



**ADVENTIST HEALTH
WHITE MEMORIAL**

COMMUNITY HEALTH
NEEDS ASSESSMENT

2022



Executive Summary

Non-profit health systems, community-based organizations and public health agencies across the country all share a similar calling: to provide public service to help improve their community members' lives. One area of public service where these entities share responsibility is ensuring all community members have the opportunity to live a healthy life.

The Community Health Needs Assessment (CHNA) is one-way public service agencies support the health of their communities. These assessments are required of non-profit hospitals and public health departments every three and five years, respectively, to understand the health needs of the communities they serve. The purpose of this assessment is to engage the communities in identifying community health needs, and to align resources across the community benefit functions of a non-profit hospital, strategies of public health, and services of community-based organizations to drive towards improved health for all.

For 2022, Adventist Health White Memorial took this requirement one step further with the vision of designing a story-centric and people-centric CHNA. We envisioned a concise report that the entire community could contribute to and access, regardless of public health context or reading ability. This process involved input from community focus groups and key informant interviews representing the broad interests of the community served by hospitals and collaborative organizations. In addition, input was gathered from local public health officials, community-based organizations, medical providers, students, parents, and members of selected underserved, low-income and minority populations. We intentionally prioritized understanding the social and health needs of uninsured or underinsured, low-income and minority persons in the community (see description of Focus Group participants, Section III.B).

To conduct this assessment, we used secondary and primary data from focus groups and key informant interviews conducted between October 2021 – January 2022. A local Steering Committee (see Section I.E) reviewed data and prioritized community health needs over the course of three meetings (data collection planning, data review and needs prioritization) taking place between October 2021 – March 2022. This group determined the following final community health priority areas:

Access to Care

Financial Stability

Food Security

Mental Health

In this report, you will first find a Community Summary that introduces the community served by our hospital and lists the prioritized community health needs. The Community Summary is a brief overview of the main points from the CHNA followed by an in-depth and detailed report including:

Our Partners: CHNA Steering Committee (see Section I.E)

Description of Hospital and Community Served (see Section II)

Significant Identified Health Needs and Priority Areas Selected (see Section III)

Data Collection and Analysis (see Section IV)

Prioritization Process (see Section IV)

Next Steps (see Section IV.C)

We hope this report is leveraged by all local partners and community members, empowering them to own the potential of healthy living for all. The entire report is published online and available in print form by contacting community.benefit@ah.org.

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 Identity and Qualifications

 Adventist Health Community Well-Being Team

 Berkeley IGS

 CARES

 Center for Behavioral Health Integration

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What if ...

Everyone from newborns to older patients easily received the unique care they needed?

Families and individuals had jobs and the financial resources they needed to live a safe and healthy life?

Healthy food choices were easy and available to all individuals and families?

Everyone had someone to talk to about their mental well-being?



Community Vision Summary

Taking a step toward a healthier, better life

This is the vision of the future as seen through the Community Health Needs Assessment, or CHNA. The goal of the CHNA is to leverage community stakeholders and data to identify and maximize resources and to focus on meeting the most significant health needs of our community over the next three years.

Members of the CHNA Steering Committee – comprised of healthcare, civic, public, and business leaders – led this process of identifying and addressing health needs for a healthier community. These members took a deep look at where people live, learn, work and play to discover areas of opportunity that, through collaboration, could be strengthened and lead to a healthier you, stronger families and safer communities.

This CHNA involved interviews with community-based organizations, education, family services, gang

populations, healthcare, higher education, mental health, Public Health and the unhoused. We also conducted a community survey and gathered public data. Through this process, we learned about our community members' current state of health and listened to their greatest concerns for their friends and family.

There were nine significant health needs focusing on the social determinants of health identified through this in-depth analysis and discussion. These needs were access to care, COVID, environment & infrastructure, financial stability, food security, health risk behaviors, housing, inclusion & equity and mental health. The Steering Committee then selected high priority needs based on severity and prevalence, intentional alignment around common goals, feasibility of potential interventions, and opportunities to

maximize available resources over a three-year period, which were: access to care, financial stability, food security and mental health.

Additionally, the committee recognizes the impact of unique environmental challenges caused by air pollution, including airborne lead and arsenic. Despite this environmental hardship, the community has shown a dedication to improving the well-being of its residents, and the committee will be focused on discovering how environmental pollution impacts the selected high-priorities.

The following pages share opportunities where you, your family and your community can drive change for improved well-being.

Join us to activate our diverse community, improve lives, and make a "what if" dream into a powerful "what is" reality.

What if . . .

Everyone from newborns to older patients received the unique care they needed, thanks to good **Access to Care**

Families and individuals had jobs and the financial resources they needed to live safe and healthy lives, with access to organizations that can help when needed to ensure **Financial Stability**

Healthy food choices were easy and available to all individuals and families with support in getting nutritious meals, leading to better **Food Security**

Everyone had someone to talk to about their mental well-being, with accessible programs addressing **Mental Health**

Getting to know our White Memorial CHNA service area*

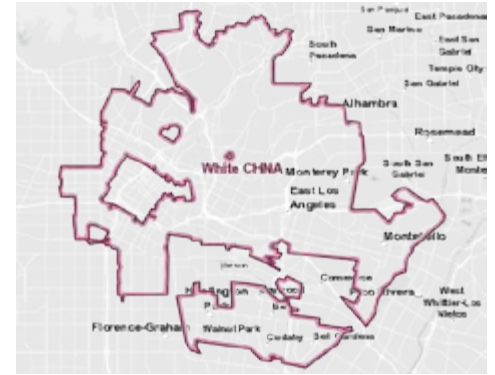
From Mariachi Plaza to Evergreen Cemetery, Boyle Heights is one of Los Angeles' most historic and vibrant communities. Just three miles east of downtown Los Angeles, Boyle Heights is home to generations of immigrants with 76% of the community served by White Memorial Hospital being Hispanic, and the epicenter of several historical social justice movements.

This small neighborhood has an impressive total population of 1,109,487. A community rich in art, music, food and small business'. The median household income is \$52,384, and of that, 45.66% is spent on housing and transportation. Among this population, 30.84% of children live in poverty and 2.27% of students are unhoused, compared to the state average of 4.25% and national average of 2.77%.

True to its historical roots as a center of civic engagement, this population boasts a voter participation rate of 67.5%.

Let's begin with an overview of the last three years including a closer look at community member comments, priorities, and numbers that guided the decision-making process towards a path to better health, wholeness, and hope.

**This service area represents Adventist Health White Memorial's primary service areas (PSA), accounting for 75% of hospital discharges. Additionally, we took a collaborative approach and expanded our PSA by inviting Steering Committee members to include the zip codes of those they serve, creating the Adventist Health White Memorial (AHWM) CHNA service area.*



What if our community worked together and made life all-around better?
What if we offered various pathways to meet our diverse needs, so every member of our community experienced better health, prosperity and longevity?

CHNA 2019 successes and lessons learned



Before we look ahead, let's look back at a few highlights from our 2019 CHNA prioritized health needs to see what we've accomplished and learned since then. Over the last three years, we've focused on access to care, health conditions and mental health.

Working together with the community, we created strategies designed to educate and break down barriers to care and well-being for White Memorial's service area community. We held virtual and

in-person sessions with our patients and community members experiencing chronic diseases such as diabetes, enrolled 81 individuals in our Wellness Program, and provided post-partum mental health education and support tools to nearly 6,000 community members including over 300 mental health assessments. Additionally, we partnered with our onsite Wellness and Family Care Specialists to offer weekly mental health classes and activities in our Community Garden.

Despite being forced to close during the COVID-19 pandemic, our Community Information Center was able to refer and coordinate resources for over 2,000 community members while it was still open.

The COVID-19 global pandemic caused extraordinary challenges for Adventist Health White Memorial, leading us to pivot our focus to helping patients and families stop the spread of the virus, and provide access to free vaccines for all throughout the county.

Access to Care

COMMUNITY VOICES

- Residents say being an undocumented community member limits the ability to receive numerous social service benefits.
- Interviewees emphasized that limited access to providers includes inadequate time to meet with providers when you do have an appointment.
- “Not only are there concerns about the number of doctors available, there are concerns about the cultural and linguistic diversity of local providers.”
- “Due to the limited number of providers the Emergency Room becomes the default provider for many.”

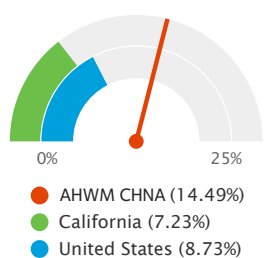


White Memorial residents provided important feedback regarding challenges they face and changes they would like to see. They shared about financial constraints, how these impact language barriers, and their ability to access insurance. Immigrant residents noted that their status limits their ability to receive benefits. The Hispanic

community identified healthcare access as a particular problem, referencing concerns about available doctors and the challenges of cultural and linguistic diversity. The provider shortage might require residents to rely on the Emergency Room, and language proficiencies between providers and patients can be challenging.

SECONDARY DATA INFOGRAPHIC STATS:

Uninsured Population, Percent



Primary Care Providers, Rate per 100,000 Population

Report Area	Total Population (2020)	Number of Facilities	Number of Providers	Providers, Rate per 100,000 Population
AHWM CHNA	1,055,914	521	1,015	96.13
Los Angeles County, CA	10,014,009	4,193	10,158	101.44
California	39,538,223	12,051	39,455	99.79
United States	334,735,155	117,465	349,603	104.44

**Community Health
Needs Survey:**

Los Angeles County*

22% of those surveyed
selected Access to Care
as a top health concern.

*Survey region is defined by
the survey administrator.

See Section V. B. for more information.

Additional information came through
a review of publicly available data,
supporting the concerns residents
raised. It also showed 14.5% of the
residents do not have access to health
insurance, and 14.4% of households
do not have a motor vehicle, a rate
higher than the state (7%) and the
nation (8.5%). However, most of the
population (93%) lives within half a
mile of public transportation. Health

literacy and limited English proficiency
can be additional barriers to access
to care.

Thanks to residents' feedback and ideas
much was discovered. The focus now is
to respond to what's been learned and
work toward creating a brighter future.

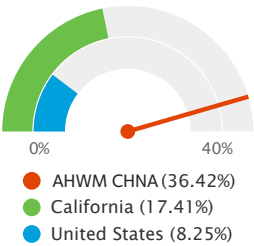
**Find Access to Care resources
in your community to
live better, longer.**

California Transit Inc.

323-234-8750, california-transit.com

Get Connected Get Help with 211, Powered by people
in your community, available 24/7, 800-339-6993,
Unitedwayla.org

Population Age 5+ with Limited
English Proficiency, Percent



Population Age 25+ with No High School Diploma, Percent

Report Area	Total Population Age 25+	Population Age 25+ with No High School Diploma	Population Age 25+ with No High School Diploma, Percent
AHWM CHNA	727,859	268,127	36.84%
Los Angeles County, CA	6,909,179	1,395,909	20.20%
California	26,665,143	4,286,538	16.08%
United States	222,836,834	25,562,680	11.47%

Financial Stability

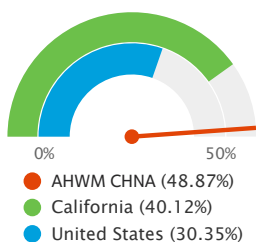
COMMUNITY VOICES

- It was noted that accessing healthcare services and community resources can be difficult due to language and educational barriers.
- Interviewees stated that attending healthcare appointments can be difficult for many due to limited time and competing work demands.
- It was noted repeatedly that financial instability doesn't stem from not working, but that the community is very hard working, and many people hold multiple jobs to support themselves and their families.
- "COVID has exacerbated financial problems for many, largely for losing work due to illness or caring for others who are sick."



SECONDARY DATA INFOGRAPHIC STATS:

Percentage of Households where Housing Costs Exceed 30% of Income



Income - Childhood Poverty Rate

Report Area	Total Population	Population Under Age 18	Population Under Age 18 in Poverty	Percent Population Under Age 18 in Poverty
AHWM CHNA	1,084,705	250,618	77,286	30.84%
Los Angeles County, CA	9,884,138	2,145,717	419,142	19.53%
California	38,589,882	8,815,673	1,480,649	16.80%
United States	318,564,128	72,065,774	12,598,699	17.48%

Community Health Needs Survey:

Los Angeles County*

86% of those surveyed selected Financial Stability as a top health concern.

*Survey region is defined by the survey administrator.

See Section V. B. for more information.

Having financial stability provides access to safe housing, healthy foods, and everyday necessities so that families can fully participate in community life and plan for the future.

Residents shared that with each urban-neighborhood makeover, neighbors have moved because they couldn't afford their homes anymore.

Due to limited time and money many neighborhood members have poor diets as they don't have the resources to get healthy foods. Residents have also noticed a large percentage of neighbors living paycheck to paycheck, unveiling basic financial instability.

As one resident put it, financial instability doesn't stem from not working, because the community is very hard working. Yet people hold multiple jobs to support themselves and their families.

In addition to these concerns are the numbers, which paint a picture of problematic outcomes. The unemployment rate is 7.65%, which is higher than the US overall (5.38%) and California (6.18%). Childhood poverty is remarkably high (31%) – almost double that of California. The median household income of \$52,384 is lower than both California and the US by a substantial amount.

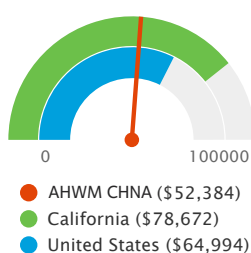
Find Health Conditions – Financial Stability resources in your community to live better, longer.

Los Angeles City Housing Authority

213-205-5585, affordablehousing.com/housing-authority-ca/los-angeles-city-housing-authority-680

Get Connected Get Help with 211, Powered by people in your community, available 24/7, 800-339-6993, Unitedwayla.org

Median Household Income



Employment – Unemployment

Report Area	Labor Force	Number Unemployed	Unemployment Rate
AHWL CHNA	569,860	43,579	7.65%
Los Angeles County, CA	5,247,546	338,720	6.45%
California	19,875,973	1,229,079	6.18%
United States	164,759,496	8,870,516	5.38%

Food Security

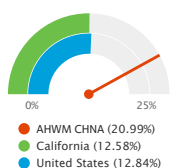
COMMUNITY VOICES

- Residents noted that not having a variety of grocery stores in the community is seen as a food security barrier.
- Interviewees emphasized that having to choose what to spend your money on often leads to poor dietary habits.
- Even when food is easily available locally it's not often healthy and affordable. This is seen as a particular problem for seniors, residents shared.
- "Local food carts are seen as a viable option to combat food desserts."
- "Obesity is seen as a direct consequence of food insecurity."

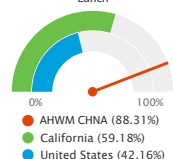


SECONDARY DATA INFOGRAPHIC STATS:

Population in Poverty, Percent



Percentage of Students Eligible for Free or Reduced Price School Lunch



Population in Poverty Race Alone, Percent

Report Area	White	Black or African American	Native American or Alaska Native	Asian	Some Other Race	Multiple Race
AHWM CHNA	21.69%	32.87%	17.61%	18.57%	21.26%	15.27%
Los Angeles County, CA	12.86%	20.18%	16.31%	10.99%	17.81%	12.11%
California	11.38%	19.60%	18.36%	10.04%	17.34%	11.74%
United States	10.60%	22.07%	24.13%	10.61%	19.66%	15.08%

Community Health Needs Survey:

Los Angeles County*

31% of those surveyed selected Food Security as a top health concern.

*Survey region is defined by the survey administrator.

See Section V. B. for more information.

Access to healthy food is a concern across the globe. It is focused on ensuring that all people, at all times, have access to safe and nutritious food that will support active, healthy lives.

White Memorial shares many of these concerns, with the hospital facing significant food security challenges.

The community has 21% of its residents living in poverty, which is 8% higher than state and national averages. Poverty rates are even greater for Black and for female residents. Additionally, 88% of students receive free or reduced-price

school lunches – more than double the national average and almost 30% higher than the California average.

Input from community members tells of the challenges that residents face, ranging from a shortage of grocery stores, food that is often not healthy or affordable, and obesity that results from a lack of access to wholesome, healthy foods.

With community collaboration, secure food access, communication and education, families can work toward healthier choices and begin to change futures.

Find Health Conditions – Food Security resources in your community to live better, longer.

Los Angeles Regional Food Bank

323-234-3030, lafoodbank.org

The Salvation Army

323-587-4221, southeastcommunities.salvationarmy.org

Get Connected Get Help with 211, Powered by people in your community, available 24/7, 800-339-6993, Unitedwayla.org

Children Eligible for Free or Reduced Price Lunch by School Year, 2012-13 through 2020-21

Report Area	2012-2013	2013-2014	2014-2015	2015-2016	2016-2017	2017-2018	2018-2019	2019-2020	2020-2021
AHWM CHNA	66.7%	84.5%	86.6%	88.3%	86.5%	86.5%	88.0%	88.8%	88.3%
Los Angeles County, CA	58.9%	67.1%	66.8%	67.8%	67.5%	67.5%	68.8%	69.1%	69.0%
California	56.4%	58.3%	58.7%	58.9%	58.1%	58.1%	59.4%	59.4%	59.2%
United States	51.8%	52.4%	52.3%	52.7%	52.1%	52.1%	52.4%	52.1%	53.2%

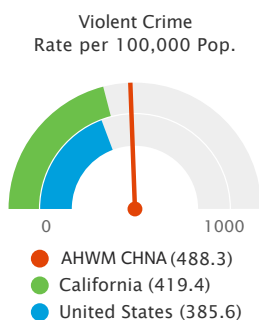
Mental Health

COMMUNITY VOICES

- It was noted that stigma around mental health services makes it less likely for some community members to seek assistance.
- Several interviewees suggested that normalizing mental health struggles will benefit community youth in the eyes of community members.
- Interviewees felt that a lack of Spanish-speaking therapists created access limitations for some.
- “Financial problems and unstable housing situations lead to a greater need for mental health services.”
- “Addressing stigma is viewed as critical.”



SECONDARY DATA INFOGRAPHIC STATS:



Mental Health Care Providers, Rate per 100,000 Population

Report Area	Total Population (2020)	Number of Facilities	Number of Providers	Providers, Rate per 100,000 Population
AHWM CHNA	1,055,914	63	1,264	119.70
Los Angeles County, CA	10,014,009	1,493	13,419	134.00
California	39,538,223	5,078	59,430	150.31
United States	334,735,155	56,424	442,757	132.27

Community Health Needs Survey:

Los Angeles County*

48% of those surveyed selected Mental Health as a top health concern.

*Survey region is defined by the survey administrator.

See Section V. B. for more information.

Input from a variety of residents has led to the realization that mental health is a concern that needs to be acknowledged and addressed.

A survey of community residents showed that 48% of those polled shared mental health as a top health concern. Community members commented there is a stigma attached to needing mental health services, and

that the Hispanic community is less likely to access mental health care due to this associated stigma.

Parents noted the need to learn more about anxiety and depression in order to better support their children. This acknowledgment by parents will help normalize mental health struggles and help children learn and adapt.

Community members also commented financial problems, physical health issues and unstable housing as stressors that contribute to their mental well-being. Through healthy collaboration, residents can seek and share resources to empower each other.

Find Mental Health resources in your community to live better, longer.

Northeast Mental Health Center

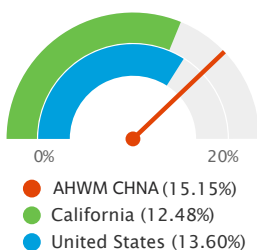
323-478-8200, dmh.lacounty.gov

Variety Boys and Girls Club

323-269-3177, vbgc.org

Get Connected Get Help with 211, Powered by people in your community, available 24/7, 800-339-6993, Unitedwayla.org

Percentage of Adults with Poor Mental Health



Risk Factors – Stress & Trauma – Unemployment

Report Area	Labor Force	Number Unemployed	Unemployment Rate
AHWM CHNA	569,860	43,579	7.65%
Los Angeles County, CA	5,247,546	338,720	6.45%
California	19,875,973	1,229,079	6.18%
United States	164,759,496	8,870,516	5.38%

What if ...

It's not a prescription that changes your health?

Instead, it's a collaboration between you and your care providers?

And it's community-based organizations working together to support you?

Many of us have given away the condition of our health to doctors, hospitals and health programs. But in reality, it's not any one plan or pill that will change your well-being. It's you. It's us, together with our community, working to create equitable opportunities so we can all actively move more, eat well, and be connected to community life, friends and family.

It took many committed community members to help create the 2022 CHNA. Steering Committee members shared their ideas and concerns and worked – and continue to work – to create a new vision.

Proudly, we share that this CHNA is part of a county-wide collaboration—but these community organizations can't do it alone. It takes collaboration, partnership, consistency and teamwork.

People of all walks of life offered ideas for the 2022 CHNA, helping to lead the way by focusing on needs otherwise too often overlooked. The final efforts are proving to be useful and enlightening – potentially leading to new directions and new opportunities.



To all who helped, we say **THANK YOU**. To those who now see the needs and opportunities, we welcome you. Change changes. Let's work together to inspire health, wholeness and hope in our community.

We thank the Adventist Health White Memorial CHNA Steering Committee, which collaborated and partnered to create the 2022 CHNA. Through a series of three collaborative meetings, engagement of community members, and reviewing data, each committee member brought their unique perspective and view as seen through their job and the work they performed during the development of the CHNA.

Lucy Aparicio

Los Angeles City Council
Representative Asian
Pacific Community Fund of
Southern California

Rosie Arroyo

California Community
Foundation

Gabi Barbarena

Founder/CEO, ARAS Inc.

Jasmine Borrego

President, TELACU
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Southern California

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Itohan Oyamendan

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Soledad Enrichment Action
(SEA)

Nancy Saucedo

Northeast Mental Health

Patricia Siqueiros

Variety Boys and Girls Club

Maryam Sesay

Director of Operations,
Queens Care Health
Centers

Sohpia Sleap

Proyecto Pastoral

Mel Tillekeratne

Shower of Hope and Hope
Housing

Julie Villalpando

Queens Care Health
Centers

Michele Wolfe

Puente Learning Center

II. About Us

A. Adventist Health White Memorial

Adventist Health White Memorial is a 353-bed not-for-profit, faith-based, teaching hospital, providing a full range of inpatient, outpatient, emergency and diagnostic services to communities in and near downtown Los Angeles.

Founded on Seventh-day Adventist heritage and values, Adventist Health provides compassionate community care.



B. Adventist Health

Adventist Health is a faith-inspired, nonprofit integrated health system serving more than 80 communities on the West Coast and Hawaii. 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 34,000 includes associates, medical staff physicians, allied health professionals and volunteers driven in pursuit of one mission: living God's love by inspiring health, wholeness and hope. Together, we are transforming the American healthcare experience with an innovative, yet timeless, whole-person focus on physical, mental, spiritual and social healing to support community well-being.

C. Adventist Health Community Benefit & Well-Being Approach to CHNA

Adventist Health is committed to health, wholeness and hope in the communities across our system, which includes improving well-being. Diseases of despair including mental health, substance abuse, suicide and chronic illness continue to escalate.

America leads the world in medical research and medical care, and for all we spend on health care, we should be the healthiest people on Earth. Yet some of the most important indicators, like how long we live, are areas where we don't make the top 25. It's time we stop thinking of health as something we get at the doctor's office and rather as something that

starts within our families, schools, places of worship and workplaces—in our playgrounds, parks, and in the air we breathe, the food we eat and the water we drink. The more we see the problem of health in this way, the more opportunities we have to improve it.

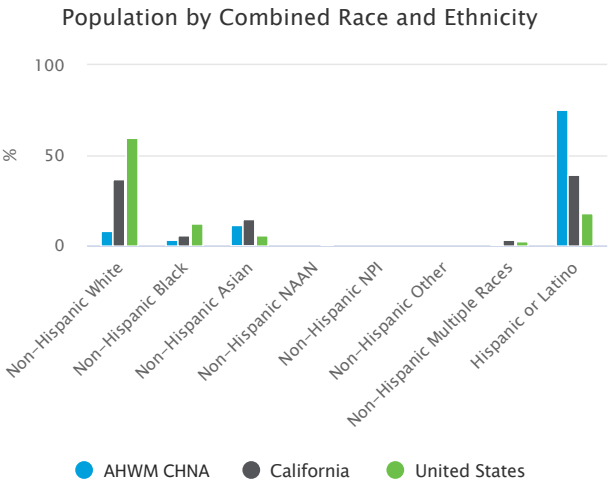
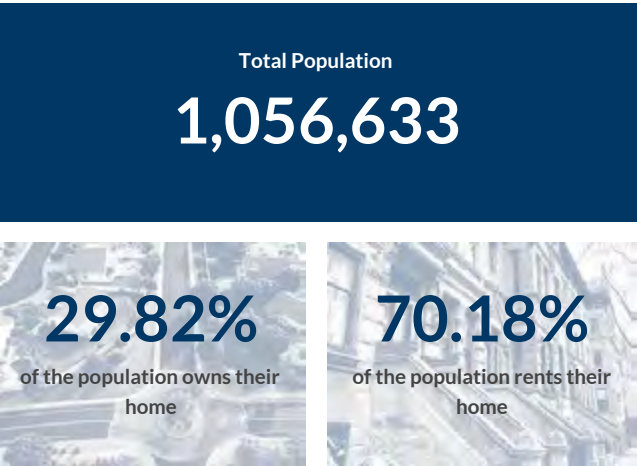
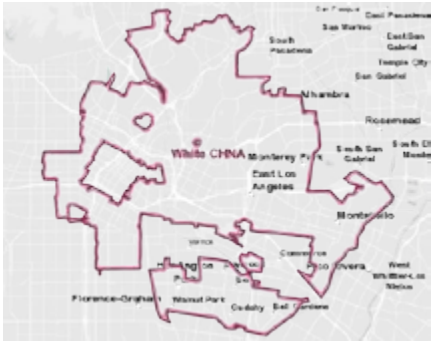
The conditions in which we live, work and play have an enormous impact on our health long before we ever see a doctor—these are the principles of well-being. A key aspect of our strategy to support individual, organizational and community well-being is our relationship with Blue Zones®, a pioneer in taking a systemic and environmental approach to improving the well-being of entire cities and communities. Together, we have built the Well-Being Division, an entity within our organization that exists to empower everyone, everywhere to live longer, better lives.

D. Who We Serve

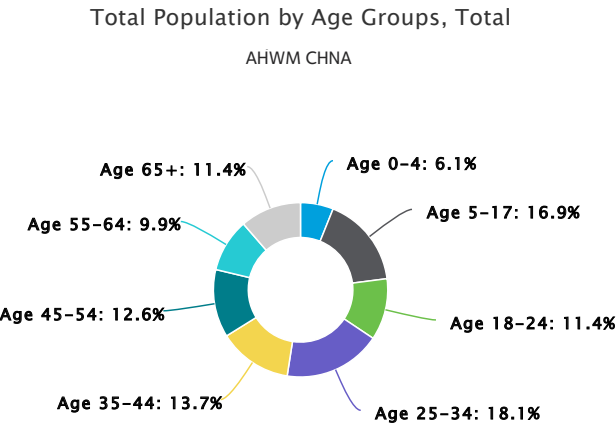
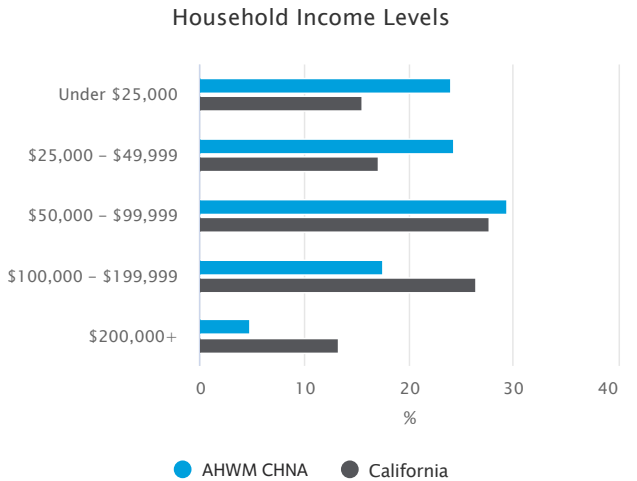
DEMOGRAPHIC PROFILE

The following zip codes represent Adventist Health White Memorial's primary service area (PSA), accounting for 75% of hospital discharges. Additionally, we took a collaborative approach and expanded our PSA by inviting Steering Committee members to include the zip codes of those they serve.

The Adventist Health White Memorial CHNA market has a total population of 1,056,633 (based on the 2020 Decennial Census). The largest city in the service area is East Los Angeles CDP, with a population of 126,496. The service area is comprised of the following zip codes: 90031, 90042, 90201, 90012, 90270, 91754, 90026, 90023, 90007, 90057, 90255, 90640, 90065, 90022, 90063, 90033, 90032, 90006, 90011, 90021, 91803.



Note: NAAN = Native American or Alaska Native, NPI = Native Hawaiian or Pacific Islander.



III. Significant Identified Health Needs, Primary, Secondary Data & Written Comments

A. Significant Identified Health Needs

Steering Committee members, alongside their staff, boards and constituencies reviewed and discussed a presentation of significant identified health needs, which was a list of the top five needs across each data source (see section V for methodology). They then voted to select priorities that demonstrated the greatest need based on severity and prevalence, intentional alignment around common goals, feasibility of potential interventions, and opportunities to maximize available resources over a three-year period. From the list of significant identified health needs in the table, the following three health needs were prioritized as a high priority need, based on the criteria considered (see Section IV. A for full prioritization methodology): Access to Care, Health Risk Behaviors and Mental Health.

TABLE OF SIGNIFICANT IDENTIFIED HEALTH NEEDS

High Priority Needs	
Access to Care	See Sections III.C - E
Financial Stability	See Sections III.C - E
Food Security	See Sections III.C - E
Mental Health	See Sections III.C - E
Lower Priority Needs	
COVID 211la.org/resources/subcategory/covid-19-info-supports/	49% of surveyed residents identified COVID as a community health need.
Housing-Unhoused 211la.org/resources/subcategory/housing/	59% of surveyed residents identified homelessness as a community health need.
Housing-Cost 211la.org/resources/subcategory/housing/	Inadequate housing stock and excessive housing costs affect many people in this region. 66% of surveyed residents identified housing costs as a community health need.
Social Equity 211la.org/resources/subcategory/immigration/	Institutionalized inequities in the community and the entire country hamper community access to needed services, supports, and opportunities in the opinions of focus group participants.
Environment 211la.org/resources/subcategory/utilities-community-services/	This community has a substantial number of factors in the physical environment that can negatively impact the health of the community, but also unique resources to begin addressing this.
Health Risk Behaviors 211la.org/resources/subcategory/mental-health/	The smoking rate is higher than the state average, 30% of adults do not get the recommended amount of exercise, and only 25% of adults 65+ are up to date on core preventative services.

B. Primary, Secondary, and Survey Data Overview

This Community Health Needs Assessment was developed using four separate sources of primary and secondary data. This mixed methods approach is considered a preferred practice for needs assessments because it allows for the greatest understanding of community needs from the broadest range of perspectives. Primary data refers to data collected and analyzed specifically for this project, while secondary data refers to data compiled and analyzed by external groups and utilized here.

Qualitative primary data collection involved focus group interviews with local service providers and service recipients and individual key informant interviews with local leaders. These were conducted in person and virtually. Direct quotes were taken from a transcription of key informant interviews and are intended to be 100% accurate but could not be verified in all situations. This information

was collected by the Adventist Health Community Well-Being team and evaluation consultants from the Center for Behavioral Health Integration. Secondary data was amassed and analyzed across 45 different data sets by the University of Missouri Extension Center for Applied Research and Engagement Systems (CARES). Finally, survey data sets of registered voters in the community were collected and analyzed by UC Berkeley Institute of Governmental Studies (IGS). A detailed explanation of data collection methodology can be found in Sections IV and V.

In total, seven focus groups were conducted with 56 participants, and seven key informant interviews were held. Survey data was gathered from the Los Angeles County region (region name defined by survey administrator, UC Berkeley IGS). See Section V. B. for more information.

DESCRIPTION OF PARTICIPANTS

The CHNA Steering Committee (membership found in Section I. E) 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 incomes and the underserved – were heard. Analytical methods for focus groups and key informant interviews found in Section IV. B.

FOCUS GROUPS

- ▶ Twelve (12) focus groups
- ▶ Fifty-six (56) people participated

Focus group comments were gathered during in-person, virtual and hybrid focus groups, typically running 90-minutes.

KEY INFORMANTS

- ▶ Seven (7) individual interviews

During 60-minute interview key informants shared their greatest concerns around health needs, health equity and social determinants of health for those they serve.

PARTICIPATING ORGANIZATIONS

Adventist Health White Memorial, Alma Family Services, Asian Pacific Community Fund, California State University Los Angeles, Los Angeles County Department of Mental Health, Los Angeles County Department of Public Health, Proyetco Pastoral, PUENTE Learning Center, Soledad Enrichment Action, Shower of Hope, The East Los Angeles Community Union, University of California Los Angeles and Weingart East Los Angeles YMCA

REPRESENTED RACE/ETHNICITIES

Asian Pacific Islander, Hispanic, Multi-Race and White

REPRESENTED POPULATIONS

Community-based healthcare organizations focusing on education, family services, formerly incarcerated, low-income, mental health, minority populations, public health, students and unhoused populations.

The three high-priority health needs are described in further detail on the following pages.

SURVEY RESULTS

REGION & STATEWIDE SUMMARY

Los Angeles County: Survey Results of Top Needs

See Section V. B. for more information.

Needs	White Memorial	Statewide
Financial Stability-Cost of Living	86%	83%
Housing-Cost	66%	63%
Housing-Unhoused	59%	55%
COVID	49%	48%
Mental Health	48%	47%
Food Security	31%	31%
Education	26%	24%
Employment	23%	22%
Access to Care-Primary	22%	23%
Environment & Infrastructure-Transportation	16%	15%
Access to Care-Senior Care	15%	15%





C. Access to Care

Boyle Heights residents face several barriers to accessing healthcare when needed. On the provider, community, and individual side there are factors that make it more difficult to prevent and treat healthcare conditions in a manner that can be expected in other parts of the state and the county. The community of Boyle Heights has limited provider availability which impacts access to care. There are 96.13 primary care providers per 100k population, as compared to California at 99.79 and US at 104.44. Additionally, the percentage of the population living in geographical areas designated as a Health Professional Shortage Area is very high at 29.08% and is higher than both California's rate (19.15%) and the national rate (22.5%).

Additionally, 14.5% of the population are without health insurance. The rate of uninsured persons is much greater than the state average of 7.2% and of the nation's 8.7%. While 14.4% of household do not have a motor vehicle- a rate higher than the state (7%) and the nation (8.5%), most of the population (93%) is living within half a mile of public transportation.

Health literacy and educational attainment are possible barriers to healthcare access and positive health outcomes. 36.8% of the adult population do not have a high school diploma, compared to 16.1% in California and 11.5% in the United States. Adding to that is the similar rate of 36.4% of the population with limited English proficiency, as compared to 17.4% in California and 8.3% in

the United States potentially limiting opportunities to access resources to learn about health matters, schedule appointments or get test results..



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PRIMARY COMMENTS**FOCUS GROUPS COMMENTS
(PARAPHRASED FROM PRIMARY DATA
INTERVIEW NOTES)**

- Residents say being an undocumented community member limits the ability to receive numerous social service benefits.
- Interviewees emphasized that limited access to providers includes inadequate time to meet with providers when you do have an appointment.
- Money, health literacy, language barriers, and insurance are seen as reasons why healthcare is difficult to access.
- Community members noted that access can also be limited due to concerns about the quality of care, especially in hospitals.
- A lot of the population are not fully informed and are afraid to seek resources/medical assistance when needed, residents believed.

KEY INFORMANT COMMENTS

- “Not only are there concerns about the number of doctors available, there are concerns about the cultural and linguistic diversity of local providers.”
- “Due to the limited number of providers the Emergency Room becomes the default provider for many.”
- “Healthcare access is seen as a particular problem for the Hispanic/Latino community.”
- “Limited education can make healthcare seem intimidating sometimes.”

Secondary Data Summary

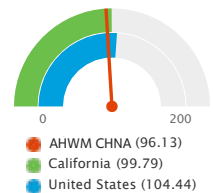
Access to Care

Availability - Primary Care - Primary Care Providers

This indicator reports the number of providers with a CMS National Provider Identifier (NPI) that specialize in primary care. Primary health providers include practicing physicians specializing in general practice medicine, family medicine, internal medicine, and pediatrics. The facilities that specialize in primary health care are also listed (but are not included in the calculated rate). Data are from the latest Centers for Medicare and Medicaid Services (CMS) National Provider Identifier (NPI) downloadable file.

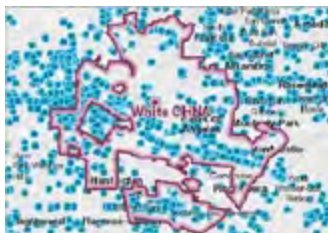
Report Area	Total Population (2020)	Number of Facilities	Number of Providers	Providers, Rate per 100,000 Population
AHWM CHNA	1,055,914	521	1,015	96.13
Los Angeles County, CA	10,014,009	4,193	10,158	101.44
California	39,538,223	12,051	39,455	99.79
United States	334,735,155	117,465	349,603	104.44

Primary Care Providers, Rate per 100,000 Population



Note: This indicator is compared to the state average.

Data Source: Centers for Medicare and Medicaid Services, CMS - National Plan and Provider Enumeration System (NPPES), July 2022. Source geography: Address



Primary Care Physicians, All, CMS NPPES July 2022

- Primary Care Physicians, All, CMS NPPES July 2022
- AHWM CHNA

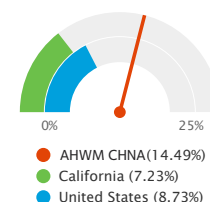
Barriers - Medical Insurance - Population without Medical Insurance

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

In the report area 14.49% 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 7.23%. 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
AHWM CHNA	1,095,446	158,691	14.49%
Los Angeles County, CA	9,970,085	914,046	9.17%
California	38,838,726	2,806,173	7.23%
United States	321,525,041	28,058,903	8.73%

Uninsured Population, Percent

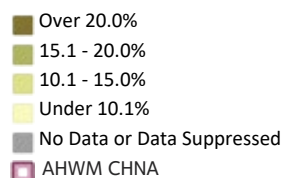


Note: This indicator is compared to the state average.

Data Source: US Census Bureau, *American Community Survey*, 2016-20. Source geography: Tract



Uninsured Population, Percent by Tract, ACS 2016-20

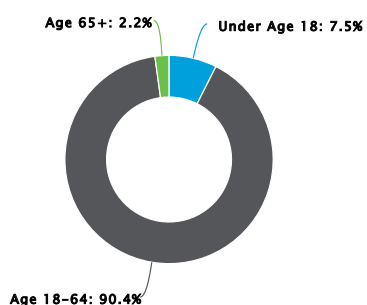


Uninsured Population by Age Group, Total

This indicator reports the total uninsured population by age group.

Report Area	Under Age 18	Age 18-64	Age 65+
AHWM CHNA	11,823	143,422	3,446
Los Angeles County, CA	83,994	809,639	20,413
California	308,355	2,439,126	58,692
United States	4,016,835	23,640,483	401,585

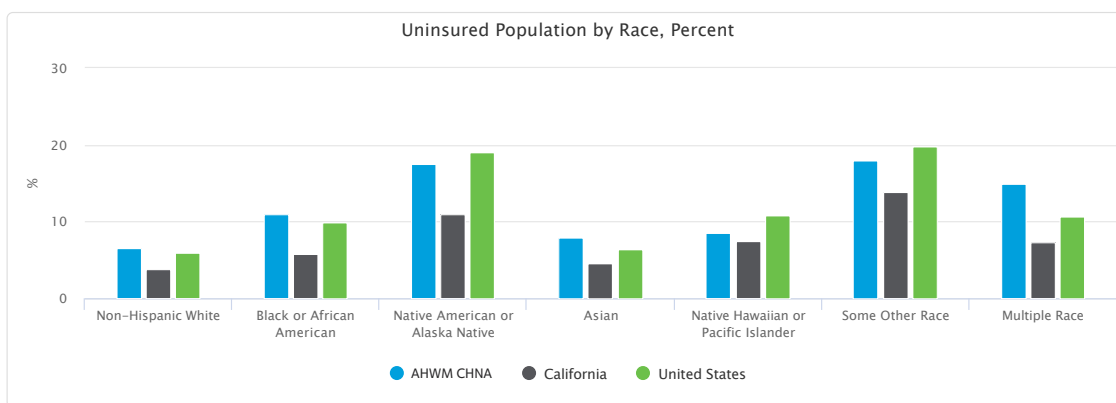
Uninsured Population by Age Group, Total
AHWM CHNA



Uninsured Population by Race, Percent

This indicator reports the percentage of uninsured population by race alone.

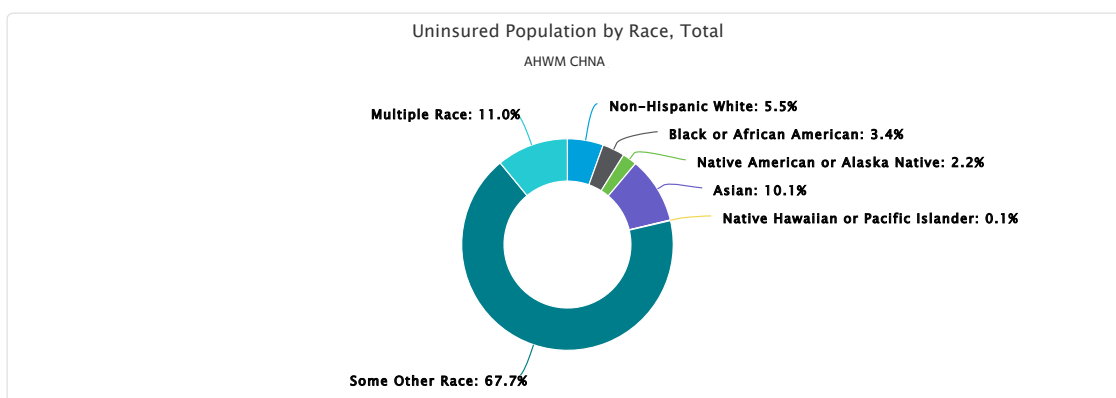
Report Area	Non-Hispanic White	Black or African American	Native American or Alaska Native	Asian	Native Hawaiian or Pacific Islander	Some Other Race	Multiple Race
AHWM CHNA	6.55%	10.95%	17.46%	7.92%	8.51%	17.99%	14.99%
California	3.87%	5.85%	11.02%	4.50%	7.47%	13.82%	7.24%
United States	5.93%	9.94%	18.99%	6.44%	10.79%	19.79%	10.67%



Uninsured Population by Race, Total

This indicator reports the total uninsured population by race alone.

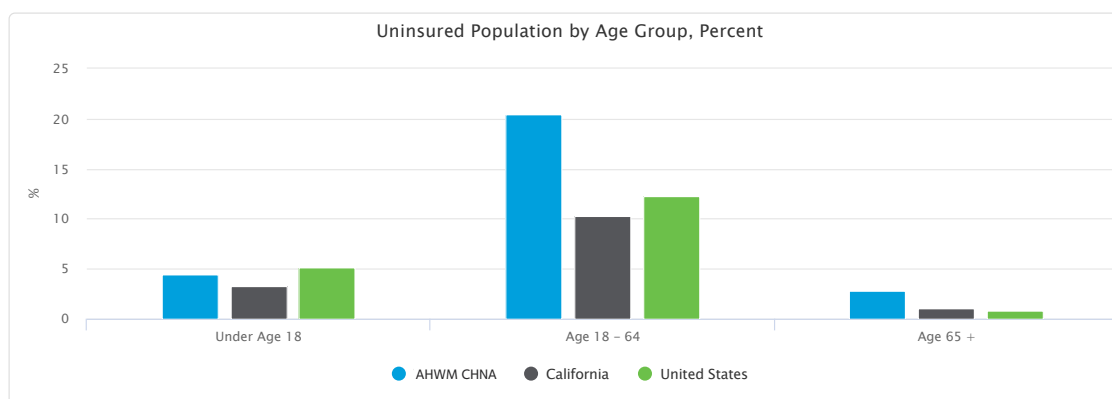
Report Area	Non-Hispanic White	Black or African American	Native American or Alaska Native	Asian	Native Hawaiian or Pacific Islander	Some Other Race	Multiple Race
AHWM CHNA	5,281	3,298	2,139	9,778	98	65,196	10,580
California	547,635	126,535	33,530	261,111	10,979	768,688	223,444
United States	11,475,294	3,972,510	497,979	1,179,390	64,404	3,281,019	1,776,683



Uninsured Population by Age Group, Percent

This indicator reports the percentage of uninsured population by age group.

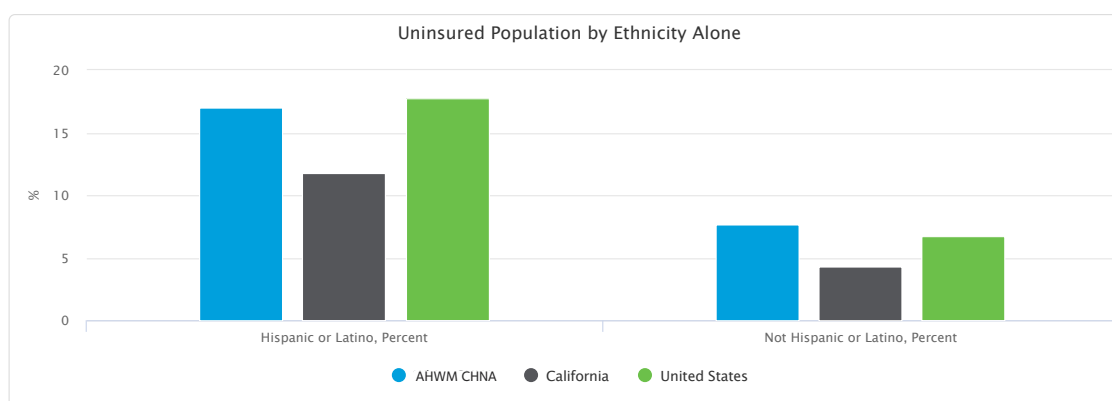
Report Area	Under Age 18	Age 18 - 64	Age 65 +
AHWM CHNA	4.39%	20.41%	2.79%
Los Angeles County, CA	3.64%	12.81%	1.52%
California	3.26%	10.24%	1.06%
United States	5.18%	12.26%	0.79%



Uninsured Population by Ethnicity Alone

This indicator reports the uninsured population by ethnicity alone.

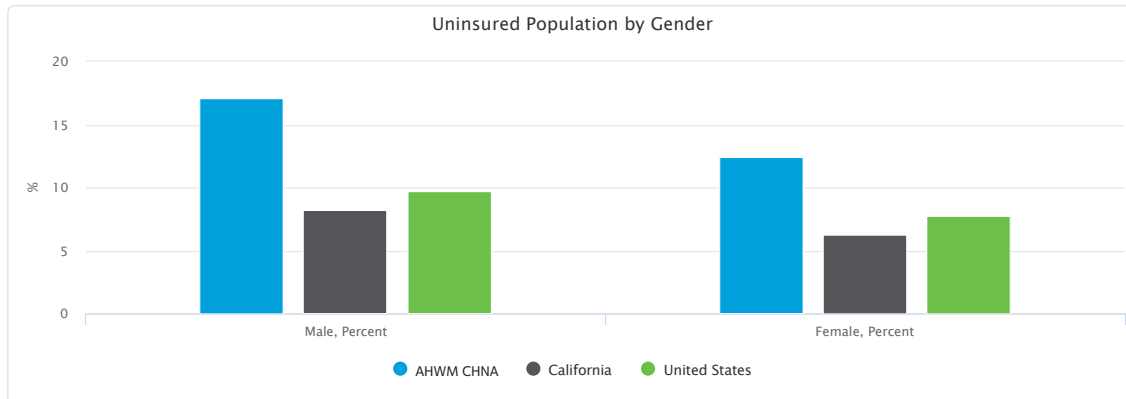
Report Area	Hispanic or Latino	Not Hispanic or Latino	Hispanic or Latino, Percent	Not Hispanic or Latino, Percent
AHWM CHNA	133,802	19,087	17.05%	7.69%
California	1,793,633	1,012,540	11.79%	4.29%
United States	10,382,464	17,676,439	17.72%	6.72%



Uninsured Population by Gender

This indicator reports the uninsured population by gender.

Report Area	Male	Female	Male, Percent	Female, Percent
AHWM CHNA	88,949	63,940	17.12%	12.46%
California	1,580,869	1,225,304	8.25%	6.23%
United States	15,300,004	12,758,899	9.74%	7.76%

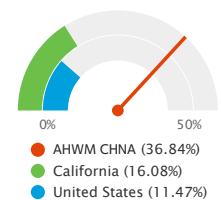


Barriers - Health Literacy - Educational Attainment

Within the report area there are 268,127 persons aged 25 and older without a high school diploma (or equivalency) or higher. This represents 36.84% of the total population aged 25 and older. This indicator is relevant because educational attainment is linked to positive health outcomes (Freudenberg & Ruglis, 2007).

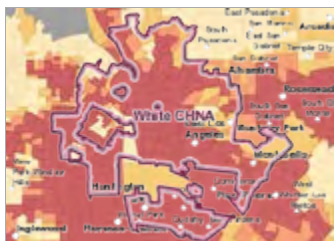
Report Area	Total Population Age 25+	Population Age 25+ with No High School Diploma	Population Age 25+ with No High School Diploma, Percent
AHWM CHNA	727,859	268,127	36.84%
Los Angeles County, CA	6,909,179	1,395,909	20.20%
California	26,665,143	4,286,538	16.08%
United States	222,836,834	25,562,680	11.47%

Population Age 25+ with No High School Diploma, Percent

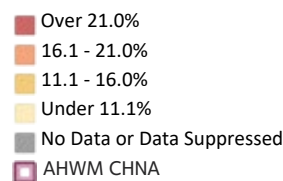


Note: This indicator is compared to the state average.

Data Source: US Census Bureau, American Community Survey, 2016-20. Source geography: Tract

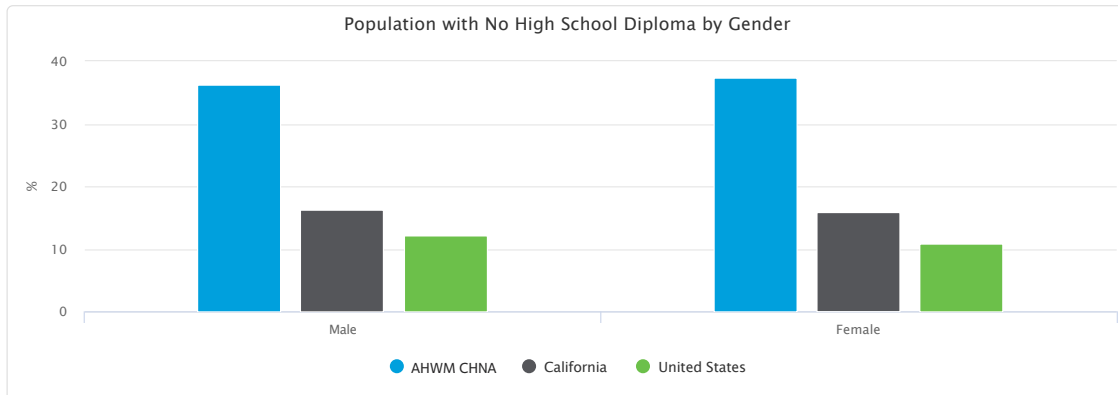


Population with No High School Diploma (Age 25+), Percent by Tract, ACS 2016-20



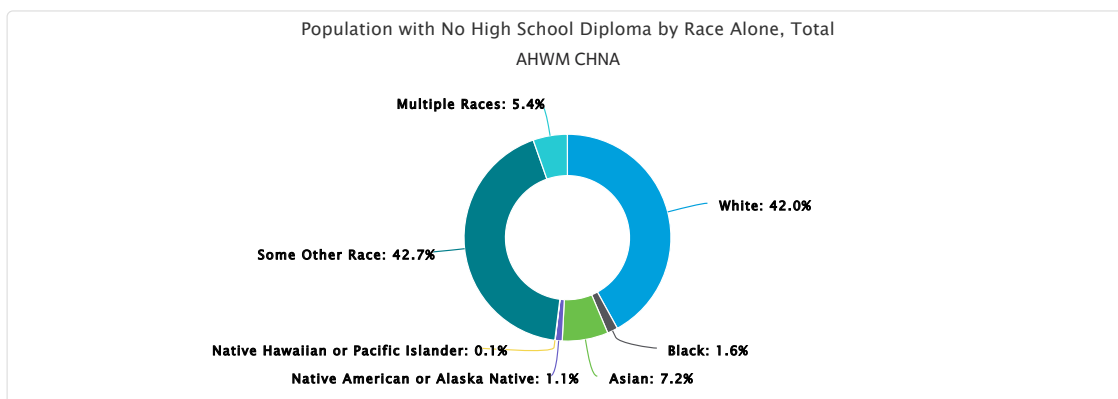
Population with No High School Diploma by Gender

Report Area	Male	Female	Male, Percent	Female, Percent
AHWM CHNA	131,255	136,872	36.22%	37.45%
Los Angeles County, CA	675,234	720,675	20.13%	20.27%
California	2,135,833	2,150,705	16.34%	15.82%
United States	13,141,042	12,421,638	12.19%	10.80%



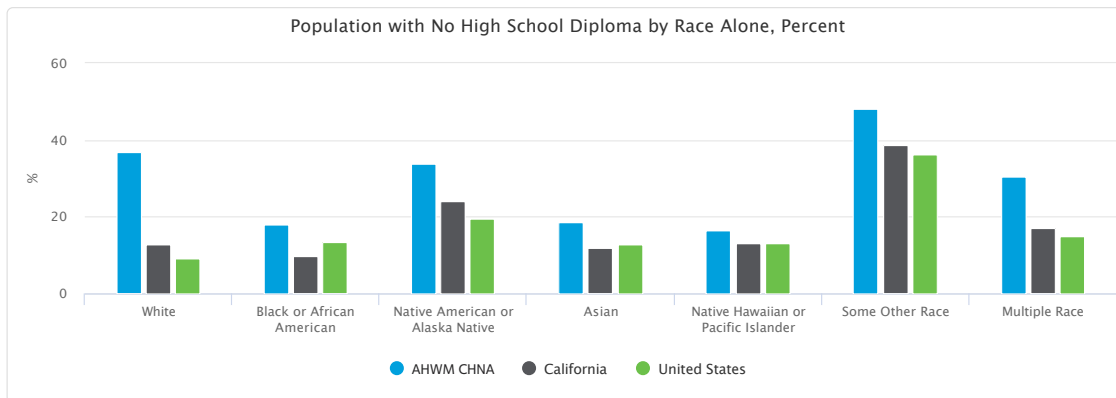
Population with No High School Diploma by Race Alone, Total

Report Area	White	Black	Asian	Native American or Alaska Native	Native Hawaiian or Pacific Islander	Some Other Race	Multiple Races
AHWM CHNA	112,623	4,393	19,217	2,946	156	114,382	14,410
Los Angeles County, CA	582,754	57,540	130,910	16,583	2,242	523,744	82,136
California	1,977,822	151,677	510,287	49,513	13,418	1,312,799	271,022
United States	15,123,109	3,547,596	1,655,662	327,426	51,083	3,624,534	1,233,270



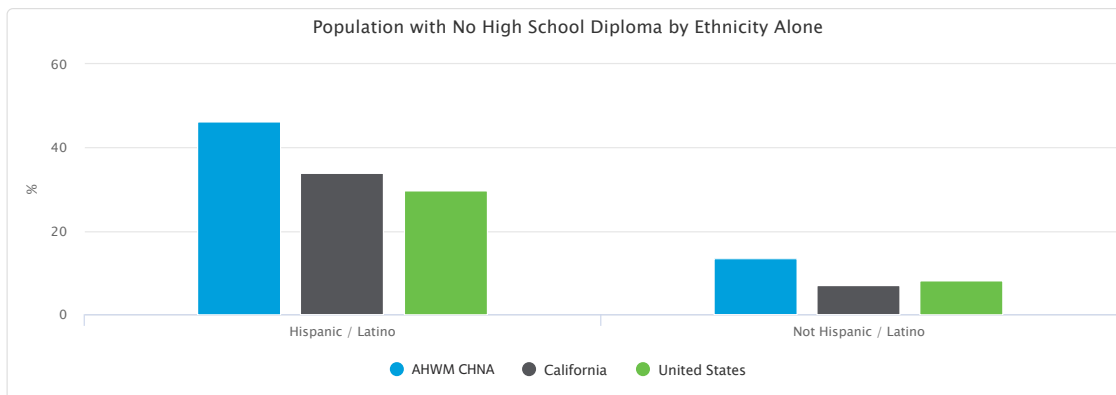
Population with No High School Diploma by Race Alone, Percent

Report Area	White	Black or African American	Native American or Alaska Native	Asian	Native Hawaiian or Pacific Islander	Some Other Race	Multiple Race
AHWM CHNA	36.99%	18.11%	33.77%	18.43%	16.53%	48.05%	30.59%
Los Angeles County, CA	17.05%	9.99%	31.37%	11.59%	12.68%	40.11%	20.00%
California	12.72%	9.82%	23.96%	11.96%	13.03%	38.68%	16.99%
United States	9.28%	13.33%	19.41%	12.71%	13.15%	36.14%	15.01%



Population with No High School Diploma by Ethnicity Alone

Report Area	Hispanic or Latino	Not Hispanic or Latino	Hispanic or Latino, Percent	Not Hispanic or Latino, Percent
AHWM CHNA	240,107	28,020	46.15%	13.50%
Los Angeles County, CA	1,097,469	298,440	36.85%	7.59%
California	3,025,438	1,261,100	33.80%	7.12%
United States	10,134,213	15,428,467	29.74%	8.17%

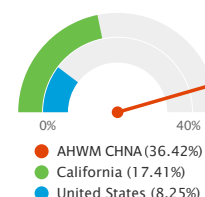


Barriers - Health Literacy - Limited English Proficiency

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 1,041,911 total population aged 5 and older in the report area, 379,426 or 36.42% have limited English proficiency.

Report Area	Population Age 5+	Population Age 5+ with Limited English Proficiency	Population Age 5+ with Limited English Proficiency, Percent
AHWM CHNA	1,041,911	379,426	36.42%
Los Angeles County, CA	9,447,621	2,191,084	23.19%
California	36,936,941	6,432,102	17.41%
United States	306,919,116	25,312,024	8.25%

Population Age 5+ with Limited English Proficiency, Percent

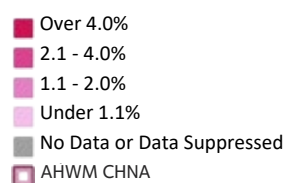


Note: This indicator is compared to the state average.

Data Source: US Census Bureau, [American Community Survey](#), 2016-20. Source geography: Tract



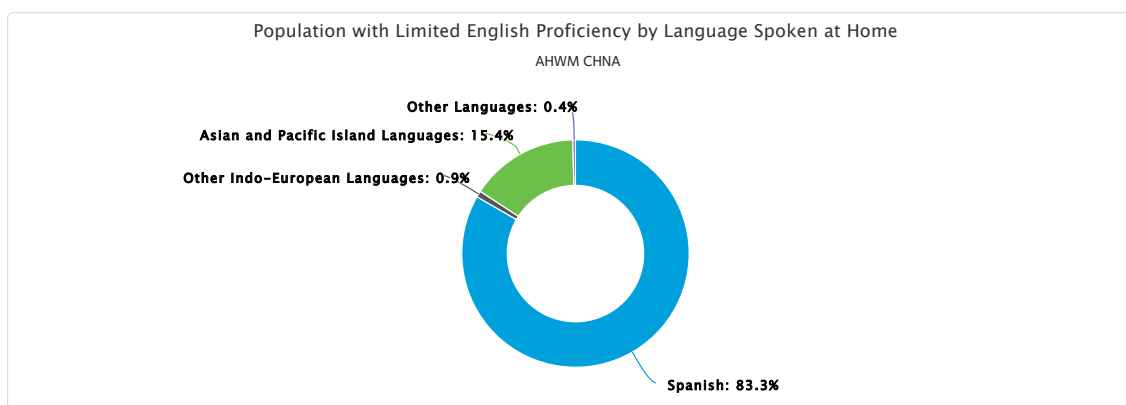
Population with Limited English Proficiency, Percent by Tract, ACS 2016-20

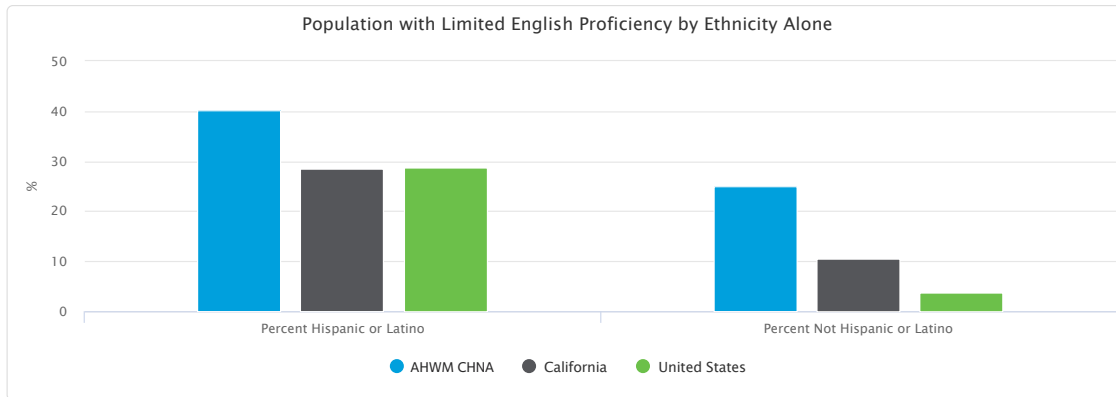


Population with Limited English Proficiency by Language Spoken at Home

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
AHWM CHNA	316,187	3,360	58,441	1,438
Los Angeles County, CA	1,458,177	180,483	521,211	31,213
California	4,083,013	499,656	1,720,073	129,360
United States	15,949,582	3,422,525	4,886,876	1,053,041

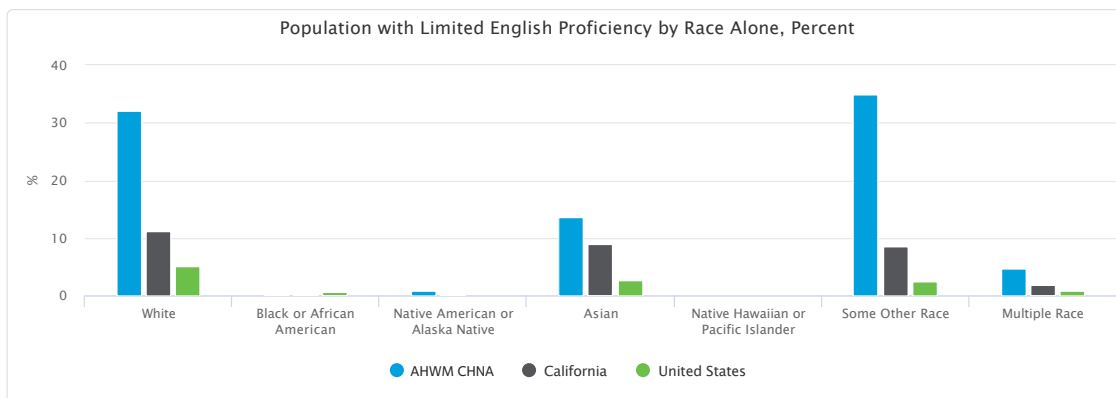




Population with Limited English Proficiency by Race Alone, Percent

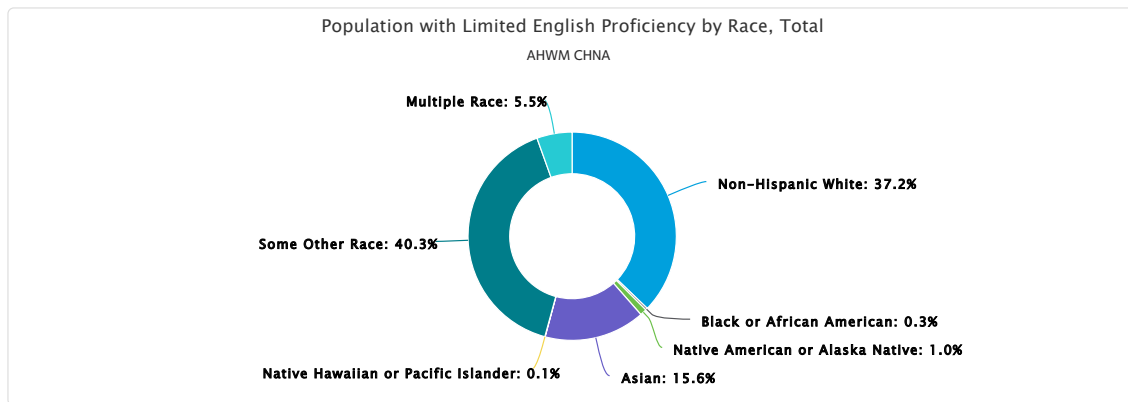
This indicator reports the percentage of the population aged 5 and older who speak a language other than English at home and speak English less than "very well" by race alone in the report area.

Report Area	White	Black or African American	Native American or Alaska Native	Asian	Native Hawaiian or Pacific Islander	Some Other Race	Multiple Race
AHWM CHNA	32.16%	0.28%	0.90%	13.53%	0.05%	34.84%	4.74%
Los Angeles County, CA	17.61%	0.32%	0.39%	11.82%	0.05%	15.44%	2.59%
California	11.14%	0.23%	0.21%	8.84%	0.08%	8.58%	1.77%
United States	5.12%	0.55%	0.09%	2.55%	0.03%	2.48%	0.82%



English less than "very well" by race alone in the report area.

Report Area	Non-Hispanic White	Black or African American	Native American or Alaska Native	Asian	Native Hawaiian or Pacific Islander	Some Other Race	Multiple Race
AHWM CHNA	141,084	1,231	3,941	59,329	209	152,846	20,786
Los Angeles County, CA	800,056	14,703	17,584	537,214	2,455	701,517	117,555
California	2,323,258	47,356	43,331	1,842,890	17,098	1,788,369	369,800
United States	11,134,122	1,196,004	202,081	5,545,968	71,524	5,388,974	1,773,351





C. Financial Stability

Many of the health needs in Boyle Heights are directly or indirectly affected by financial instability. When an individual or family is struggling financially it can greatly affect their ability to maintain adequate physical and mental health. There are many challenges to financial stability for community members, and progress in any given community should be measured with that in mind.

The rate of unemployment is 7.65%, above both the US (5.38%) and California (6.18%). The childhood poverty rate is remarkably high (30.8%), almost double that of California (17.5%) and the United States (16.8%). There are alarming racial disparities in childhood poverty, with Native Hawaiian

or Pacific Islander community seeing a 52.3% rate and the Black community a 43.2% rate versus the white community at 14.2%.

The median household income (\$52,384) is substantially lower than both California (\$78,672) and the US (\$64,994). One in four people in the population has debt in collections. For nearly one in two households in this community the housing costs exceed 30% of their income. That is a higher rate than in California (40.1%) and the US (30.6%). Lower-than-average incomes are especially noteworthy given the exceedingly high cost of living and housing prices in the area.



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PRIMARY COMMENTS

FOCUS GROUPS

- It was noted that accessing healthcare services and community resources can be difficult due to language and educational barriers.
- Interviewees stated that attending healthcare appointments can be difficult for many due to limited time and competing work demands.
- Interviewees noted gentrification has had an impact on Boyle Heights. Residents have moved out because they can't afford the neighborhood.
- Several interviewees noted that limited time and money leads to poor diet options for many.
- A number of interviewees noted that relatively few educational opportunities lead to few job opportunities later in life.
- Some community members noted that having few job opportunities is a problem for many, especially youth and people with criminal justice involvement.

KEY INFORMANT COMMENTS

- It was noted repeatedly that financial instability doesn't stem from not working but that the community is very hard working, and many people hold multiple jobs to support themselves and their families.
- "COVID has exacerbated financial problems for many, largely for losing work due to illness or caring for others who are sick."
- "A large percentage of residents are seen as living paycheck to paycheck, which makes even basic financial stability a problem."
- "Hard work and financial stability don't always come together due to low wages."
- "Many employers will not allow time off of work for healthcare appointments."
- "Inadequate housing stock is a huge problem, along with exorbitant housing costs."

Secondary Data Summary

Financial Stability

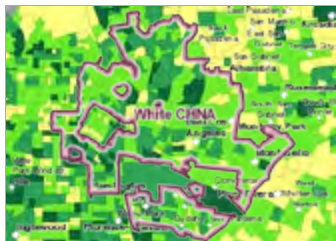
Employment - Unemployment

According to the most recent the American Community Survey estimates, total unemployment in the report area is 43,579, or 7.65% of the civilian non-institutionalized population age 16 and older. 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.

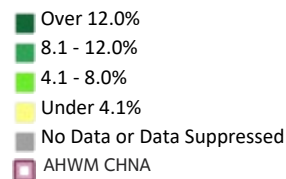
Report Area	Labor Force	Number Unemployed	Unemployment Rate
AHWM CHNA	569,860	43,579	7.65%
Los Angeles County, CA	5,247,546	338,720	6.45%
California	19,875,973	1,229,079	6.18%
United States	164,759,496	8,870,516	5.38%

Note: This indicator is compared to the state average.

Data Source: US Census Bureau, [American Community Survey](#). 2016-20. Source geography: Tract



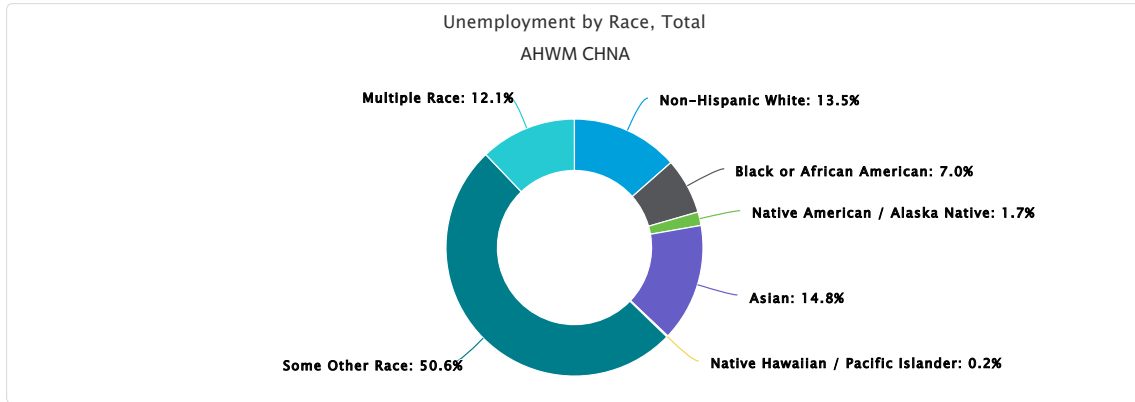
Unemployed Workers, Percent by Tract, ACS 2016-20



Unemployment by Race, Total

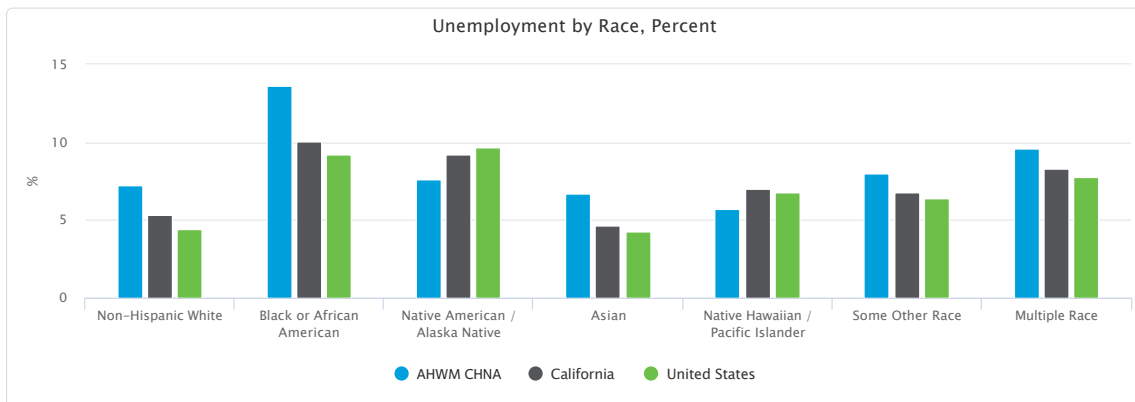
Data Source: US Census Bureau, American Community Survey. 2016-20. Source geography: Tract

Report Area	Non-Hispanic White	Black or African American	Native American / Alaska Native	Asian	Native Hawaiian / Pacific Islander	Some Other Race	Multiple Race
AHWM CHNA	4,133	2,152	521	4,542	46	15,497	3,707
Los Angeles County, CA	90,253	40,186	3,069	38,198	797	68,876	30,601
California	402,121	110,197	13,728	144,492	5,681	193,399	115,127
United States	4,432,807	1,853,375	115,397	421,021	20,879	541,963	564,122



Unemployment by Race, Percent

Report Area	Non-Hispanic White	Black or African American	Native American / Alaska Native	Asian	Native Hawaiian / Pacific Islander	Some Other Race	Multiple Race
AHWM CHNA	7.27%	13.65%	7.63%	6.69%	5.72%	8.01%	9.58%
Los Angeles County, CA	6.22%	9.97%	7.65%	4.81%	5.80%	6.33%	8.71%
California	5.36%	10.08%	9.25%	4.65%	7.04%	6.79%	8.32%
United States	4.38%	9.20%	9.70%	4.26%	6.76%	6.43%	7.76%

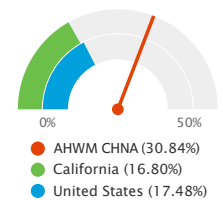


Income - Childhood Poverty Rate

In the report area 30.84% or 77,286 children aged 0-17 are living in households with income below the Federal Poverty Level (FPL). This indicator is relevant because poverty creates barriers to access including health services, healthy food, and other necessities that contribute to poor health status.

Report Area	Total Population	Population Under Age 18	Population Under Age 18 in Poverty	Percent Population Under Age 18 in Poverty
AHWM CHNA	1,084,705	250,618	77,286	30.84%
Los Angeles County, CA	9,884,138	2,145,717	419,142	19.53%
California	38,589,882	8,815,673	1,480,649	16.80%
United States	318,564,128	72,065,774	12,598,699	17.48%

Percent Population Under Age 18 in Poverty

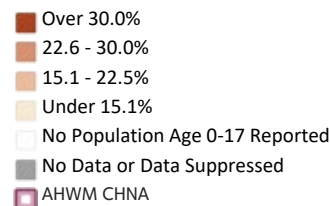


Note: This indicator is compared to the state average.

Data Source: US Census Bureau, *American Community Survey*, 2016-20. Source geography: Tract



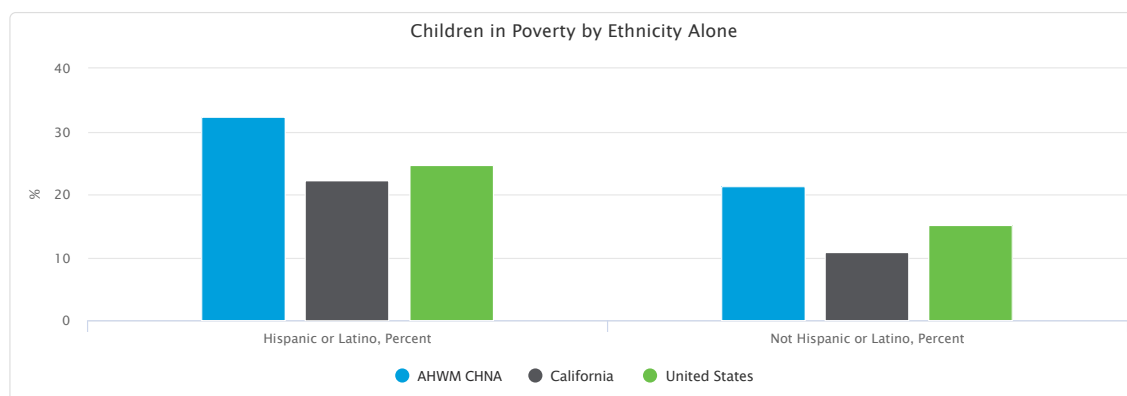
Population Below the Poverty Level, Children (Age 0-17), Percent by Tract, ACS 2016-20



Children in Poverty by Ethnicity Alone

This indicator reports children aged 0-17 living in households with income below the federal poverty level by ethnicity alone.

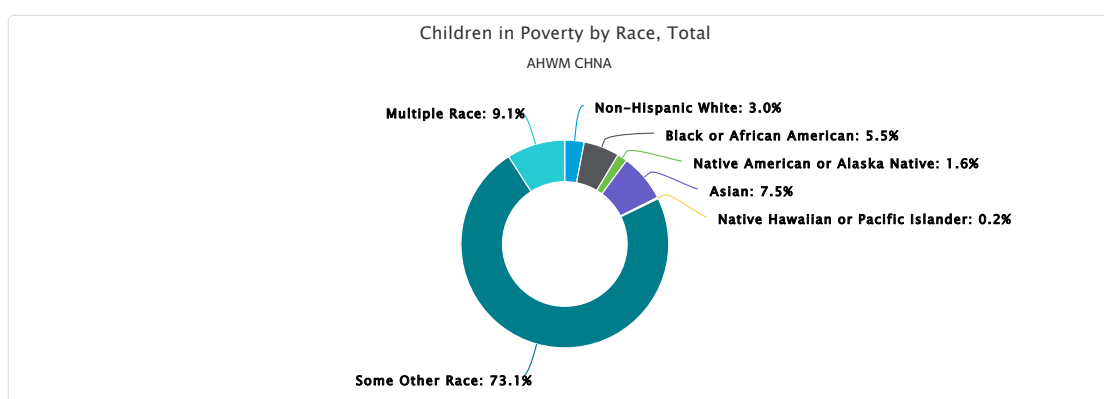
Report Area	Hispanic or Latino	Not Hispanic or Latino	Hispanic or Latino, Percent	Not Hispanic or Latino, Percent
AHWM CHNA	70,312	6,974	32.28%	21.32%
Los Angeles County, CA	317,407	101,735	24.48%	11.98%
California	1,013,787	466,862	22.32%	10.92%
United States	4,487,018	8,111,681	24.68%	15.05%



Children in Poverty by Race, Total

This indicator reports the total children aged 0-17 living in households with income below the federal poverty level by race alone.

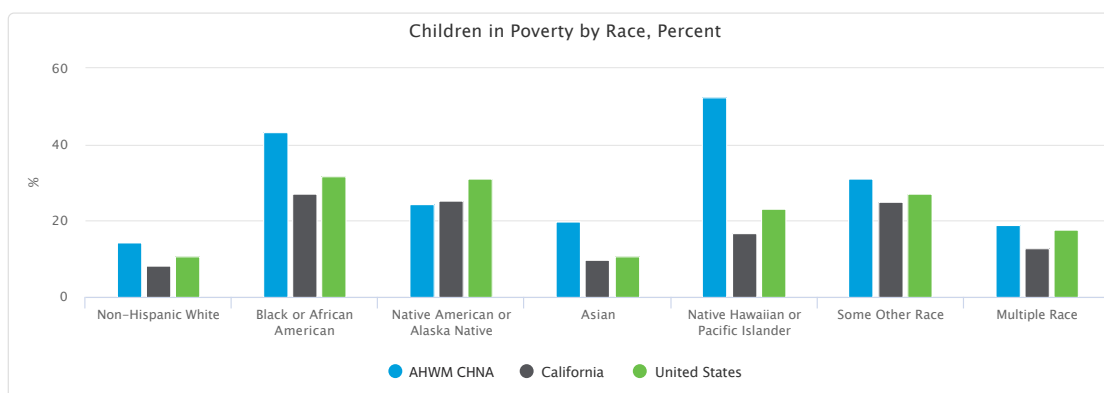
Report Area	Non-Hispanic White	Black or African American	Native American or Alaska Native	Asian	Native Hawaiian or Pacific Islander	Some Other Race	Multiple Race
AHWM CHNA	1,262	2,311	656	3,110	81	30,480	3,785
Los Angeles County, CA	26,639	42,147	3,685	24,749	750	143,026	31,524
California	182,435	124,650	17,742	106,168	5,141	378,293	149,598
United States	3,805,465	3,169,873	214,829	388,057	34,982	1,282,237	1,163,442



Children in Poverty by Race, Percent

This indicator reports percent of children aged 0-17 living in households with income below the federal poverty level by race alone.

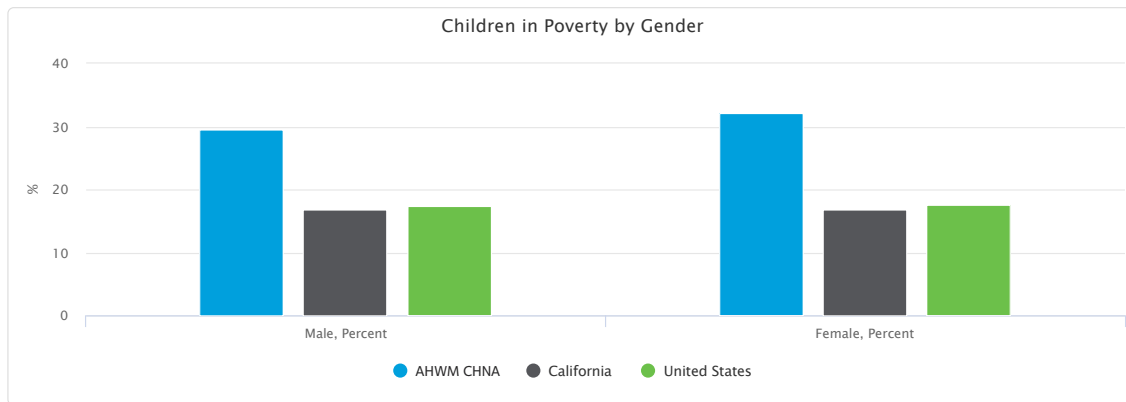
Report Area	Non-Hispanic White	Black or African American	Native American or Alaska Native	Asian	Native Hawaiian or Pacific Islander	Some Other Race	Multiple Race
AHWM CHNA	14.20%	43.16%	24.31%	19.66%	52.26%	31.12%	18.85%
Los Angeles County, CA	7.45%	27.37%	22.50%	10.20%	15.70%	26.15%	13.20%
California	8.30%	27.13%	25.30%	9.84%	16.73%	24.94%	12.86%
United States	10.58%	31.80%	31.16%	10.58%	23.24%	27.24%	17.63%



Children in Poverty by Gender

This indicator reports children aged 0-17 living in households with income below the federal poverty level by gender.

Report Area	Male	Female	Male, Percent	Female, Percent
AHWM CHNA	38,289	38,997	29.53%	32.24%
Los Angeles County, CA	213,820	205,322	19.50%	19.57%
California	753,182	727,467	16.73%	16.87%
United States	6,414,903	6,183,796	17.43%	17.54%



Income - Median Household Income

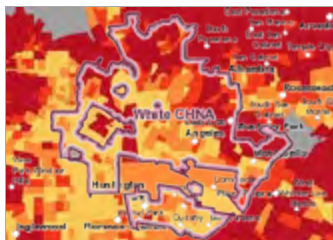
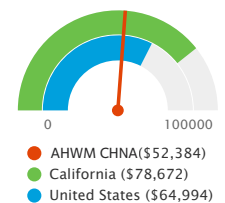
This indicator reports median household income based on the latest 5-year American Community Survey estimates. This includes the income of the householder and all other individuals 15 years old and over in the household, whether they are related to the householder or not. Because many households consist of only one person, average household income is usually less than average family income. There are 325,457 households in the report area, with an average income of \$72,555 and median income of \$52,384.

Report Area	Total Households	Average Household Income	Median Household Income
AHWM CHNA	325,457	\$72,555	\$52,384
Los Angeles County, CA	3,332,504	\$103,220	\$71,358
California	13,103,114	\$111,622	\$78,672
United States	122,354,219	\$91,547	\$64,994

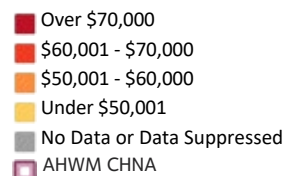
Note: This indicator is compared to the state average.

Data Source: US Census Bureau, [American Community Survey](#), 2016-20. Source geography: Tract

Median Household Income



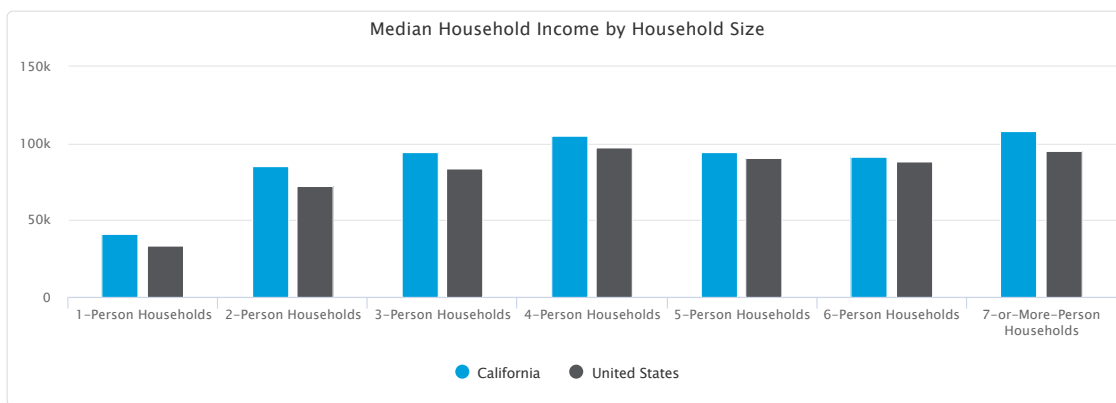
Median Household Income by Tract, ACS 2016-20



Median Household Income by Household Size

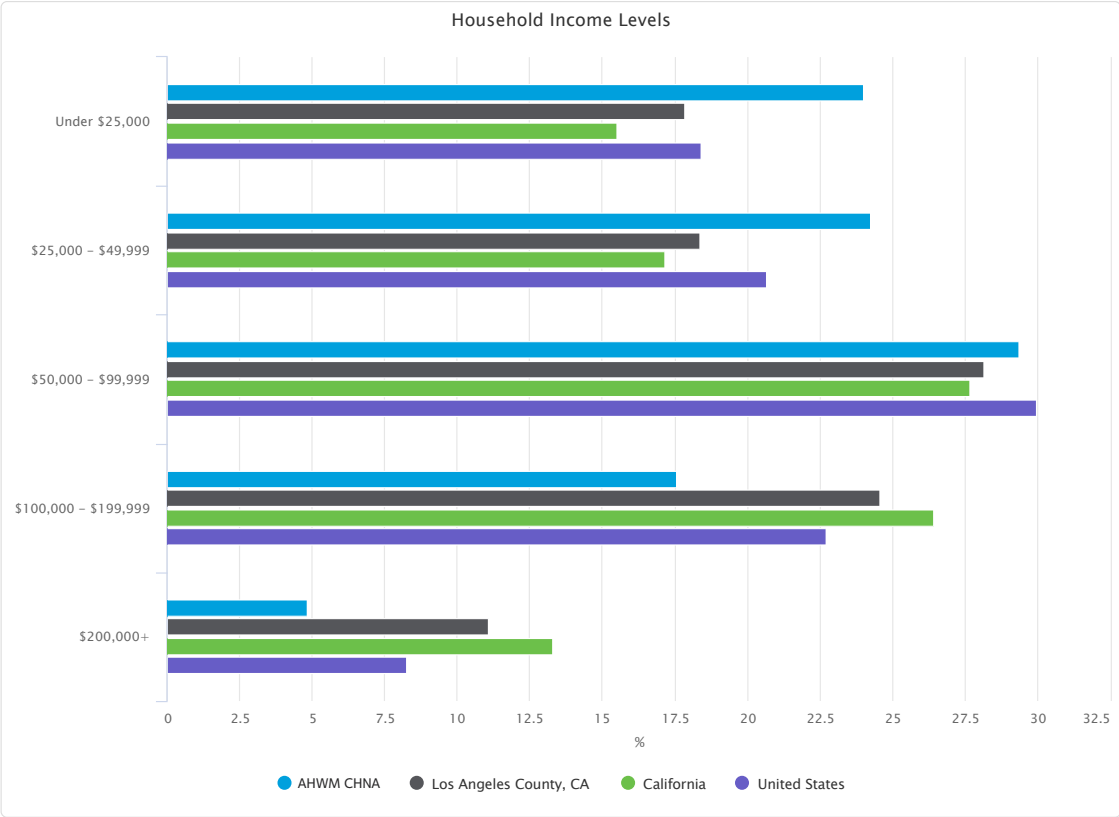
This indicator reports the median household income of the report area by household size.

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
AHWM CHNA	No data	No data	No data	No data	No data	No data	No data
Los Angeles County, CA	\$38,873	\$77,790	\$83,549	\$92,447	\$84,476	\$87,168	\$103,511
California	\$40,788	\$85,056	\$94,221	\$104,973	\$94,232	\$91,578	\$107,797
United States	\$33,265	\$72,238	\$84,033	\$97,660	\$90,979	\$88,413	\$94,924



Household Income Levels

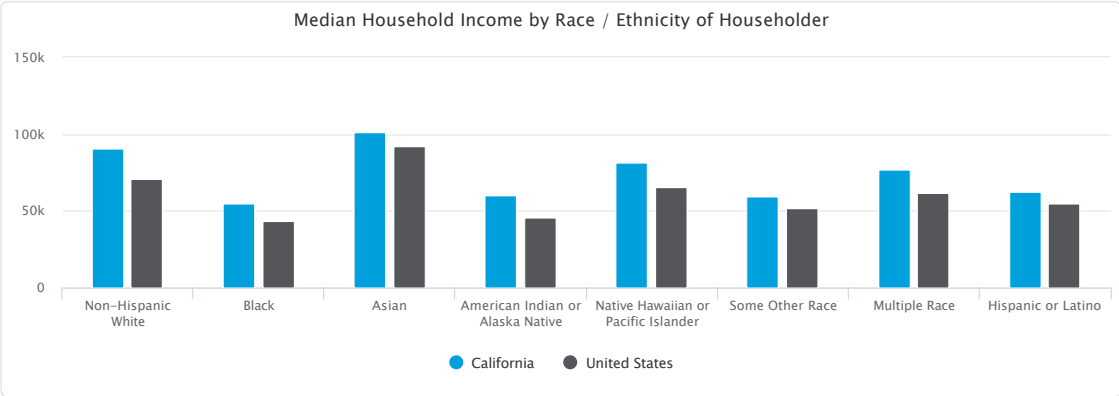
Report Area	Under \$25,000	\$25,000 - \$49,999	\$50,000 - \$99,999	\$100,000 - \$199,999	\$200,000+
AHWM CHNA	24.02%	24.26%	29.35%	17.54%	4.82%
Los Angeles County, CA	17.83%	18.37%	28.17%	24.56%	11.08%
California	15.51%	17.14%	27.66%	26.42%	13.27%
United States	18.41%	20.64%	29.95%	22.73%	8.26%



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
AHWM CHNA	No data	No data	No data	No data	No data	No data	No data	No data
Los Angeles County, CA	\$91,323	\$51,259	\$83,252	\$62,427	\$78,831	\$56,747	\$71,943	\$59,837
California	\$90,496	\$54,976	\$101,380	\$60,182	\$81,682	\$59,287	\$76,733	\$62,330
United States	\$70,843	\$43,674	\$91,775	\$45,877	\$65,804	\$51,900	\$61,870	\$54,632

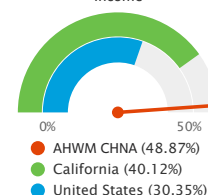


Security - Housing Cost Burden (30%)

This indicator reports the percentage of the households where housing costs are 30% or more of 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. Of the 328,297 total households in the report area, 160,454 or 48.87% of the population live in cost burdened households.

Report Area	Total Households	Cost Burdened Households (Housing Costs Exceed 30% of Income)	Cost Burdened Households, Percent
AHWM CHNA	328,297	160,454	48.87%
Los Angeles County, CA	3,332,504	1,516,514	45.51%
California	13,103,114	5,256,527	40.12%
United States	122,354,219	37,128,748	30.35%

Percentage of Households where Housing Costs Exceed 30% of Income

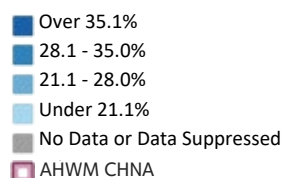


Note: This indicator is compared to the state average.

Data Source: US Census Bureau, American Community Survey, 2016-20. Source geography: Tract



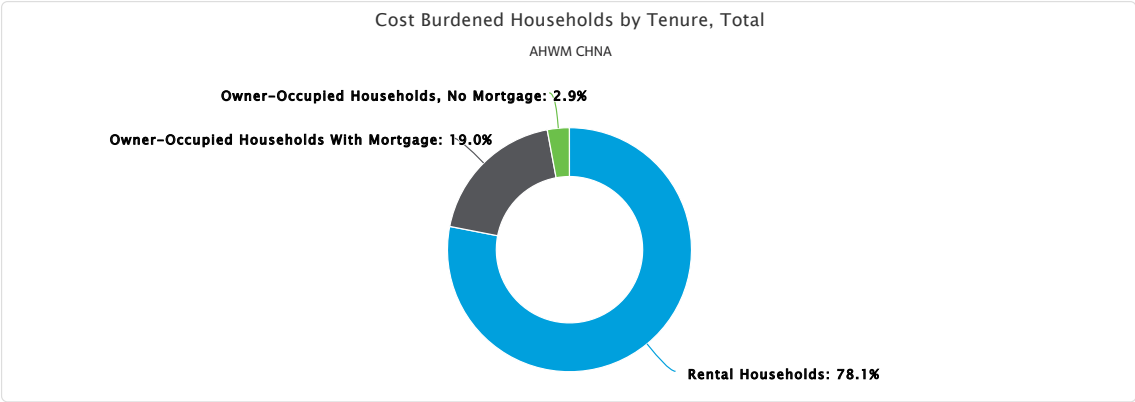
Cost Burdened Households (Housing Costs Exceed 30% of Household Income), Percent by Tract, ACS 2016-20



Cost Burdened Households by Tenure, Total

These data show the number of households that spend more than 30% of the household income on housing costs. In the report area, there were 160,454 cost burdened households according to the U.S. Census Bureau American Community Survey (ACS) 2016-2020 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.

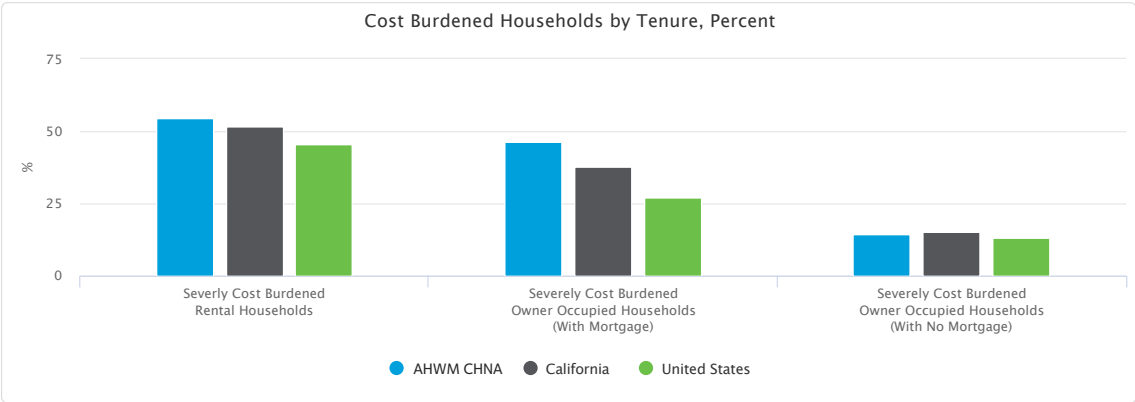
Report Area	Cost Burdened Households	Cost Burdened Rental Households	Cost Burdened Owner Occupied Households (With Mortgage)	Cost Burdened Owner Occupied Households (With No Mortgage)
AHWM CHNA	160,454	125,265	30,513	4,676
Los Angeles County, CA	1,516,514	978,047	466,027	72,440
California	5,256,527	3,019,235	1,906,204	331,088
United States	37,128,748	19,886,052	13,344,089	3,898,607



Cost Burdened Households by Tenure, Percent

These data show the percentage of households by tenure that are cost burdened. Cost burdened rental households (those that spent more than 30% of the household income on rental costs) represented 54.57% of all of the rental households in the report area, according to the U.S. Census Bureau American Community Survey (ACS) 2016-2020 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	Percentage of Rental Households that are Cost Burdened	Owner Occupied Households (With Mortgage)	Percentage of Owner Occupied Households w/ Mortgages that are Cost Burdened	Owner Occupied Households (No Mortgage)	Percentage of Owner Occupied Households w/o Mortgages that are Cost Burdened
AHWM CHNA	229,551	54.57%	65,843	46.34%	32,903	14.21%
Los Angeles County, CA	1,798,032	54.40%	1,081,570	43.09%	452,902	15.99%
California	5,861,796	51.51%	5,035,650	37.85%	2,205,668	15.01%
United States	43,552,843	45.66%	48,974,364	27.25%	29,827,012	13.07%





E. Food Security

Access to healthy, affordable food is a fundamental part of lifelong health, and the residents of the community serviced by White Memorial hospital face some significant challenges in this area. This community has a much greater percentage of residents who live in poverty (21%). This is 8% higher than state and national averages.

Poverty rates are even greater for Black and for female residents. 88% of students receive free or reduced-price school lunches, more than double the national average and almost 30% higher than the California average. These numbers have grown steadily over the last nine years.



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PRIMARY COMMENTS**FOCUS GROUPS COMMENTS**

- Residents noted that not having a variety of grocery stores in the community is seen as a food security barrier.
- Interviewees emphasized that having to choose what to spend your money on often leads to poor dietary habits.
- Even when food is easily available locally it's not often healthy and affordable. This is seen as a particular problem for seniors, residents shared.
- Community members noted that relying on small, local stores for produce leads to limited options in both quality and quantity.
- Cultural and generational factors are also seen as driving dietary habits, according to interviewees.

KEY INFORMANT COMMENTS

- "Local food carts are seen as a viable option to combat food desserts."
- "Obesity is seen as a direct consequence of food insecurity."
- Community members felt that the high price of health foods leads to unhealthy dietary choices, which contributes to conditions like diabetes.
- Some interviewees expanded the definition of food desserts
- to include places where there are limited affordable healthy food choices.
- The quick, cheap choice seems best to many community members, despite the consequences.
- Interviewees noted the irony of food desserts in a state that generates 40% of American produce.

Secondary Data Summary

Food Security

Economic Security - Poverty (100% FPL)

Poverty is considered a *key driver* of health status.

Within the report area 20.99% or 227,674 individuals for whom poverty status is determined are living in households with income below the Federal Poverty Level (FPL). This indicator is relevant because poverty creates barriers to access including health services, healthy food, and other necessities that contribute to poor health status.

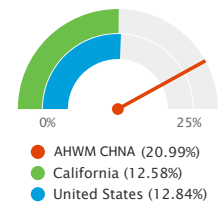
Note: The total population measurements for poverty reports are lower, as poverty data collection does not include people in group quarters. See Methodology for more details.

Report Area	Total Population	Population in Poverty	Population in Poverty, Percent
AHWM CHNA	1,084,705	227,674	20.99%
Los Angeles County, CA	9,884,138	1,401,656	14.18%
California	38,589,882	4,853,434	12.58%
United States	318,564,128	40,910,326	12.84%

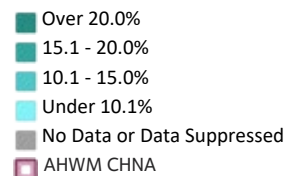
Note: This indicator is compared to the state average.

Data Source: US Census Bureau, American Community Survey, 2016-20. Source geography: Tract

Population in Poverty, Percent



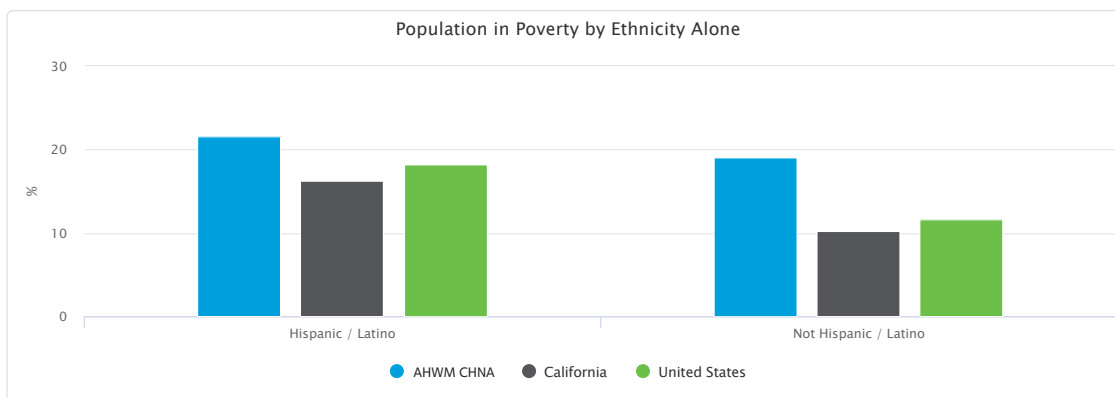
Population Below the Poverty Level, Percent by Tract, ACS 2016-20



Population in Poverty by Ethnicity Alone

This indicator reports the population in poverty in the report area by ethnicity alone.

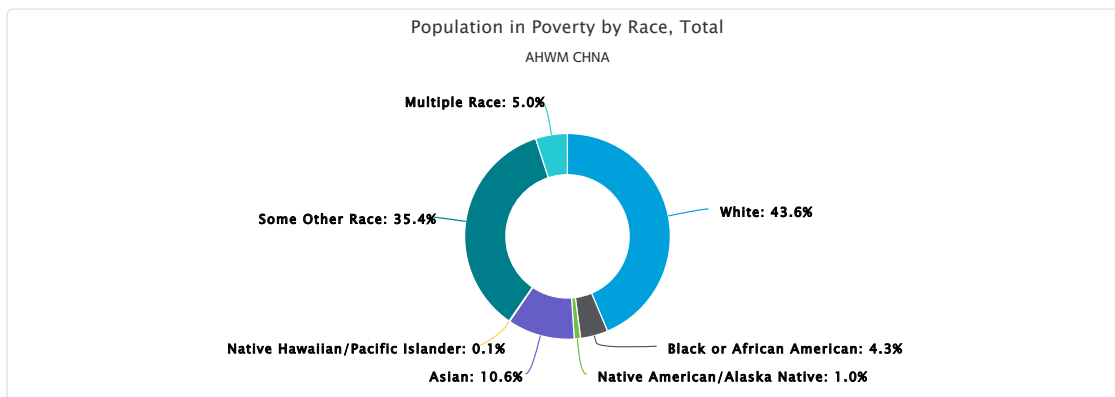
Report Area	Hispanic or Latino	Not Hispanic or Latino	Hispanic or Latino, Percent	Not Hispanic or Latino, Percent
AHWM CHNA	178,883	48,791	21.56%	19.13%
Los Angeles County, CA	811,959	589,697	16.93%	11.59%
California	2,454,410	2,399,024	16.24%	10.22%
United States	10,642,653	30,267,673	18.29%	11.62%



Population in Poverty by Race, Total

This indicator reports the total population in poverty in the report area by race alone.

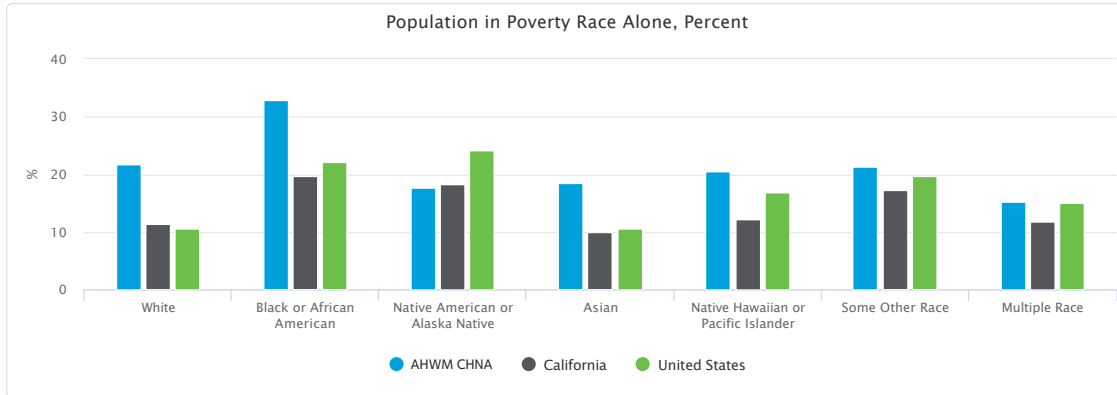
Report Area	Non-Hispanic White	Black or African American	Native American or Alaska Native	Asian	Native Hawaiian or Pacific Islander	Some Other Race	Multiple Race
AHWM CHNA	99,335	9,883	2,226	24,060	248	80,545	11,377
Los Angeles County, CA	606,783	158,947	12,461	161,028	2,618	372,864	86,955
California	2,464,103	421,298	55,491	577,350	17,823	957,857	359,512
United States	23,820,939	8,726,814	626,766	1,917,691	99,642	3,234,981	2,483,493



Population in Poverty Race Alone, Percent

This indicator reports the percentage of population in poverty in the report area by race alone.

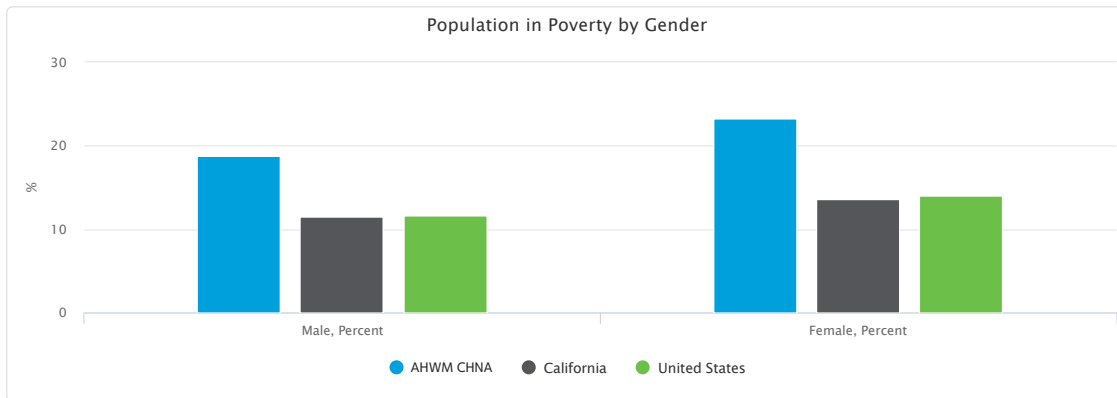
Report Area	White	Black or African American	Native American or Alaska Native	Asian	Native Hawaiian or Pacific Islander	Some Other Race	Multiple Race
AHWM CHNA	21.69%	32.87%	17.61%	18.57%	20.50%	21.26%	15.27%
Los Angeles County, CA	12.86%	20.18%	16.31%	10.99%	10.68%	17.81%	12.11%
California	11.38%	19.60%	18.36%	10.04%	12.19%	17.34%	11.74%
United States	10.60%	22.07%	24.13%	10.61%	16.81%	19.66%	15.08%



Population in Poverty by Gender

This indicator reports the population in poverty in the report area by gender.

Report Area	Male	Female	Male, Percent	Female, Percent
AHW CHNA	102,238	125,436	18.77%	23.23%
Los Angeles County, CA	630,981	770,675	12.97%	15.36%
California	2,194,991	2,658,443	11.50%	13.63%
United States	18,171,512	22,738,814	11.64%	13.99%



Economic Security - Free/Reduced Price Lunch

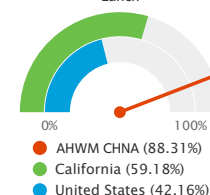
Free or reduced price lunches are served to qualifying students in families with income between under 185 percent (reduced price) or under 130% (free lunch) of the US federal poverty threshold as part of the federal National School Lunch Program (NSLP).

Out of 151,912 total public school students in the report area, 134,155 were eligible for the free or reduced price lunch program in the latest report year. This represents 88.31% of public school students, which is higher than the state average of 59.18%.

Note: States with more than 80% records "not reported" are suppressed for all geographic areas, including hospital service area, census tract, zip code, school district, county, state, etc.

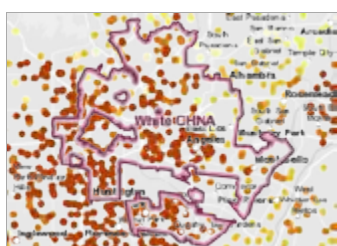
Report Area	Total Students	Students Eligible for Free or Reduced Price Lunch	Students Eligible for Free or Reduced Price Lunch, Percent
AHWM CHNA	151,912	134,155	88.31%
Los Angeles County, CA	1,374,222	947,825	68.97%
California	5,958,941	3,526,048	59.18%
United States	53,244,287	22,445,622	42.16%

Percentage of Students Eligible for Free or Reduced Price School Lunch

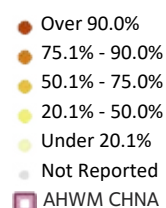


Note: This indicator is compared to the state average.

Data Source: National Center for Education Statistics, [NCES - Common Core of Data](#), 2020-2021. Source geography: Address



Students Eligible for Free or Reduced-Price Lunch, NCES CCD 2020-21



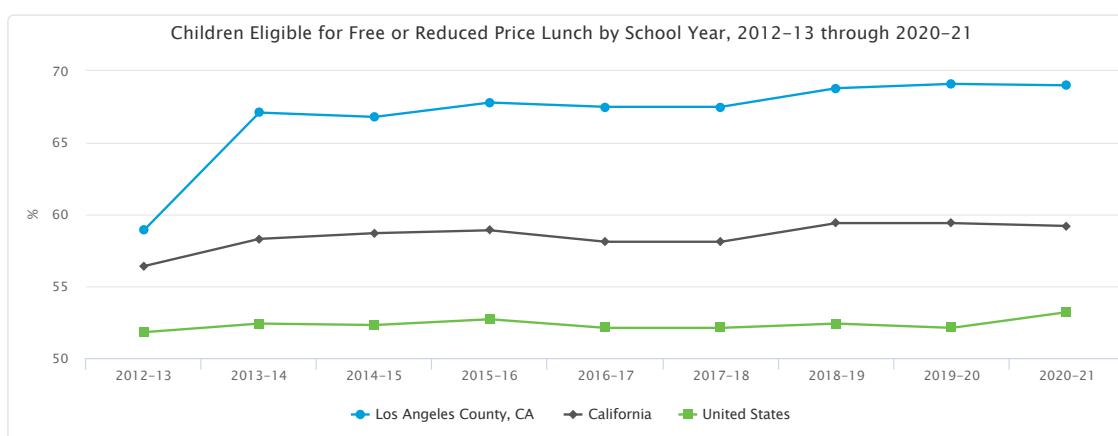
Children Eligible for Free or Reduced Price Lunch by School Year, 2012-13 through 2020-21

The table below shows local, state, and national trends in student free and reduced lunch eligibility by percent.

Note: The states below have more than 80% public schools labeled as "not reported" in 2020-2021. For consistency, these states still have their values calculated with the limited records on all geographic levels (unless there is not a single record reported in the selected area). Use with caution when comparing to other years. This issue might occur in other states/years as well.

For 2020-2021, watch out for Alaska, Arizona, Delaware, District of Columbia, Illinois, Massachusetts, Montana, Ohio, Oregon, Tennessee, Virginia, American Samoa, and Northern Mariana Islands.

Report Area	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21
AHWM CHNA	66.7%	84.5%	86.6%	88.3%	86.5%	86.5%	88.0%	88.8%	88.3%
Los Angeles County, CA	58.9%	67.1%	66.8%	67.8%	67.5%	67.5%	68.8%	69.1%	69.0%
California	56.4%	58.3%	58.7%	58.9%	58.1%	58.1%	59.4%	59.4%	59.2%
United States	51.8%	52.4%	52.3%	52.7%	52.1%	52.1%	52.4%	52.1%	53.2%



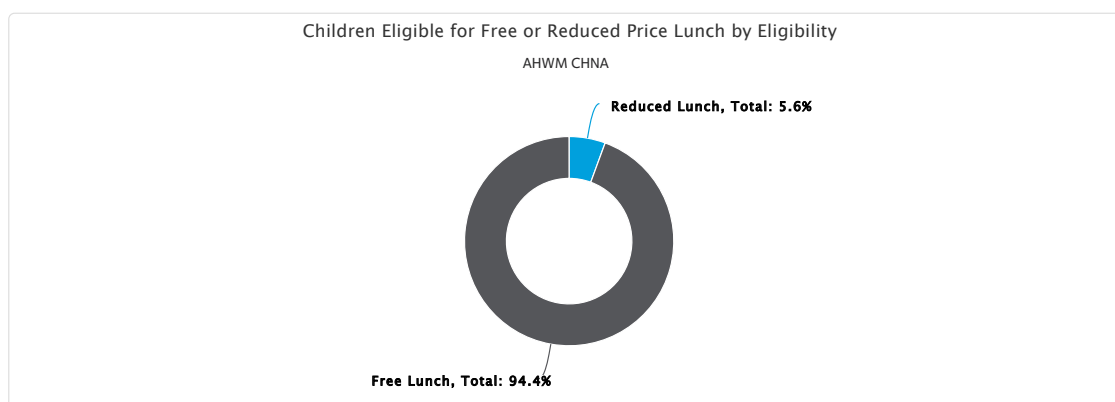
Children Eligible for Free or Reduced Price Lunch by Eligibility

The table below displays the number and percentage of students eligible for free or reduced price lunch by income eligibility category. Percentages in the table below are out of the total student population.

Note: States with more than 80% records labeled as "not reported" are suppressed for all geographic areas.

Report Area	Free Lunch, Total	Free Lunch, Percent	Reduced Lunch, Total	Reduced Lunch, Percent
AHWM CHNA	126,638	83.4%	7,516	4.9%
Los Angeles County, CA	861,951	62.7%	85,874	6.2%
California	3,140,705	52.7%	385,343	6.5%
United States	19,950,407	37.5%	1,952,641	3.7%

The chart below displays the percentage of the students in each eligibility category out of the total number of students eligible for free or reduced price lunch.



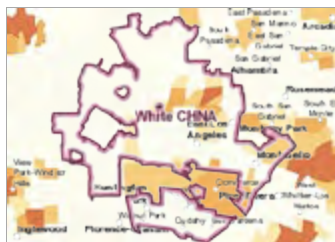
Food Access - Access to Healthy Food

This indicator reports the percentage of the population with low food access. Low food access is defined as living more than ½ mile from the nearest supermarket, supercenter, or large grocery store. Data are from the April 2021 Food Access Research Atlas dataset. This indicator is relevant because it highlights populations and geographies facing food insecurity.

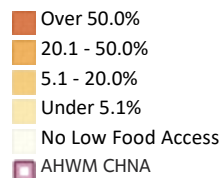
1.20% of the total population in the report area have low food access. The total population in the report area with low food access is 13,049.

Report Area	Total Population (2010)	Population with Low Food Access	Percent Population with Low Food Access
AHWM CHNA	1,090,591	13,049	1.20%
Los Angeles County, CA	9,818,605	641,326	6.53%
California	37,253,956	4,951,436	13.29%
United States	308,745,538	68,611,398	22.22%

Note: This indicator is compared to the state average.
Data Source: US Department of Agriculture, Economic Research Service, USDA Food Access Research Atlas, 2019. Source geography: Tract



Population with Limited Food Access, Percent by Tract, USDA - FARA 2019





F. Mental Health

Access to care is limited by the availability of mental health providers, which constitutes a major barrier for residents. There are only 119.7 mental health care providers per 100k people in Boyle Heights, as compared to 150.3 in California and 132.3 in the United States. Additionally, 14.5% of the population is uninsured.

Stress and other mental health risk factors are evident in this area. The violent crime rate, including homicide, rape, robbery, and aggravated assault is higher in this area (488.3 per 100k people) as compared to California (420.9) and the United States (385.6). The unemployment rate is also higher in this area, creating financial instability and barriers to access. The rate is 7.65% in this area compared to 6.18% in California and 5.38% nationally.



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PRIMARY COMMENTS**FOCUS GROUPS**

- It was noted that stigma around mental health services makes it less likely for some community members to seek assistance.
- Several interviewees suggested that normalizing mental health struggles will benefit community youth in the eyes of community members.
- Interviewees felt that a lack of Spanish-speaking therapists created access limitations for some.
- Several interviewees felt that the Hispanic community is less likely to access mental health services due to associated stigma.
- Parents need education around anxiety/depression in order to be better able to support their kids, residents believe.
- Community members noted that youth mental health struggles are greater than in the past.

KEY INFORMANT COMMENTS

- “Financial problems and unstable housing situations lead to a greater need for mental health services.”
- “Addressing stigma is viewed as critical.”
- There is also believed to be a strong correlation between physical health problems and overall mental health, according to interviewees.
- “Community education on mental health services is seen as beneficial.”

Secondary Data Summary

Mental Health

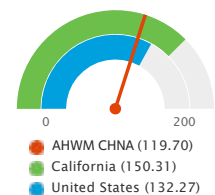
Risk Factors - Access to Care - Access to Mental Health Providers

This indicator reports the number of providers with a CMS National Provider Identifier (NPI) that specialize in mental health. Mental health providers include licensed clinical social workers and other credentialed professionals specializing in psychiatry, psychology, counseling, or child, adolescent, or adult mental health. The number of facilities that specialize in mental health are also listed (but are not included in the calculated rate). Data are from the latest Centers for Medicare and Medicaid Services (CMS) National Provider Identifier (NPI) downloadable file.

Within the report area there are 1,264 mental health providers with a CMS National Provider Identifier (NPI). This represents 119.70 providers per 100,000 total population.

Report Area	Total Population (2020)	Number of Facilities	Number of Providers	Providers, Rate per 100,000 Population
AHWM CHNA	1,055,914	63	1,264	119.70
Los Angeles County, CA	10,014,009	1,493	13,419	134.00
California	39,538,223	5,078	59,430	150.31
United States	334,735,155	56,424	442,757	132.27

Mental Health Care Providers, Rate per 100,000 Population



Note: This indicator is compared to the state average.

Data Source: Centers for Medicare and Medicaid Services, CMS - National Plan and Provider Enumeration System (NPPES), July 2022. Source geography: Address



Mental Health Providers, All, CMS NPPES July 2022

- Mental Health Providers, All, CMS NPPES July 2022
- AHWM CHNA

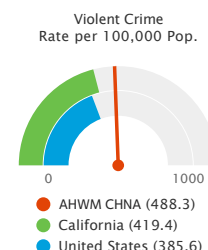
Risk Factors - Stress & Trauma - Violent Crime Rate

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, 5,225 violent crimes occurred in 2014 and 2016 (two years). The violent crime rate of 488.3 per 100,000 residents is higher than the statewide rate of 419.4 per 100,000.

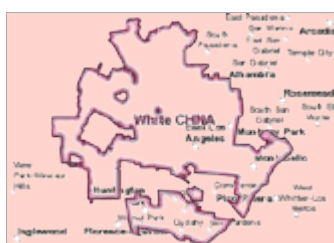
Note: Data are suppressed for counties if, for both years of available data, the population reported by agencies is less than 50% of the population reported in Census or less than 80% of agencies measuring crimes reported data.

Report Area	Violent Crimes	Violent Crime Rate (Per 100,000 Pop.)
AHWM CHNA	5,225	488.3
Los Angeles County, CA	49,549	488.3
California	327,327	419.4
United States	2,445,671	385.6



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. Source geography: County



Violent Crime, Rank by County, CHR 2022

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

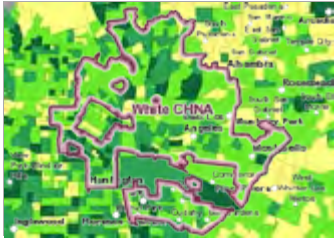
Risk Factors - Stress & Trauma - Unemployment

According to the most recent the American Community Survey estimates, total unemployment in the report area is 43,579, or 7.65% of the civilian non-institutionalized population age 16 and older. 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.

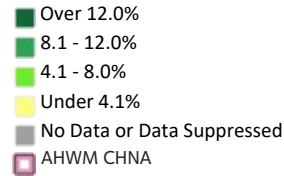
Report Area	Labor Force	Number Unemployed	Unemployment Rate
AHWM CHNA	569,860	43,579	7.65%
Los Angeles County, CA	5,247,546	338,720	6.45%
California	19,875,973	1,229,079	6.18%
United States	164,759,496	8,870,516	5.38%

Note: This indicator is compared to the state average.

Data Source: US Census Bureau, American Community Survey. 2016-20. Source geography: Tract



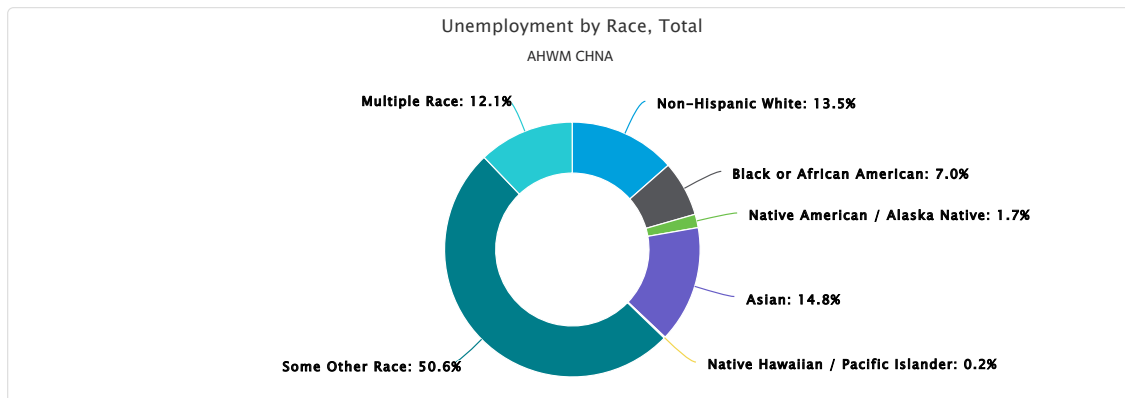
Unemployed Workers, Percent by Tract, ACS 2016-20



Unemployment by Race, Total

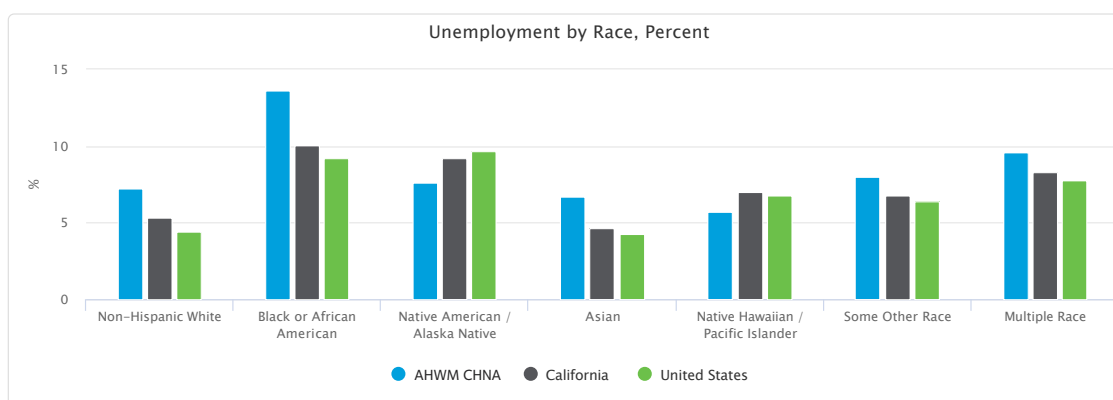
Data Source: US Census Bureau, American Community Survey. 2016-20. Source geography: Tract

Report Area	Non-Hispanic White	Black or African American	Native American / Alaska Native	Asian	Native Hawaiian / Pacific Islander	Some Other Race	Multiple Race
AHWM CHNA	4,133	2,152	521	4,542	46	15,497	3,707
Los Angeles County, CA	90,253	40,186	3,069	38,198	797	68,876	30,601
California	402,121	110,197	13,728	144,492	5,681	193,399	115,127
United States	4,432,807	1,853,375	115,397	421,021	20,879	541,963	564,122



Unemployment by Race, Percent

Report Area	Non-Hispanic White	Black or African American	Native American / Alaska Native	Asian	Native Hawaiian / Pacific Islander	Some Other Race	Multiple Race
AHWM CHNA	7.27%	13.65%	7.63%	6.69%	5.72%	8.01%	9.58%
Los Angeles County, CA	6.22%	9.97%	7.65%	4.81%	5.80%	6.33%	8.71%
California	5.36%	10.08%	9.25%	4.65%	7.04%	6.79%	8.32%
United States	4.38%	9.20%	9.70%	4.26%	6.76%	6.43%	7.76%



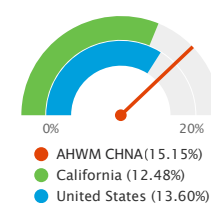
Health Outcomes - Anxiety & Depression - Poor Mental Health

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. Data were from the 2019 Behavioral Risk Factor Surveillance System (BRFSS) annual survey.

Within the report area, there were 15.15% of adults 18 and older who reported poor mental health in the past month of the total population.

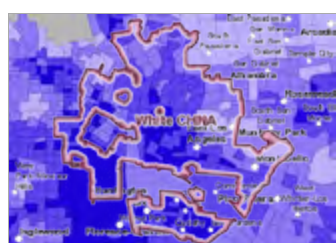
Report Area	Total Population (2019)	Adults with Poor Mental Health (Crude)	Adults with Poor Mental Health (Age-Adjusted)
AHWM CHNA	1,091,999	15.15%	No data
Los Angeles County, CA	10,039,107	12.40%	12.20%
California	39,512,223	12.48%	12.39%
United States	328,239,523	13.60%	13.90%

Percentage of Adults with Poor Mental Health



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, 2019. Source geography: Tract



Poor Mental Health, Prevalence Among Adults Age 18+ by Tract, CDC BRFSS PLACES Project 2019

- Over 16.0%
- 13.1% - 16.0%
- 10.1% - 13.0%
- Under 10.1%
- No Data or Data Suppressed
- AHW CHNA

G. Written Comments

We value your input in 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.

H. Data Limitations

Focus group and key informant interviews were conducted solely with volunteers, which could affect the representativeness of the information collected. Broad-scale community engagement is difficult in geographically large, rural communities and large, high-population areas. Some of the secondary data sets used in this needs assessment were collected prior to COVID-19. The survey only sampled registered voters, leaving out a fully representative sample. As a result, it is not possible to know the full impact COVID-19 has had on the lives of the communities studied or the impact it had on data collection. It is likely sensitivity to COVID-19 affected focus group participation at a minimum. Despite these limitations, the data provided can be seen as an accurate reflection of community health needs.



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IV. Identification of Community's Priority Health Needs

A. Criteria and Process Used for Prioritization of Health Needs

The local Steering Committee (membership found in Section I. E) was responsible for identifying the community health needs to include in the new CHNA. To facilitate this process, a series of meetings were held in each community to 1) present the results of the CHNA data collection process and 2) prioritize the significant identified health needs.

The first part of this series involved Adventist Health System staff and a consultant presenting the primary and secondary data analysis findings to the Steering Committee. The primary data collection included focus groups, key informant interviews, and a community survey, while the secondary data collection included a review of 120 metrics used to determine factors having the greatest impact on community health. Each Steering Committee received a

90-minute data presentation of these results, highlighting the top five needs for each data source and the supporting data that led to their inclusion (see Section V for methodology). A conversation about the findings was a part of these data reviews, but the determination of priority needs was not included, the main goal of these meetings being the provision of information to drive the data-driven decision-making required for the high priority needs selection. At the end of the meeting the Steering Committee was provided with two prioritization tools, data slides and a robust secondary data report to review before the next meeting. The committee members were also asked to discuss the data with their colleagues and organizational leadership and to complete a brief poll a few days prior to the prioritization

meeting. The poll allowed them to identify the three-to-five needs they viewed as most important, based on the criteria provided during the 90-minute data presentation to the CHNA steering committee (see Prioritization Tools #1 and #2).

The prioritization meetings were designed to build consensus around the high priority community health needs identified by the steering committee members. The meetings were facilitated by Adventist Health System staff and relied on the CHNA data presented at the prior meeting, the poll results, and an extensive conversation between members. Each meeting concluded with committee members prioritizing the list of significant identified needs (with typically three-to-five needs selected as high-priority).

B. Next Steps

The next step in our CHNA process includes the development of the Community Health Implementation Strategy (CHIS). The CHIS implementation consists of a long-term community health improvement plan that strategically

identifies and implements evidence-based solutions and programs to address our priority needs.

We believe the power of community transformation lies in the hands of the community. The voices we have

heard have an impact and influence the next steps of creating a strategy to improve the health needs of the community for all. If you would like to learn more, share ideas or stay connected, please contact us at community.benefit@ah.org.

PRIORITIZATION TOOL #1



CRITERIA FOR CONSIDERING WHICH HEALTH NEED TO ADDRESS

Operations Tracked and shared progress/data 'Quick Wins' through collaboration Political willingness	Partners Resources Assets Existing orgs/programs addressing all/parts of Need CBO's are focused on this Need Community willingness	Finance Gov. or public funding available when applying collaboratively Available grants for this Need Need meets the vision/mission of Gov. or philanthropic orgs	Equity Current Orgs/programs addressing Need with Safety-Net pop. Everyone will benefit Addressing Need could lessen absenteeism at work/school
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PRIORITIZATION TOOL #2

Feasibility: High feasibility means there is alignment and/or resources in place to take actional steps to address this Need in a 1-3 year timeframe. Low feasibility means it will take more than 3 years to show a community benefit by addressing this Need.

Impact: High impact means the most community members, or the community members most in need, will benefit from addressing this Need. Low impact means this priority will not benefit a large part of the community, or that the people who will benefit are not in need.

example

	Less Impact	High Impact
High Feasibility	● Community Vitality	● Education ● Food Security ● Housing
Less Feasibility	● Environment & Infrastructure	● Mental Health

V. Process and Methods to Conduct the CHNA

A. Secondary Data Methodology



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Introduction

Since the passage of the 2010 Patient Protection and Affordable Care Act, non-profit hospitals are required to complete a community health needs assessment (CHNA) at least every three years. The purpose of the CHNA is to better align the community benefit functions of non-profit hospitals with the needs of the communities which they serve. To this end, requirements for completing a CHNA are broadly defined by the Internal Revenue Service (IRS)¹ to include “identifying and prioritizing community health needs” (Pennel, 2015), which must involve the input from “broad interests of that community” (IRS). Best practices for CHNAs as defined by the CDC, the AHA Community Health Improvement (AHCI) and others all specify the inclusion of both primary and secondary data (Barnett, 2012; Institute of Medicine, 2010; Stoto & Ryan-Smith, 2015; AHCI, 2017). In practice, however, there is little consensus on how this data is used to define community health needs.

While much research exists on the subject of population health measurement, research findings specific to quantitative analysis in Community Health Needs Assessments are limited. Among the existing literature, authors find “wide-ranging diversity in CHNA approaches and report quality”.

Best practices for utilizing secondary data

One reason for this is the lack of guidelines or even requirements for incorporating secondary data into an assessment of community needs. Despite this, evaluators agree that utilizing both primary and secondary data to prioritize community health needs is a “best practice”.

Several common issues with secondary data which hinder its ability to define health priorities have been defined in the literature. These include the lack of data availability at the appropriate levels of disaggregation (both geographic and for population subgroups), the lack of real-time or current data, and the lack of appropriate benchmarks (Stoto, Davis, & Atkins, 2019).

This document describes the methodological approach used to identify health needs using secondary data.

Basic Approach

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 which best represented each category based on a review of multiple health measurement frameworks. Next, metrics were scored based on three criteria relevant to the mission of “helping people live longer, better.” 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.

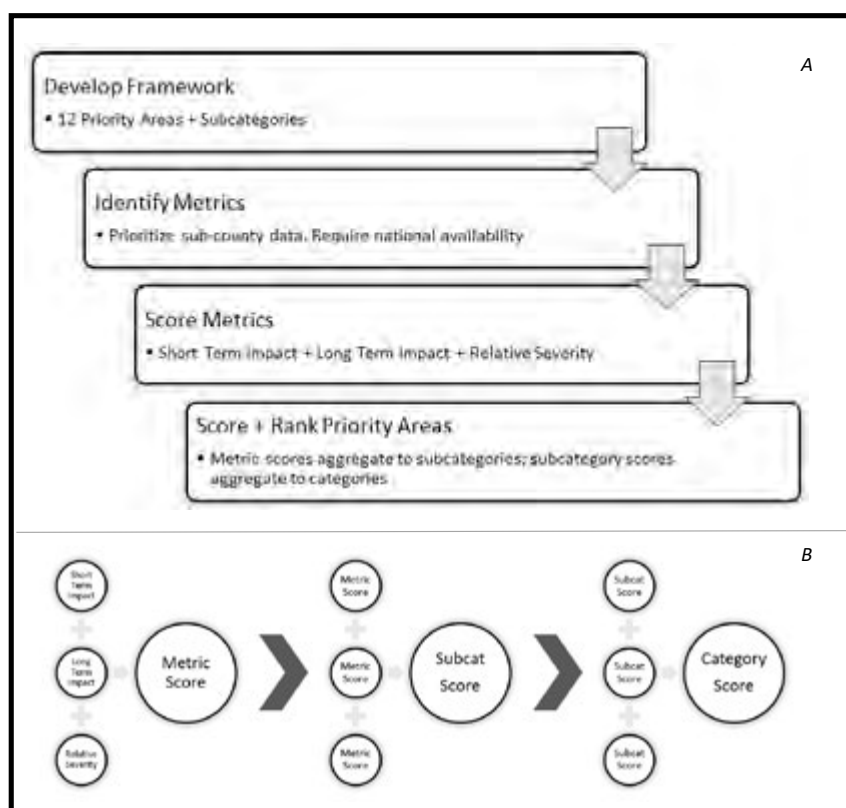


Figure 1. A. Approach to framework and scoring methodology development. B. Diagram of scoring approach.

Framework Development

A set of 12 priority conceptual areas were identified from a review of past cycle CHNAs. In order to generate a score or rank for these priority needs areas, our first task was to operationalize them by selecting appropriate data by which to measure each one. 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 & Roadmaps

¹ <https://www.irs.gov/charities-non-profits/community-health-needs-assessment-for-charitable-hospital-organizations-section-501r3>



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- 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. Indicators which did not correspond into the 12 categories were not included in the analysis. Additionally, indicators representing similar concepts (e.g., poverty, childhood poverty, household poverty) were reduced to a single metric.

Next, indicators were grouped into subcategories within each priority health needs category. The final framework consists of more than 100 individual metrics across the 12 categories, each with a minimum of two subcategories (CARES, 2022).

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 status²) and a long-term goal (length of life, measured by life expectancy at birth³). This approach was adopted in part to reflect the hospital system's mission of "helping people live longer, better".

Metrics with strong negative relationships with the outcome variables (scoring below -.40) were removed from the framework⁴.

To address the third criterium, 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.

² Source: BRFSS PLACES 2018 Poor Mental Health Days + Poor Physical Health Days

³ Source: CDC NCHS USA LEEP

⁴ Removal was preferred over inverting the score direction since indicators were selected which theoretically represented conditions for good health. One example of this removal occurred with the metric "access to grocery stores", where a lower density of grocery stores correlated with a higher life expectancy and well-being. It is predicted that this relationship is due to confounding factors or a limitation of the measurement definition selected, and not an indication that a higher density of grocery stores causes worse health.



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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 which perform better than average for a metric will see scores adjusted down (lower priority), and communities which 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.

$$SubC_c = \sum_c \frac{SubC}{n}$$

$$Cat_c = \sum_c \frac{SubC}{n}$$

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 1 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.



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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 major drivers 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 are limited. For example, data on the prevalence of overall homelessness is not available for small (e.g., sub-county) geographic areas. Without data sets 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. Data analysis found scores to be influenced by the geographic scale and the geographic universe (e.g., state, region, or US 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 (Spring, 2022), the latest available data on health behaviors, outcomes, and social determinants represented the 2019 calendar year, 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. However, the significant events of 2020 and 2021 (e.g., the COVID-19 pandemic) are largely unrepresented in these data.

References

Association for Community Health Improvement. Community Health Assessment Toolkit. 2017. [cited 2018 Oct 28]. Available from: www.healthycommunities.org/assesstoolkit.

Barnett, K. (2012). Best practices for community health needs assessment and implementation strategy development: A review of scientific methods, current practice, and future potential. Atlanta, GA: Centers for Disease Control and Prevention.



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Castrucci, B. C., Rhoades, E. K., Leider, J. P., & Hearne, S. (2015). What gets measured gets done: an assessment of local data uses and needs in large urban health departments. *Journal of public health management and practice: JPHMP*, 21 Suppl 1(Suppl 1), S38–S48.

<https://doi.org/10.1097/PHH.0000000000000169>

Catholic Health Association of the United States. Assessing and Addressing Community Health Needs. 2015. [cited 2018 Oct 28]. Available from: <https://www.chausa.org/communitybenefit/assessing-and-addressing-community-health-needs>.

Institute of Medicine. For the public's health: the role of measurement in action and accountability. Washington, DC: National Academies Press; 2010.

Stoto, M. A., Davis, M. V., & Atkins, A. (2019). Beyond CHNAS: Performance Measurement for Community Health Improvement. *Egems (generating Evidence & Methods to Improve Patient Outcomes)*, 7(1), 45. DOI: <http://doi.org/10.5334/egems.312>

Stoto, MA, Davis, MV and Atkins, A. Making Better Use of Population Health Data for Community Health Needs Assessments. *eGEMs*. 2019; 7(1): 44, pp. 1–9. DOI: <https://doi.org/10.5334/egems.305>

University of Wisconsin Population Health Institute. County health rankings and roadmaps. 2014. [cited 2018 Oct 28]. Available from: <http://www.countyhealthrankings.org/>.

B. Survey Methodology and Questions

The Berkeley IGS Poll is a regularly scheduled non-partisan survey of California public opinion conducted by the Institute of Governmental Studies (IGS) at the University of California, Berkeley. A component of the University of California system's flagship Berkeley campus, IGS is the oldest organized research unit in the UC system and the state's oldest public policy research center.

METHODOLOGY: The poll is administered online by distributing email invitations to stratified random samples of California registered voters. The invitation provides respondents with a short summary of the poll's purpose, its sponsorship, how long the survey is likely to take and how the recipient's email was obtained.

The statistical tabulations in this volume are based on a Berkeley IGS Poll completed online in English and Spanish July 18-24, 2021, among 5,795 California registered voters by the Institute of Governmental Studies (IGS) at the University of California, Berkeley. Funding for the poll was provided in part by the Los Angeles Times.

The survey distributed email invitations to stratified random samples of the state's registered voters. Each email invited voters to participate in a non-partisan survey conducted by the University and provided a link to the IGS website where the survey was housed. Reminder emails were distributed to non-responding voters, and an opt-out link was offered to voters not wishing to participate and not wanting to receive further email invitations.

Samples of registered voters with email addresses were provided to IGS by Political Data, Inc., a leading supplier of registered voter lists in California. The email addresses of voters were derived from information contained on the state's official voter registration rolls. Prior to the distribution of the emails, the overall sample was stratified by age and gender in an attempt to obtain a proper balance of survey respondents across all major segments of the registered voter population.

To protect the anonymity of survey respondents, voters' email addresses and all other personally identifiable information derived from the original voter listing were purged from the data file and replaced with a unique and anonymous identification number during data processing. In addition, post-stratification weights were applied to align the overall sample of the registered voters to population characteristics of the state's registered voters.

The sampling error associated with the results from the survey is difficult to calculate precisely due to the effects of sample stratification and the post-stratification weighting. Nevertheless, it is likely that the results from the overall sample of registered voters are subject to a sampling error of approximately +/- 2 %age points at the 95% confidence level.

The survey question response options were based on the community health needs framework that also defined this work's secondary and primary data collection. In addition, survey response language was adjusted to be accessible to all community members.

The following list shows how response options correspond to the community needs framework.

SURVEY QUESTION

Please choose the five things from this list that make it hard for you and others in your community to be healthy.

- ▶ Not being able to see a doctor or go to a hospital
- ▶ Not enough good jobs
- ▶ Lack of transportation
- ▶ Lack of senior care
- ▶ Poor schools
- ▶ Not enough affordable housing
- ▶ Limited affordable, healthy food
- ▶ COVID-19
- ▶ Homelessness
- ▶ Mental Health
- ▶ Cost of Living

NEEDS CROSSWALK

- ▶ Access to Care-Primary Care
- ▶ Financial Stability-Employment
- ▶ Environment & Infrastructure-Transportation
- ▶ Access to Care-Senior Care
- ▶ Education
- ▶ Housing-Cost
- ▶ Food Security
- ▶ COVID
- ▶ Housing-Unhoused
- ▶ Mental Health
- ▶ Financial Stability-Cost of Living

C. Focus Group and Key Informant Methodology and Guide

Primary data collection was designed to gather first-person input on community health needs directly from community members. Between October 2021 – January 2022, 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 virtual and/or 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 (see Section V) used for both types of interviews were nearly identical. All focus groups and interviews began with participants identifying up to five high priority community health needs from their perspective, chosen from a standard list provided by the facilitator. This standard list was comprised of common community health needs based on the larger framework of social determinants of health used for secondary data collection (see Section V). The facilitators — a team of Adventist Health System staff and a consultant — then moved through a series of questions for each identified need, focusing on depth of need, examples of the impact of the need,

attempts at addressing the need historically, barriers to reducing the need, and reasonable improvement goals over three years. The only variation in the focus group and key informant interview guides was the inclusion of additional prompts for key informants allowing for greater depth of response. A notetaker was present for each focus group and key informant interview, and all interviews were recorded. Note documents and audio recordings were provided to the qualitative analysis team, which were Adventist Health System staff and a consultant, to facilitate analysis. Focus groups were conducted in teams of two, with a lead facilitator and a notetaker. All focus groups were conducted in English or Spanish. In some cases, the facilitator was provided by a Steering Committee member, either due to language needs, expertise with a specific community group, or both.

Deductive analysis of all focus groups and key informant interview data was performed by coding all available data to a social determinants of health framework developed by Adventist Health and CARES. This framework contains twelve major categories and over 52 common community health needs subcategories. Open coding, combining all relevant codes, was done at the category and subcategory level utilizing Dedoose coding software. Focus group and key informant data were analyzed and coded into single or multiple subcategories. The number of subcategory comments was rolled up to the major category level. Axial coding, where common and highly relevant data codes were combined into themes, was conducted on all category and subcategory data, and

major themes were developed for each of the top five-to-six categories/subcategories based on relative importance determined by the number of total codes and the review by the axial coding team.

Once major themes were identified, the primary data team, comprised of both facilitators and qualitative data analysts, reviewed themes and supporting data to determine the final community needs to include in the Steering Committee data reveal. The final needs were the themes that occurred most frequently, both in terms of the number of times specific needs were identified and the urgency, frequency, and intensity of the related comments. Combined with the identified survey and secondary data needs (the five largest needs of the 12 on which secondary data was collected), these themes represented the findings the Steering Committee used to determine (described in Section IV) the final set of high priority health needs included in this CHNA report. Primary interview data was presented as identified needs, a summary of the need, and supporting data taken from the qualitative analysis. Wherever possible, the supporting data was provided in the form of direct quotes from participants.

FACILITATOR'S SCRIPT

WELCOME

- ▶ Warmly introduce yourself and note taker
 - We're from Community Benefit Solutions.
 - If site host is present, thank them for bringing everyone together.
- ▶ Duration
 - Spend the next 90 minutes together (focus group).
 - Spend the next 60 minutes together (key informant).
- ▶ Share the "why" they are here and "what" we're asking of them
 - You're here today because we want to hear your opinions about the health needs of your community.
 - Every community has things that help people be healthy and things that make it harder to stay healthy.
 - This is part of a larger plan and your input will be put together with comments from others in your community into a Community Health Needs Assessment report. This will help your community organizations and leaders as they work toward identifying the challenges and barriers you're seeing so they can work to fix the problems you're facing in trying to stay healthy.
- ▶ More about a Community Health Needs Assessment report
 - The Community Health Needs Assessment is a public document and represents the collaborative work between community agencies and the local hospital(s), partnering to identify, gather and analyze the health needs of their community. This process provides communities a way to prioritize health needs, assess local resources and plan to address

key community health needs.

▶ Your Acknowledgment

- We'll be asking you questions today and you're free to answer only the questions you're comfortable with.
- Please know that notable quotes/comments from today's meeting could appear in the CHNA and will be labeled as an Anonymous Community Quote – please rest assured that we won't share any names.
- *"Today's Focus Group is being recorded to ensure we capture all the concerns, thoughts and ideas about the health and well-being of your community. Some comments might be highlighted in the CHNA report and will not list the individual's name."*
- We want to hear from everyone, so please understand if we move from one comment to the next – we want to make sure everyone is heard.
- Does anyone have any questions about this?
- How about any problems being involved in this group?

ACTIVITY EXPLANATION

- ▶ 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.
- As you look around the room, you'll see three posters on the wall.
- They show photos of common problems people face, many of them related to health. (Editorial note: these photos portrayed social determinants of health, for participants to select from. In some cases participants were given printed versions of the photos when they requested them. This allowed

all participants to be involved regardless of mobility.

- Please take a few minutes to vote with the 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.*
- *Which of these things causes the most problems for you or others who live here?*
- *We're specifically interested in learning about things that make it hard for you or 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 about that – for instance, doctor – it could be, I can't get an appointment, there isn't a pediatrician near me.
- We'll give you 10 minutes to walk around.

TALLY RESPONSES:

- ▶ Visually tally the votes and clearly call out the top five issues that were identified for the notetaker and audience to hear.
- ▶ Spend around 15 minutes going through these questions and the topic-specific follow-up questions.
- ▶ Repeat for as many problems as time allows, leaving five minutes to wrap up at the end.
- ▶ Use the same prompting questions for each of the five identified issues.

Question Prompters

- 1 One of the topics that many people identified is _____. For those of you that think this is a health problem in your community:
- 2 Another topic many people identified is _____. For those of you that think this is a health problem in your community:
- 3 People also said that _____ is a problem. For those of you that think this is a health problem in your community:

QUESTIONS:

- ▶ Why is this a big concern?
- ▶ How do you see it affecting people around you?
- ▶ What have people tried to do to address this problem?
- ▶ What else do you think should be done?
- ▶ What are the biggest barriers to fixing this problem?
- ▶ If this problem got better, how would your community look different in 3 years?
- ▶ How has this problem been affected by COVID-19?
- ▶ Do you think this problem affects everyone in your community equally?
If not, why is that?
Who is most affected by this?

CLOSING QUESTION:

- ▶ Are there other important health needs in your community that we have not already addressed?
- ▶ (Let 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 all 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, summarizing our findings and action plans identified with the community.
If you would like us to send you a text or email with a link to that report, just provide us with your information on the way out.
- ▶ As a thank you to you all, we have a gift card for you as you leave. **Good health to you all!**

TOPIC-SPECIFIC PROMPTS

ACCESS TO CARE

What are the main things that stop people from seeing the doctor when they need to?

CHRONIC CONDITIONS/PHYSICAL HEALTH

What are the most common medical conditions that people have in your community?

How do you know?

HEALTH RISK BEHAVIORS

Personal choices can affect people's health at times. These can include not exercising enough, an unhealthy diet, smoking, drug use, unsafe driving habits, and many others.

What risky health behaviors do you think might affect your community?

MENTAL HEALTH

How can you tell that mental health problems are showing up in your community?

FOOD SECURITY

What examples have you seen of people struggling to have enough food to eat?

How common of a problem do you think this is?

What is being done to help?

INFRASTRUCTURE

What transportation barriers exist in your community?

COMMUNITY VITALITY

What are the best things about living here?

PHYSICAL ENVIRONMENT

What kind of access do you have to nature?

What limits people's access to the outside world?

COMMUNITY SAFETY

What are the biggest threats to your safety in your community?

What is being done to address these safety concerns?

HOUSING

What are the biggest housing problems facing your community?

What impact do these problems cause?

FINANCIAL STABILITY

What kind of job opportunities are there around here?

EDUCATION

How would you describe the educational opportunities for kids?

What about for people going to college or going back to school?

INCLUSION & EQUITY

How culturally diverse is your community?

How well does your community embrace this diversity?

What examples are there of times when diversity issues were not handled well?

D. Adventist Health White Memorial 2019 Implementation Strategy Evaluation of Impact



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about the full Community
Health Plan Update

E. Purpose of the Community Health Needs Assessment (CHNA) Report

The Community Health Needs Assessment (CHNA) is a public document and represents the collaborative work between community stakeholders and the local hospital(s), partnering to identify, gather and analyze the health needs of their community. This process provides communities a way to prioritize health needs, assess local resources and plan to address

key community health needs.

The Patient Protection and Affordable Care Act (ACA), enacted on March 23, 2010, included new requirements for nonprofit hospitals in order to maintain their tax-exempt status. The provision was the subject of final regulations providing guidance on the requirements of section 501(r) of the Internal Revenue Code. Included in the new regulations is a requirement

that all nonprofit hospitals must conduct a community health needs assessment (CHNA) and develop an implementation strategy (IS) every three years (<https://www.govinfo.gov/content/pkg/FR-2014-12-31/pdf/2014-30525.pdf>). The required written IS plan is set forth in a separate written document.

F. CHNA Consultants Used to Conduct the Assessment

IDENTITY AND QUALIFICATIONS

ADVENTIST HEALTH COMMUNITY WELL-BEING TEAM

The Adventist Health Community Well-Being Team coordinated the data collection, analysis and writing for these reports. The Community Well-Being team members listed below encompass highly relevant and diverse experience in healthcare, philanthropy and foundation, Medicaid managed care and quality improvement, public health and community health, consumer insights research and community benefit reporting. Those team members include:

Samantha Gomez, MPH, CHES®:
Project Manager

Amanjit “Amy” Lasher:
Administrative Director

Jesus Mora-Castro:
Public Health Intern

Janelle Ringer:
Project Manager

Paul Sandman, MBA, CPA:
Community Integration Analyst

Susan Passalacqua:
Project Manager

Jade Tuleu:
Project Manager

Lisa Wegley:
Project Manager

BERKELEY INSTITUTE OF GOVERNMENTAL STUDIES (IGS)

Berkeley IGS promotes research, educational activities, and public service in the areas of American and California politics and broad domains of public policy. The Berkeley IGS Poll is a periodic survey of California public opinion on important matters of politics, public policy, and public issues. The poll, which is disseminated widely,

seeks to provide a broad measure of contemporary public opinion, and to generate data for subsequent scholarly analysis.

The Matsui Center provides students with internships and real-world learning opportunities. The faculty-led research groups develop and support state-of-the-art research on critical issues facing the nation today. The Berkeley IGS Poll provides accurate, unbiased information on what California residents think and vote on.

UC Berkeley remains central to the most important governance actions and conversations unfolding today. American democracy faces deep and systemic challenges; by training the next generation of leaders and citizens, incubating policy-relevant research, and elevating critical public discussions IGS is determined to be a part of the solution.

G. Cristina Mora & Eric Schickler...IGS
Co-Directors
igs@berkeley.edu
510-642-4465

Mark Di Camillo
Berkeley IGS Poll Director
mdicamillo@berkeley.edu

www.igs.berkeley.edu/about

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, the 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 US, including vulnerable, rural, and underserved populations. CARES web-based technologies help organizations and policymakers make more informed decisions about access, address issues of equity, and support the allocation of public and private resources.

CARES staff have backgrounds 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, significant experience in project management, user training and support, data documentation, and client design sessions directly supports the wide variety of projects at CARES.

Chris Barnett
(barnettc@missouri.edu) serves as director for CARES.

Angela Johnson
(johnsonange@missouri.edu) serves as assistant director and lead research project analyst for CARES.

For more information, please visit careshq.org/about/

CENTER FOR BEHAVIORAL HEALTH INTEGRATION

The Center for Behavioral Health Integration is a small collaborative of mental health professionals and researchers providing evaluation, training, and program implementation support to human service organizations.

www.c4bhi.org

Project Lead: Patrick Kinner

Evaluation Consultant

Oct 2018 – Present 3 years 8 months

New England

Providing evaluation, research, writing, and strategic planning support throughout the world of human services.

Patrick Kinner joins Adventist Health as an Evaluation Consultant with more than 10 years of experience helping organizations collect high-quality data to improve their services and share their successes. He holds a vast background working with large health systems, state public health offices, and with innovative entrepreneurs and organizations to improve systems and services across the human service spectrum. Every passionate and committed organization has a gap between what they hope to accomplish and what they actually accomplish. As an evaluation consultant, Kinner identifies those gaps to collect data to understand the causes and help you use that data to change minds and turn heads. This can take the form of small-scale internal evaluation projects or long-term research efforts to test, validate, and publish your theory of change. His work has been instrumental in helping organizations secure additional funding and partnerships, and in making major structural changes in initiatives when necessary.



Project Lead: Keren Meital Kinner

Evaluation Consultant

January 2019 – Present

New England

Providing evaluation, data analysis and visualization services to human service organizations.

Keren's experience in the fields of mental health, education, and software development intersect as she helps organizations collect, understand, and act upon performance and cultural improvement data. In her role as a program evaluator, she focuses on quantitative and qualitative data analysis as well as data visualization through Tableau. With the help of regular and timely data visualization cycles, she helps organizations easily access and understand the latest information, inspect progress and back draw, and help identify new themes, gaps, learnings, and enhancements. Keren regularly works with universities, hospitals, health centers, and innovative entrepreneurs.

VI. Glossary of Terms, Definition of Health Needs

Glossary of Terms

ACCESS TO CARE:

Accessing care with reliable transportation at the right time and location is often a challenge. In addition, not having access to insurance, low-cost care, interpreters, and programming prevents many people from getting treatment. Helping families secure insurance, transportation and access through mobile health options can help them find the care they need.

COMMUNITY SAFETY:

Being safe in your neighborhood is key to developing a real sense of community: where neighbors engage and work toward the common goal of safety and friendship. This may include a formal neighborhood watch program with local police, or simply an ongoing awareness of what's happening, to ensure safe homes and safe people.

COMMUNITY VITALITY:

A sense of belonging, a place where people feel connected, where neighbors are encouraged to participate in their community across socioeconomic status, physical ability, race/ethnicity or other differences, and where businesses can thrive — this is the definition of community vitality. These are a few of the aspects of what makes a community a community, with neighbors supporting neighbors and preserving the quality of life for all to share.

EDUCATION:

Educational opportunities can deeply impact choices, quality of life and life span, from children to adults. Studies have documented that educational attainment affects health and develops a healthy sense of empowerment. As school-aged children grow in knowledge, so can parents — touching multiple generations with opportunities. Whether it is a kindergartener or a newcomer to the United States, education can improve futures.

ENVIRONMENT & INFRASTRUCTURE:

Clean water, clean air and accessible walkways and streets are key to healthy neighborhoods. Walking and biking require safe sidewalks and roads. In a digital world where access to high-speed internet provides opportunities to attend school, work, go to a doctor and conduct daily tasks, high-speed internet access is also an infrastructure necessity.

FINANCIAL STABILITY:

The definition of financial stability is broad and encompasses the ability to cover daily living expenses, allowing individuals to fully engage in life's opportunities. Things like safe housing, access to healthy foods and other necessities are impacted by financial stability. The gap between income and cost of living, along with a lack of stability, can be a barrier for individuals and families from securing the care

and resources they need. Over time, the lack of financial means impacts health and physical, emotional, and social well-being.

FOOD SECURITY:

Food security is the ability of all people, at all times, to have physical, social and financial access to healthy and nutritious food. Food security also involves the ability to purchase affordable healthy foods, and to cook and store them.

Today, that is a goal and a challenge, as costs increase, and access to finding affordable healthy options is limited.

HEALTH CONDITIONS:

Obesity, heart disease, cancer and diabetes — examples of chronic diseases — are the leading causes of death and disability in the United States. The conditions in which we live contribute to our well-being and influence our choices, which can lead to potentially serious diseases. Access to clean and healthy food, water, air, safe schools, affordable housing, and reliable safety-net programs play a major role in the health and well-being of a community. These conditions can make a significant difference in combatting the leading causes of death and disability in the United States, such as obesity, heart disease, cancer and diabetes.

HEALTH RISK BEHAVIORS:

Each day, decisions are made that impact lives – directly and indirectly. These decisions range from abuse of drugs and alcohol, to smoking, to misuse of medications. Relying on unhealthy food choices is another example of a behavior that can be a life-threatening health risk. But life changes, such as consistent physical exercise and healthier food choices, when supported by financial stability, equitable social conditions, and a healthy natural and built environment, offer the opportunity to change direction and live healthier lives. Sometimes, it's our opportunities and choices that lead to some of these serious diseases. Often, the conditions in which we live can influence and contribute to our health. Access to healthy foods, green space for exercise, quality of our air and schools, affordable housing and the reliability of safety-net programs often play a role in community health.

HOUSING:

The definition of housing varies from person to person, as individuals and families struggle to find safe housing – a place to rest and live that is affordable and in good condition. Today, families face a shortage of housing stock, long wait lists and complicated steps required to secure a place to live. Families may find that they can't afford housing, so they double up with another family or remain in a home that is too small or even unsafe. Efforts continue to address these very real concerns and to seek solutions.



INCLUSION & EQUITY:

The definition of inclusion and equity includes fairness, justice, prosperity, and opportunity – for all people of all ages to feel welcomed, with a fair chance to participate, thrive, and reach their full potential. Inclusion and equity reflect those social conditions, systems, and policies that make it so all individuals in a community have equal opportunities to live good lives.

MENTAL HEALTH:

Mental health includes our psychological, social and emotional well-being. It affects how we think, feel and act, and sometimes leads to behaviors like self-harm or self-medication. Mental health is important at every stage of life, and not knowing when or where to ask for help often leaves children, teens, adults and families feeling alone and helpless.

VII. Approval Page

2022 CHNA Approval

This community health needs assessment was adopted on October 20, 2022 by the Adventist Health System/West Board of Directors. The final report was made widely available on December 31, 2022.



Thank you for reviewing our 2022 Community Health Needs Assessment. We are proud to serve our local community, and are committed to making it a healthier place for all.

John Raffoul, Dpa, Fache
Adventist Health White Memorial

COMMUNITY HEALTH NEEDS ASSESSMENT