2025–2028
COUNTY OF MONTEREY
HEALTH DEPARTMENT

Community Health Improvement Plan

January 2025

COUNTY OF MONTEREY
HEALTH DEPARTMENT

2025–2028 County of Monterey Health Department Community Health Improvement Plan (CHIP)

The 2025–2028 County of Monterey Community Health Improvement Plan (CHIP) addresses specific strategies to improve health and disparate conditions in Monterey County. It describes how the County of Monterey Health Department and community partners can work together on specific goals, strategies, and measures of progress. Partners may, in turn, align their priorities and actions with the CHIP to achieve greater impacts.

The CHIP includes information about our local health network and resources available to address priority issues. By increasing knowledge and awareness through data, communication, and shared aims, we can advance the health and wellness for all people of Monterey County. Local health network providers review the CHIP annually and, in collaboration with dedicated community leaders, identify new priorities every three years by evaluating our achievements. This approach ensures a collaboratives effort and continual dedication toward addressing our top health concerns.

The Health Department values the input of over 300 organizations in our community assessment and CHIP process. Individual organizations and collective efforts – essentially our local public health system partners – are described by name and internet addresses in the body and appendix of this report. The invitation to become involved is always open.

To learn more about how to connect with our planning process and be added to our partner organization database, please contact:

Population Health Team
County of Monterey Health Department,
Administration Bureau
PopulationHealth@countyofmonterey.gov

Or by contacting the Health Department at **831-755-4500** or **HealthWebmaster@countyofmonterey.gov**

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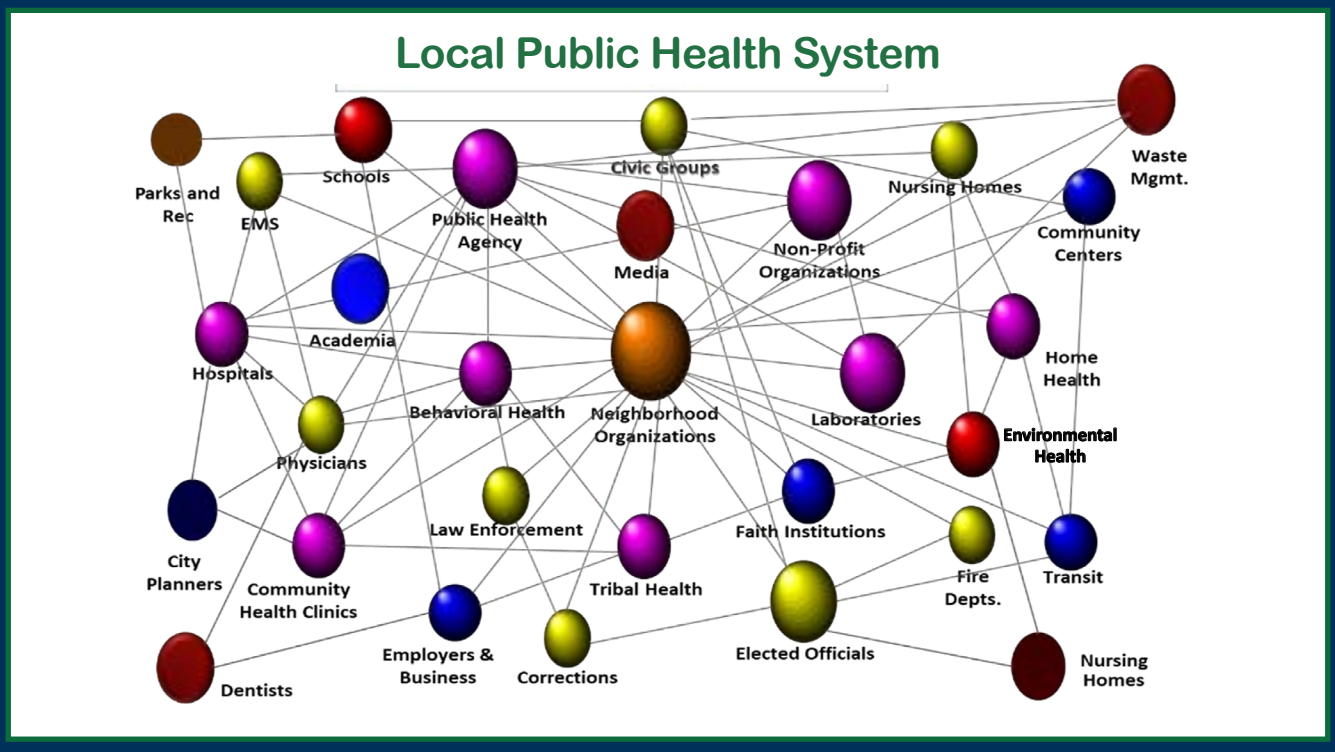


Introduction

By their nature, complex problems – such as population-based health disparities – require multi-pronged strategies to change policies, environments (including physical, economic, and social environments), and institutions, as well as knowledge, beliefs, and behaviors.

The participation of diverse, cross-sector agencies, organizations, and institutions is critical to improve health for entire communities and to reduce the inequities that drive disparate health outcomes.

The 2025–2028 County of Monterey Community Health Improvement Plan (CHIP) focuses on five health priorities identified through extensive engagement with community members and partner organizations. The work started with the 2022 Community Health Needs Assessment (CHNA), a collaborative effort by the Monterey County Health Needs Collaborative, which includes the Community Hospital of the Monterey Peninsula, the County of Monterey Health Department, Mee Memorial Healthcare System, Natividad Medical Center, Salinas Valley Health, and United Way Monterey County. The CHNA incorporated data from both primary research (random-sample telephone survey, portal-based community outreach survey, and key informant survey) and secondary sources, including vital statistics and public health surveillance data.

The telephone survey resulted in 801 unduplicated and verified surveys and the community outreach survey resulted in 2,348 unduplicated and verified surveys, for a total of 3,149 responses completed through these surveys. An online key informant survey of 128 community leaders was conducted between March 17 and April 19, 2022, providing qualitative information.

Find the 2022 CHNA

www.mtyhd.org/CHNA

2022 CHNA Findings Informed 2025–2028 CHIP Priorities

The data, opinion, and respondent geographic information provided in the 2022 CHNA directly informed this CHIP's selection of health priorities and action plan. Identified as "Areas of Opportunity" in the CHNA, significant community health needs were determined after analyzing health data compared to state and national benchmarks, and the number of persons affected and potential impacts of specific health issues. In September 2022, 136 community leaders met online to prioritize CHNA preliminary health issues using the following criteria:

> Scope & Severity

How many people may be affected? How does local data compare to state or national levels? To what degree does each health issue lead to death or disability, impair quality of life, or impact other health issues?

> Ability to Impact

How likely can the health system improve outcomes, given available resources, competencies, and spheres of influence?

Using a scoring system, the Monterey County Health Needs Collaborative determined a prioritized list of community health issues in 2022 (see the 11 community health issues on the following page). The top four health issues for the 2025–2028 CHIP (highlighted in blue in the list on the following page) were identified through extensive community input, an analysis of Areas of Opportunity conducted for the 2022 CHNA, the Health Department's 2014–2018 CHIP priorities, the Public Health Accreditation Board's 2022 Standards and Measures for Reaccreditation, and input from the county's Director of Health Services. For the 2025–2028 CHIP, the top four health issues include: **access to health care, diabetes, mental health, and nutrition-physical activity-healthy weight**. A fifth priority, health equity policy development, was identified to strengthen health equity efforts. Achieving greater health equity, with a focus on social determinants of health, is a national priority (Healthy People 2030) and an important element of the Health Department's Strategic Plan.

Health issues highlighted in blue below are included in this 2025–2028 CHIP:

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

I. 2025–2028 Summary of County of Monterey Health Department CHIP Priorities

PRIORITY

Preventing and Managing Diabetes

OBJECTIVE

Decrease diabetes-related complications, and the prevalence of diabetes and pre-diabetes for people experiencing health disparities.

PRIORITY

Addressing Behavioral Health Needs

OBJECTIVE

Increase use of behavioral health access to services program for people experiencing health disparities.

PRIORITY

Increasing Access to Health Services

OBJECTIVE

Increase access to health services for people experiencing health disparities.

PRIORITY

Improving Nutrition, Physical Activity, and Healthy Weight

OBJECTIVE

Increase access to healthy foods for people experiencing health disparities.

OBJECTIVE

Increase access to physical activity opportunities for people experiencing health disparities.

PRIORITY

Developing Health Equity Policies

OBJECTIVE

Build stronger health equity engagement among Health Department staff and community partners.

OBJECTIVE

Establish and maintain a Community-Driven Health Equity Fund (CDHEF) to sustain health equity programs and projects.

OBJECTIVE	STRATEGIES
Decrease diabetes-related complications, and the prevalence of diabetes and pre-diabetes for people experiencing health disparities.	• Provide Hemoglobin A1c screening among Health Department FQHC clinic patients between ages 18 and 75 who are diagnosed with type 1 and type 2 diabetes. • Provide depression screening for Health Department FQHC patients between ages 18 and 75 who are diagnosed with Type I or Type II Diabetes.

OBJECTIVE	STRATEGIES
Increase use of behavioral health access to services program for people experiencing health disparities.	• Provide timely access to initial Health Department Behavioral Health clinic services for clients seeking behavioral health services. • Engage Health Department Behavioral Health clinic clients in outpatient services to prevent rehospitalization for behavioral health needs.

OBJECTIVE	STRATEGIES
Increase access to health services for people experiencing health disparities.	• Utilize bilingual Community Health Workers (CHW) to facilitate access to healthcare by people experiencing health disparities. • Utilize bilingual Community Health Workers to link adults to experiencing health disparities to primary care providers.

OBJECTIVE	STRATEGIES
Increase access to healthy foods for people experiencing health disparities.	• Promote and support breastfeeding as a way to safeguard the health of low-income women, infants and children. • Support the utilization of Electronic Benefit Transfer (EBT) at Monterey County Farmers' Markets to increase access to healthy foods among low-income residents.

OBJECTIVE	STRATEGY
Increase access to physical activity opportunities for people experiencing health disparities.	• Encourage pediatric participation in the Health Department's nutritional counseling program.

OBJECTIVE	STRATEGY
Build stronger health equity engagement among Health Department staff and community partners.	• Effectively engage with our diverse community and address local health disparities by using Spectrum of Community Engagement to Ownership Framework to train staff and partners.

OBJECTIVE	STRATEGY
Establish and maintain a Community-Driven Health Equity Fund (CDHEF) to sustain health equity programs and projects	• Use a participatory budgeting process to address health disparities in communities that are disproportionately affected by health inequities.

II. Data Behind 2025–2028 CHIP Health Priorities

Diabetes

Type 2 diabetes mellitus is the seventh leading cause of death in the United States, and when poorly controlled or untreated, can lead to amputations, vision loss, and kidney damage (Healthy People 2030). People who are diagnosed with diabetes have an increased risk of depression—but coordinated treatment for both chronic illnesses can be effective and improve both conditions (Mayo Clinic).

Sixty-four percent of recent survey respondents considered the prevalence of diabetes to be a major problem in Monterey County (CHNA 2022).

Within Monterey County, some populations experience higher rates of diabetes, including adults 65 and older, low-income residents, and Hispanic residents (CHNA 2022).
Certain environmental factors can also increase the risk of diabetes. For example, structural racism and economic inequities mean that many low-income residents and racial/ethnic groups face numerous barriers to regularly having nutritious meals with sufficient fruits and vegetables—which increases the risk of developing type 2 diabetes (Jones H, 2023).

1 in 10

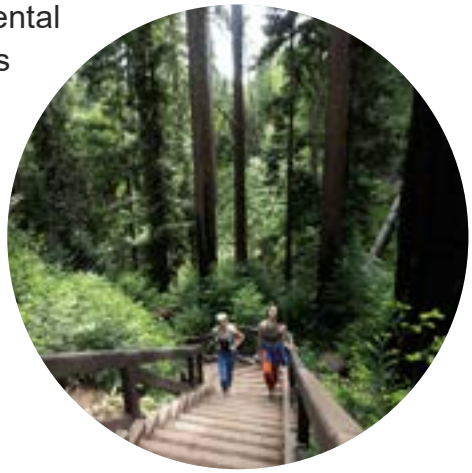
Monterey County adults have been diagnosed with diabetes (BRFSS, 2021)

Mental Health

Approximately 13% of adults in the United States have fair or poor mental health, although only half of all people with mental disorders are believed to receive the treatment they need. Seventy-seven percent of Monterey County CHNA survey respondents identified poor mental health conditions to be a major problem (CHNA 2022).

Nineteen percent of Monterey County adults reported being unable to get mental health services when needed in the prior year. Disparities are also seen across the county, with 28% of North County survey respondents reported having challenges getting mental health services, 26% of very low-income earners, and 31% who identify as LGBTQ also reported being unable to get mental health services when needed in the prior year (CHNA 2022).

It is essential to recognize the profound impact of environmental factors have on our community's well-being. Mental health is influenced by a complex interplay of genetic, psychological, lifestyle, and environmental elements, including natural, social, and built environments. Factors such as access to green spaces, noise levels, air quality, and housing conditions can either support or undermine mental well-being. Since many Monterey County households experience substandard housing, wildfire risk, or proximity to flood zones, addressing environmental stressors is a critical preventive measure. Understanding the relationship between mental health and environmental health is crucial for developing comprehensive strategies that will promote and sustain healthier communities in Monterey County.



Access to Health Services

Receiving health care services in a timely manner (soon after being injured or experiencing new symptoms, as well as on the recommended schedule for preventative screenings) is key to achieving the best health outcomes (Institute of Medicine, 1993). Forty-one percent of Monterey County CHNA survey respondents considered the lack of access to healthcare services as a major problem in Monterey County (CHNA 2022). Access to health services has three components (Healthy People 2020):

Insurance

Insurance coverage facilitates entry into the health care system. Uninsured people are less likely to receive regular medical care and more likely to have poor health status.

> Eight percent of Monterey County adults 18 to 64-years-old reported having no health coverage (CHNA 2022). Some populations were more likely to be uninsured: South County residents (12%), very low-income earners (13%), and Asian and Hispanic residents (both 10%).

8%

of Monterey County adults 18 to 64-years-old reported having no health coverage

Timely Care

The ability to receive health care when needed creates the best circumstances for positive outcomes.

> Fifty-three percent of adults county-wide reported having difficulty getting a doctor's appointment. Thirty-three percent of Monterey County adults cited difficulties in finding a doctor, 34% cited inconvenient office hours, and 30% cited the cost of receiving treatment (CHNA 2022).

53%

of adults county-wide reported having difficulty getting a doctor's appointment

Usual Source of Care

Having regular access to a primary care physician (or other health provider) is associated with individuals receiving recommended screening and prevention services.

> Seventy-four percent of Monterey County adults (including 82% of low-income earners and 86% of North County residents) reported having difficulty or delaying obtaining health care services in the past year (CHNA 2022).

74%

of Monterey County adults reported having difficulty or delaying obtaining health care services

Access to health services is an important social determinant of health. The Health Department's expertise can be a valuable asset in expanding healthcare access while addressing the environmental health and social justice concerns affecting many Monterey County residents, especially vulnerable populations. Through collaboration, healthcare providers and community stakeholders can reduce barriers to care, promote equitable access to essential resources, and build healthier, more resilient communities.

Additionally, access to health care is not only influenced by physical and economic barriers but also by language accessibility. Language justice plays a critical role in ensuring equitable health outcomes, as the ability to communicate effectively with providers directly impacts access to and quality of care. Disparities in health care access are often linked to a patient's ability to speak English and a provider's ability to communicate in the patient's primary language. In a meta-analysis of published research papers on the subject, most studies found that individuals with limited English proficiency were more likely to forgo necessary medical care, less likely to receive preventive care, less likely to have a usual source of care, and more likely to miss preventive care visits, compared to English proficient populations (Jirmanus 2022). Further, the quality of care is lowered when patients do not understand their health care providers, when patients and providers do not speak the same language, and when a provider's approach is not linguistically competent.

82%

of Monterey County adults age 18 and older who speak a language other than English in their homes speak English well, or very well. (CHIS 2022)

Nutrition, Physical Activity, and Healthy Weight

Poor nutrition and limited physical activity correlate with unhealthy weight and a high Body Mass Index (BMI). Ease of access to supermarkets and a variety of healthy foods are associated with increased daily consumption of fruits and vegetables and a lower prevalence of obesity and overweight BMI (Wang, 2007).

Additionally, the 2018 US Department of Health and Human Services' Physical Activity Guidelines for Americans report states that nearly 80% of adults nationwide are not meeting the key guidelines for both aerobic and muscle-strengthening activity, while only about half meet the key guidelines for aerobic physical activity.

In Monterey County, 28% of adults reported it was somewhat or very difficult to buy fresh produce at a price they can afford (CHNA 2022). Similarly, 26% of Monterey County adults reported having no leisure-time for physical activity in the past month. The availability of recreation/ fitness facilities for every 100,000 population in Monterey County is lower than for the state and the U.S.

28%

of adults reported it was somewhat or very difficult to buy fresh produce at a price they can afford (CHNA 2022)

Health Inequities

The disparities in health outcomes seen today are the result of a long history of systemic inequities. These inequities have and continue to unfairly distribute resources, opportunities, barriers, and hazards based on demographics (race, ethnicity, gender, socio-economic class, sexual orientation, disability status, etc.) and/or where people live and spend time (ZIP code, school district, employment sector, etc.).

Eliminating health disparities caused by societal inequities, prejudice, and an unhealthy built environment is imperative as a matter of fairness, public health, and economic responsibility (Davis, 2005). Closing health disparity gaps requires a collaborative, community-wide effort involving government agencies, private residents and businesses, and nonprofit organizations working at policy, institutional, neighborhood, and individual levels to address the social determinants of health (SDOH).

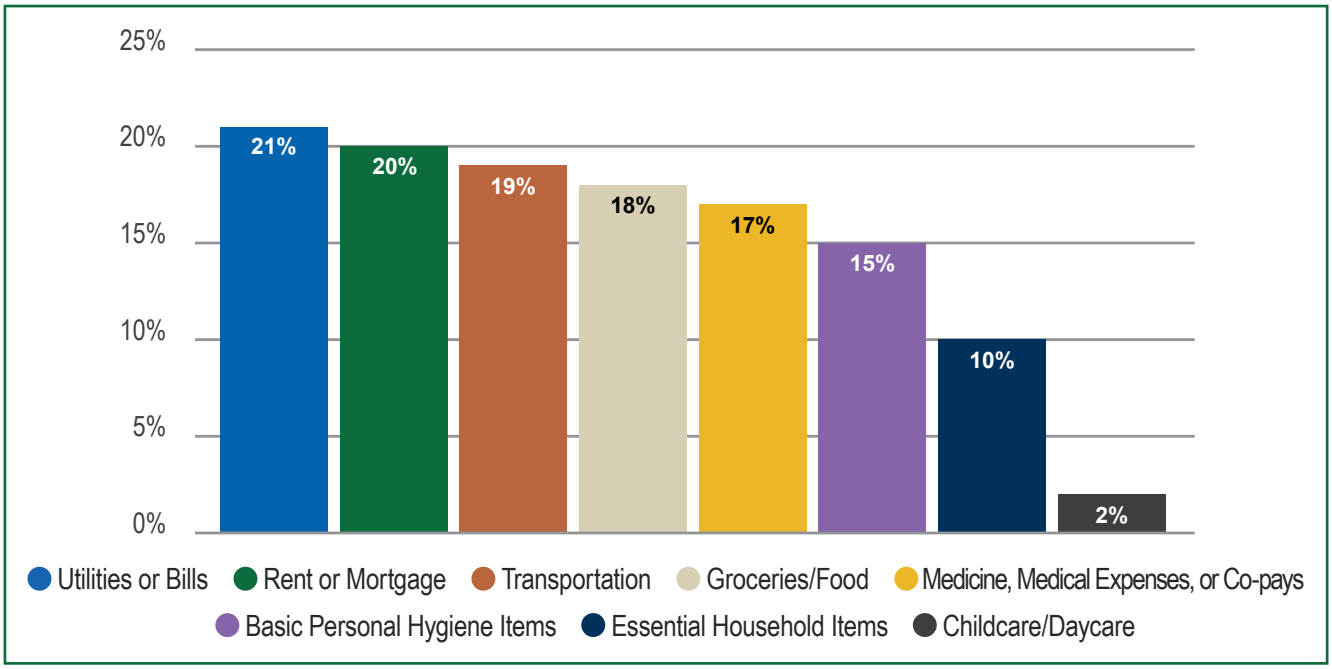
SDOH are the social and physical conditions in which people live, learn, work, and play—factors that influence a wide range of health and quality-of-life outcomes. The World Health Organization defines health equity as "the opportunity for all people to attain their full health potential and for no one to be disadvantaged from achieving this potential because of their social position or other socially determined circumstances."

Examples of SDOH, as identified by the Centers for Disease Control and Prevention (CDC) and Healthy People 2030, include:

- Economic stability, safe housing, transportation, and neighborhoods
- Access to quality education, multilingual abilities, and literacy skills
- Access to quality health care, nutritious foods, and physical activity
- Neighborhood environment, clean air, water, and soil.
- Social and community equity and engagement

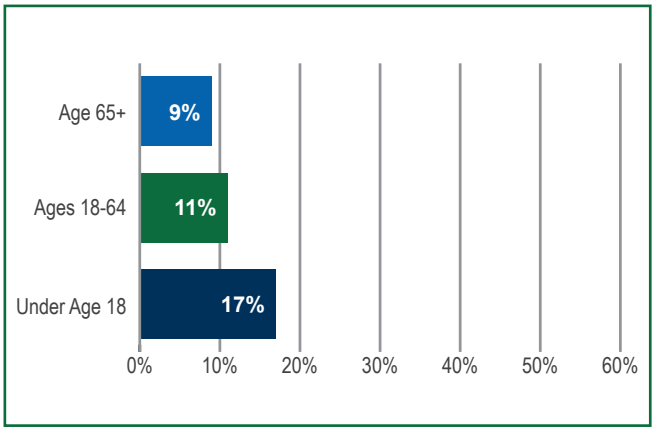
In Monterey County, survey responses revealed that 46% of respondents could not afford one or more of the following living expenses, while 34% could not afford two or more of the following living expenses (CHNA 2022):

Monterey County Survey Respondents Who Could Not Afford Essential Living Expenses



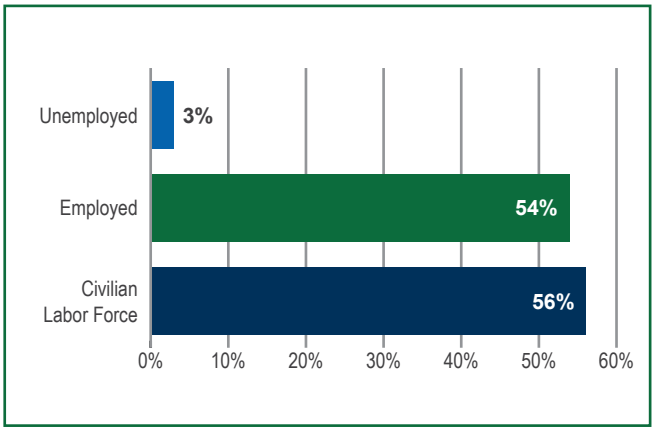
Key Social Determinants of Health in Monterey County

Poverty by Age Group



Source: 2022 ACS 1-Year Estimates, Table DP03

Employment Status for Residents



Source: 2022 ACS 1-Year Estimates, Table DP03

III. 2025–2028 CHIP Action Plan Matrix

The following Action Plan Matrix details objectives, strategies, indicators, baseline data, goals, and examples of agencies and organizations working to improve health and health equity while focusing on the County of Monterey's 2025 – 2028 CHIP priority health issues. The following matrix serves as an abbreviated representation of health improvement work happening in Monterey County among numerous community-based organizations and public agencies.

The objectives, strategies, indicators, and goals were developed by County of Monterey Health Department staff. This draft was shared with approximately 165 community leaders, partner organizations, and County of Monterey Health Department employees in July 2024. A list of the organizations that were solicited for comments on the draft 2025–2028 CHIP is presented in Appendix C.

Objectives in the 2025–2028 CHIP were developed as "SMARTIE" objectives, an evolution of SMART objectives.

SMARTIE FORMAT

Specific
The objective states the anticipated outcome, the population to be served, and the amount of change expected.

Measurable
Definitions are stated for when milestones have been reached, and objectives have been achieved.

Attainable
Objectives are challenging but achievable within the capabilities of the activity and available resources.

Relevant
Objectives are aligned with the strategic plan and results of needs assessments, with input from the population of focus and community being served.

Time-Based
A timeline is assigned to each objective including the start and end of activities, and milestones, to access the activity's progress.

Inclusive
Input from the population of focus, service providers, and community partners has been encouraged and considered.

Equitable
The objective addresses the unique needs and circumstances of different populations.

PRIORITY

Preventing and Managing Diabetes

OBJECTIVE

Decrease diabetes-related complications, and the prevalence of diabetes and pre-diabetes for people experiencing health disparities.

STRATEGY 1

Provide Hemoglobin A1c screening among Health Department FQHC clinic patients between ages 18 and 75 who are diagnosed with type 1 and type 2 diabetes.

INDICATOR

Percent of patients between the ages of 18 and 75 who are diagnosed with Type I or Type II Diabetes and have a Hemoglobin A1c test completed over the calendar year with a result ≤ 9.

METRICS—BASELINE DATA

76% on 2023 calendar year

GOAL

Improve on 2023 calendar year results (76%) by 2027.

Data Source: Clinic Services UDS data.

STRATEGY 2

Provide depression screening for Health Department FQHC patients between ages 18 and 75 who are diagnosed with Type I or Type II Diabetes.

INDICATOR

Percent of patients between the ages of 18 and 75 who are diagnosed with Type I or Type II Diabetes and have had a depression screening
AND received follow-up, when necessary, per calendar year.

METRICS—BASELINE DATA

100% on 2023 calendar year

GOAL

Maintain 2023 calendar year baseline of 100% baseline through calendar year 2027.

Data Source: UDS data.

RESPONSIBLE HEALTH DEPARTMENT BUREAU: Clinic Services Bureau

PRIORITY

Addressing Behavioral Health Needs

OBJECTIVE

Increase use of behavioral health access to services program for people experiencing health disparities.

STRATEGY 1

Provide timely access to initial Health Department Behavioral Health clinic services for clients seeking behavioral health services.

INDICATOR

Percentage of new Behavioral Health clients seeking behavioral health services who receive initial service within 10 business days of initial nonurgent request, per fiscal year.

METRICS—BASELINE DATA

55% on 2023-2023 fiscal year

GOAL

Improve 2022-2023 fiscal year baseline (55%) by 2027.

Data Source: Avatar

STRATEGY 2

Engage Health Department Behavioral Health clinic clients in outpatient services to prevent rehospitalization for behavioral health needs.

INDICATOR

Percentage of behavioral Health clients who remain unhospitalized after discharge for 30 or more days following admission to Natividad acute psychiatric services.

METRICS—BASELINE DATA

85% on 2022-2023 fiscal year

GOAL

Increase 2022-2023 fiscal year baseline (85%) by 2027.

Data Source: Avatar

RESPONSIBLE HEALTH DEPARTMENT BUREAU: **Behavioral Health Bureau**

PRIORITY

Increasing Access to Health Services

OBJECTIVE

Increase access to health services for people experiencing health disparities.

STRATEGY 1

Utilize bilingual Community Health Workers (CHW) to facilitate access to healthcare by people experiencing health disparities.

INDICATOR

Number of individuals over the age of 18, requiring assistance by a CHW to complete a Medi-Cal application per fiscal year.

METRICS—BASELINE DATA

359 on 2022-2023 fiscal year

GOAL

Improve on 2022-2023 fiscal year baseline by 2027.

Data Source: Medi-Cal enrollment data.

STRATEGY 2

Utilize bilingual Community Health Workers to link adults to experiencing health disparities to primary care providers.

INDICATOR

The number of individuals over the age of 18 linked to a primary care provider by a County of Monterey CHW per fiscal year.

METRICS—BASELINE DATA

0 on 2022-2023 fiscal year

GOAL

Improve on 2022-2023 fiscal year baseline by 2027.

Source: CORE Program data.

RESPONSIBLE HEALTH DEPARTMENT BUREAU: Administration Bureau

PRIORITY

Improving Nutrition, Physical Activity, and Healthy Weight

OBJECTIVE

Increase access to healthy foods for people experiencing health disparities.

STRATEGY 1

Promote and support breastfeeding as a way to safeguard the health of low-income women, infants and children.

INDICATOR

Percentage of Women, Infants, and Children (WIC) clients with infants at 6 months of age who report feeding their infant(s) some or only breast milk per calendar year.

METRICS—BASELINE DATA

55% on 2023 calendar year

GOAL

Improve on 2023 baseline (55%) by 2027.

Source: WIC.

STRATEGY 2

Support the utilization of Electronic Benefit Transfer (EBT) at Monterey County Farmers' Markets to increase access to healthy foods among low-income residents.

INDICATOR

The dollar amount of EBT funds spent by county residents at Farmers' Markets per calendar year.

METRICS—BASELINE DATA

$72,142.00 on 2023 calendar year

GOAL

Improve of 2023 baseline to reach $72,142.00 by 2027.

Source: CFHL and Everyone's Harvest.

RESPONSIBLE HEALTH DEPARTMENT BUREAU: Public Health Bureau

OBJECTIVE

Increase access to physical activity opportunities for people experiencing health disparities.

STRATEGY 1

Encourage pediatric participation in the Health Department's nutritional counseling program.

INDICATOR

The percentage of patients, ages 3-17 years old, with a documented weight assessment and received counseling for a diet & exercise plan per calendar year.

METRICS—BASELINE DATA

85% of patients aged 3-17yrs with a documented weight assessment and received counseling for a diet & exercise plan on calendar year 2023.

GOAL

Improve on 2023 baseline by end of calendar year 2027.

Source: Clinic Services UDS

RESPONSIBLE HEALTH DEPARTMENT BUREAU: Public Health Bureau

PRIORITY

Developing Health Equity Policies

OBJECTIVE

Build stronger health equity engagement among Health Department staff and community partners.

STRATEGY 1

Effectively engage with our diverse community and address local health disparities by using Spectrum of Community Engagement to Ownership Framework to train staff and partners.

INDICATOR

The number of staff and partners trained to engage with diverse community members and address local health disparities using the Spectrum of Community Engagement to Ownership (SCEO) framework, per calendar year.

METRICS—BASELINE DATA

40 on calendar year 2023

GOAL

Improve number of staff trained from 2023 baseline data to 80 staff by 2027.

Data Source: Administration Bureau

OBJECTIVE

Establish and maintain a Community-Driven Health Equity Fund (CDHEF) to sustain health equity programs and projects.

STRATEGY 1

Use a participatory budgeting process to address health disparities in communities that are disproportionately affected by health inequities.

INDICATORS

The amount of funding (in dollars) that is annually contributed to the CDHEF by the Health Department per calendar year.

METRICS—BASELINE DATA

$0.00 on calendar year 2023

GOAL

Increase contributions from 2023 baseline to $1M to CDHEF by end of calendar year 2027.

Source: Admin Finance

RESPONSIBLE HEALTH DEPARTMENT BUREAU: Administration Bureau

IV. Tracking our Progress

The Health Department has recorded its bureau and department-wide performance indicators since they were initially developed in 2005, and many indicators are carried over from year to year to demonstrate progress and trends over time. Each bureau sets goals, selects at least three activities to measure, develops means of measuring progress, and reports outcomes quarterly. An example of a Public Health Bureau performance indicator for the first quarter of 2024-2025 appears below. In this case, the target was exceeded by 21%. The CHIP indicators will be integrated into this tool to ensure that progress is monitored at least annually (and whenever possible, on a quarterly basis).

Example of Excel-based County of Monterey Health Department Performance Measure Tracking Tool

Public Health Bureau (3 of 3)								
3. Improve maternal and infant health through promotion of breastfeeding								
Performance Measure	2023-2024	2024-2025	Q1	Qt 2	Qt 3	Qt 4	% of Annual Target	Year to Date
CDC 10 Essential Public Health Services #1, 2, 3, 5, & 7	Target	Target	Actual	Actual	Actual	Actual		
MCHD Strategic Plan Goal #1, 2, & 3	50.0%	50.0%	60.5%				121.0%	60.5%
What: Proportion of clients enrolled in the Women, Infants, and Children (WIC) program with infants at 6 months of age who feed their infant(s) some or only breast milk.								
Why: Breastfeeding has many benefits for infants, children, and mothers and is a key strategy to improve public health. Breastfeeding helps reduce diseases like asthma, diabetes, and obesity.								
Data Source: WIC WISE								
How we're doing: Quarter 1: We exceeded our stated standards and statewide averages. Quarter 2: Quarter 3: Quarter 4:								

In the near future, the Health Department will upload current and recent historic data to Clear Impact, a dashboard that will automatically compare accomplishments to goals, calculate changes over time and show trends, when possible, in a dynamic, viewer friendly online format.

V. Coalitions, Collaboratives, and Collective Impact Groups

The following coalitions, collaboratives, and collective impact groups represent our community assets across Monterey County that are known to be actively engaged in activities that promote health and wellness. The efforts of these and other groups show the greatest promise to achieve community health and well-being for all county residents.

Getting Involved

Individuals, organizations, and agencies are encouraged to engage in these ongoing public health system efforts to improve community health. Individual agencies and organizations, plus collective efforts, are described by name and internet addresses in the body and appendix of this report. The County of Monterey Health Department maintains and regularly updates a database of contact information for more than 150 organizations. There are many ways to get involved, large and small, and the invitation to join this effort is open. We look forward to working with you! If you would like to learn more about how to connect, if you want to be added to our partner organization database, or if you are a partner who is not mentioned in this Community Health Improvement Plan, please contact us:

County of Monterey Health Department
Administration Bureau
Population Health Team
PopulationHealth@countyofmonterey.gov
https://www.countyofmonterey.gov/government/departments-a-h/health

Health Department
831-755-4500
HealthWebmaster@countyofmonterey.gov.

Child Abuse Prevention Council (CAPC)

The Monterey County CAPC works to reduce the incidence of child abuse and neglect by coordinating prevention and awareness efforts in Monterey County. Free training for mandated reporters, educators, childcare workers, and non-profit agencies that work with children is provided. CAPC is a prime sponsor of community events and non-profit agencies who provide an array of family services. Members of the Council are appointed by the Board of Supervisors and represent a broad cross section of public officials, service organizations, and Monterey County residents.

Focus

Children and youth under age 18.

Strategies

Coordination of efforts, treatment, education, and awareness.

Link

https://capcmonterey.org/

Coalition of Homeless Services Providers

The Coalition of Homeless Services Providers is a group of private non-profit and public organizations working together to address the complex issues of homelessness. The Coalition's mission is to eliminate homelessness in Monterey County by promoting interagency coordination to develop and sustain a comprehensive system of housing and services designed to maximize the self-sufficiency of individuals and families.

Focus

Services for people who are homeless.

Strategies

10-year plan, multi-agency/organization involvement, Leadership Council and Action Teams, federal grant sourcing, annual data assessment.

Link

https://chsp.org/

Communities for Sustainable County of Monterey

Communities for Sustainable Monterey County works to meet the challenge of declining resources and climate change by helping communities transition to sustainable practices.

Focus

Decrease fossil fuel and other non-renewable resource use; environmental protection.

Strategies

Education and advocacy.

Link

http://www.sustainablemontereycounty.org/

Community Alliance for Safety and Peace (CASP)

More than 30 organizations and leaders joined to create CASP, including youth service organizations, county housing and health officials, local and state elected officials, criminal justice and law enforcement officials, educational leaders, business leaders, representatives of the faith community, and private funding organizations. The coalition works to reduce violence and build a better future for children through the For Our Future/Para Nuestro Futuro campaign's activities, events, and resources.

Focus

Violence reduction and prevention.

Strategies

Comprehensive planning and goals; advocacy and resources for safety and peace.

Link

https://caspmc.org/

Communities Organized for Relational Power in Action (COPA)

COPA works to develop the leadership skills of ordinary people to engage effectively in public life with power to negotiate with public and private sector leaders to change the economic, social, political, and cultural pressures on their families.

Focus

Housing, public safety, health care, economic development, education, immigration. Strategies: broad-based, institutional organizing for effective action through empowerment.

Strategies

Developing leaders capable of working together to address the issues affecting families in our community.

Link

https://www.copaiaf.org/

Community Hospital of the Monterey Peninsula Kids Eat Right

Community Hospital of the Monterey Peninsula's Kids Eat Right is a free program that offers kid-friendly, science-based education to children and families. The initiative aims to help end the childhood obesity epidemic within a generation. The free five-week program is available in both English and Spanish for Monterey County schools for fourth and fifth graders. The program also teaches parents and community members the importance of healthy nutrition and activity in youth.

Focus

Children and family nutrition.

Strategies

Teaching school children and families to make good food choices.

Link

https://www.montagehealth.org/about/caring/kids-eat-right/

Community Wellness Collaborative

The Community Wellness Collaborative focuses on mental health and is led by the Community Foundation for Monterey County's President/CEO Dan Baldwin, and Michael Castro, Director of Community Initiatives and Partnerships, along with a Steering Committee made up of local leaders and practitioners in the field. Mental health affects us all. This Collaborative is an example of Monterey County coming together to highlight and address issues that are affecting its community.

Focus

Mental health

Strategies

Strategy plan is under development.

Link

Contact Michael Castro at: michaelc@cfmco.org.

Early Childhood Development Initiative (ECDI)

Recognizing the tremendous need and significant long-term impact of investments in early childhood, the Children's Council of Monterey County launched an Early Childhood Development Initiative (ECDI) in 2013. First 5 Monterey County and the County of Monterey Health Department co-chair the Initiative. ECDI will use a collective impact approach, urging implementing agencies to develop common goals, coordinate resources, build capacity, and share data and information to maximize impact. The first step of this Initiative is to develop a countywide strategic vision, road map, and action plan for children from the prenatal stage through age 5 and their families.

Focus

Early childhood, countywide.

Strategies

Collaboration among multiple partners that are focused on shared early childhood development goals, awareness, community mobilization and advocacy, and coordination of direct programs.

Link

https://www.countyofmonterey.gov/government/departments-a-h/health/hd-initiatives/early-childhood-development

Food Safety Advisory Council

The Food Safety Advisory Council (FSAC) works with Environmental Health's Food and Pool Safety Program in developing policies, regulations, and interpretive guides. FSAC also assists the food industry in understanding laws, regulations, and the reasoning behind them. FSAC is a collaborative effort between business and government, comprised of representatives from the retail food industry, related businesses, and Food Protection Program staff. The overall goal of the Council is to enhance cooperation, involvement and understanding between county government and the food industry. FSAC has provided valuable input on pertinent issues such as new legislation, new industry products, and implementation of new policies.

Focus

Food safety and protection

Strategies

Enhance cooperation, involvement and understanding between county government and the food industry; new legislation, new industry products, and implementation of new policies.

Link

https://www.countyofmonterey.gov/government/departments-a-h/health/environmental-health/consumer-health-protection/food/food-safety-advisory-council

Gonzales Community Collaborative

The Gonzales Community Collaborative seeks to build bridges between public schools, community organizations, and local businesses to support the children, youth, adults, and families of Gonzales through collaborative dialogue and sharing information and resources that create an informed, educated, and healthy community.

Focus

Children, youth, adults, and families of Gonzales

Strategies

School district and city collaborative planning and policy making

Health in All Policies (HiAP)

HiAP is a collaborative approach to improve population health by incorporating health considerations into decision making in all sectors and policy areas. HiAP brings together a cross sector of partners to consider how their work influences or affects health and how we can improve health while advancing shared goals. HiAP is the framework used by the County of Monterey to address health inequities and focuses on identifying the root causes of poor health.

Focus

Eliminating physical, social, economic, and institutional hindrances to health equity.

Strategies

Education, training, and action teams.

Link

https://www.countyofmonterey.gov/government/departments-a-h/health/planning-evaluation-and-policy-pep/health-in-all-policies-hiap

Healthy Moms, Healthy Babies

Healthy Moms, Healthy Babies is as a catalyst for change and creates partnerships among community groups, agencies, nonprofit organizations, professional associations, businesses, and government agencies to promote optimal health for mothers and babies and to strengthen families and build healthy communities.

Focus

Improving infant, maternal, and family health

Strategies

Education and collaborative partnerships of public and private organizations to promote, protect, and support breastfeeding

Link

https://thealliance.health/for-members/health-and-wellness/healthy-moms-healthy-babies/

Illegal Dumping and Litter Abatement Task Force

The Illegal Dumping and Litter Abatement Task Force (IDLATF) is a working group with members from local city and county governments, solid waste haulers and landfill operators, law enforcement, business leaders in agriculture, members of the community, as well as private landowners and ranchers, whose only focus is to reduce illegal dumping in Monterey County.

Focus

Reduce illegal dumping in Monterey County

Strategies

Public education and community clean-ups, enforcement of mandatory garbage requirements, and inter-agency cooperation.

Link

http://www.mtyhd.org/illegaldumpingtaskforce

Impact Monterey County

Impact Monterey County is a comprehensive, county-wide community dialogue sponsored by United Way Monterey County that will shine a light on community conditions and solicit residents' aspirations for their quality of life as regards education, economic self-sufficiency, and health. With the participation of approximately 1-2% of county residents, our community will benefit from the alignment of stakeholders toward common goals and measurements that improve conditions for all.

Focus

Community aspirations for improved quality of life.

Strategies

Access and measure community needs, collaborate with other works in progress, align stakeholders toward common goals, implement a common agenda, measure progress, and sustain.

Link

https://www.impactmontereycounty.org/

Montage Health Prescribe Safe

Prescribe Safe, a program led by Montage Health, has partnered with more than 35 local businesses and agencies to address the opioid addiction problem since 2014. By 2018, Monterey County had improved to have the second-lowest opioid-related death rate of any county in California. But in the last several years, counterfeit medications have entered the market, many with a toxic or lethal dose of fentanyl, causing a staggering increase in opioid-related overdoses and deaths. Prescribe Safe aims to save and improve lives by helping to prevent and address addiction and overdoses in schools and in the community.

Focus

The initiative guides, educates, and provides resources for local physicians and patients in the safe use of prescription medications and promotes safe and effective pain management

Strategies

Provide resources on the recent fentanyl epidemic, reduce inappropriate prescribing of pain medications and sedatives, and increase access to addiction treatment

Link

www.montagehealth.org/prescribesafe

Monterey County Child Care Planning Council

Monterey County Child Care Planning Council creates a comprehensive, integrated childcare delivery system that offers safe, high quality, culturally sensitive, affordable childcare to Monterey County families who need it; that allows parental choice; and is supported by a partnership of public and private resources.

Focus

Preschool and afterschool childcare.

Strategies

Forum for childcare issues and policy development

Link

https://www.facebook.com/MontereyCountyChildCarePlanningCouncil/

Monterey County Children's Council

The Council's purpose is to enhance services and decrease duplicative efforts in child and youth service provisions by developing a comprehensive and collaborative delivery system of services for children and their families. The Council was established by the Board of Supervisors on June 9, 1992, and is comprised of over 25 organizations representing a diverse group of stakeholders including business, funders, philanthropy, service providers, law enforcement, health and mental health, and social services.

Focus

Children's education, health, and well-being.

Strategies

All Kids, Our Kids (a countywide movement dedicated to building stronger, more resilient children and youth by creating positive, caring, and supportive schools and communities through positive youth development) and Early Childhood Development Initiative (see above).

Link

https://www.unitedwaymcca.org/monterey-county-childrens-council

Monterey County Collaborates

The Collaborates' mission is to support, educate and empower youth and families to create safe and healthy environments. The Collaborates work to reduced tobacco use, encourage smoke-free housing, promote safe and walkable communities, inform healthier lifestyles, educate on oral health practices, and endorse responsible alcohol and cannabis use.

Focus

Policy development and collaborative action.

Strategies

Community education, prevention, and policy development.

Link

https://www.countyofmonterey.gov/government/departments-a-h/health/public-health/tobacco-program/monterey-county-collaborates

Monterey County Health Needs Collaborative

Monterey County Health Needs Collaborative is a group of organizations dedicated to improving the health of the Monterey County community. The partnership includes Community Hospital of the Monterey Peninsula, Salinas Valley Memorial Healthcare System, Mee Memorial Healthcare System, Natividad, the County of Monterey Health Department, and United Way Monterey County.

These trusted local entities worked closely during the pandemic to provide our community with education, resources, vaccination clinics, testing, and more. Forming the Health Needs Collaborative is a way to broaden our partnership and leverage our resources to meet common health goals.

Focus

Population health and health disparity reduction.

Strategies

Convening partnerships and leveraging our resources to meet common health goals.

Link

https://www.unitedwaymcca.org/HealthyMontereyCounty

Monterey County Immunization Coalition

The Monterey County Immunization Coalition is comprised of professionals from the medical community, schools, and other community- based organizations. The coalition has 6 goals: To increase vaccine rates by promoting vaccines to all populations/ ages; to remove barriers to obtaining vaccinations; to educate parents and providers; to decrease missed opportunities; to expand the coalition and to coordinate our efforts.

Focus

Advocating for the benefits of immunizations.

Strategies

Advocacy and education.

Link

https://www.countyofmonterey.gov/government/departments-a-h/health/boards-collaboratives/monterey-county-immunization-coalition

Monterey County Maternal Mental Health Task Force

The Monterey County Maternal Mental Health Task Force (MMHTF), chaired by the County of Monterey Health Department's Behavioral Health Bureau, leads work on strategies to expand access and improve treatment and support for parents' mental health.

Focus

The Task Force supports collective actions to reduce equity gaps and disparities in each of these areas, to ensure all pregnant and parenting mothers and their families thrive.

Strategies

The Task Force supports resilience and wellness of pregnant and parenting mothers and primary caregivers, and their families by 1) increasing awareness and decreasing the stigma associated with maternal mental health concerns; 2) increasing socio-emotional and community supports for pregnant and parenting mothers and families; and 3) promoting better access to mental health services, uniform and consistent screening, and treatment for maternal mental health concerns and other challenges.

Link

https://brightbeginningsmc.org/maternal-mental-health-task-force/

Monterey Regional Health Development Group (MoReHealth)

MoReHealth is comprised of health care and community leaders in Monterey County who meet quarterly to share ideas, discuss initiatives, interact with State and federal legislators, and engage invited speakers on health care topics. MoReHealth attendees include local hospital executives, physicians, military health care leaders, government officials, allied health professionals, and executives from community agencies, media, and education sectors. Recent examples of MoReHealth agenda topics include the Affordable Care Act including enrollment and provider capacity in Monterey County, local Employee Health Promotion programs, Health Needs Assessments in Monterey County, and federal legislation to improve local Medicare physician payments.

Focus

Events and trends affecting the health and medical care of Monterey County residents.

Strategies
Events and trends affecting the health and medical care of Monterey County residents.

Link
Elsa Jimenez, MoReHealth Chair (jimenezem@countyofmonterey.gov)

Nonprofit Alliance for Monterey County

Nonprofit Alliance of Monterey County (NAMC) is an unincorporated membership organization governed by Core Leadership, a 10 to 15-member group elected annually and representing the range of key actors in the nonprofit industry. NAMC strives to develop and implement programs that encourage its members to work collaboratively and support one another, that improve the internal operations and structures of nonprofit organizations, and that speak to the larger community about the critical role of the nonprofit industry in society.

Focus
Nonprofit public benefit organizations.

Strategies
Collaboration and training around diversity and economic impacts.

Link
https://nonprofitalliancemontereycounty.org/

Nutrition and Fitness Collaborative of the Central Coast (NFCCC)

Nutrition and Fitness Collaborative of the Central Coast (NFCCC), is comprised of 50+ agencies spanning Monterey, Santa Cruz, and San Benito counties, representing schools, agencies, and organizations working to improve the health and well- being of Central Coast residents.

Focus
Planning, information and data sharing, networking, coordination.

Strategies
Trainings, conferences, community forums, mini-grants.

Link
https://www.countyofmonterey.gov/government/departments-a-h/health/public-health/nutrition-education-and-obesity-prevention-neop/nutrition-fitness-collaborative-of-the-central-coast

Safety Net Integration Committee

This committee is comprised of the county's four hospitals, health and insurance providers, and IT experts working to integrate Safety Net Provider Electronic Medical Record patient care information through participation in the Peninsula Health Information Link. This work will improve the ability of the county's health care safety net to coordinate care for low-income populations through implementation of new strategies that strengthen the integration of community health centers (CHCs), safety net hospitals and county-operated safety net providers.

Focus

Increase safety-net patient access to health care and efficiently share health information between safety-net providers.

Strategies

Integrate Safety Net Provider Electronic Medical Record patient care information through participation in the Peninsula Health Information Link.

Link

Contact County of Monterey Health Department Clinic Services, 831-755-4500

Seaside Leadership Team

The Seaside Leadership Team was created in August 2012 as part of the Community Transformation Grant Initiative. Monterey County was one of 12 counties chosen to become a CA4Health county and the community of Seaside was chosen for their readiness to build a healthier community among their diverse population. Through collaboration, a Leadership Team was convened to meet bi-monthly and to begin to address health disparities in the community of Seaside.

Focus

Four strategic areas include: 1) chronic disease self –management, 2) reducing sugary sweetened beverage consumptions, 3) Safe Routes to School and healthy environments such as 4) smoke-free multi-unit housing opportunities. The Leadership Team will implement a collaborative approach that will be sustainable in years to come with great results.

Strategies

Train community health workers and clinic staff to deliver Living Well series for community residents to improve chronic disease and managed care. Train youth leaders as change agents in reducing sugary sweetened beverage consumption among their peers and highlight the problem of second-hand smoking in multi-unit housing. Provide technical assistance to City of Seaside for vendor policy revision.

Link

Contact County of Monterey Health Department/Prevention Team at 831-755-4541

Sexual Assault Response Team (SART) Coalition

The Sexual Assault Response Team (SART) is a victim-sensitive program designed to provide a team approach to responding to survivors of sexual assault in our community who have decided to report the assault. SART consists of trained nurse examiners and physicians' assistants, also known as Sexual Assault Forensic Examiners, local law enforcement agencies, and certified sexual assault victim counselors from the Monterey County Rape Crisis Center. The SART approach helps reduce trauma and increase support, while ensuring efficient and consistent evidence collection. Forensic exam costs are covered by law enforcement.

Focus

Victims of sexual assault and survivors of child sexual abuse, and their families and support groups.

Strategies

Reduce trauma and increase support; endure efficient and consistent evidence collection

Link

http://www.mtryrapecrisis.org/

VI. Appendices

Appendix A: Glossary and Definitions

A

A1c Score: The score is a blood test that indicates the average blood sugar level over the past two to three months, measured by the percentage of hemoglobin in the red blood cells. It is used to diagnose diabetes.

Access to Health Care Services: a situation in which a person cannot access health services due to distance, language, financial, or social issues that reduces access to healthcare services and increases the risk of poor health outcomes.

Active transportation: human-powered mobility such as biking, walking, or rolling.

B

Benchmarks: a standard or point of reference against which things may be compared or assessed.

Body Mass Index (BMI): an indicator of fat in the body by measuring a person's weight in kilograms divided by the square of their height in meters.

C

Community Health Improvement Plan (CHIP): a plan that describes strategies, stakeholders, goals, and measures of progress to improve specific health concerns and disparities.

D

Diabetes: a physical condition in which a body does not produce enough or any insulin resulting in an unhealthy blood glucose level.

E

Evidence-based program (EPB): the systematic process where-by decisions are made and actions or activities are undertaken, using the best evidence available.

G

Goal: an idea of the future or desired result that a person or a group of people envision, plan, and commit to achieve.

H

HbA1c: a hemoglobin blood test that indicates the measure of blood sugar (glucose).

Health Disparities: preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations.

Health Equity: the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors.

Health Literacy: the degree to which individuals have the ability to find, understand, and use information and services to inform health-related decisions and actions for themselves and others.

M

Mental Health: a person's condition with regard to their social, psychological, and emotional well-being.

P

Population-based health: measures of a community's or region's collective health.

Practice-based Program (PBP): the cumulative knowledge and learning acquired by practitioners through years of innovation, reflection, and refinement.

R

Random sample: a type of probability sampling in which the researcher randomly selects a subset of participants from a population.

S

SMART objectives: objectives that are specific, measurable, attainable, relevant, and time bound.

SMARTIE objectives: objectives that are specific, measurable, attainable, relevant, time-bound, inclusive, and equitable.

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

Strategy: the determination of basic long-term goals, the adoption of courses of action, and the allocation of resources necessary for achieving goals.

U

Usual Source of Care: the particular medical professional, doctor's office, clinic, health center, or other place where a person would usually go if sick or in need of advice about his or her health.

Appendix B: PHAB Standards & Measures for Reaccreditation—CHIP Requirements (2022)

Section 5.2.1 of the national Public Health Accreditation Board (PHAB) Standards and Measures requires that local public health jurisdictions adopt a community health improvement plan (CHIP) to guide the health department, its partners, and stakeholders in improving the population's health. The CHIP should reflect the results of a collaborative planning process that includes significant involvement by key sectors. The health department and its partners may use the CHIP to prioritize existing activities and set new priorities, and as the basis for taking collective action and facilitate collaborations. To fulfill accreditation and reaccreditation standards, local health departments must include a CHIP dated within 5 years as the documentation for Measure 5.2.1 A.

Local health departments seeking PHAB accreditation or reaccreditation must submit the CHIP for their jurisdiction that includes the following elements:

a. Two or more health priorities that the CHIP addresses in collaboration with community partners.
b. One or more measurable objective(s) for each health priority to monitor progress and strategically modify how the CHIP is implemented.
c. Specific strategies to improve the health priorities addressed in the CHIP
    a. Need to use evidence-based, practice-based, and/or promising practices, or an innovative method to meet the needs of the population.
    b. Each strategy must have a clear timeframe and identify the Health Department staff, program, or community partner that will coordinate the collaborative implementation of that strategy, by formal agreement.
    c. At least two of the strategies must include a policy recommendation (and at least one policy recommendation must aim to alleviate the root causes of health inequities).
d. A list of community assets and resources that will be used to address at least one of the health priorities.
e. A description of the process that will be used to track the status of implementation efforts and monitor results/progress toward the CHIP objectives and goals.

Appendix C: Organizations Invited to Give Input & Comments on the Draft 2025–2028 County of Monterey CHIP

American Cancer Society

American Heart Association

Aspire Health

Blue Zones Project

Breathe California

Building Healthy Communities Monterey County

C4 Consulting

California State University Monterey Bay

California Coast YMCA

Central Coast Alliance for Health

Central Coast Overdose Prevention

Child Abuse Prevention Council

Community Hospital of Monterey Peninsula (CHOMP)

City of Gonzales

City of Salinas

Community Foundation for Monterey County

Community Health Innovations

ECHO Housing

Eden Housing

First 5 Monterey County

Foundation for a Drug-Free World

Harmony At Home

Interim Inc.

King City Police Department

Latino Coordinating Center

Monterey County Collaborates

County of Monterey Health Department Bureaus

Monterey County Office of Education

Monterey County Oral Health Program

County of Monterey Public Works Department

Monterey Peninsula Unified School District

Nutrition & Fitness Collaborative of the Central Coast

City of Pacific Grove

Parents Against Vaping

Partners for Peace

Pajaro Valley Prevention and Student Assistance

Radio Bilingue

Salinas Police Department

County of San Benito

County of Santa Cruz

Sun Street Centers

Salinas Valley Memorial Health

The Epicenter

The Village Project

UCLA

Appendix D: References

Access to Health Care in America. 1993. Institute of Medicine; Committee on Monitoring Access to Personal Health Care Services; Michael Millman, Ph.D., Editor.

Behavioral Risk Factor Surveillance System, 2021. Centers for Disease Control and Prevention. Found at https://www.cdc.gov/brfss/annual_data/annual_2021.html

California Health Interview Survey (CHIS). UCLA Center for Health Policy Research, Los Angeles, CA. Public Use Files. 2022

Community Health Needs Assessment (CHNA), 2022. Monterey County Health Needs Collaborative. Available here: https://www.unitedwaymcca.org/HealthyMontereyCounty

Davis, R., Cook, D., Cohen, L. A community resilience approach to reducing ethnic and racial disparities in health. American Journal of Public Health. 2005: Vol. 95 No. 12; 2168-2172

Devine P, Forscher P, Austin A. Long-term reduction in implicit race bias: A prejudice habit-breaking intervention. J Exp Soc Psychol. 2012 Nov; 48(6): 1267–1278. doi: 10.1016/j.jesp.2012.06.003

Fawkes L, Chiu W, Roh T, McDonald T, Sansom G. Human health risk assessment of heavy metals in residential soil—Houston, Texas. September 2024. Journal of Exposure Science & Environmental Epidemiology. DOI:10.1038/s41370-024-00713-7

Godsil R, Tropp L, Goff P, Powell J. 2014. Addressing Implicit Bias, Racial Anxiety, and Stereotype Threat in Education and Health Care. Perception Institute, The Science of Equality, Volume 1.

Healthy People 2020. U. S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. https://www.cdc.gov/nchs/healthy_people/hp2020.htm

Healthy People 2030. U. S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. https://health.gov/healthypeople/priority-areas/health-equity-healthy-people-2030

Jirmanus L, Ranker L, Touw S, et al. Impact of United States 2017 Immigration Policy changes on missed appointments at two Massachusetts Safety-Net Hospitals. J Immigrant Minority Health 24, 807–818 (2022). https://doi.org/10.1007/s10903-022-01341-9

Jones H, 2023. 6 Environmental Risk Factors for type 2 Diabetes. Available online at https://www.verywellhealth.com/environmental-risk-factors-for-type-2-diabetes-6537605

American Lung Association (ALA). State of the Air 2024 Report. https://www.lung.org/research/sota

U.S. Department of Health and Human Services (DHHS). Physical Activity Guidelines for Americans, 2nd edition. Washington, DC: U.S. Department of Health and Human Services; 2018.

Wang M, Kim S, Gonzalez A, MacLeod W, Winkleby M. Socioeconomic and food-related physical characteristics of the neighborhood environment are associated with body mass index. Journal of Epidemiology & Community Health 2007; 61 491-498

Zilbermint M. Diabetes and climate change. Journal of Community Hospital Internal Medicine Perspectives. 2020;10(5):409-412. doi:10.1080/20009666.2020.1791027

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