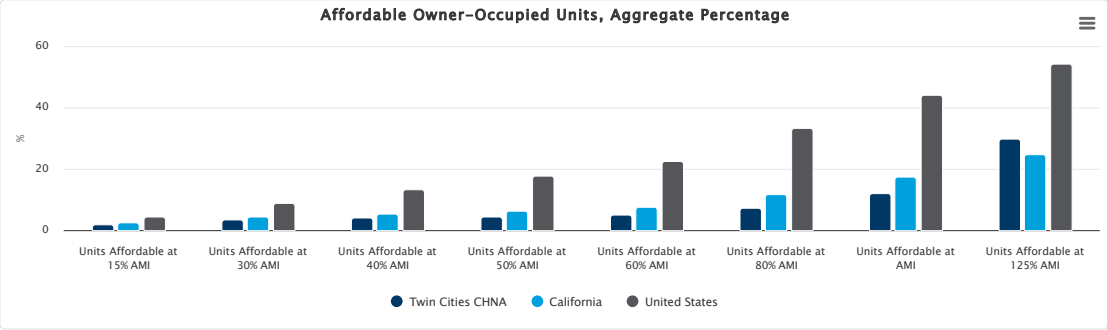
Data Source: US Census Bureau, American Community Survey. 2019-23.



Affordable Owner-Occupied Units, Aggregate Percentage

Report Area	Units Affordable at 15% AMI	Units Affordable at 30% AMI	Units Affordable at 40% AMI	Units Affordable at 50% AMI	Units Affordable at 60% AMI	Units Affordable at 80% AMI	Units Affordable at AMI	Units Affordable at 125% AMI
Twin Cities CHNA	1.88%	3.49%	3.95%	4.40%	4.79%	6.99%	11.77%	29.74%
California	2.53%	4.23%	5.26%	6.28%	7.41%	11.66%	17.41%	24.59%
United States	4.43%	8.88%	13.04%	17.72%	22.48%	33.17%	43.97%	54.19%

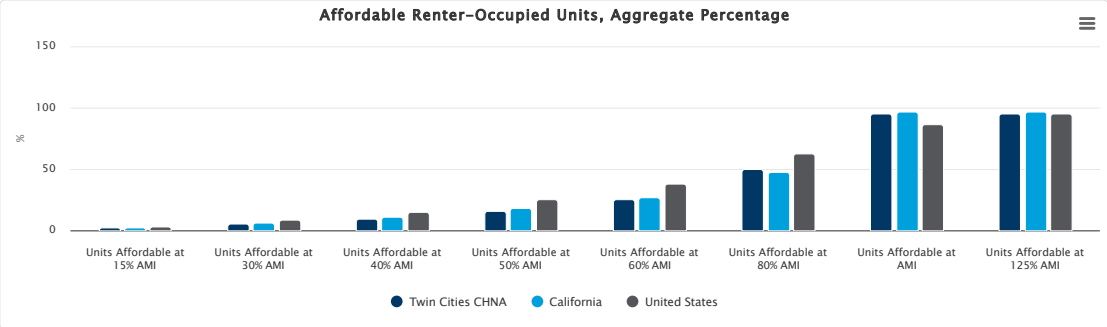
Data Source: US Census Bureau, American Community Survey. 2019-23.



Affordable Renter-Occupied Units, Aggregate Percentage

Report Area	Units Affordable at 15% AMI	Units Affordable at 30% AMI	Units Affordable at 40% AMI	Units Affordable at 50% AMI	Units Affordable at 60% AMI	Units Affordable at 80% AMI	Units Affordable at AMI	Units Affordable at 125% AMI
Twin Cities CHNA	2.25%	5.45%	8.84%	15.24%	24.67%	49.82%	94.46%	94.69%
California	2.02%	6.13%	10.51%	17.73%	26.55%	47.13%	96.76%	96.76%
United States	2.47%	8.09%	14.61%	25.24%	37.75%	62.66%	85.86%	94.79%

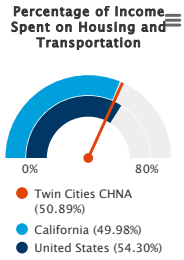
Data Source: US Census Bureau, American Community Survey. 2019-23.



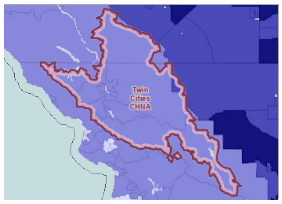
Housing Costs - Housing + Transportation Affordability Index

This indicator reports information about location affordability. Affordability is calculated by estimating the percentage of household income needed for combined housing and transportation costs for a family earning the Area Median Income (AMI). The expected values for housing and transportation are modelled by the US Department of Housing and Urban Development (HUD) using data from the US Census Bureau and the US Department of Transportation.

Report Area	Total Households	Median Household Income	Percentage of Income Spent on Housing	Percentage of Income Spent on Transportation	Percentage of Income Spent on Housing and Transportation
Twin Cities CHNA	36,121	63,993	24.60%	26.29%	**50.89%**
Monterey County, CA	125,916	60,889	24.82%	25.36%	50.18%
San Luis Obispo County, CA	104,404	64,014	24.62%	25.27%	49.89%
California	12,807,387	65,551	26.97%	23.01%	49.98%
United States	117,716,237	57,081	26.36%	27.93%	54.30%



Note: This indicator is compared to the state average.
Data Source: Partnership for Sustainable Communities (HUD, DOT, and EPA), Location Affordability Portal. 2019.



Location Affordability Index, Family at AMI, Percent Income Spent on Housing and Transportation by Tract, HUD & DOT 2019

- Over 60.0%
- 55.0 - 60.0%
- 50.0 - 54.9%
- Under 50.0%
- No Data
- Twin Cities CHNA

Housing Quality - Substandard Housing - Severe Housing Problems

This indicator reports the number and percentage of owner- and renter-occupied housing units having at least one of the following conditions: 1) lacking complete plumbing facilities, 2) lacking complete kitchen facilities, 3) with 1.51 or more occupants per room, 4) selected monthly owner costs as a percentage of household income greater than 50%, and 5) gross rent as a percentage of household income greater than 50%. Selected conditions provide information in assessing the quality of the housing inventory and its occupants. This data is used to easily identify homes where the quality of living and housing can be considered substandard.

Report Area	Occupied Households	Percentage of Households with One or More Severe Problems
Twin Cities CHNA	42,620	**16.25%**
Monterey County, CA	129,975	17.22%
San Luis Obispo County, CA	106,790	15.42%
California	13,217,585	15.73%
United States	125,207,785	13.07%

Note: This indicator is compared to the state average.
Data Source: US Department of Housing and Urban Development, Consolidated Planning/CHAS Data. 2017-2021.

Housing Quality - Renter Occupied Households

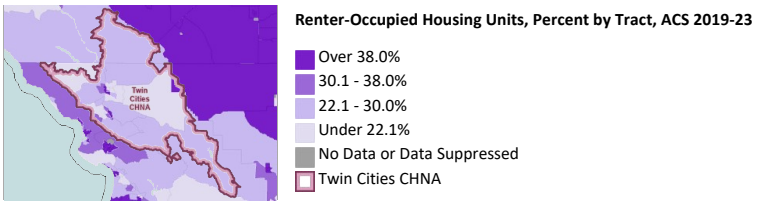
Tenure provides a measurement of home ownership, which has served as an indicator of the nation's economy for decades. This data covers all occupied housing units, which are classified as either owner occupied or renter occupied. These data are used to aid in the distribution of funds for programs such as those involving mortgage insurance, rental housing, and national defense housing. Data on tenure allows planners to evaluate the overall viability of housing markets and to assess the stability of neighborhoods. The data also serve in understanding the characteristics of owner occupied and renter occupied units to aid builders, mortgage lenders, planning officials, government agencies, etc., in the planning of housing programs and services.

Renter-Occupied Housing

All occupied housing units that are not owner occupied, whether they are rented or occupied without payment of rent, are classified as renter occupied.

Report Area	Total Occupied Housing Units	Renter-Occupied Housing Units	Percent Renter-Occupied Housing Units
Twin Cities CHNA	37,906	12,156	32.07%
Monterey County, CA	132,046	63,013	47.72%
San Luis Obispo County, CA	108,897	41,494	38.10%
California	13,434,847	5,940,036	44.21%
United States	127,482,865	44,590,828	34.98%

Data Source: US Census Bureau, American Community Survey. 2019-23.

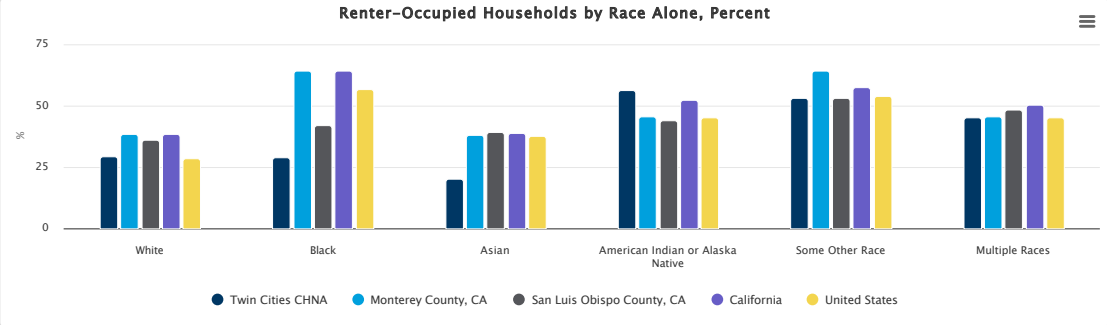


Renter-Occupied Households by Race Alone, Percent

This indicator reports the percentage of renter-occupied households by race alone.
The percentage values could be interpreted as, for example, *"Of all the households with white residents within the report area, the percentage of renter-occupied households is (value)."*

Report Area	White	Black	Asian	American Indian or Alaska Native	Some Other Race	Multiple Races
Twin Cities CHNA	29.09%	28.93%	20.00%	56.31%	52.80%	44.92%
Monterey County, CA	38.17%	64.06%	37.74%	45.30%	64.01%	45.63%
San Luis Obispo County, CA	35.77%	41.75%	38.93%	43.70%	53.14%	48.37%
California	38.42%	64.04%	38.76%	52.33%	57.28%	50.37%
United States	28.29%	56.40%	37.65%	45.23%	53.79%	45.15%

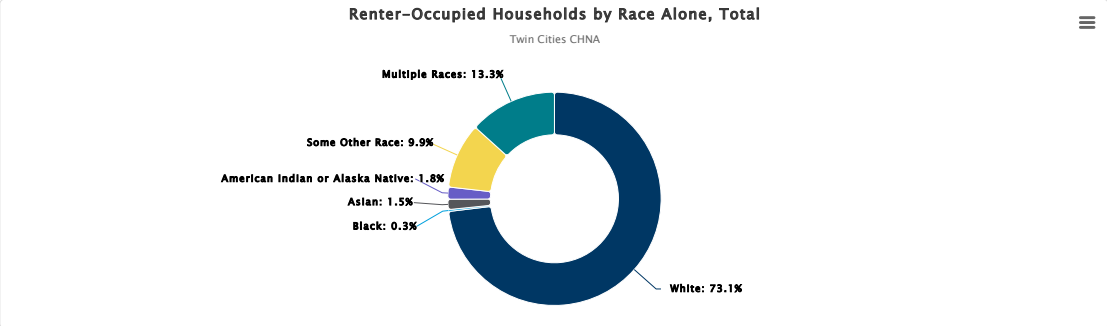
Data Source: US Census Bureau, American Community Survey. 2019-23.



Renter-Occupied Households by Race Alone, Total

Report Area	White	Black	Asian	American Indian or Alaska Native	Some Other Race	Multiple Races
Twin Cities CHNA	8,887	35	188	223	1,206	1,618
Monterey County, CA	23,773	1,750	3,188	482	26,339	7,174
San Luis Obispo County, CA	31,302	349	1,266	378	2,700	5,436
California	2,670,554	519,742	781,320	71,331	1,011,146	862,392
United States	24,817,846	8,774,870	2,476,100	421,620	3,356,307	4,643,158

Data Source: US Census Bureau, American Community Survey. 2019-23.

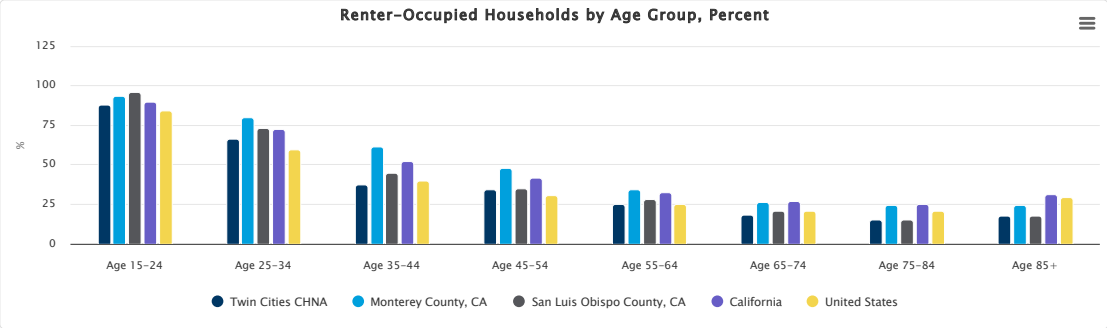


Renter-Occupied Households by Age Group, Percent

This indicator reports the percentage of renter-occupied households by age group.
The percentage values could be interpreted as, for example, *"Of all the households with residents age 25-34 within the report area, the percentage of renter-occupied households is (value)."*

Report Area	Age 15-24	Age 25-34	Age 35-44	Age 45-54	Age 55-64	Age 65-74	Age 75-84	Age 85+
Twin Cities CHNA	87.50%	66.16%	37.32%	34.39%	25.05%	18.07%	14.98%	17.78%
Monterey County, CA	93.09%	79.59%	61.38%	47.51%	34.17%	26.39%	24.49%	24.46%
San Luis Obispo County, CA	95.99%	72.96%	44.87%	34.81%	28.14%	20.93%	14.84%	17.55%
California	89.57%	72.52%	52.19%	41.71%	32.58%	26.84%	25.24%	30.91%
United States	83.90%	59.16%	39.42%	30.53%	24.91%	20.84%	20.50%	29.07%

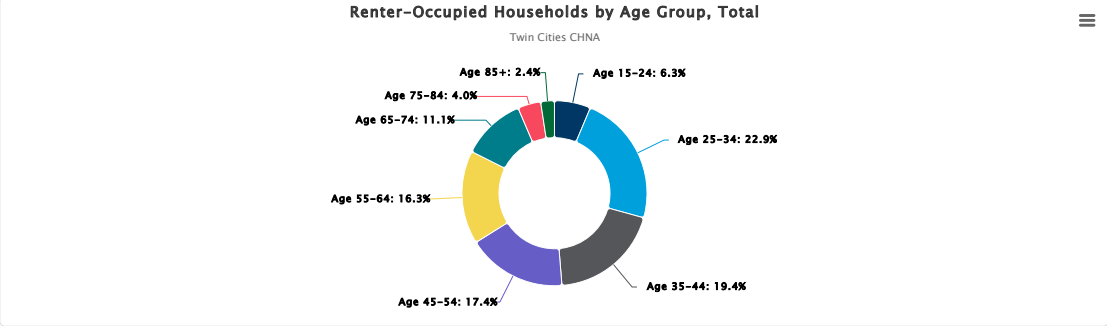
Data Source: US Census Bureau, American Community Survey. 2019-23.



Renter-Occupied Households by Age Group, Total

Report Area	Age 15-24	Age 25-34	Age 35-44	Age 45-54	Age 55-64	Age 65-74	Age 75-84	Age 85+
Twin Cities CHNA	770	2,790	2,362	2,113	1,986	1,355	490	291
Monterey County, CA	3,558	14,844	15,506	11,914	8,126	5,351	2,437	1,277
San Luis Obispo County, CA	7,319	9,071	7,264	4,989	5,727	4,719	1,646	759
California	326,341	1,480,212	1,340,099	1,052,031	827,939	531,364	250,971	131,079
United States	3,977,057	11,517,516	8,781,707	6,771,875	6,065,919	4,216,918	2,095,129	1,164,707

Data Source: US Census Bureau, American Community Survey. 2019-23.



Housing Quality - Owner Occupied Households

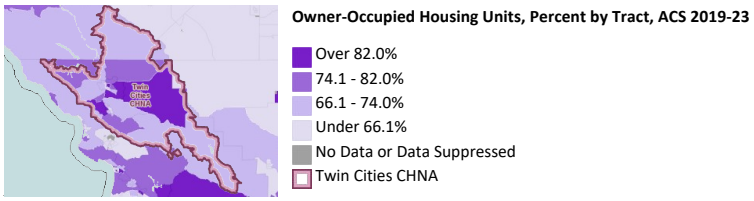
Tenure provides a measurement of home ownership, which has served as an indicator of the nation's economy for decades. This data covers all occupied housing units, which are classified as either owner occupied or renter occupied. These data are used to aid in the distribution of funds for programs such as those involving mortgage insurance, rental housing, and national defense housing. Data on tenure allows planners to evaluate the overall viability of housing markets and to assess the stability of neighborhoods. The data also serve in understanding the characteristics of owner occupied and renter occupied units to aid builders, mortgage lenders, planning officials, government agencies, etc., in the planning of housing programs and services.

Owner-Occupied Housing

A housing unit is owner-occupied if the owner or co-owner lives in the unit, even if it is mortgaged or not fully paid for. The unit also is considered owned with a mortgage if it is built on leased land and there is a mortgage on the unit. Mobile homes occupied by owners with installment loan balances also are included in this category.

Report Area	Total Occupied Housing Units	Owner-Occupied Housing Units	Percent Owner-Occupied Housing Units
Twin Cities CHNA	37,906	25,749	67.93%
Monterey County, CA	132,046	69,033	52.28%
San Luis Obispo County, CA	108,897	67,403	61.90%
California	13,434,847	7,494,811	55.79%
United States	127,482,865	82,892,037	65.02%

Data Source: US Census Bureau, American Community Survey. 2019-23.

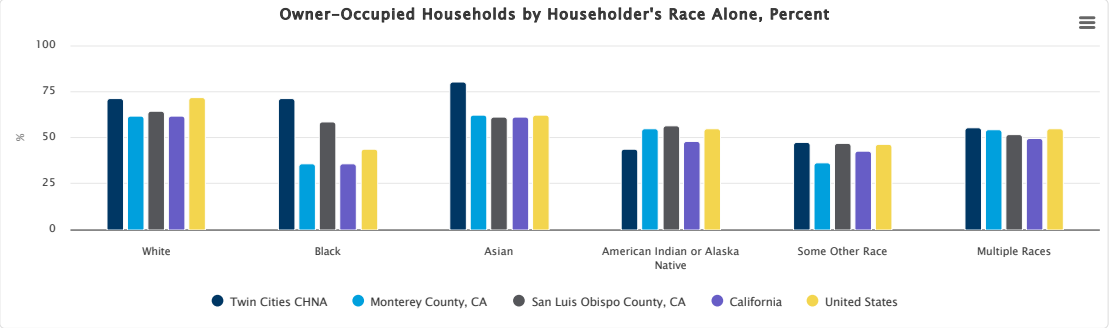


Owner-Occupied Households by Householder's Race Alone, Percent

This indicator reports the percentage of owner-occupied households by householder's race alone.
The percentage values could be interpreted as, for example, *"Of all the housing units with a white householder within the report area, the percentage of owner-occupied households is (value)."*

Report Area	White	Black	Asian	American Indian or Alaska Native	Some Other Race	Multiple Races
Twin Cities CHNA	70.91%	71.07%	80.00%	43.69%	47.20%	55.08%
Monterey County, CA	61.83%	35.94%	62.26%	54.70%	35.99%	54.37%
San Luis Obispo County, CA	64.23%	58.25%	61.07%	56.30%	46.86%	51.63%
California	61.58%	35.96%	61.24%	47.67%	42.72%	49.63%
United States	71.71%	43.60%	62.35%	54.77%	46.21%	54.85%

Data Source: US Census Bureau, American Community Survey. 2019-23.

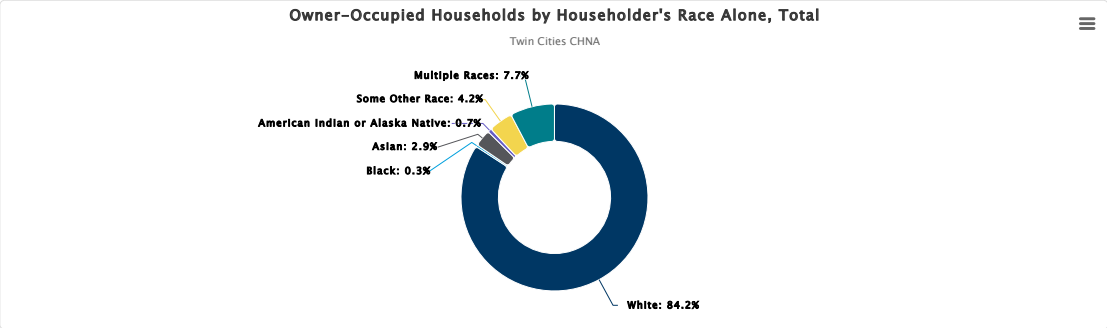


Owner-Occupied Households by Householder's Race Alone, Total

This indicator reports the total count of owner-occupied households by householder's race alone.

Report Area	White	Black	Asian	American Indian or Alaska Native	Some Other Race	Multiple Races
Twin Cities CHNA	21,661	86	752	173	1,078	1,984
Monterey County, CA	38,511	982	5,259	582	14,808	8,549
San Luis Obispo County, CA	56,214	487	1,986	487	2,381	5,802
California	4,281,260	291,813	1,234,600	64,984	754,096	849,791
United States	62,899,230	6,782,072	4,100,873	510,579	2,883,070	5,639,929

Data Source: US Census Bureau, American Community Survey. 2019-23.

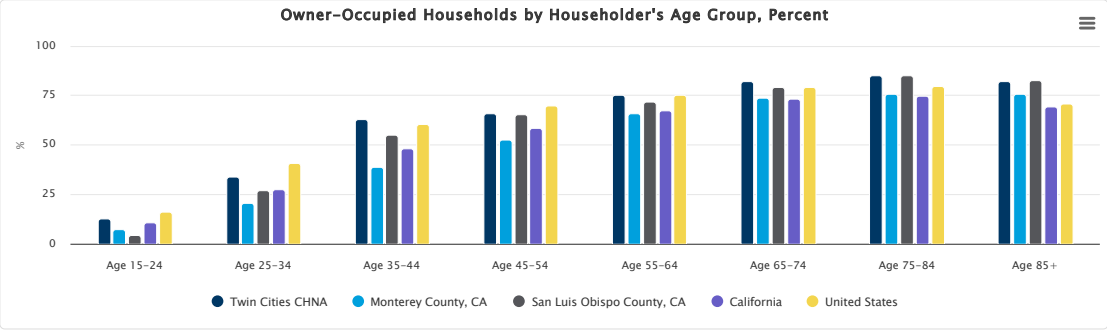


Owner-Occupied Households by Householder's Age Group, Percent

This indicator reports the percentage of owner-occupied households by householder's age group.
The percentage values could be interpreted as, for example, *"Of all the housing units with a householder aged 15-24 within the report area, the percentage of owner-occupied households is (value)."*

Report Area	Age 15-24	Age 25-34	Age 35-44	Age 45-54	Age 55-64	Age 65-74	Age 75-84	Age 85+
Twin Cities CHNA	12.50%	33.84%	62.68%	65.61%	74.95%	81.93%	85.02%	82.22%
Monterey County, CA	6.91%	20.41%	38.62%	52.49%	65.83%	73.61%	75.51%	75.54%
San Luis Obispo County, CA	4.01%	27.04%	55.13%	65.19%	71.86%	79.07%	85.16%	82.45%
California	10.43%	27.48%	47.81%	58.29%	67.42%	73.16%	74.76%	69.09%
United States	16.10%	40.84%	60.58%	69.47%	75.09%	79.16%	79.50%	70.93%

Data Source: US Census Bureau, American Community Survey. 2019-23.

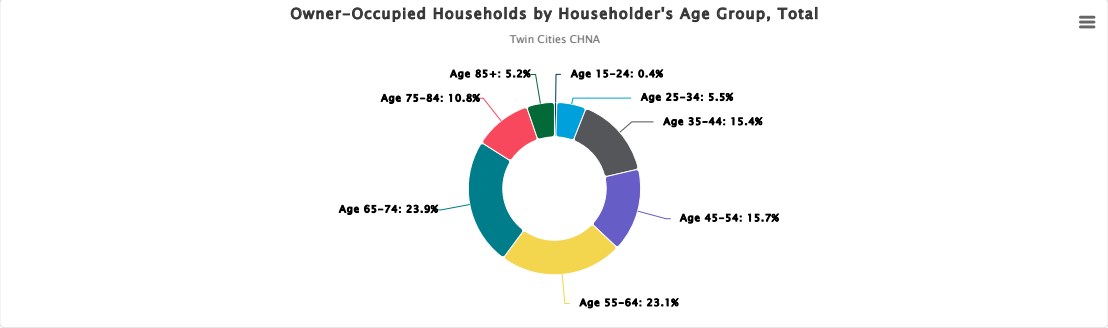


Owner-Occupied Households by Householder's Age Group, Total

This indicator reports the total count of owner-occupied households by householder's age group.

Report Area	Age 15-24	Age 25-34	Age 35-44	Age 45-54	Age 55-64	Age 65-74	Age 75-84	Age 85+
Twin Cities CHNA	110	1,427	3,967	4,032	5,943	6,145	2,781	1,346
Monterey County, CA	264	3,806	9,758	13,165	15,658	14,923	7,515	3,944
San Luis Obispo County, CA	306	3,362	8,926	9,345	14,623	17,827	9,447	3,567
California	38,004	560,934	1,227,554	1,470,260	1,712,935	1,448,690	743,495	292,939
United States	763,343	7,950,972	13,497,818	15,410,995	18,285,898	16,015,654	8,125,312	2,842,045

Data Source: US Census Bureau, American Community Survey. 2019-23.

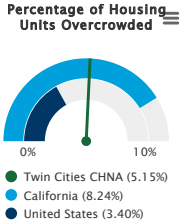


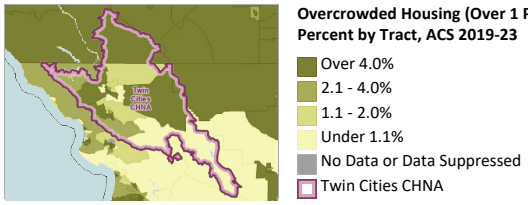
Housing Quality - Overcrowded Housing

This indicator reports data on overcrowded housing from the latest 5-year American Community Survey. The Census Bureau has no official definition of crowded units, but this report considers units with more than one occupant per room to be crowded.

Report Area	Total Occupied Housing Units	Overcrowded Housing Units	Percentage of Housing Units Overcrowded
Twin Cities CHNA	37,906	1,953	5.15%
Monterey County, CA	132,046	18,490	14.00%
San Luis Obispo County, CA	108,897	4,175	3.83%
California	13,434,847	1,107,572	8.24%
United States	127,482,865	4,335,284	3.40%

Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2019-23.





Homelessness – K-12 Students Experiencing Homelessness

This indicator reports the number of children and youth experiencing homelessness enrolled in the K-12 public school system during the 2023-24 school year. This data source reports the number of students experiencing homelessness, defined as individuals who lack a fixed, regular, and adequate nighttime residence. This includes those who are temporarily doubled-up, living in temporary shelters, hotels/motels or are unsheltered. Data was collected by the California Department of Education (CDE) through the California Longitudinal Pupil Achievement Data System (CALPADS).

Homelessness – K-12 Students Experiencing Homelessness 2023-24

Location	Total Enrolled Students	Students Experiencing Homelessness	Students Experiencing Homelessness, Percent
San Luis Obispo County	33,958	3,858	11.36%
California	6,023,851	286,853	4.76%

Data Source: dq.cde.ca.gov/dataquest/. Accessed May 2025.

Homelessness – K-12 Students Experiencing Homelessness, Percent by Race/Ethnicity 2023-24

Location	American Indian or Alaska Native	Asian	Black or African American	Filipino	Hispanic or Latino	Native Hawaiian or Pacific Islander	None Reported	Two or More Races	White
San Luis Obispo County	16.81%	7.60%	12.20%	11.63%	19.19%	2.56%	10.83%	6.61%	4.35%
California	7.83%	1.49%	7.59%	2.16%	6.23%	6.48%	3.89%	3.22%	2.15%

Data Source: dq.cde.ca.gov/dataquest/. Accessed May 2025.

Mental Health

Mental health is a state of well-being where individuals cope with life's challenges, work productively and contribute to their communities. This concept goes beyond the absence of mental disorders, emphasizing the capacity for resilience, emotional stability and social well-being.

Mental health is an important component of overall health and is interdependent with social determinants such as income, education, social support and access to healthcare. Mental health conditions can increase the risk of chronic health conditions such as diabetes, heart disease and stroke. For instance, depression can lead to poor self-care, which exacerbates certain health conditions (National Institute of Mental Health). Inversely, the presence of health conditions can increase the risk for mental illness as individuals with one or more chronic illnesses often experience higher levels of stress and anxiety, which can trigger mental health issues. According to the Substance Abuse and Mental Health Services Administration, 23.1 percent of U.S. adults (59.3 million) experienced a mental health condition in 2022. Living with a mental health condition can vary in severity, causing distress and negatively affecting personal, social and work life. For some, it can significantly impact their ability to carry out daily obligations.

The growing prevalence of mental health is an issue affecting many community residents. People noted a variety of factors that contribute to poor mental health, including a lack of community and limited access to mental health services. One focus group participant highlighted the importance of community, noting if people "just felt like they belonged in their community, [...] that would enable them to take better care of themselves." Key informants concluded that "we have very, very poor access to mental health and that really is becoming an issue [...] to people who are already lonely, to people who aren't connected" and "we just don't have access. If you look at our list of providers and how to get them, I would say mental health care is a luxury here." In a community survey, more than one in ten respondents (11.1%) selected mental health problems as one of the biggest health problems they're facing, behind aging problems and being overweight.

Despite increased risk factors, opportunities to address indicators of mental health do exist. Securing more resources and programming, along with sharing existing opportunities, can improve health outcomes and reduce disparities. For additional data, see the following pages.

Scan QR Code to explore the full live data report on Mental Health or visit: cares.page.link/sW4s

Data Highlights

Community Voices: *exploring local perceptions, thoughts & beliefs*

"1 in 3 [have] anxiety and a diagnosable behavioral health condition."

"I think kids are different. I think adults are different too because the way we consume media is different and making people angrier, which is being passed down to their kids..."

"Substance abuse is a barrier to them. They are in a traumatic state and trying to get services and they don't know which way to turn."

"I don't think we get the full support that we need. There's a lot of trauma here and many people are not trauma-informed."

"They're bringing [in] a mobile health, mental health van and it's their outreach team...So their expectation is that someone who comes to them needs their help...versus outreach [and] building trust within that group, having conversation and inviting them into the van."

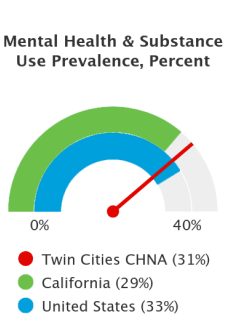
"We have a lot of people who feel isolated, but if they just felt like they belonged in their community, then I feel...that would enable them to take better care of themselves."

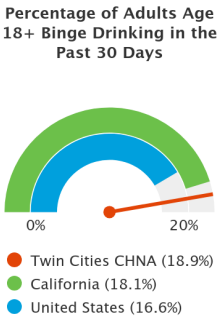
"I think there's still so many ramifications of dealing with the COVID isolationism, the COVID fallout in education and socialization, and children, and the loneliness that seniors feel."

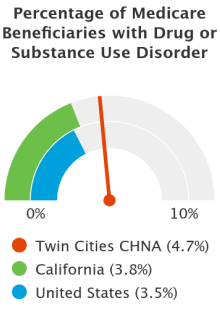
"...We have very, very poor access to mental health and that really is becoming an issue. It's tangential...to people who are already lonely, to people who aren't connected."

"I think that it [unemployment] creates stress in families which relates to drug use and domestic violence."

"One thing that's new is behavioral wellness coaches... they're basically the promatoras of behavioral health. So these are folks with lived experiences. They're not necessarily licensed, but they have certifications and they can provide a lot of support and that's a way to extend the workforce...take the lower acuity issues, get to people faster and sooner."







Community Resources

County of San Luis Obispo Health Agency Behavioral Health
Slocounty.ca.gov/departments/health-agency/behavioral-health
800-783-0607

County of San Luis Obispo
Slocounty.ca.gov/departments/health-agency/behavioral-health/all-behavioral-health-services/mental-health-adult-services
800-838-1381

TMHA Central Coast Hotline:
Text or Call 800-783-0607
t-mha.org/central-coast-hotline.php

Community Health Needs Assessment Full Report

Location

Twin Cities CHNA

Health Needs: Mental Health

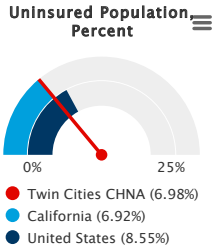
Risk Factors - Access to Care - Medical Insurance

The lack of health insurance is considered a *key driver* of health status.

In the report area 6.98% of the total civilian non-institutionalized population are without health insurance coverage. The rate of uninsured persons in the report area is greater than the state average of 6.92%. This indicator is relevant because lack of insurance is a primary barrier to healthcare access including regular primary care, specialty care, and other health services that contributes to poor health status.

Report Area	Total Population (For Whom Insurance Status is Determined)	Uninsured Population	Uninsured Population, Percent
Twin Cities CHNA	98,347	6,862	**6.98%**
Monterey County, CA	420,702	41,838	9.94%
San Luis Obispo County, CA	276,628	16,050	5.80%
California	38,761,738	2,682,732	6.92%
United States	327,425,278	28,000,876	8.55%

Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2019-23.



View larger map

Uninsured Population, Percent by Tract, ACS 2019-23

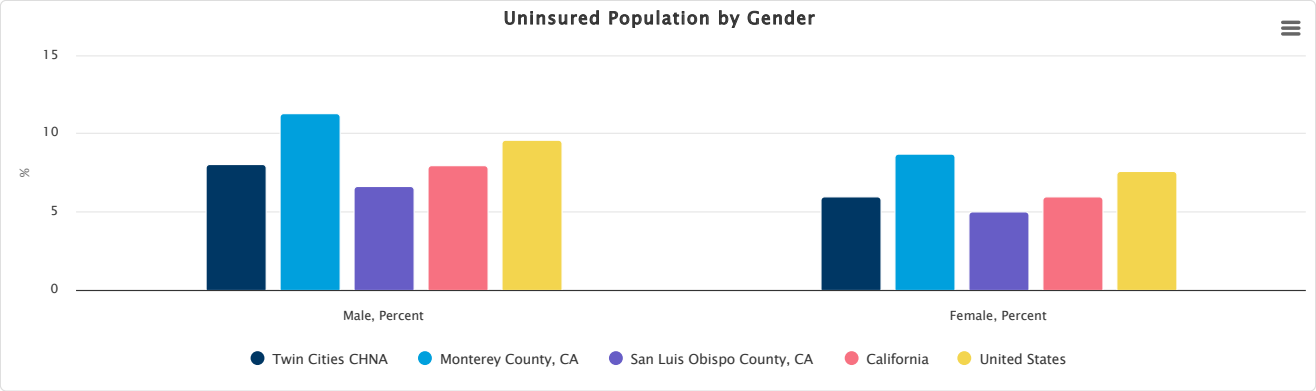
- Over 20.0%
- 15.1 - 20.0%
- 10.1 - 15.0%
- Under 10.1%
- No Data or Data Suppressed
- Twin Cities CHNA

Uninsured Population by Gender

This indicator reports the uninsured population by gender.
The percentage values could be interpreted as, for example, *"Of all the male population within the report area, the proportion without health insurance coverage is (value)."*

Report Area	Male	Female	Male, Percent	Female, Percent
Twin Cities CHNA	3,902	2,958	7.99%	5.98%
Monterey County, CA	23,421	18,417	11.24%	8.68%
San Luis Obispo County, CA	9,135	6,915	6.63%	4.98%
California	1,526,004	1,156,728	7.93%	5.92%
United States	15,443,840	12,557,036	9.59%	7.55%

Data Source: US Census Bureau, American Community Survey. 2019-23.

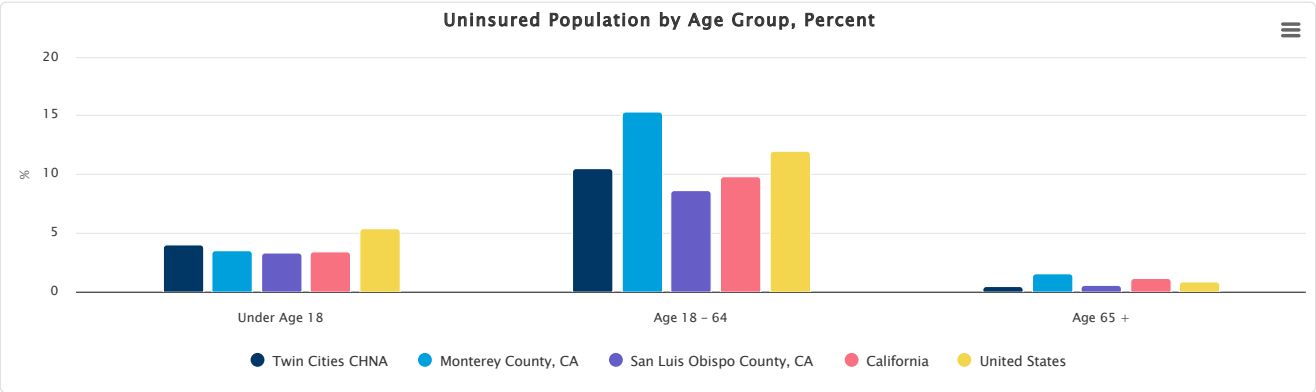


Uninsured Population by Age Group, Percent

This indicator reports the percentage of uninsured population by age group.
The percentage values could be interpreted as, for example, *"Of all the population under age 18 within the report area, the proportion without health insurance coverage is (value)."*

Report Area	Under Age 18	Age 18 - 64	Age 65 +
Twin Cities CHNA	3.95%	10.54%	0.42%
Monterey County, CA	3.50%	15.34%	1.52%
San Luis Obispo County, CA	3.30%	8.61%	0.57%
California	3.35%	9.77%	1.09%
United States	5.39%	11.98%	0.83%

Data Source: US Census Bureau, American Community Survey. 2019-23.

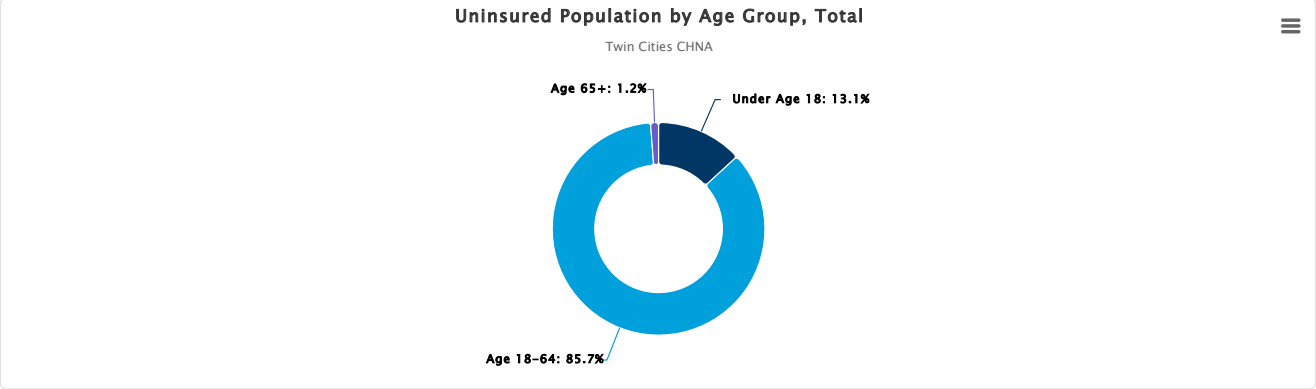


Uninsured Population by Age Group, Total

This indicator reports the total uninsured population by age group.

Report Area	Under Age 18	Age 18-64	Age 65+
Twin Cities CHNA	901	5,875	83
Monterey County, CA	4,176	36,718	944
San Luis Obispo County, CA	1,845	13,863	342
California	310,351	2,307,944	64,437
United States	4,208,983	23,338,717	453,176

Data Source: US Census Bureau, American Community Survey. 2019-23.

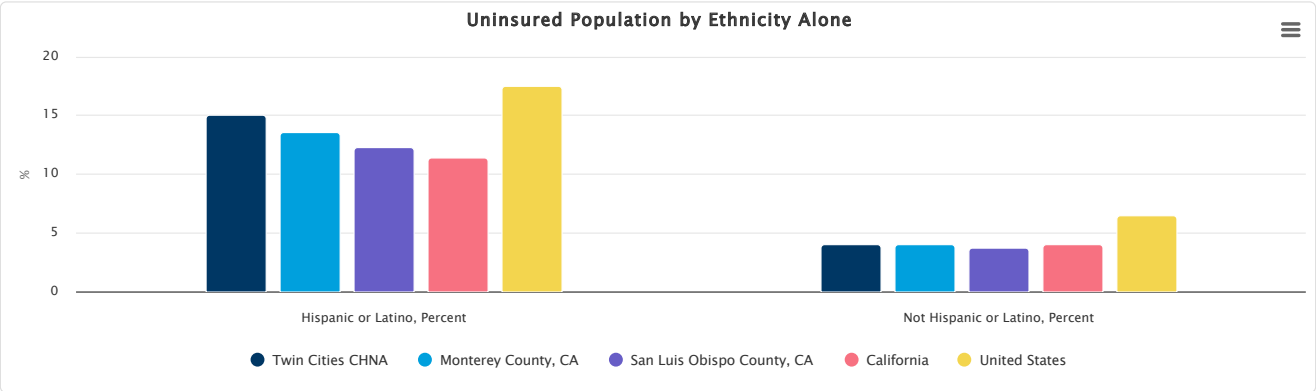


Uninsured Population by Ethnicity Alone

This indicator reports the uninsured population by ethnicity alone.
The percentage values could be interpreted as, for example, *"Of all the Hispanic population within the report area, the proportion without health insurance coverage is (value)."*

Report Area	Hispanic or Latino	Not Hispanic or Latino	Hispanic or Latino, Percent	Not Hispanic or Latino, Percent
Twin Cities CHNA	4,005	2,855	15.07%	3.98%
Monterey County, CA	35,505	6,333	13.59%	3.97%
San Luis Obispo County, CA	8,276	7,774	12.23%	3.72%
California	1,760,029	922,703	11.37%	3.96%
United States	10,900,185	17,100,691	17.47%	6.45%

Data Source: US Census Bureau, American Community Survey. 2019-23.

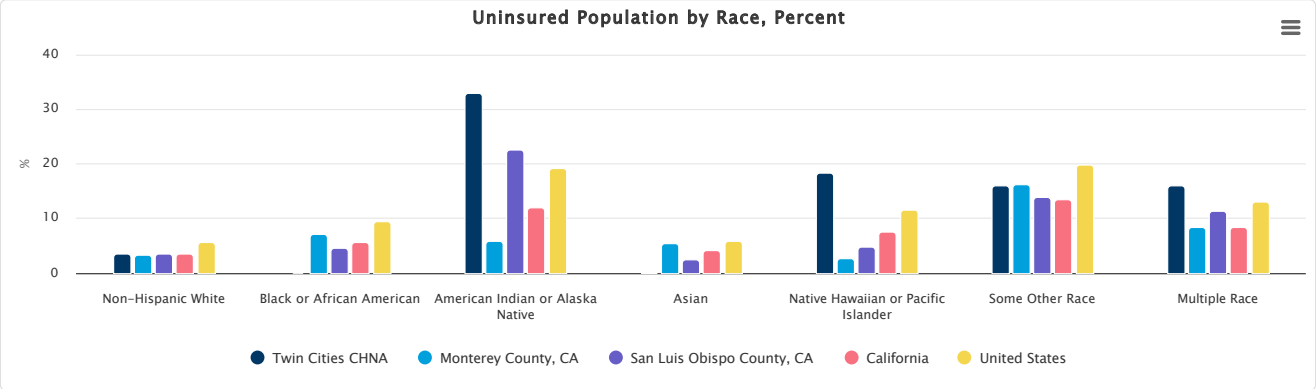


Uninsured Population by Race, Percent

This indicator reports the percentage of uninsured population by race alone.
The percentage values could be interpreted as, for example, *"Of all the non-Hispanic white population within the report area, the proportion without health insurance coverage is (value)."*

Report Area	Non-Hispanic White	Black or African American	American Indian or Alaska Native	Asian	Native Hawaiian or Pacific Islander	Some Other Race	Multiple Race
Twin Cities CHNA	3.48%	0.00%	32.97%	0.14%	18.29%	15.99%	16.04%
Monterey County, CA	3.37%	7.17%	5.90%	5.39%	2.74%	16.26%	8.44%
San Luis Obispo County, CA	3.54%	4.46%	22.61%	2.35%	4.85%	13.96%	11.24%
California	3.52%	5.65%	11.90%	4.06%	7.56%	13.37%	8.27%
United States	5.71%	9.46%	19.22%	5.89%	11.59%	19.70%	12.98%

Data Source: US Census Bureau, American Community Survey. 2019-23.



Uninsured Population by Race, Total

This indicator reports the total uninsured population by race alone.

Report Area	Non-Hispanic White	Black or African American	American Indian or Alaska Native	Asian	Native Hawaiian or Pacific Islander	Some Other Race	Multiple Race
Twin Cities CHNA	2,202	0	393	4	10	1,338	2,244
Monterey County, CA	3,820	521	195	1,321	58	28,387	4,847
San Luis Obispo County, CA	6,439	95	582	243	23	2,590	4,617
California	471,187	118,238	52,186	242,128	10,982	903,127	524,941
United States	10,876,176	3,775,959	549,575	1,134,010	71,131	4,280,782	4,567,337

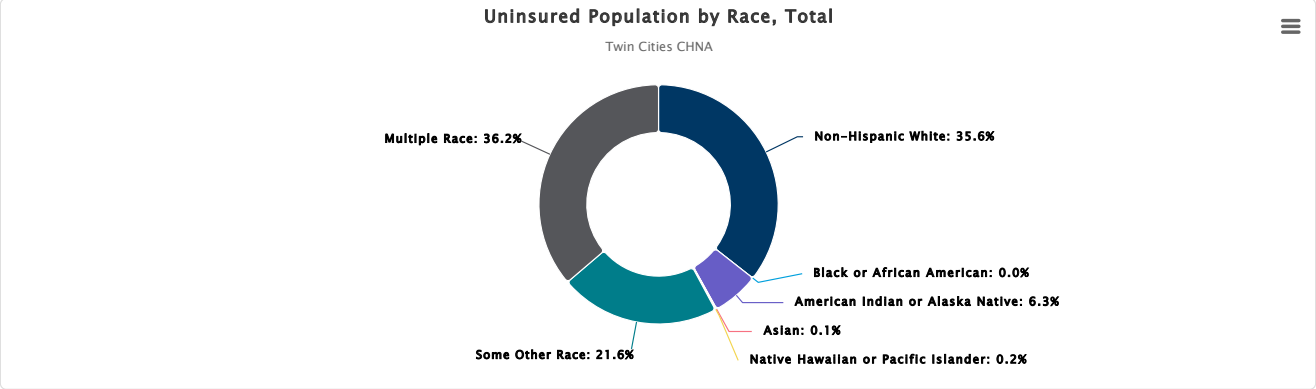
Data Source: US Census Bureau, American Community Survey. 2019-23.

Uninsured Population by Race, Total

This indicator reports the total uninsured population by race alone.

Report Area	Non-Hispanic White	Black or African American	American Indian or Alaska Native	Asian	Native Hawaiian or Pacific Islander	Some Other Race	Multiple Race
Twin Cities CHNA	2,202	0	393	4	10	1,338	2,244
Monterey County, CA	3,820	521	195	1,321	58	28,387	4,847
San Luis Obispo County, CA	6,439	95	582	243	23	2,590	4,617
California	471,187	118,238	52,186	242,128	10,982	903,127	524,941
United States	10,876,176	3,775,959	549,575	1,134,010	71,131	4,280,782	4,567,337

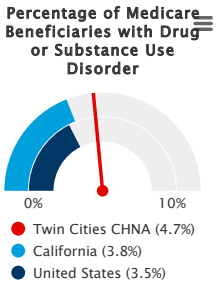
Data Source: US Census Bureau, American Community Survey. 2019-23.



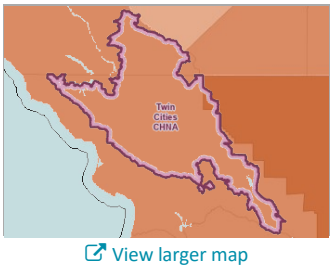
Risk Factors - Drugs & Alcohol - Substance Use Disorder

This indicator reports the percentage of the Medicare Fee-for-Service population with substance use disorder. Data are based upon Medicare administrative enrollment and claims data for Medicare beneficiaries enrolled in the Fee-for-Service program. Within the report area, there are a total of 832 beneficiaries with substance use disorder. This represents a 4.7% of the Medicare Fee-for-Service beneficiaries.

Report Area	Total Medicare Fee-for-Service Beneficiaries	Beneficiaries with Drug/Substance Use Disorder	Percentage with Drug/Substance Use Disorder
Twin Cities CHNA	17,545	832	**4.7%**
Monterey County, CA	53,963	1,622	3.0%
San Luis Obispo County, CA	49,804	2,365	4.7%
California	2,859,642	107,557	3.8%
United States	33,499,472	1,172,214	3.5%



Note: This indicator is compared to the state average.
Data Source: Centers for Medicare & Medicaid Services, Centers for Medicare & Medicaid Services - Chronic Conditions. 2018.



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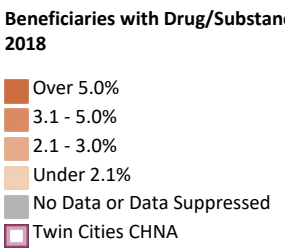
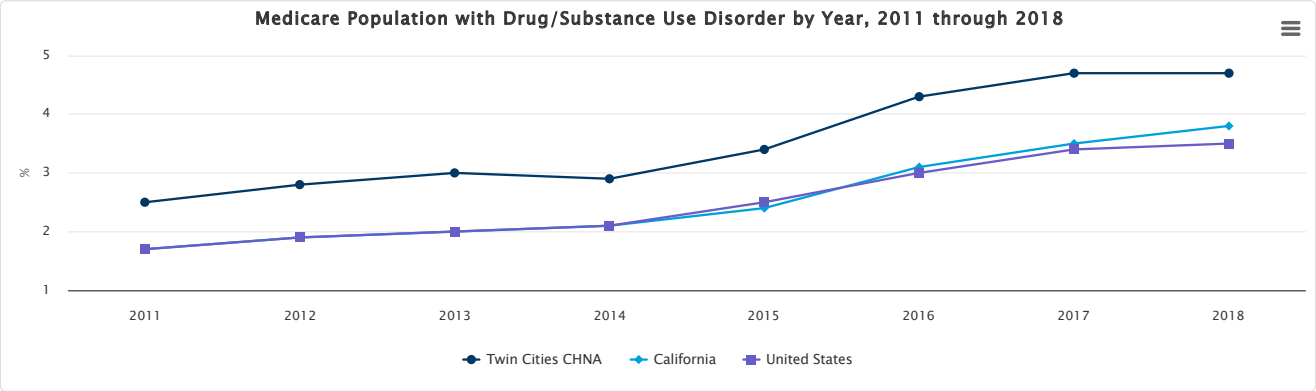


Medicare Population with Drug/Substance Use Disorder by Year, 2011 through 2018

This indicator reports the percentage of the Medicare Fee-for-Service population with drug or substance use disorders over time.

Report Area	2011	2012	2013	2014	2015	2016	2017	2018
Twin Cities CHNA	2.5%	2.8%	3.0%	2.9%	3.4%	4.3%	4.7%	4.7%
Monterey County, CA	1.5%	1.6%	1.7%	1.8%	1.9%	2.3%	2.7%	3.0%
San Luis Obispo County, CA	2.5%	2.8%	3.0%	2.9%	3.4%	4.4%	4.7%	4.7%
California	1.7%	1.9%	2.0%	2.1%	2.4%	3.1%	3.5%	3.8%
United States	1.7%	1.9%	2.0%	2.1%	2.5%	3.0%	3.4%	3.5%

Data Source: Centers for Medicare & Medicaid Services, Centers for Medicare & Medicaid Services - Chronic Conditions. 2018.

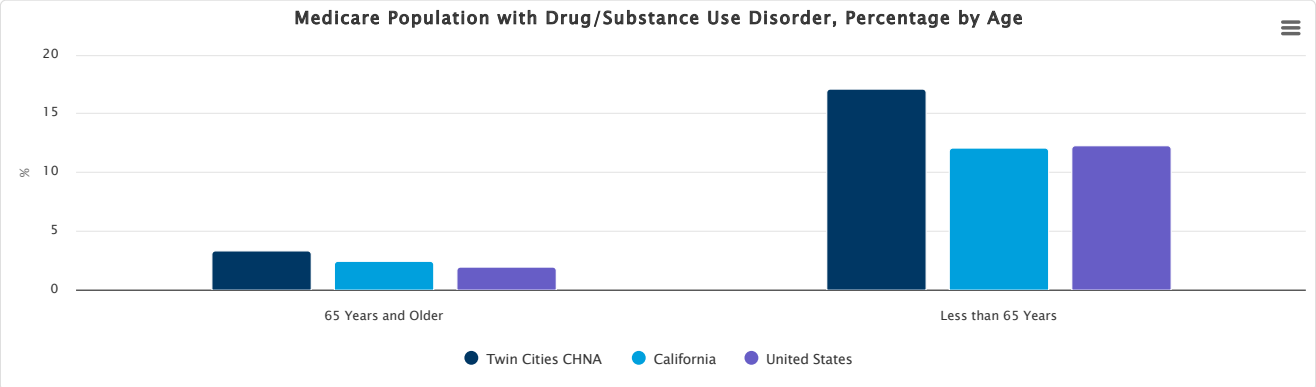


Medicare Population with Drug/Substance Use Disorder, Percentage by Age

This indicator reports the prevalence of drug or substance use disorders among Medicare beneficiaries by age.
The percentage values could be interpreted as, for example, *"Of all the Medicare beneficiaries age 65 and older within the report area, the proportion with drug or substance use disorders is (value)."*

Report Area	65 Years and Older	Less than 65 Years
Twin Cities CHNA	3.3%	17.1%
Monterey County, CA	1.8%	12.4%
San Luis Obispo County, CA	3.3%	17.1%
California	2.4%	12.1%
United States	1.9%	12.3%

Data Source: Centers for Medicare & Medicaid Services, Centers for Medicare & Medicaid Services - Chronic Conditions. 2018.

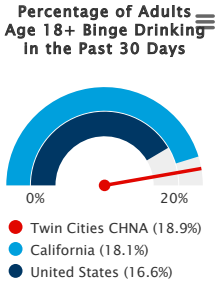


Risk Factors - Drugs & Alcohol - Binge Drinking

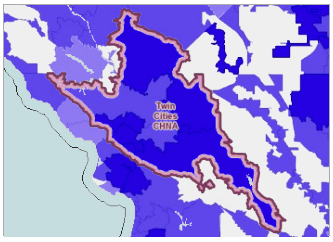
This indicator reports the percentage of adults age 18 and older who report having five or more drinks (men) or four or more drinks (women) on an occasion in the past 30 days.

Within the report area there are 18.9% adults age 18+ who reported having four or more drinks in the last month of the total population age 18+.

Report Area	Total Population	Adults Age 18+ Binge Drinking in the Past 30 Days (Crude)	Adults Age 18+ Binge Drinking in the Past 30 Days (Age-Adjusted)
Twin Cities CHNA	99,679	**18.9%**	No data
Monterey County, CA	432,858	17.0%	17.6%
San Luis Obispo County, CA	282,013	19.4%	21.2%
California	39,029,342	18.1%	18.8%
United States	333,287,557	16.6%	18.0%



Note: This indicator is compared to the state average.
Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal. 2022 .



View larger map

Binge Drinking, Percent of Adults Age 18+ by ZCTA, CDC BRFSS PLACES Project 2022

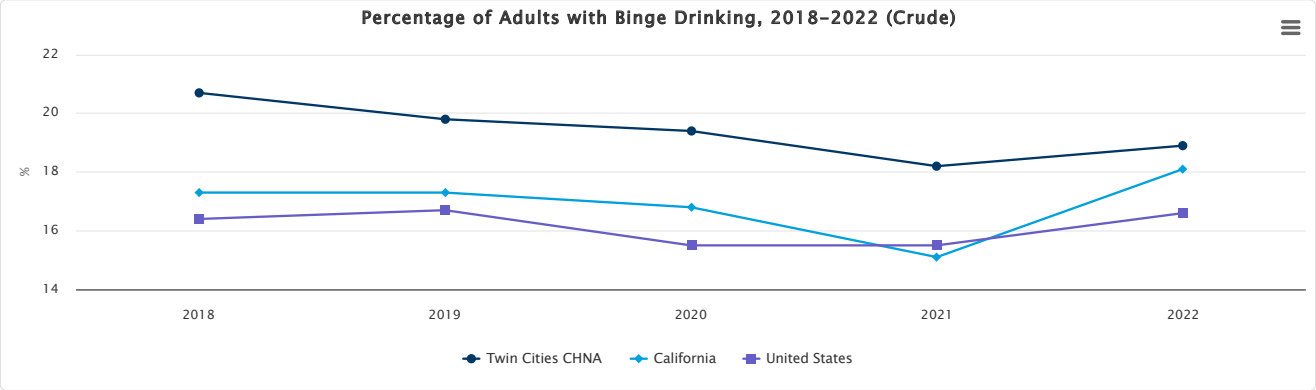
- Over 19.0%
- 16.1 - 19.0%
- 13.1 - 16.0%
- Under 13.1%
- No Data or Data Suppressed
- Twin Cities CHNA

Percentage of Adults with Binge Drinking, 2018-2022 (Crude)

The table and chart below display annual trends in the percentage of adults age 18+ who report binge drinking.

Report Area	2018	2019	2020	2021	2022
Twin Cities CHNA	20.7%	19.8%	19.4%	18.2%	18.9%
Monterey County, CA	17.5%	18.2%	17.6%	14.9%	17.0%
San Luis Obispo County, CA	20.0%	19.3%	18.3%	17.1%	19.4%
California	17.3%	17.3%	16.8%	15.1%	18.1%
United States	16.4%	16.7%	15.5%	15.5%	16.6%

Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal. 2022 .

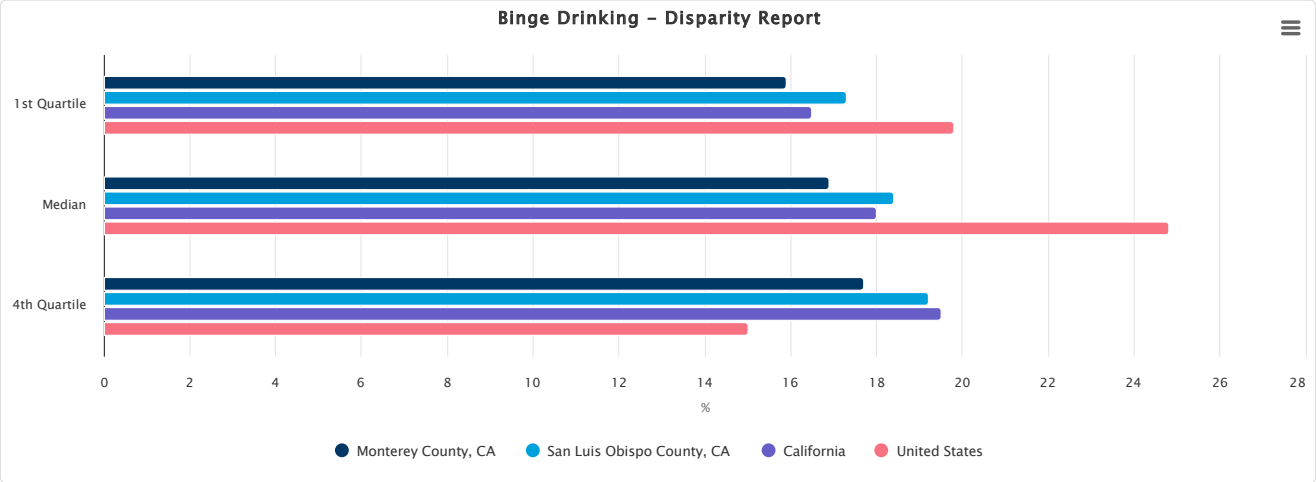


Binge Drinking - Disparity Report

The table and chart below display the median and interquartile ranges for census tract values related to the indicator.

Report Area	1st Quartile	Median	4th Quartile
Monterey County, CA	15.90%	16.90%	17.70%
San Luis Obispo County, CA	17.30%	18.40%	19.20%
California	16.50%	18.00%	19.50%
United States	19.80%	24.80%	15.00%

Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal. 2022 .

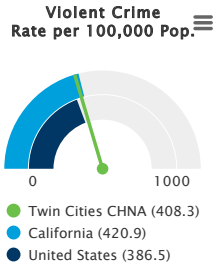


Risk Factors - Stress & Trauma - Violent Crime Rate

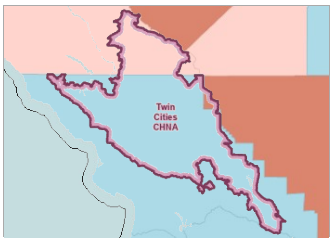
This indicator reports the rate of violent crime offenses reported by law enforcement per 100,000 residents. Violent crime includes homicide, rape, robbery, and aggravated assault. The data for this indicator are obtained from the 2022 County Health Rankings, which utilizes figures from the 2014 and 2016 FBI Uniform Crime Reports. This indicator is relevant because it assesses community safety.

In the report area, 404 violent crimes occurred in 2014 and 2016 (two years). The violent crime rate of 408.3 per 100,000 residents is lower than the statewide rate of 420.9 per 100,000.
Note: Data are suppressed for counties if, for both years of available data, the population reported by agencies is less than 50% of the population reported in Census or less than 80% of agencies measuring crimes reported data.

Report Area	Violent Crimes	Violent Crime Rate (Per 100,000 Pop.)
Twin Cities CHNA	404	**408.3**
Monterey County, CA	1,828	420.6
San Luis Obispo County, CA	1,146	408.2
California	164,253	420.9
United States	1,240,534	386.5



Note: This indicator is compared to the state average.
Data Source: Federal Bureau of Investigation, FBI Uniform Crime Reports. Additional analysis by the National Archive of Criminal Justice Data. Accessed via the Inter-university Consortium for Political and Social Research. 2014&2016.



View larger map

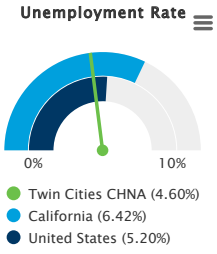
Violent Crime, Rank by County, County Health Rankings 2022

- 1st Quartile (Top 25%)
- 2nd Quartile
- 3rd Quartile
- 4th Quartile (Bottom 25%)
- Bottom Quintile (Rhode Island Only)
- No Data or Data Suppressed; -1
- Twin Cities CHNA

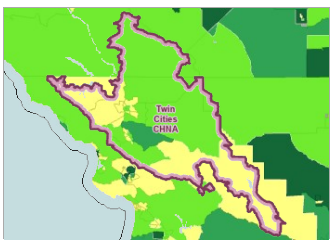
Risk Factors - Stress & Trauma - Unemployment

According to the most recent American Community Survey estimates, total unemployment in the report area is 2,269, or 4.60% of the civilian labor force. This indicator is relevant because unemployment creates financial instability and barriers to access including insurance coverage, health services, healthy food, and other necessities that contribute to poor health status.

Report Area	Labor Force	Number Unemployed	Unemployment Rate
Twin Cities CHNA	49,337	2,269	**4.60%**
Monterey County, CA	202,644	10,068	5.13%
San Luis Obispo County, CA	139,458	7,005	5.05%
California	20,144,078	1,282,259	6.42%
United States	169,855,626	8,759,317	5.20%



Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2019-23.



View larger map

Unemployed Workers, Percent by Tract, ACS 2019-23

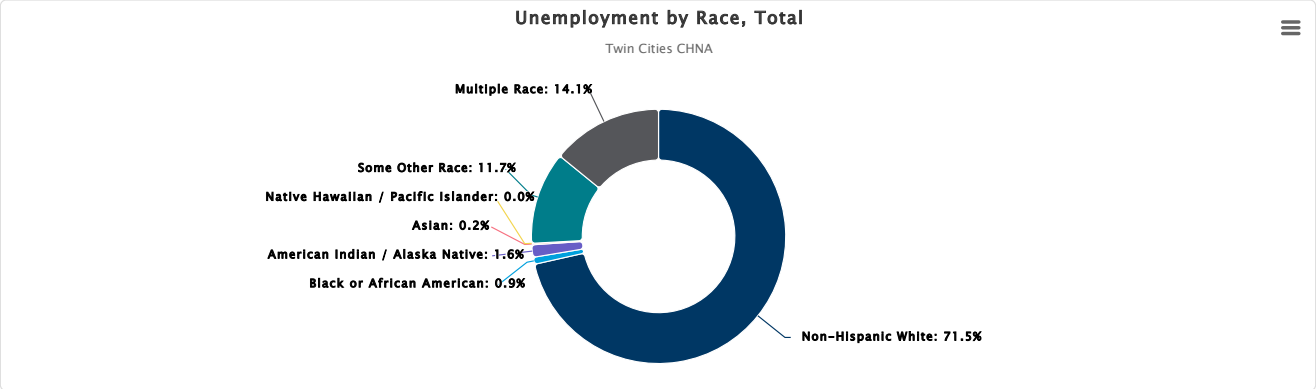
- Over 12.0%
- 8.1 - 12.0%
- 4.1 - 8.0%
- Under 4.1%
- No Data or Data Suppressed
- Twin Cities CHNA

Unemployment by Race, Total

This indicator reports the total count of unemployed population in the report area by race.

Report Area	Non-Hispanic White	Black or African American	American Indian / Alaska Native	Asian	Native Hawaiian / Pacific Islander	Some Other Race	Multiple Race
Twin Cities CHNA	1,528	19	34	4	0	251	302
Monterey County, CA	3,091	251	129	796	164	2,733	1,622
San Luis Obispo County, CA	4,795	57	49	255	0	614	863
California	413,831	106,059	18,806	158,934	6,166	236,196	227,927
United States	4,184,342	1,757,752	108,909	456,672	22,627	698,102	1,076,447

Data Source: US Census Bureau, American Community Survey. 2019-23.

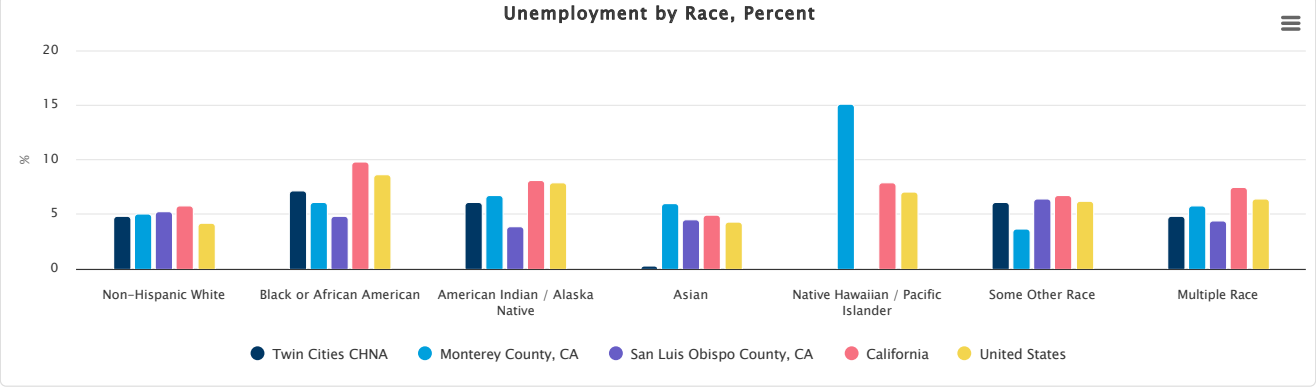


Unemployment by Race, Percent

This indicator reports the percentage of unemployed population in the report area by race. The values could be interpreted as, for example, *"Of all the Non-Hispanic White population in civilian labor force in the report area, the unemployment rate is (value)."*

Report Area	Non-Hispanic White	Black or African American	American Indian / Alaska Native	Asian	Native Hawaiian / Pacific Islander	Some Other Race	Multiple Race
Twin Cities CHNA	4.77%	7.14%	6.09%	0.22%	0.00%	6.05%	4.83%
Monterey County, CA	5.03%	6.11%	6.69%	5.94%	15.12%	3.68%	5.81%
San Luis Obispo County, CA	5.24%	4.86%	3.84%	4.49%	0.00%	6.44%	4.41%
California	5.81%	9.76%	8.07%	4.88%	7.88%	6.77%	7.44%
United States	4.17%	8.58%	7.87%	4.28%	7.05%	6.21%	6.40%

Data Source: US Census Bureau, American Community Survey. 2019-23.

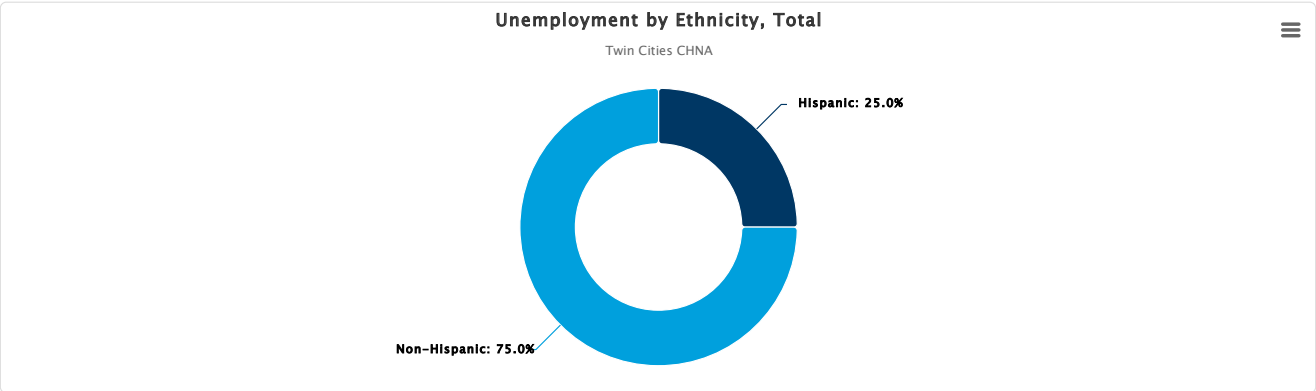


Unemployment by Ethnicity, Total

This indicator reports the total count of unemployed population in the report area by ethnicity.

Report Area	Hispanic	Non-Hispanic
Twin Cities CHNA	567	1,700
Monterey County, CA	5,342	4,726
San Luis Obispo County, CA	1,570	5,435
California	537,311	744,948
United States	1,889,916	6,869,401

Data Source: US Census Bureau, American Community Survey. 2019-23.

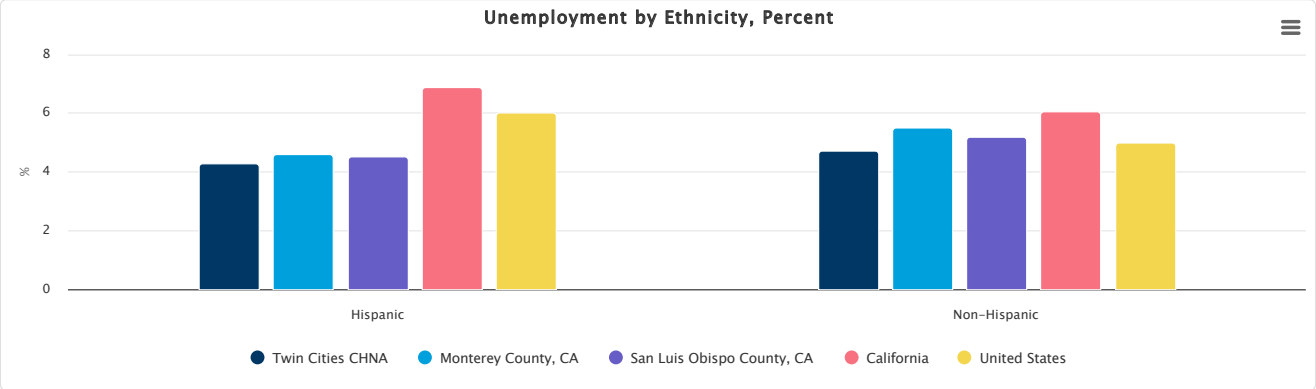


Unemployment by Ethnicity, Percent

This indicator reports the percentage of unemployed population in the report area by ethnicity. The values could be interpreted as, for example, *"Of all the Hispanic population in civilian labor force in the report area, the unemployment rate is (value)."*

Report Area	Hispanic	Non-Hispanic
Twin Cities CHNA	4.27%	4.72%
Monterey County, CA	4.58%	5.49%
San Luis Obispo County, CA	4.51%	5.19%
California	6.87%	6.04%
United States	6.00%	4.97%

Data Source: US Census Bureau, American Community Survey. 2019-23.

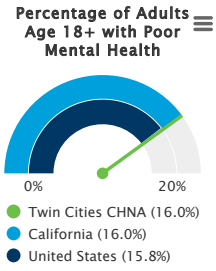


Health Outcomes - Anxiety & Depression - Poor Mental Health

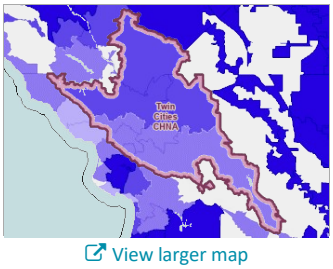
This indicator reports the percentage of adults age 18 and older who report 14 or more days during the past 30 days during which their mental health was not good.

Within the report area, there were 16.0% of adults 18 and older who reported poor mental health in the past month of the total population age 18 and older.

Report Area	Total Population	Adults Age 18+ with Poor Mental Health (Crude)	Adults Age 18+ with Poor Mental Health (Age-Adjusted)
Twin Cities CHNA	99,679	16.0%	No data
Monterey County, CA	432,858	17.9%	18.1%
San Luis Obispo County, CA	282,013	16.6%	17.4%
California	39,029,342	16.0%	16.4%
United States	333,287,557	15.8%	16.4%



Note: This indicator is compared to the state average.
Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal. 2022 .



View larger map

Frequent Mental Distress, Prevalence Among Adults Age 18+ by ZCTA, CDC BRFSS PLACES Project 2022

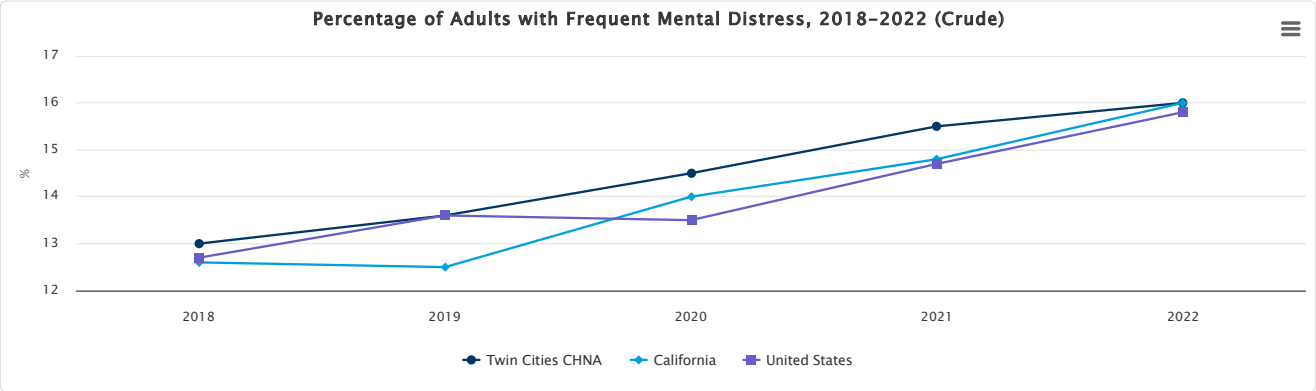
- Over 18.0%
- 16.1 - 18.0%
- 14.1 - 16.0%
- Under 14.1%
- No Data or Data Suppressed
- Twin Cities CHNA

Percentage of Adults with Frequent Mental Distress, 2018-2022 (Crude)

The table and chart below display annual trends in the percentage of adults age 18+ whose report frequent mental distress.

Report Area	2018	2019	2020	2021	2022
Twin Cities CHNA	13.0%	13.6%	14.5%	15.5%	16.0%
Monterey County, CA	13.6%	13.2%	14.5%	15.5%	17.9%
San Luis Obispo County, CA	12.6%	12.9%	14.0%	15.1%	16.6%
California	12.6%	12.5%	14.0%	14.8%	16.0%
United States	12.7%	13.6%	13.5%	14.7%	15.8%

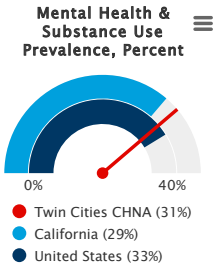
Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal. 2022 .



Health Outcomes - Anxiety & Depression - Mental Health Diagnoses

This indicator reports the unsmoothed age-adjusted rate of mental health & substance use prevalence for Medicare FFS population in 2022. Data were obtained from the CMS Mapping Medicare Disparities tool.
Note: Data are suppressed 1) where total population is less than 11 or 2) when the count of a measure is less than 3 (rate displayed as zero for such counties.)

Report Area	FFS Beneficiaries	Mental Health & Substance Use Prevalence, Total	Mental Health & Substance Use Prevalence, Percent
Twin Cities CHNA	17,797	5,513	**31%**
Monterey County, CA	54,612	14,199	26%
San Luis Obispo County, CA	50,519	15,661	31%
California	2,778,184	805,673	29%
United States	30,900,366	10,197,121	33%



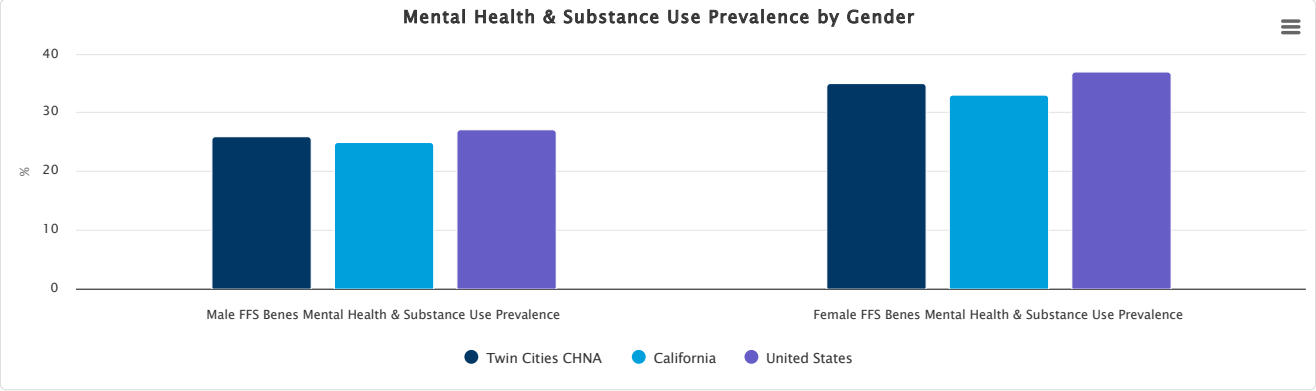
Note: This indicator is compared to the state average.
Data Source: Centers for Medicare and Medicaid Services, Mapping Medicare Disparities Tool. 2022.

Mental Health & Substance Use Prevalence by Gender

This indicator reports the unsmoothed age-adjusted rate of mental health & substance use prevalence by gender for Medicare FFS population in 2022.
Note: Data are suppressed 1) where total population is less than 11 or 2) when the count of a measure is less than 3 or greater than 0 (rate displayed as zero.)

Report Area	Male FFS Benes	Female FFS Benes	Male FFS Benes Mental Health & Substance Use Prevalence, Percent	Female FFS Benes Mental Health & Substance Use Prevalence, Percent
Twin Cities CHNA	8,183	9,614	26%	35%
Monterey County, CA	24,887	29,725	22%	30%
San Luis Obispo County, CA	23,229	27,290	26%	35%
California	1,273,797	1,504,387	25%	33%
United States	14,047,306	16,853,060	27%	37%

Data Source: Centers for Medicare and Medicaid Services, Mapping Medicare Disparities Tool. 2022.

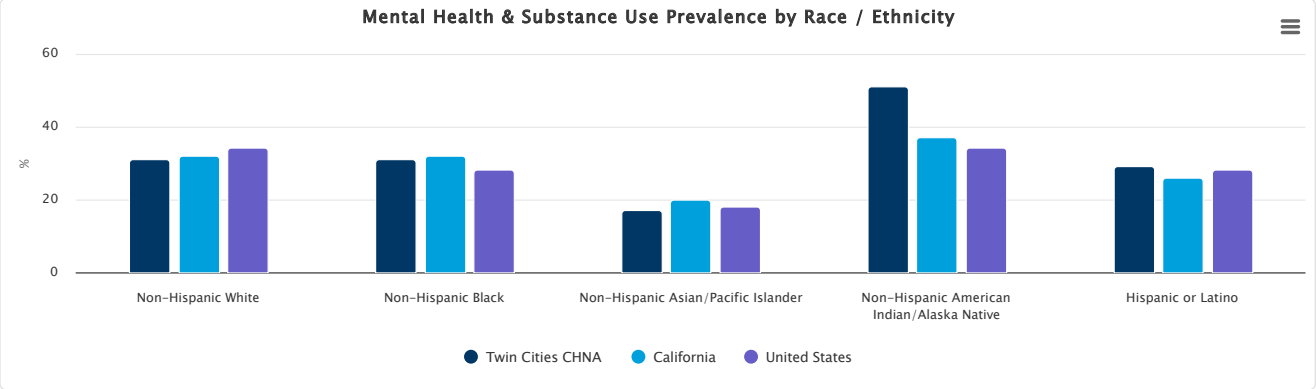


Mental Health & Substance Use Prevalence by Race / Ethnicity

This indicator reports the unsmoothed age-adjusted rate of mental health & substance use prevalence by race and ethnicity for Medicare FFS population in 2022.
Note: Data are suppressed 1) where total population is less than 11 or 2) when the count of a measure is less than 3 or greater than 0 (rate displayed as zero.)

Report Area	Non-Hispanic White	Non-Hispanic Black	Non-Hispanic Asian/Pacific Islander	Non-Hispanic American Indian/Alaska Native	Hispanic or Latino
Twin Cities CHNA	31%	31%	17%	51%	29%
Monterey County, CA	30%	29%	18%	42%	23%
San Luis Obispo County, CA	31%	31%	17%	51%	29%
California	32%	32%	20%	37%	26%
United States	34%	28%	18%	34%	28%

Data Source: Centers for Medicare and Medicaid Services, Mapping Medicare Disparities Tool. 2022.

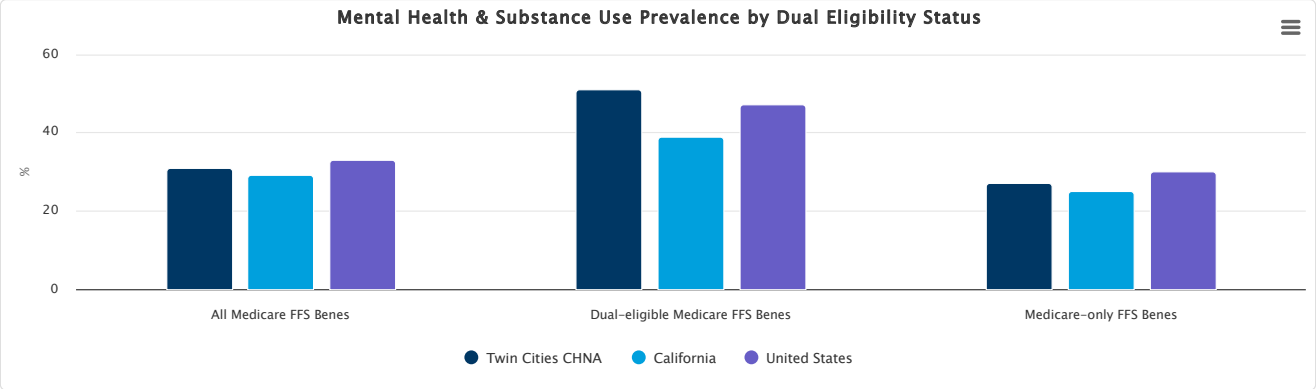


Mental Health & Substance Use Prevalence by Dual Eligibility Status

This indicator reports the unsmoothed age-adjusted rate of mental health & substance use prevalence by dual eligibility status for Medicare FFS population in 2022.
Note: Data are suppressed 1) where total population is less than 11 or 2) when the count of a measure is less than 3 or greater than 0 (rate displayed as zero.)

Report Area	All Medicare FFS Benes	Dual-eligible Medicare FFS Benes	Medicare-only FFS Benes
Twin Cities CHNA	31%	51%	27%
Monterey County, CA	26%	34%	23%
San Luis Obispo County, CA	31%	51%	27%
California	29%	39%	25%
United States	33%	47%	30%

Data Source: Centers for Medicare and Medicaid Services, Mapping Medicare Disparities Tool. 2022.



Health Outcomes - Deaths of Despair - Suicide Mortality

This indicator reports the 2019-2023 five-year average rate of death due to intentional self-harm (suicide) per 100,000 population. Figures are reported as crude rates. Rates are resummarized for report areas from county level data, only where data is available. This indicator is relevant because suicide is an indicator of poor mental health.

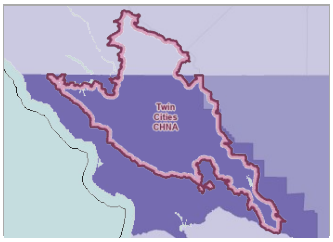
Within the report area, there are a total of 84 deaths due to suicide. This represents a crude death rate of 16.8 per every 100,000 total population.
Note: Data are suppressed for counties with fewer than 20 deaths in the time frame.

Health Outcomes - Deaths of Despair - Suicide Mortality

This indicator reports the 2019-2023 five-year average rate of death due to intentional self-harm (suicide) per 100,000 population. Figures are reported as crude rates. Rates are resummarized for report areas from county level data, only where data is available. This indicator is relevant because suicide is an indicator of poor mental health.
Within the report area, there are a total of 84 deaths due to suicide. This represents a crude death rate of 16.8 per every 100,000 total population.
Note: Data are suppressed for counties with fewer than 20 deaths in the time frame.

Report Area	Total Population, 2018-2022 Average	Five Year Total Deaths, 2018-2022 Total	Crude Death Rate (Per 100,000 Population)
Twin Cities CHNA	99,666	84	16.8
Monterey County, CA	433,175	233	10.8
San Luis Obispo County, CA	282,434	238	16.9
California	39,222,534	21,240	10.8
United States	331,563,969	240,465	14.5

Note: This indicator is compared to the state average.
Data Source: Centers for Disease Control and Prevention, CDC - National Vital Statistics System. Accessed via CDC WONDER. 2019-2023.



View larger map

Suicide Mortality, Crude Rate (Per 100,000 Pop.) by County, CDC NVSS 2019-23

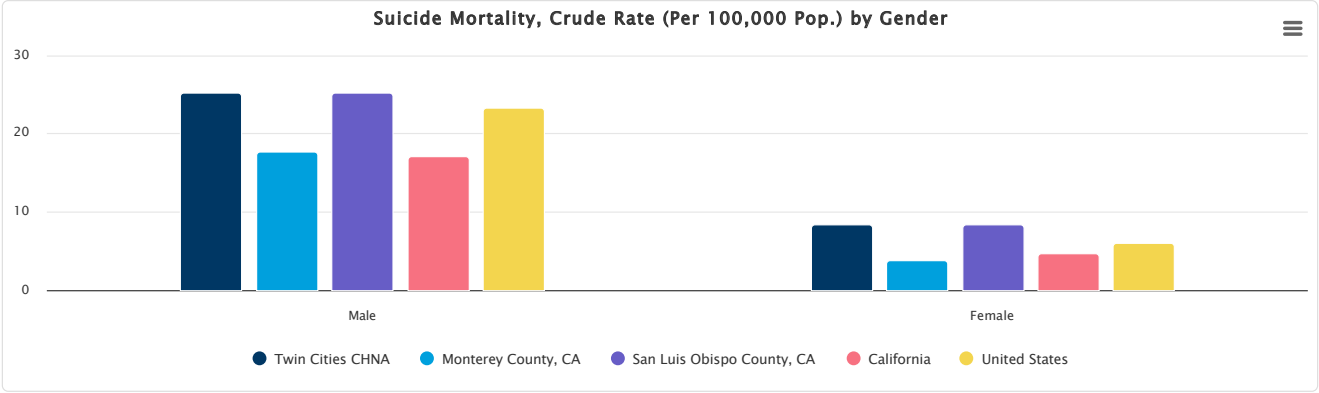
- Over 20.0
- 16.1 - 20.0
- 12.1 - 16.0
- Under 12.1
- Data Suppressed (<10 Deaths)
- Twin Cities CHNA

Suicide Mortality, Crude Rate (Per 100,000 Pop.) by Gender

The table and chart below display crude mortality rates from deaths due to intentional self-harm (suicide) for the 5-year period 2019-2023. Rates are calculated per 100,000 population and grouped by gender.

Report Area	Male	Female
Twin Cities CHNA	25.2	8.3
Monterey County, CA	17.6	3.7
San Luis Obispo County, CA	25.2	8.3
California	17.0	4.7
United States	23.3	6.0

Data Source: Centers for Disease Control and Prevention, CDC - National Vital Statistics System. Accessed via CDC WONDER. 2019-2023.

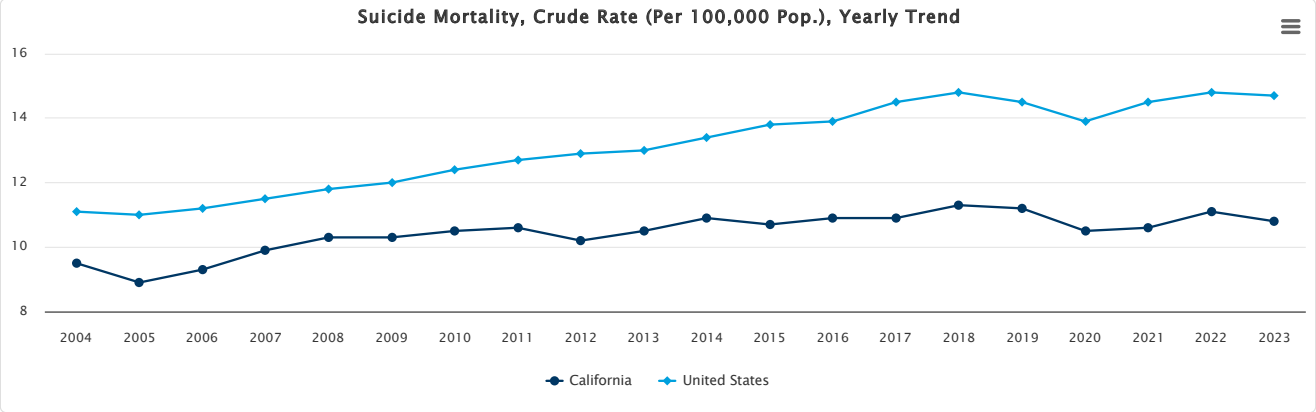


Suicide Mortality, Crude Rate (Per 100,000 Pop.), Yearly Trend

This indicator reports the crude rate of death due to suicide per 100,000 people over time.

Report Area	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
California	9.5	8.9	9.3	9.9	10.3	10.3	10.5	10.6	10.2	10.5	10.9	10.7	10.9	10.9	11.3	11.2	10.5	10.6	11.1	10.8
United States	11.1	11.0	11.2	11.5	11.8	12.0	12.4	12.7	12.9	13.0	13.4	13.8	13.9	14.5	14.8	14.5	13.9	14.5	14.8	14.7

Note: No county data available. See data source and methodology for more details.
Data Source: Centers for Disease Control and Prevention, CDC - National Vital Statistics System. Accessed via CDC WONDER. 2019-2023.



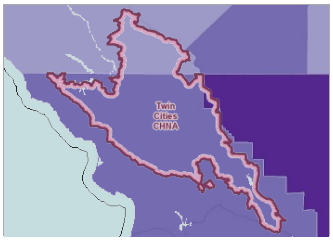
Health Outcomes - Deaths of Despair - Deaths of Despair

This indicator reports average rate of death due to intentional self-harm (suicide), alcohol-related disease, and drug overdose, also known as "deaths of despair", per 100,000 population. Figures are reported as crude rates. Rates are resummarized for report areas from county level data, only where data is available. This indicator is relevant because death of despair is an indicator of poor mental health.

Within the report area, there were 323 deaths of despair. This represents a crude death rate of 64.8 per every 100,000 total population.
Note: Data are suppressed for counties with fewer than 20 deaths in the time frame.

Report Area	Total Population, 2018-2022 Average	Five Year Total Deaths, 2018-2022 Total	Crude Death Rate (Per 100,000 Population)
Twin Cities CHNA	99,666	323	64.8
Monterey County, CA	433,175	1,034	47.7
San Luis Obispo County, CA	282,434	916	64.9
California	39,222,534	100,758	51.4
United States	331,563,969	970,307	58.5

Note: This indicator is compared to the state average.
Data Source: Centers for Disease Control and Prevention, CDC - National Vital Statistics System. Accessed via CDC WONDER. 2019-2023.



View larger map

Deaths of Despair, Crude Rate (Per 100,000 Pop.) by County, CDC NVSS 2019-23

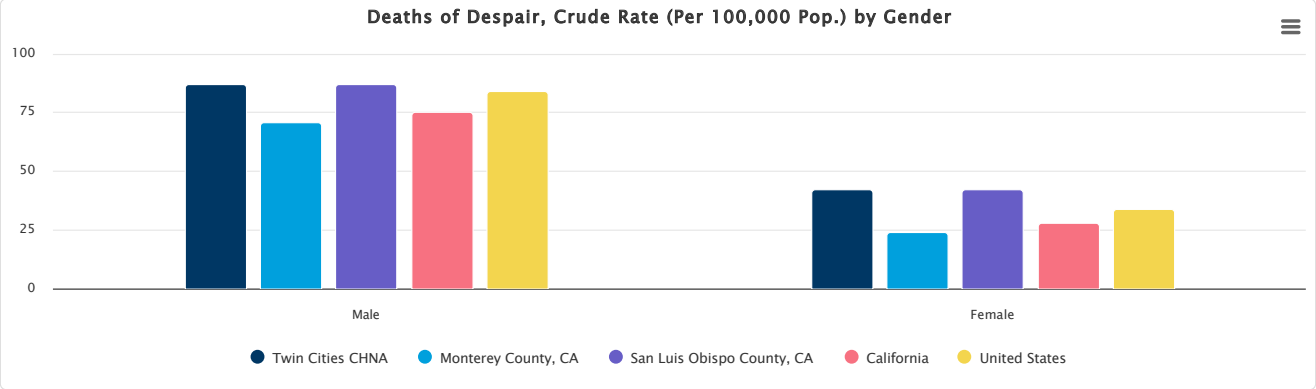
- Over 70.0
- 50.1 - 70.0
- 40.1 - 50.0
- Under 40.1
- Data Suppressed (<10 Deaths)
- Twin Cities CHNA

Deaths of Despair, Crude Rate (Per 100,000 Pop.) by Gender

The table and chart below display crude mortality rates from deaths due to intentional self-harm (suicide), alcohol-related disease, and drug overdoses, also known as "deaths of despair" for the 5-year period 2019-2023. Rates are calculated per 100,000 population and grouped by gender.

Report Area	Male	Female
Twin Cities CHNA	87.0	42.0
Monterey County, CA	70.8	23.8
San Luis Obispo County, CA	87.1	42.1
California	75.0	27.9
United States	84.0	33.7

Data Source: Centers for Disease Control and Prevention, CDC - National Vital Statistics System. Accessed via CDC WONDER. 2019-2023.

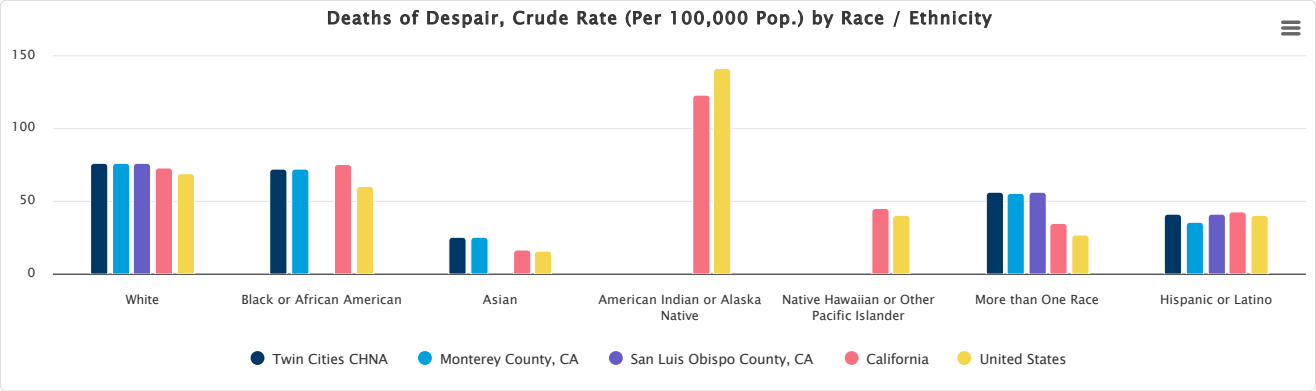


Deaths of Despair, Crude Rate (Per 100,000 Pop.) by Race / Ethnicity

The table and chart below display crude mortality rates from deaths due to intentional self-harm (suicide), alcohol-related disease, and drug overdoses, also known as "deaths of despair" for the 5-year period 2019-2023. Rates are calculated per 100,000 population and grouped by combined race and Hispanic origin.

Report Area	White	Black or African American	Asian	American Indian or Alaska Native	Native Hawaiian or Other Pacific Islander	More than One Race	Hispanic or Latino
Twin Cities CHNA	75.6	71.9	25.2	No data	No data	55.8	40.9
Monterey County, CA	76.0	71.9	25.2	No data	No data	55.5	35.2
San Luis Obispo County, CA	75.6	No data	No data	No data	No data	55.8	41.0
California	72.3	75.3	16.5	122.8	45.0	34.8	42.2
United States	68.3	59.7	15.7	141.1	39.9	26.8	40.1

Data Source: Centers for Disease Control and Prevention, CDC - National Vital Statistics System. Accessed via CDC WONDER. 2019-2023.

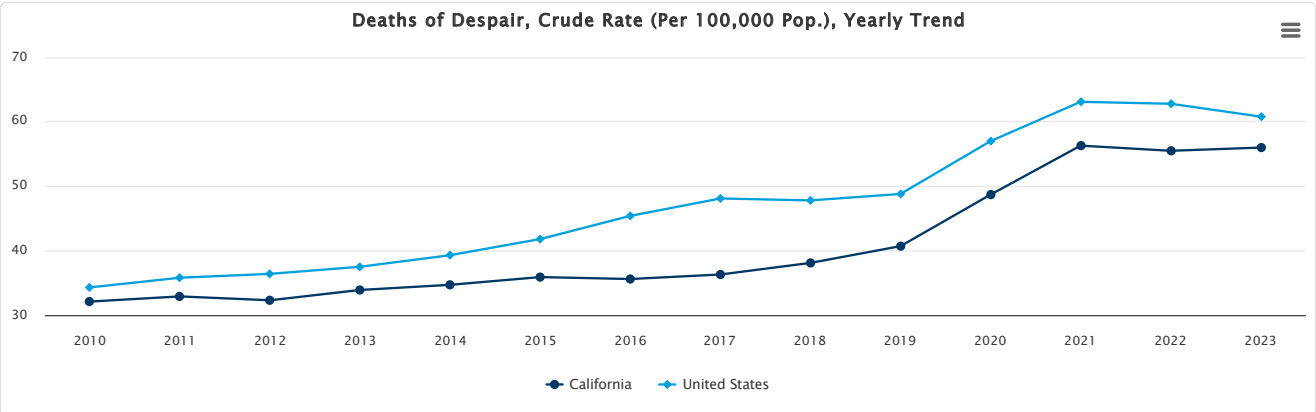


Deaths of Despair, Crude Rate (Per 100,000 Pop.), Yearly Trend

The table below shows crude death rates due to intentional self-harm (suicide), alcohol-related disease, and drug overdoses, also known as "deaths of despair," per 100,000 population over time.

Report Area	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
California	32.1	32.9	32.3	33.9	34.7	35.9	35.6	36.3	38.1	40.7	48.7	56.3	55.5	56.0
United States	34.3	35.8	36.4	37.5	39.3	41.8	45.4	48.1	47.8	48.8	57.0	63.1	62.8	60.8

Note: No county data available. See data source and methodology for more details.
Data Source: Centers for Disease Control and Prevention, CDC - National Vital Statistics System. Accessed via CDC WONDER. 2019-2023.



From the **list** of significant health needs, Steering Committee members **identified** the following as high priorities. The remaining lower priority needs were also identified by **Steering Committee** members as important community needs to address.

A. Identified Significant Health Needs

The following lists all significant health needs identified during the 2025 CHNA process. Also included are links to resources related to each health need.

High Priority Needs

Access to Care

slohealthaccess.org
unitedwayslo.org/community-strengthening/211-helpline

Less than five percent (4.17%) of the population lives within one mile of a hospital with an emergency room (U.S. Department of Health and Human Services, 2023). Focus group participants and key informants highlighted the need for more access to primary care across all ages, especially pediatric specialists.

Housing

slocounty.ca.gov/departments/social-services/homeless-services-division
slocounty.ca.gov/departments/planning-building/department-services/housing-hub/housing-hub#gsc.tab=0

Based on the area median income, households spend more than half of their income (50.89%) on housing and transportation alone (Partnership for Sustainable Communities, 2019). Focus group participants noted how homelessness is closely connected to the high cost of living. Key informants described the lack of resources such as non-profit organizations serving the homeless population.

Mental Health

slocounty.ca.gov/departments/health-agency/behavioral-health
slocounty.ca.gov/departments/health-agency/behavioral-health/all-behavioral-health-services/mental-health-adult-services

Within the report area, 18.9% of adults 18 and older reported binge drinking (Centers for Disease Control and Prevention, 2022). Both focus group participants and key informants expressed how they have seen a rise in mental health diagnoses, especially anxiety and depression among students and staff.

Lower Priority Needs **please note web address leads to multiple 211 resources within each priority need*

Community Infrastructure

slocounty.ca.gov/departments/administrative-office/countywide-projects-programs/regional-infrastructure-and-affordable-housing-pla/
reachcentralcoast.org/slo-county-hip/

Nearly one in ten households (8.85%) have no internet access in their home or use dial-up as their only form of internet connection. Key informants highlighted how access to a computer and internet is often what limits accessing services that may impact their health. Focus group participants mentioned that a lack of community amenities like sidewalks, bike lanes and safe routes are important in areas like schools.

Financial Stability

unitedwayslo.org/family-financial-stability/
slocounty.ca.gov/departments/social-services/cash-assistance-programs/
Cash Assistance Programs: www.slocounty.ca.gov/departments/social-services/cash-assistance-programs

More than one-third of the population (35.78%) spends 30% or more of their household income on housing costs, resulting in making difficult choices when it comes to meeting other basic needs, health needs and social needs. Focus group participants noticed more people moving out of the community because of the cost of living, even those with two incomes.

Health Risk Behaviors

slocounty.ca.gov/departments/health-agency/behavioral-health/all-behavioral-health-services/access-and-crisis-services
slohealthcounts.org/mentalhealth
sloiwma.recyclist.co/guide/needles-and-sharps/?embeddedguide=true

Within the report area, health risk behaviors such as binge drinking, smoking, substance use disorders and opioid drug claims all perform worse than the California benchmark (CDC, 2022 and Centers for Medicare and Medicaid Services, 2018).

Social & Economic Context

sloiwma.recyclist.co/guide/needles-and-sharps/?embeddedguide=true
tri-counties.org/wp-content/uploads/2017/11/slo-county-social-svs-resource-sheet.pdf
slocounty.ca.gov/departments/social-services

Local government expenditures on public works and welfare totals to $6,666 per capita compared to California's $9,464. Focus groups and key informants raised concerns around increased loneliness, people moving out of the community and a lack of resources or services relevant to the community's needs.

Scan QR Code to explore the full live data report or visit: cares.page.link/RJmJ

B. Description of Focus Groups & Key Informant Interviews

The CHNA Steering Committee identified vulnerable populations and worked with local organizations to coordinate focus groups and key informant interviews to ensure that minority populations — the voices of those with chronic disease, low income and the underserved were heard. See below for more details regarding focus groups and key informant interviews. Themes and quotes from focus groups and key informant interviews are available in Section III. High Priority Health Needs.

Logistics

Four (4) focus groups with thirty (30) people participating. Focus groups were in-person, typically running 90 minutes.

Four (4) key informant interviews. Interviews were conducted virtually, running 60 minutes.

Participating Organizations

- CenCal Health
- City of Atascadero
- El Camino Homeless Organization (ECHO)
- Jack's Helping Hand
- Pacific Premier Bank
- San Luis Obispo Council of Government
- San Luis Obispo County Fire Department
- San Luis Obispo County Office of Education
- San Luis Obispo Legal Assistance Foundation
- San Luis Obispo Health Counts Steering Committee
- Transitions Mental Health Association

Represented Race/Ethnicity

- African American
- Asian
- LatinX
- Native Hawaiian or Pacific Islander
- White

Represented Populations

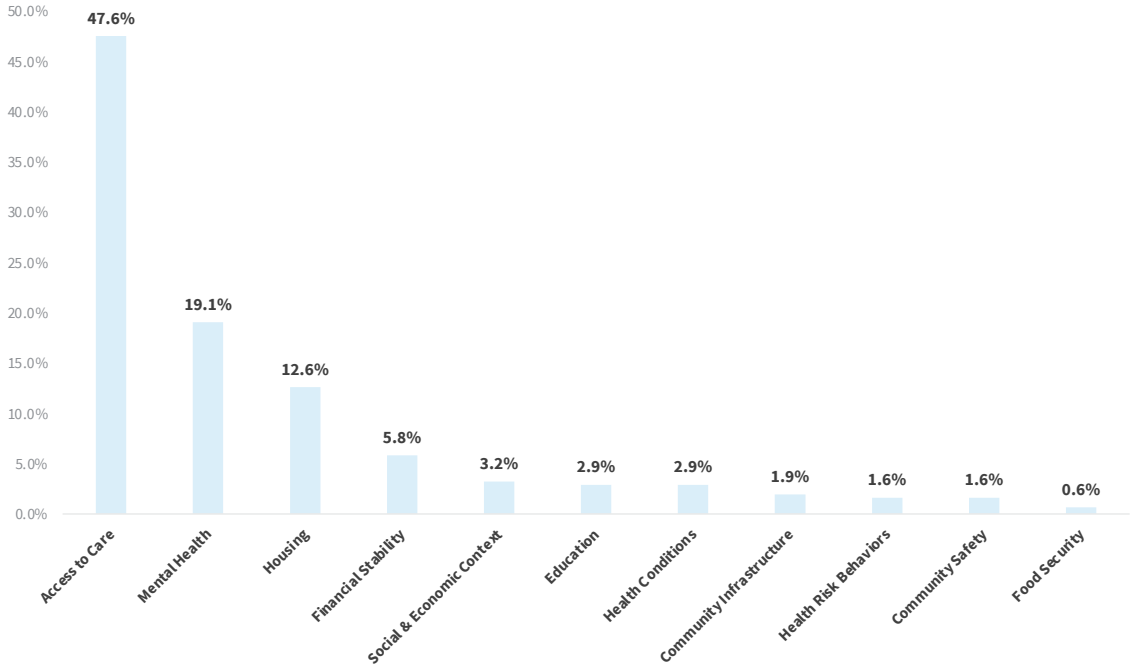
- Civil Government
- Healthcare Consumer
- Healthcare Workforce
- Human Services
- Law enforcement
- Low-income
- Medically Underserved
- Men
- Miniority Population
- Older Adults
- Public Health
- Substance Use Disorder
- Unhoused population
- Women

C. Focus Groups & Key Informant Interviews Results

The focus group and key informant interview charts below highlight the percentage of mentions for each selected need within the Community Impact Framework. For additional details on focus group and key informant interview methodology, see Section V. Process and Methods to Conduct the CHNA.

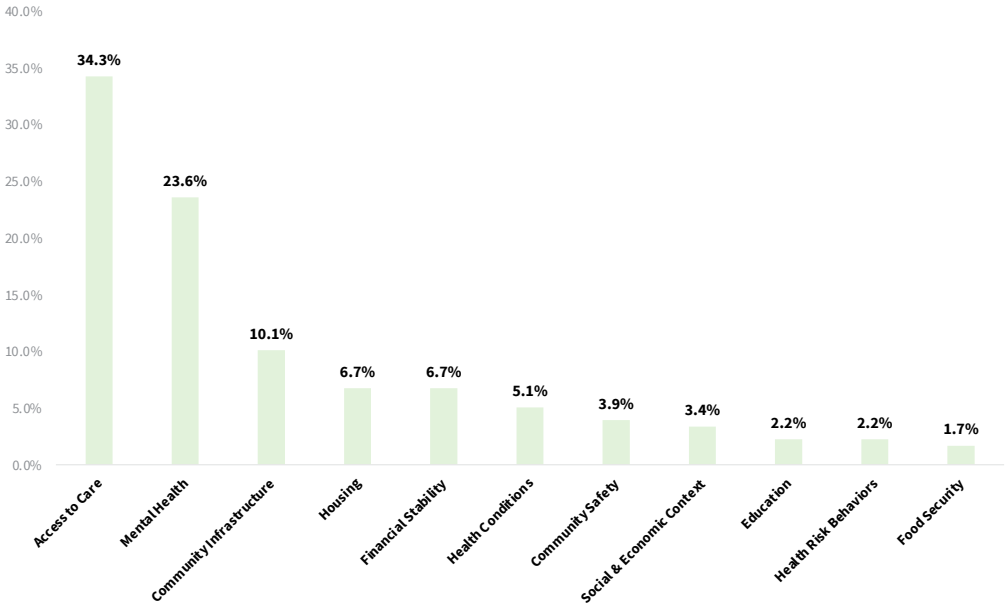
Focus Groups

The following chart details the percentage by which focus group participants mentioned or discussed the 12 categories from our Community Impact Framework.



Key Informant Interviews

The following chart details the percentage by which key informant interviews mentioned or discussed the 12 categories from our Community Impact Framework.



D. Secondary Data Results

Below are the secondary data results that rank the 12 categories from our Community Impact Framework from 1 to 100. Higher scores have the greatest impact on life expectancy and general health status. For additional information on scoring methodology see Section V. Process and Methods to Conduct the CHNA.

Priority Health Needs

Health needs in Twin Cities CHNA were determined using quantitative analysis of data. Needs were identified based on their impact on short-term health (well-being) and long-term health (life expectancy), as well as prevalence in the market relative to state benchmarks. Priority areas are scored on a scale of 1 to 100, with higher scores indicating higher health needs.

Adults Age 18+ with Poor or Fair General Health (Crude)
16.6%
California: 18.8%

Life Expectancy at Birth (2010-2015)
80.49
California: 80.32

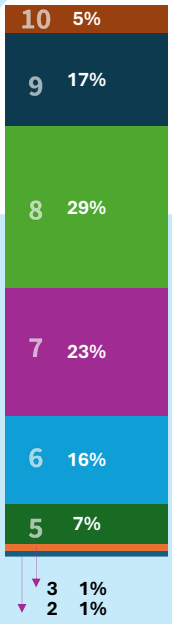
Mental Health	Access to Care	Health Risk Behaviors	Financial Stability	Housing	Education
50	47	45	45	44	42

Food Security	Climate & Natural Environment	Social & Economic Context	Health Conditions	Community Safety	Community Infrastructure
41	35	33	33	32	31

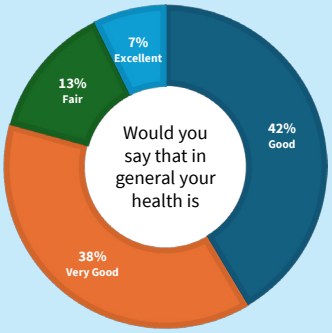
Legend: Excellent Very Good Good Fair Poor

E. Survey Results

Community surveys collect data from a broad population to understand real-time perspectives on health and well-being. Survey questions focus on gathering data related to major health issues, life satisfaction, access to medical care and community resources.



Imagine a 10-step ladder. At the top life is great, a 10. At the bottom, life is not good, a 0. Which step of the ladder are you standing on right now?

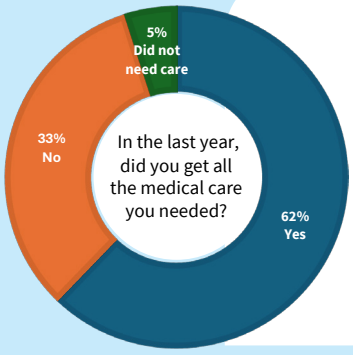


Select 3-5 things that you believe make it hard to live and be well

High cost of living	24.4%
Lack of affordable housing	19.7%
Can't get medical care	19.4%
Not enough good jobs	9.3%
Racism	5.0%
Access to affordable healthy food	4.7%
Limited childcare options	3.9%
Lack of transportation	3.6%
High risk for natural disasters (fire, floods, earthquakes)	3.2%
Limited access to social services for me or my family members	2.2%
No friends or connection to community	2.2%
Lack of good schools	1.8%
Bad air and/or water quality	0.7%
Grand Total	**100.0%**

Select 1-5 of the biggest health problems you're facing.

Aging problems (e.g. arthritis, hearing/vision loss, dementia, etc.)	23.3%
Being overweight	12.2%
Mental health problems (e.g. extreme sadness, fear, worry, anger or stress)	11.1%
High blood pressure	9.5%
No health problems	6.9%
Vision/Hearing problems	5.8%
Asthma/COPD	4.8%
Problems with mobility	4.2%
Illness that spreads (like flu, COVID, TB)	4.2%
Poor eating habits	3.7%
Cancer	3.2%
Heart disease/Stroke	3.2%
Respiratory/Lung disease	2.6%
Diabetes/Kidney disease	2.6%
Mother-baby care	1.1%
Alcohol and/or drug misuse	1.1%
Child/Partner abuse	0.5%
Grand Total	**100.0%**



If you did not get all the medical care you needed, what are the reasons why?

Poor quality of doctors/nurses	21.6%
It costs too much	17.6%
Specialists not covered by insurance	13.7%
Location of medical care	13.7%
I do not have a primary care doctor	11.8%
Inconvenient hours of operation	11.8%
I did not know where to get care	7.8%
I do not have health insurance	2.0%
Grand Total	**100.0%**

Select the resources that your community needs more of to help you live better.

Healthcare and prescription costs	23.4%
Childcare or senior care	19.1%
Housing options	18.7%
Parks, recreation and outdoor activities	8.6%
Managing stress and depression	8.1%
Social/Community events	7.7%
Utilities/Internet	5.7%
Local food banks	3.8%
Neighborhood safety	2.4%
Legal services	1.4%
Personal safety	1.0%
Grand Total	**100.0%**

Twin Cities Survey Responses
82

The following pages **reflect** the **process** and **methods** used to **conduct** this CHNA.

V. Process & Methods to Conduct the CHNA

A. Introduction

This Community Health Needs Assessment (CHNA) process aligns with the American Hospital Association Community Health Improvement (i.e. Healthy Communities) guidelines and was designed after an analysis of best practices for CHNAs, as defined by the Centers for Disease Control and Prevention (CDC), Community Commons, and the National Association of County & City Health Officials (NACCHO).

This CHNA was conducted using four distinct sources of primary and secondary data. This mixed methods approach is a preferred practice for needs assessments as it allows for data triangulation, providing the greatest understanding of community needs from the broadest range of perspectives. Having multiple avenues for contributing perspectives has been shown to better include the voices of all community members, particularly vulnerable and disadvantaged groups (Ravaghi et al., 2023).

For this CHNA process, a local Steering Committee was formed to help coordinate the collection of primary data, with an emphasis on incorporating the perspectives of underserved populations. Primary data collection involved focus group interviews, individual key informant interviews and surveys. Secondary data was also collected, involving a review of over 150 metrics from state and national sources which were analyzed to determine factors having the greatest impact on community health. All collected CHNA data was coded and analyzed according to a Community Impact Framework. Framework development, data types, data collection, analysis and prioritization methods are described in the following pages.

B. Community Impact Framework

To organize health findings throughout this CHNA, a multi-tiered Community Impact Framework was used to categorize data into community health needs. To develop the Community Impact Framework, an initial set of 12 conceptual health need areas were identified by reviewing an analysis of past cycle CHNAs, which was conducted by the American Hospital Association, and comparing to existing SDoH frameworks like Well-Being in the Nation (WIN) and Kaiser Family Foundation. After conducting an analysis of appropriate and available public, secondary data to measure each category, a set of sub-categories and subsequent indicators were codified to make up a systematic framework. To this end, a landscape scan of available data was performed by evaluating existing population health measurement frameworks. Four primary frameworks were evaluated:

- Well-Being in the Nation (WIN) Measurement Framework
- National Committee for Vital and Health Statistics (NCVHS) Measurement Framework for Community Health & Well Being
- County Health Rankings and Roadmaps
- Healthy People 2030 Leading Health Indicators

Attributes for each indicator within the frameworks were identified, including data source, geographic level, extent, time period and update frequency. Next, indicators were filtered and removed from the list based on our inclusion criteria: ability to represent the reference community (e.g., geographic scale), recency, update frequency and source reliability. Indicators from each framework were assigned to each of the 12 categories, with some indicators assigned to multiple categories. The final framework consists of more than 150 individual metrics across the 12 categories, each with a minimum of two subcategories (CARES, 2022). For a full glossary of terms that include all 12 categories, see Appendix A. Glossary of Terms and Definitions of Health Needs.

Health Needs	Access to Care	Availability - Hospitals & Clinics | Availability - Mental Health Care | Availability - Primary Care Availability - Specialty Care | Barriers - Health Literacy | Barriers - Medical Insurance | Barriers - Transportation
	Health Conditions	Asthma & COPD | Cancers | Chronic Brain Disorders | Heart Disease & Stroke | Kidney & Liver Diseases Obesity & Diabetes | Impairments | Preventable Death Health Status | Aging Conditions
	Health Risk Behaviors	Alcohol | Diet & Nutrition | Illicit Drugs | Physical Inactivity | Preventative Care | Reproductive Health STIs | Tobacco
	Mental Health	Health Outcomes - Anxiety & Depression | Health Outcomes - Deaths of Despair | Risk Factors - Access to Care Risk Factors - Drugs & Alcohol | Risk Factors - Stress & Trauma
Basic Needs	Food Security	Economic Security | Food Access
	Education	Achievement | Attainment | Early Childhood
	Financial Stability	Employment | Income | Security
	Housing	Homelessness | Housing Costs | Housing Quality
Social Needs	Climate & Natural Environment	Physical Environment - Air & Water | Physical Environment - Heat & Climate
	Community Safety	Injuries | Public Safety | Risk Factors
	Community Infrastructure	Access to Childcare | Community Amenities | Internet & Technology | Transportation
	Social & Economic Context	Civic Engagement | Economic Vitality | Place Attachment | Social Inclusion | Socioeconomic Disadvantage

C. Data Overview: Description, Benefits & Limitations

The below information includes context related to each data source, to aid interpretation of the data included in the following sections.

Description

Key Informant Interviews

Qualitative data from semi-structured conversations with community leaders who possess specialized knowledge about a particular community. Key informants are selected based on their firsthand experience, expertise, or position within a specific community.

Focus Group

Qualitative data from structured, but fluid discussions led by a facilitator with a small group of community members who reside in that local area. Participants are chosen for their ability to represent the needs of underrepresented, underserved, or vulnerable populations within the community.

Survey

Quantitative data collected in real time for this report, representing health concerns and priorities across a broad sample of the community and patients. The survey consists of questions related to health status, health needs and resources available to the community.

Secondary Public Data

Quantitative data previously collected by government agencies, research institutions, or other organizations. This report references a pool of 150 data indicators curated by the University of Missouri Extension Center for Applied Research and Engagement Systems (CARES).

Benefits

Key Informant Interviews

- **In-depth Insight:** These interviews are designed to gather in-depth insights, perspectives and expertise that may not be readily available through other sources.
- **Contextual Understanding:** The information gathered helps our organization gain an understanding of complex health barriers and sociocultural contexts beyond what is available in quantitative data.
- **Validation:** Conducting key informant interviews can serve as a means of validating other data sources.
- **Community Engagement:** Supports collaborative efforts to address community health needs.

Focus Group

- **Interactive and In-depth Insights:** Community members are encouraged to interact with each other, which provides insights and generates discussion that uncover a range of needs and perspectives. Focus groups encourage participants to build on each other's responses, leading to richer, more detailed insights.
- **Contextual Understanding:** The information gathered helps our organization gain an understanding of complex health barriers and sociocultural contexts beyond what is available in quantitative data.
- **Validation:** Conducting focus groups can serve as a means of validating other data sources.
- **Community Engagement:** Supports collaborative efforts to address community health needs. We prioritized engaging underrepresented individuals who face negative socioeconomic or health effects, such as low-income populations, minorities and those with chronic health conditions.

Survey

- **Full Anonymity:** Personally identifiable information is not collected.
- **Wide Reach and Generalizability:** Data from a large number of respondents makes it possible to generalize findings to a larger community.
- **Cost-Effectiveness:** Surveys can be a relatively cost-effective method for reaching a large audience.

Secondary Public Data

- **Public Data:** Data is publicly available and therefore a cost-effective method for assessing health needs.
- **Diverse and Longitudinal Data:** The data includes a diverse set of 150 metrics spanning census data, economic indicators, and health statistics and publicly released survey results, allowing for the ability to conduct comparative analyses over time.
- **Wide Reach and Generalizability:** Data from a large number of respondents makes it possible to generalize findings to a larger community.

Limitations

Key Informant Interviews

- **Subjectivity and Perspective Bias:** Key informants who volunteer to participate may have their own biases or limited perspectives, which can shape their responses.
- **Limited Generalizability:** Informants may lack generalizability to the broader community since informants are selected based on involvement in specific area.

Focus Group

- **Limited Generalizability:** Findings from focus groups may not be broadly representative of the entire community due to the small sample size of volunteers.
- **Social Desirability Bias:** Participants may provide responses that they perceive as socially desirable or acceptable in a group setting, rather than fully disclosing less favorable or controversial information.

Survey

- **Sampling Bias:** Community members who choose to complete the survey may have their own biases or limited perspectives, which can shape their responses.
- **Distribution and Data Collection:** Surveys distributed digitally used a global online translation service, which may present challenges with the quality of understanding cultural nuances and word-for-word translation. Surveys were also distributed in paper form to local organizations who entered results from their constituents, which could affect the accuracy of the information collected.
- **Limited Depth of Responses:** Limited opportunity for participants to elaborate on their answers or provide context can result in responses that do not fully capture the complexities of health barriers.

Secondary Public Data

- **Timeliness:** The most recent public data that met our criteria (available across multiple states and, when possible, at the zip code level) was referenced. However, public data may not always be up-to-date or reflect real-time information.

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D. Focus Group & Key Informant Interview Methodology

Primary data collection was designed to gather first-person input on community health needs directly from community members. From May 2024 – November 2024, focus groups were conducted with community service providers and service recipients, and key informant interviews were conducted with community leaders. Focus group members participated in 1.5-hour in-person sessions, and key informant interviewees participated in 1-hour individual virtual interviews. Steering committee members were responsible for identifying participants and scheduling both types of interviews. Any social service provider in the community was eligible for inclusion in the focus groups, and any social service director or other community leader was eligible for key informant interview involvement. An emphasis was placed on hearing from underserved and minority populations whenever possible.

The semi-structured interview guides used for both types of interviews were nearly identical. The only variation between the focus group and key informant interview guides was the inclusion of additional prompting questions allowing for key informants to provide a greater depth of response.

The facilitators were a team of Adventist Health system staff who began all focus groups and key informant interviews by having participants identify up to five high priority community health needs from their perspective based on a social determinants of health framework with priority areas and subcategories. The facilitators then moved through a series of questions, focusing on depth of need, barriers, attempts at addressing the need historically, ways that different groups are affected and recent, emerging trends. Focus groups and key informant interviews were conducted in teams of two, with a lead facilitator and a notetaker, and all interviews were recorded. All focus groups were conducted in English or Spanish, with translation services provided as needed. Focus groups and key informant interviews were recorded with the consent of participating interviewees. All recordings were transcribed into English. In the spirit of collaboration, transcripts were shared with other non-profit hospitals within the same service area. To ensure the anonymity of participants was protected, all shared transcripts removed participant names. Remarks that detracted from the scope pertaining to community health needs were also removed.

E. Survey Methodology

A community survey was distributed as a primary data tool to gather real-time, quantitative data about the community's greatest health needs. To reflect the entire community, questions were designed to solicit responses at the individual, interpersonal and community levels. The selection process and criteria for the survey questions involved a rigorous review of other health systems' CHNAs, reputable government organizations such as the National Association of County and City Health Officials (NACCHO), the Centers for Medicare and Medicaid Services (CMS) Health-Related Social Needs Screening Tool, Healthy People 2030, and the Centers for Disease Control and Prevention (CDC). Additionally, the survey design was informed by interviewing techniques, collaboration with Steering Committee members from our previous CHNA cycle, a review of community health improvement toolkits, and the availability of state and national benchmarks.

The community survey comprised seven questions and took approximately five minutes to complete. To ensure accessibility, the questions were written at a fifth-grade reading level and translated into four languages using a global online translation service. The survey was distributed both in paper form and digitally via link, email, text, and QR code. Participation was voluntary, and responses were kept confidential. To maximize reach within the service area, the survey was shared with Steering Committee members, who then distributed it among their stakeholders, community-based organizations that volunteered to share it with their constituents, and patients at Adventist Health hospitals. For the full list of survey questions, see Appendix C.

F. Secondary Data Methodology

Basic Approach

Secondary data scoring comprised development of health needs index scores for each of the 12 categories included in the Community Impact framework. These index scores were determined using quantitative analysis of all secondary data referenced. Health needs scores for target communities in each of 12 priority areas (categories) were determined using quantitative analysis of secondary data from standard, national sources. First, metrics were selected that best represented each category based on a review of multiple health measurement frameworks. Next, metrics were scored based on three criteria relevant to life expectancy and quality of life. These criteria include impact on short-term health (well-being), impact on long-term health (life expectancy) and severity within the reference community relative to state benchmarks. Final health needs scores for each priority area were developed with possible scores ranging from 1 to 100. Higher health needs scores indicate 1) a comparatively high degree of correlation between the underlying metrics within the health needs category and the outcome variables (well-being and life expectancy), and 2) a high level of need in the community compared to other areas of the state. Figure 1 depicts this process, which is further described below.

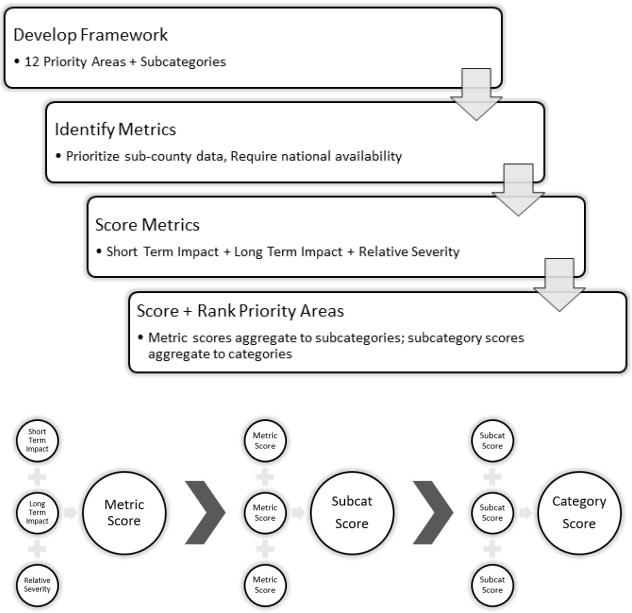

Figure 1. A. Approach to framework and scoring methodology development. B. Diagram of scoring approach.

Metric Scoring

Scores are generated for metrics (e.g., obesity prevalence) to represent the criteria mentioned above (length of life, quality of life and severity). To operationalize the first two criteria, we measure the degree of correlation between each metric and two outcome variables: a short-term goal (well-being, measured by physical and mental health status) and a long-term goal (length of life, measured by life expectancy at birth).

Metrics with strong negative relationships with the outcome variables (scoring below -.40) were removed from the framework.

To address the third criterion, we calculate the relative severity of each metric for each target community using a z-score. A z-score is a measure which quantifies the position of a raw data value (e.g., the value for one metric for a community) in relationship to the mean and distribution of all values (e.g., the value for one metric for all other areas). For this work, the calculated value for each community for a metric (e.g., obesity) is compared against the value for all counties within the community state (e.g., obesity rates for all counties in California). In this way, communities can be compared against geographic areas with similar geographic size and heterogeneity. Furthermore, z-scores for a given community are compared against a fixed number and definition of geographic areas, which exist independent of the number of communities or hospitals assessed within a state.

Transformation of Correlation Scores

To aid in interpretability, correlation scores within a single health need category and outcome category were converted to percentiles, such that the score for a single metric represents the percent of the total scores for all metrics.

Category Scores

Scores for each metric are based on three separate values, as represented in Equation 1 below. Short-term and long-term health impact scores are identical for all communities, while the relative severity score is unique. To generate a final score for each metric, we calculate the weighted average of the short-term and long-term

score and apply the z-score as an adjustment factor.

$M_c = (ST_s + LT_s) * Z_{cs}$

Equation 1. Metric scores. ST_s is the state-specific correlation score between the metric and the short term outcome variable (self-reported health status), LT_s is the state-specific correlation score between the metric and the long term outcome variable (life expectancy), and Z_{cs} is the area-specific relative severity score (z-score).

In this way, communities that perform better than average for a metric will see scores adjusted down (lower priority), and communities that perform worse than average will see scores adjusted up (higher priority).

Next, metric scores are aggregated to produce subcategory and category scores. Subcategory scores are calculated as the average of all final metric scores within a category. Finally, category scores are calculated as the average of all subcategory scores within a category.

$SubC_c = \Sigma_c SubC/n$
$Cat_c = \Sigma\ SubC/n$

Presentation of Results

All final subcategory and category scores are transformed to a 100-point scale for ease of interpretation, where 100 is the maximum possible value (highest priority) and one is the lowest theoretical possible value (lowest priority).

Subcategory scores are transformed *independently* of category scores. The maximum "real" subcategory score may be as high as 7.0, which would transform to ~100, whereas the highest category score is only about 4.0, which also transforms to ~100. Therefore, subcategory scores can be compared with other subcategory scores; category scores may be compared with category scores, however subcategory scores and category scores cannot be compared.

Limitations

This approach is subject to several limitations. First, the final selection of priority areas is heavily dependent on the structure of the measurement framework. In this work, the top-level framework was determined by the hospital system based on prior assessments; metrics were assigned to categories and grouped based on expert knowledge. However, changes to the organization of metrics within top-level categories, including the addition or removal of metrics or the reorganization of metrics within subcategories, are a major driver of category scores and results. A data-driven method for selecting a measurement framework would therefore improve the applicability of these results outside of the example health system.

Next, despite best efforts to identify relevant metrics at the community level, availability of data to represent some priority health need concepts remain limited. For example, data on the prevalence of overall homelessness is not available for small (e.g., sub-county) geographic areas. Without data that accurately represent prevalence within a community, the ability to score impact on health and well-being is limited.

An additional limitation is the flexibility of metric correlation scores with the outcome variables. Work found scores to be influenced by the geographic scale and the geographic universe (e.g., state, region, or U.S. total) at which relationships were assessed, and rescaling methods used to standardize data. Changes to one or more of these decisions produce a range of correlation scores. Ideally, relationships would be consistent across multiple geographic levels or groupings.

Finally, secondary data are hampered by lag in reporting. At the time assessments were performed (summer 2024), the latest available data on health behaviors, outcomes, and social determinants represented the 2021 and 2022 calendar years, and in some cases, data were older still. Since the first aim of this work is to measure the relationship between certain factors and well-being and life expectancy, this temporal lag is of less importance. Moreover, we incorporate a mix of other data sources to mitigate the data lag variance to take a standardized approach important for a mixed-methodology analysis.

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G. Data Analysis & Identification of Significant Health Needs

This CHNA deployed a mixed methodology combining the strengths of analyzing primary data with secondary data results. As demonstrated in steps two-four below, several actions were taken to analyze data and produce a list of significant health needs.

Preparation & Data Collection: Adventist Health staff, CARES team and CHNA Steering Committee

STEP 1: FRAMEWORK & CODEBOOK CREATION

- Map focus group and key informant interview questions to framework and codebook.
- Map secondary data indicators to framework.

STEP 2: DATA COLLECTION

- Primary Data: focus groups, key informant interviews and survey.
- Secondary Data: 150 indicators.

Data Analysis & Identification of Significant Health Needs: Adventist Health system staff and CARES team

STEP 3: AGGREGATION

- Code focus group and key informant interview groups to framework.
- Aggregate survey results per community.
- Score Secondary Data Index.

STEP 4: SYNTHESIS

- Identify list of Significant Health Needs based on:
  - Health need identified as top five across any data sources.
  - Health need is identified in two or more data sources.

EVALUATION & HEALTH NEEDS PRIORITIZATION: CHNA Steering Committee

STEP 5: EVALUATION

- Evaluate Significant Health Needs data.

STEP 6: PRIORITIZATION

- Rank "high" and "low" Priority Health Needs based on prioritization criteria.

Data Collection to Aggregation

After primary data collection, Adventist Health staff conducted a deductive coding of all focus group and key informant interview data to the Community Impact framework. Secondary public data was analyzed and index scores were created for ranking, according to the methodology outlined in Section V. Process and Methods to Conduct the CHNA.

To facilitate this coding process for focus groups and key informant interviews, as described in Step 3 of the infographic above, focus group and key informant interview transcript files were uploaded to a Microsoft AI coding solution, along with the Community Impact framework as the reference table. To generate an output, Adventist Health staff provided a written prompt to the AI solution:

You are an AI assistant tasked with analyzing and classifying provided conversational text from interviews conducted with community members regarding what they see as the top health needs in their community. The topics are related to Public Health and Social Determinants of Health (SDOH).

*Each piece of text (or excerpt) relevant to a public health need and/or social determinants of health should be classified into **all applicable** provided SDOH categories, at either the "subcategory" or "codename" levels using the following SDOH reference table: {reference table}.*

For each input text, your goal is:

*1. Identify **all relevant** (either directly or implied) SDOH-related excerpts from the provided text, based on the reference table. Use the excerpt examples, Subcategory and/or Codename Description, and code names from the SDOH reference table to assist in identifying which excerpts are relevant.*

2. Classify the excerpt under the appropriate SDOH categories. Include the entire excerpt text with accompanying context to illustrate how it corresponds with each classified category. If an excerpt cannot be coded to the code and codename level based on the reference table, use the most appropriate subcategory and leave code and codename blank. Excerpts must have two or more sentences. Excerpts must be relevant (direct or implied) to the current health needs/problems in the speaker's community.

*3. **For each classification, assign a confidence score between 0 and 1, where 1 indicates the highest confidence.***

The output was a CSV file with a list of excerpts that were coded to the category and subcategory levels of the Community Impact framework. These category and subcategory references were counted, and a percentage of excerpts coded to each category was generated to establish a ranking of top health need categories for focus groups and key informant interviews.

Data Synthesis and Identification of Significant Health Needs

Staff conducted axial coding by drawing connections between the top health needs across focus groups, key informant interviews and secondary public data. Adventist Health system staff produced a list of significant health needs and presented findings to CHNA Steering Committee, based on the following criteria:

- The health need comes up as a top five for at least one data source.
- The health need is referenced across at least two data sources.
- The health need as represented in the Community Impact framework corresponds with two or more secondary data indicators that perform worse than the CA state benchmark.

In addition to the list of significant health needs and the supporting data from axial coding of focus groups, key informant interviews and secondary public data, survey data was provided to CHNA Steering Committee for evaluation and corroboration before prioritization of significant health needs.

H. Criteria & Process Used for Identification & Prioritization of Health Need

Prioritized Criteria

The local Steering Committee was responsible for identifying and prioritizing the community health needs included in the CHNA. Steering Committee members are community stakeholders who lead and represent sectors such as local government, community-based organizations, health and human services, schools, public health and others. To facilitate the process of prioritizing health needs, Adventist Health system staff led a series of meetings held in each community to 1) present the results of the CHNA data collection process and 2) prioritize the significant identified health needs.

Prioritization Process and Selection of High Priority Needs

Following the identification of significant health needs through the analysis process, Adventist Health system staff conducted a 90-minute presentation to the Steering Committee, revealing primary and secondary data findings that led to the identification of these needs. During the presentation, staff emphasized the top five needs from each data source and the supporting data that justified their inclusion. After the data reveal meeting, Steering Committee members were provided with three prioritization tools, the presentation slides, and a secondary data report for review and discussion with organizational leadership. Additionally, members participated in a poll to identify the three to five needs they considered most critical, utilizing relevant local data sources as available.

The second part of the series involved a prioritization meeting aimed at building consensus around the community health needs identified as most critical by Steering Committee members. Steering Committee members, along with their staff, boards, and constituencies, reviewed and discussed the top five needs from each data source. They then voted to select priorities that demonstrated the greatest need based on severity and prevalence, alignment with common goals, feasibility of potential interventions, and opportunities to maximize available resources over a three-year period. The meeting concluded with committee members prioritizing the list of significant identified needs, typically selecting two to four as high-priority. See Appendix D for prioritization tools used.

I. Written Comments for 2025 CHNA

We value your input on our community health needs assessment and invite you to submit comments on this CHNA to community.benefit@ah.org. At the time of this CHNA report development, no written comments about the previous CHNA report or adopted implementation strategy were received.

J. CHNA Team Used to Conduct the Assessment

The Adventist Health Community Impact Team coordinates Community Health Needs Assessments for many of the communities we serve. The Community Impact Team convened community experts within each service area's steering committee, coordinated and/or conducted primary data collection, facilitated analysis, and wrote the report content. Team members listed below have diverse and relevant experience in healthcare, philanthropy, government, Medicaid managed care and quality improvement, public health, community health and community benefit reporting. Those team members include:

Amanjit 'Amy' Lasher
Administrative Director, Community Integration

Sarah Clair, MPA
Manager, Public Affairs

Mitchell Iwahiro, MS
Project Manager, Community Integration

Susan Passalacqua
Manager, Community Benefit Compliance

Lisa Wegley
Program Manager, Community Benefits Operations

Additionally, Adventist Health system staff supported the data collection and analysis portion of the report:

Matt Gonzales
Salesforce Administrator

Alex McFadyen, PMP
Manager, Consumer Digital Products

Philip Stanley
Digital Marketing Manager

Aldreen Venzon, Ph.D, MS, RN
Sr. Performance Analyst (System)

Cambria Wheeler
Director, Brand Engagement

CARES

Founded in 1992, the University of Missouri Extension Center for Applied Research and Engagement Systems (CARES) develops and supports mapping, reporting and collaboration systems that enable public, private and nonprofit sector organizations to effectively address issues across topics like agriculture, environment, business, community, health, safety and youth. The CARES team integrates data, mapping, visualizations and engagement tools to better serve communities and regions across the United States, including vulnerable, rural and underserved populations. CARES' web-based technologies help organizations and policy makers make more informed decisions about access, address issues of equity and support the allocation of public and private resources.

CARES staff has background in data science, Geographic Information System (GIS), database and geodatabase management, web design and user experience (UX), spatial analysis, programming, systems implementation and administration and web-based content management. Additionally, CARES holds expertise in project management, user training and support, data documentation and client design sessions that directly supports a wide variety of projects.

Angela Johnson, MPH
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For more information, please visit
https://careshq.org/about/

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VI. APPROVAL PAGE

This Community Health Needs Assessment was adopted on September 18, 2025 by the Adventist Health System/West Board of Directors. The final report was made widely available to the public on December 31, 2025.

Thank you for reviewing our 2025 Community Health Needs Assessment. We are proud to serve our local community and are committed to making it a healthier place for all.

Ryan Ashlock
President

1100 Las Tablas Road
Templeton, CA 93465

Appendix:

A. Glossary of Terms & Definitions of Health Needs

In 2020, Adventist Health analyzed the top priorities from 2019 CHNAs across all hospitals, compared these priorities against language from CHNAs across the country, and created a set of standard nomenclature categories to promote common language, referred elsewhere in this report as "Community Impact Framework". Below is a list of these categories, organized according to this framework, with the accompanying definitions. These categories and definitions are drafted based on context summarized from public health literature, community CHNAs, and national and multi-national healthcare organizations. Sources for definitions are listed below.

Access to Care

Access to care refers to the timely use of personal health services to achieve the best health outcomes. This concept encompasses the availability, affordability and appropriateness of healthcare services, as well as the accessibility of these services to all individuals, regardless of income, location or social standing. Access to care directly affects population health, influencing rates of preventable diseases, overall mortality and quality of life. Ensuring equitable access to healthcare is a central public health goal, particularly in reducing health disparities among underserved populations.

Context/Source

Healthy People 2030. "Health Care Access and Quality"

World Health Organization (WHO). "Access to Care and Financial Protection"

Agency for Healthcare Research and Quality (AHRQ). "Access to Health Care"

Climate & Natural Environment

Climate and natural environment refers to the weather patterns, ecosystems and environmental conditions that impact the health of a community. This includes factors such as air and water quality, temperature extremes, green spaces and the frequency of natural disasters. These environmental elements shape health outcomes directly by influencing respiratory health, heat-related illnesses and exposure to pollutants, and indirectly through their effects on food security, housing stability and economic opportunities, all of which are crucial social determinants of health.

Climate change and environmental degradation can exacerbate existing health disparities, disproportionately affecting low-income communities and communities of color. Public health strategies aimed at addressing climate and environmental challenges focus on building climate resilience, reducing exposure to environmental hazards, and ensuring equitable access to resources like clean air, water and green spaces. By mitigating these environmental health risks and prioritizing sustainable practices, communities can improve both immediate health outcomes and long-term resilience in the face of climate-related impacts.

Context/Source

World Health Organization. "Climate"

National Institute of Environmental Health Sciences. "Climate Change and Human Health"

Centers for Disease Control and Prevention (CDC). "Climate and Health"

Community Infrastructure

Community infrastructure refers to the physical and organizational structures that support and enhance the health, safety and well-being of residents. This includes essential elements that people rely on every day such as transportation systems, internet access, healthcare facilities, schools, parks and water and sanitation systems. When community infrastructure is accessible, safe, and well-maintained, it supports healthier living conditions, reduces health disparities and promotes social determinants of health, such as stable housing, employment opportunities and environmental quality.

Community infrastructure is a foundation for equitable access to services and resources for a healthy lifestyle and to prevent disease. Investments in infrastructure that prioritize public health — like creating walkable neighborhoods, expanding green spaces and ensuring clean drinking water — can reduce chronic illnesses, improve mental health and enhance social connections within a community.

Context/Source

Robert Wood Johnson Foundation. "Infrastructure is Public Health"

American Public Health Association. "Strengthen Public Health Infrastructure and Capacity"

Community Safety

In public health, community safety refers to the protection and well-being of individuals in a community, reducing exposure to violence, crime, environmental hazards and other risks that impact physical and mental health. Within CHNAs, community safety is examined as a determinant of health, affecting overall quality of life and contributing to disparities in health outcomes. Ensuring community safety is seen as essential for fostering environments where individuals can thrive without fear of harm. Community safety includes violence prevention, traffic safety, safe public spaces and youth engagement.

Context/Source

Centers for Disease Control and Prevention (CDC). "About Violence Prevention"

Centers for Disease Control and Prevention (CDC). "About The Public Health Approach to Violence Prevention"

Education

Education refers to the access to quality learning opportunities that shape individuals' knowledge, skills and abilities, impacting their health and well-being. Education is a key social determinant of health because it influences health behaviors, employment opportunities and economic stability. Higher levels of education are associated with better health outcomes, including lower rates of chronic diseases, longer life expectancy and improved mental health. The link between education and health is also seen in the ability to access and understand healthcare information, which can affect decisions about diet, physical activity and preventive care.

Context/Source

American Public Health Association. "Education Health"

Centers for Disease Control and Prevention (CDC). "Education Access and Quality"

Robert Wood Johnson Foundation. "Why Education Matters to Health"

Financial Stability

Financial stability refers to having a reliable and sufficient income to meet basic needs such as housing, food, healthcare and transportation. Financial stability is a critical social determinant of health, as individuals with steady income are more likely to access preventive care, afford nutritious food and maintain safe living conditions. Financial instability and poverty are linked to higher rates of chronic disease, mental health issues and reduced life expectancy due to limited access to health resources and higher exposure to stressors.

Context/Source

Centers for Disease Control and Prevention (CDC). "Economic Stability"

Food Security

Food security refers to consistent access to sufficient, safe, and nutritious food that meets the dietary needs necessary for a healthy life. Access to healthy food is fundamental to preventing malnutrition, obesity and chronic diseases such as diabetes and heart disease. When individuals and families have reliable access to affordable, nutritious food, their overall health outcomes and quality of life improve significantly.

Food insecurity, or lack of reliable access to adequate food, disproportionately impacts low-income communities and contributes to health disparities. Public health efforts to improve food security often involve enhancing access to grocery stores, farmers' markets and community gardens, as well as supporting programs like the Supplemental Nutrition Assistance Program (SNAP). By addressing Food Security, public health initiatives aim to reduce health inequities, support economic stability and foster healthier communities.

Context/Source

World Health Organization. "Food Safety"

Centers for Disease Control and Prevention (CDC). "Diabetes and Food Insecurity"

American Public Health Association. "Food and Nutrition"

Health Conditions

Chronic health conditions are defined as long-lasting illnesses that persist for at least one year and require ongoing medical attention, lifestyle adjustments, or both. These conditions include heart disease, diabetes, cancer and chronic respiratory diseases, which are among the leading causes of death and disability worldwide. In the context of CHNAs, identifying and addressing chronic health conditions is crucial for understanding the health status of a population and guiding targeted interventions. Communities with the highest prevalence of chronic health conditions also typically face social, economic and environmental barriers that challenge prevention and management of the chronic condition, requiring interventions that focus on the complex interplay of behavioral and environmental factors described in this framework.

Context/Source

Centers for Disease Control and Prevention (CDC). "About Chronic Diseases"

World Health Organization (WHO). "Noncommunicable Diseases"

Centers for Disease Control and Prevention (CDC). "Chronic Disease Prevalence in the US: Sociodemographic and Geographic Variations by Zip Code Tabulation Area"

Health Risk Behaviors

Health risk behaviors are actions that increase the likelihood of adverse health outcomes, such as chronic disease, injury or premature death. Common examples include tobacco use, excessive alcohol consumption, physical inactivity, poor diet and risky sexual behaviors. These behaviors are significant focus areas for public health interventions because they are preventable and have broad implications for community health costs, healthcare systems and individual well-being. By identifying and targeting health risk behaviors, public health professionals aim to reduce the prevalence of diseases like heart disease, diabetes and certain cancers, promoting healthier, longer lives for populations.

For CHNAs, health risk behaviors are viewed within the context of social determinants of health, like access to resources, socioeconomic status and educational opportunities. Addressing these behaviors involves considering the social and environmental factors that make certain populations more vulnerable, such as limited access to healthy foods or safe recreational spaces. Community health approaches often implement evidence-based interventions that are culturally tailored and community-specific, recognizing that sustainable behavior change requires supportive environments and policies that mitigate risk factors and empower communities to adopt healthier lifestyles.

Context/Source

Centers for Disease Control and Prevention (CDC). "Behavioral Risk Factor Surveillance System (BRFSS)"

Centers for Disease Control and Prevention (CDC). "Health Risk Behaviors Measure Definitions PLACES: Local Data for Better Health

Centers for Disease Control and Prevention (CDC). "Sexual Risk Behaviors"

Housing

Housing refers to the availability, affordability, quality and stability of living environments. Safe, stable and affordable housing directly influences health outcomes by providing protection from physical hazards, reducing stress and enabling access to essential services. Poor housing conditions, such as overcrowding, exposure to pollutants and inadequate heating or cooling can lead to respiratory illnesses, injury risks and worsened mental health, especially among vulnerable populations.

Housing instability, including frequent moves, homelessness and the risk of eviction, contributes to health disparities by limiting access to consistent healthcare, educational opportunities and community resources.

Context/Source

Robert Wood Johnson Foundation. "Housing and Health"

American Public Health Association. "Housing and Homelessness as a Public Health Issue"

Centers for Disease Control and Prevention (CDC). "Homelessness and Health"

Mental Health

Mental health, within public health and community health frameworks, is understood as a state of well-being in which individuals can cope with life's challenges, work productively, and contribute meaningfully to their communities. This concept goes beyond the absence of mental disorders, emphasizing the capacity for resilience, emotional stability and fulfilling social connections. In public health, mental health is integral to overall health and is recognized as a critical factor influencing quality of life and socio-economic productivity, with both individual and social implications.

In the context of CHNAs, mental health is seen as interdependent with social determinants like income, education, social support, and access to healthcare. Health equity approaches prioritize the mental health of underserved communities, focusing on reducing stigma, expanding culturally appropriate services and advocating for policies that remove barriers to mental health resources. This framework recognizes that improving mental health outcomes requires collective action, community engagement and tailored support strategies that reflect the unique needs and values of diverse communities.

Context/Source

World Health Organization (WHO). "Mental Health"

Centers for Disease Control and Prevention (CDC). "Mental Health"

Substance Abuse and Mental Health Services Administration (SAMHSA). "Mental Health and Wellness"

Social & Economic Context

Social and economic context in this report refers to specific social and economic aspects of an environment that can influence health and well-being of a population-place attachment, civic engagement, social inclusion, and economic vitality. Economic stability and supportive social conditions promote healthier lifestyles, reduce stress and improve access to healthcare, positively impacting health outcomes for individuals and communities.

Social and economic contexts are closely linked to health disparities, as individuals from lower-income or underserved backgrounds often face barriers to achieving home ownership, contributing to economic health, and participating in activities which support social inclusion.

Context/Source

Centers for Disease Control and Prevention (CDC). "Social Determinants of Health (SDOH)"

World Health Organization. "Social Determinants of Health"

B. Activity Explanation: Focus Groups & Key Informant Interviews

- We're going to do a brief exercise to start that will tell us the biggest problems you see related to your and your community's health needs.
  - Then we'll ask you questions about those problems.
  - As you look around the room you'll see three (3) posters on the wall.
  - They show photos of common problems people face, many of them related to health.
  - Please take a few minutes to vote using the five (5) stickers you were given when you walked in.
- Place a sticker underneath the photo that shows problems that you think are the biggest difficulties in your community.
- You can't use all your stickers under one photo but you can use them all in one poster.
- Which of these things causes the most problems for you or others who live here?
- We're interested in learning about things that make it hard for you, your family and friends to have good physical and mental health, and a good quality of life.
  - Some of the descriptions are one word and really meant for you to share more with us.
  - We'll give you 10 minutes to walk around.

Tallying, Engaging & Asking Questions:

- For focus groups, visually tally the votes and clearly call out the top five issues that were identified for the note-taker and audience to hear.
- Spend around 15 minutes going through questions and the topic-specific follow-up questions.
- Repeat for as many problems as time allows, leaving five or so minutes to wrap-up at the end.
- Use the same "Prompting Questions" for each of the five identified issues.

ACTIVITY EXPLANATION – Key Informant Interviews

- We're going to do a brief exercise to start that will tell us what the biggest problems you see are.
  - Then we'll ask you questions about those problems.
  - Here are some photos of common problems people face, many of them related to health.
  - Please take a few minutes to select five (5) problems that you think are the biggest difficulties in your community.
- We're interested in learning about things that make it hard for your organization to provide services and/or for your constituency to have good physical and mental health, and a good quality of life.
  - Some of the descriptions are one word and really meant for you to share more with us.
  - We'll give you a few minutes to make your selection.

Engaging & Asking Questions:

- Spend around 10 minutes going through questions and the topic-specific follow-up questions.
- Repeat for as many problems as time allows, leaving five or so minutes to wrap-up at the end.
- Use the same Prompting Questions for each of the five identified issues.

B. Focus Group & Key Informant Interview: Question prompter

One of the topics that you identified is _____

Questions:

1. Why do you see ___as a problem that's related to your family/community's health?
2. What do you think creates this issue?
3. How do you see the problem affecting your local friends, family or neighbors?

   Who is most affected by this?
4. What have people tried to do to address this problem? What has worked?

   What are the biggest barriers for _____ (policy/program)?

   What makes it hard to fix this problem in your community?
5. What has changed around this concern in the last 2 - 3 years?

   Are there any new emerging trends or areas of concern in the last few years?
6. If this problem got better, how would your community look different?

Closing question:

- Are there other important health needs in your community that we have not already addressed?
- Let the audience introduce and talk through topics with any remaining time. If related to our categories, you can use topic-specific prompts below.

Conclusion:

- Thank you very much for your time today. The information you provided is very helpful for us, and we'll use it to help improve the health of your community.
- Next year we will publish the Community Health Needs Assessment that will summarize what we found, and that many people in your community will take action on.
    - If you would like us to send you a text or email with a link to that report, just provide us with your information.

Focus Groups Only: As a Thank you to you all we have a gift card for you as you leave.

C. Survey Questions:

1. **Would you say that in general your health is:**
   - Excellent
   - Very Good
   - Good
   - Fair
   - Poor

2. **Select 3 - 5 things that you believe make it hard to live and be well in this community.**
   - Can't get medical care
   - Not enough good jobs
   - Lack of affordable housing
   - Lack of good schools
   - Access to affordable healthy food
   - High cost of living
   - Unsafe community
   - Bad air and/or water quality
   - No friends or connection to community
   - High risk for natural disasters (fire, floods, earthquakes)
   - Lack of transportation
   - Lack of safe roads, sidewalks, bike lanes
   - Limited childcare options
   - Limited access to social services for me or my family members
   - Racism

3. **Select up to 5 of the biggest health problems you're facing.**
   - Aging problems (e.g. arthritis, hearing/vision loss, dementia, etc.)
   - Alcohol and/or drug misuse
   - Asthma/COPD
   - Being overweight
   - Cancer
   - Child/Partner abuse
   - Diabetes/Kidney disease
   - Heart disease/Stroke
   - High blood pressure
   - Learning problems
   - Mental health problems (e.g. extreme sadness, fear, worry, anger or stress)
   - Mother-baby care
   - Problems with mobility
   - Poor eating habits
   - Respiratory/Lung disease
   - Sexually transmitted diseases (STDs)
   - Dental problems
   - Vision/Hearing problems
   - No health problems

4. **Imagine a 10-step ladder. At the top life is great, a 10. At the bottom, life is not good, a 0. Which step of the ladder are you standing on right now?**
   - 10 (I'm living my best possible life)
   - 9
   - 8
   - 7
   - 6
   - 5
   - 4
   - 3
   - 2
   - 1
   - 0 (I'm living my worst possible life)

5. **In the last year, did you get all the medical care you needed?**
   - Yes
   - No
   - Did not need care

5b. **If you did not get all the medical care you needed, what do you think are the reasons why?**
Check all that apply.
   - Doctor or clinic (healthcare provider) did not understand my language, culture or identity
   - I'm uncomfortable speaking with a doctor
   - I do not have health insurance
   - I do not have a primary care doctor
   - There was no doctor that accepted my insurance
   - I did not know where to get care
   - Getting to the clinic was too hard
   - It costs too much
   - Inconvenient hours of operation
   - Location of medical care
   - Holistic treatments not available
   - Specialists not covered by insurance
   - Poor quality of doctors/nurses

6. **Select the resources that your community needs more of to help you live better.**
   - Childcare or senior care
   - Healthcare and prescription costs
   - Housing options
   - Legal services
   - Local food banks
   - Managing stress and depression
   - Neighborhood safety
   - Parks, recreation and outdoor activities
   - Personal safety
   - Social/Community events
   - Utilities/Internet

7. **Please enter your zip code, if you don't want to share your zip code, enter 00000.**

D. Prioritization Tools:

1. Health Need – Evaluation Worksheet

Addressing the health needs of community members is complex and often requires more than one approach with coordination across multiple sectors.

Based on the primary and secondary data presented select 3 to 5 health needs that you see as needing to be addressed.

Write the name of the need at the top, use the questions to the left to evaluate side-by-side the current resources, political will, infrastructure and shared goals/focus of each need.

Use your findings to identify the needs that, through collaboration, can be thoughtfully and intentionally addressed by multiple community sector partners.

PRIORITY NEEDS COMPARISON	1		2		3		4		5		6		7	
OPERATIONS	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
Would tracked and shared progress/ data benefit multiple organizations and programs?														
Potentially, could there be 'quick wins' through collaboration and partnerships?														
Is there political willingness to act on this need?														
COMMUNITY PARTNERS/RESOURCES/ ASSETS	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
Are there existing organizations/ programs addressing all or parts of this need?														
Do CBOs' goals/strategic plans list this need as an area of focus?														
Is there community willingness to act on this need?														
FINANCE	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
Does this need have government/public funding streams available for those applying collaboratively?														
Are there current grants that could support some or all of this need?														
Does this need meet the vision/ mission of established government or philanthropic partners?														
EQUITY	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
Are there organizations/programs focused on addressing this need with safety-net, low-income and minority populations?														
Will everyone in the community equally benefit from this need being addressed?														
Would addressing this need lessen absenteeism at work/school for everyone?														
TOTAL YES RESPONSES														

2. Questions to Consider

Do we have any unifying objectives/goals?

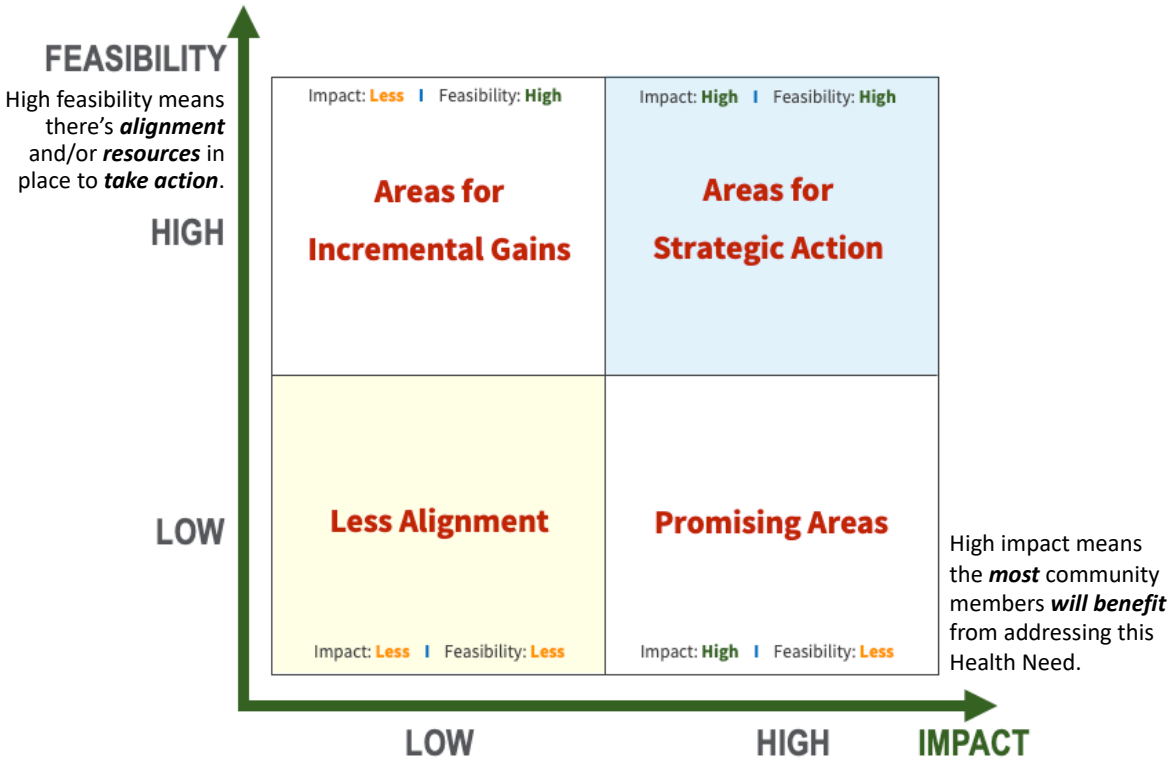
What does immediate success look like (1 - 3yrs)?

Is there available funding from grants or Quality Improvement Incentives (Payer) opportunities?

Would addressing this need free up resources for other community-wide needs?

Is this a community-wide or vulnerable population need?

3. Priority Needs Comparison



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