



**ADVENTIST HEALTH
GLENDALE**

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 Glendale 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

Health Conditions

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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What if ...

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

Health concerns were managed or even eliminated through education and engagement?

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 city government, community-based organizations, community health organizations, education, faith

communities, healthcare, higher education, minority populations, Los Angeles County Department of Public Health, public safety and seniors. 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 eight 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, education-child care, financial stability, food security, health conditions, housing 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, health conditions and mental health.

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**

Health concerns were managed or even eliminated through education and engagement, resulting in patients' fears being reduced after an awareness about their **Health Conditions**

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

Getting to know our Glendale CHNA service area*

Although largely known by its adjacent 'City of Angels' neighborhood, Glendale is its own unique community with shops, family-owned businesses, scenic Forest Lawn Memorial Park treks, and endless varieties of culturally diverse restaurants including well-known and local favorite Cuban bakery, Porto's.

The Glendale Hospital community is home to 314,658 residents and reflects a diverse culture with 33.08% being Hispanic, and the largest age group being 25-34.

The median household income is \$72,109 of which 47.77% is spent on housing and transportation. Among this population, 16.74% of children live in poverty and 5.16%

of students are unhoused, compared to the state average of 4.25% and national average of 2.77%.

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 Glendale'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 Glendale 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 poverty and homelessness including mental health and substance abuse, access to care, cardiovascular diseases including stroke, preventive wellness including diabetes and obesity and geriatric support.

Working together with the community, we created strategies designed to educate and break down barriers to care and well-being for Glendale community residents. We screened more than 300 individuals at risk of becoming unhoused, enrolled 204 participants in the homelessness program and connected 141 participants to sustainable housing. We emphasized opportunities to engage our communities by offering more than 400 community education, screening sessions and lifestyle group activities impacting a total of 14,267 lives.

Despite the challenges due to COVID-19, we were still able to provide 358 educational and lifestyle classes to our older community members who are at higher risk impacting a total of 10,354 individuals.

The COVID-19 global pandemic caused extraordinary challenges for Adventist Health Glendale 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

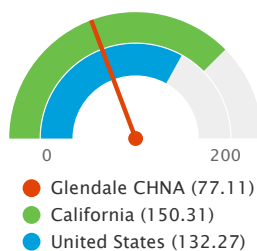
COMMUNITY VOICES

- People with inadequate insurance and who don't speak English as a first language struggle to access good quality care, interviewees noted.
- Residents will forgo some medical care if they can't afford it, with dental visits being one cited example.
- There is a strong desire by interviewees to ensure equal care regardless of insurance status.
- Community leaders said the inadequate number of providers makes it difficult for everyone to get appointments.
- Inconsistent access to care leads to chronic diseases becoming major medical problems, in the eyes of some.
- Translation services, especially in Spanish and Armenian, are seen as critically important to community members
- There aren't enough qualified childcare centers to be able to care for children for people who have to go to work or get to doctor appointments.
- The long delays in getting specialty care can lead to worse health outcomes over time.

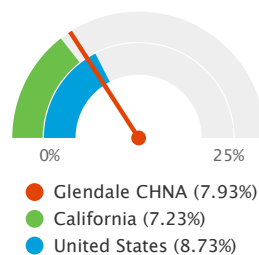


SECONDARY DATA INFOGRAPHIC STATS:

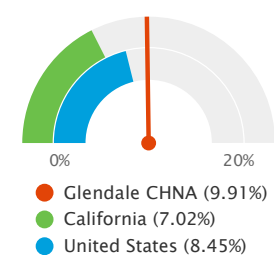
Mental Health Care Providers,
Rate per 100,000 Population



Uninsured Population, Percent



Percentage of Households with
No Motor Vehicle



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.

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

Dial-A-Ride

818-548-3960, glendaletransit.com/tools/dial-a-ride

Glendale Transportation Center

818-548-3960, glendaletransit.com/about/glendale-transportation-center

Get Connected Get Help with 211, Powered by people in your community, available 24/7, 818-981-4491, unitedway.org

Glendale offers the chance to explore local events and fun family activities. But day-to-day, the area's families have a very different perspective, facing challenges from finances to health to overall well-being.

Residents face numerous barriers to accessing health care when needed. Glendale has a limited number of mental health providers, about half that of California and the US, and 7.9% of the population is uninsured.

The number of adults in Glendale without a high school diploma (14.85%) is above that of the US (11.47%). Of children ages five and older, 28.57 percent of the population have limited English proficiency, creating barriers to healthcare access, provider communication and health literacy/education. This rate is significantly higher than that of California (17.41%) and the US (8.25%).

Residents provided input, noting the need for translation services and improved transit access, and frustration with the complicated rules of insurance and legal status.

Community voices have been heard. The challenge now is to take the next steps and move forward with new vision and new confidence.

Population Age 5+ with Limited English Proficiency, Percent

Report Area	Population Age 5+	Population Age 5+ with Limited English Proficiency	Population Age 5+ with Limited English Proficiency, Percent
Glendale CHNA	307,991	88,001	28.57%
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%

Health Conditions

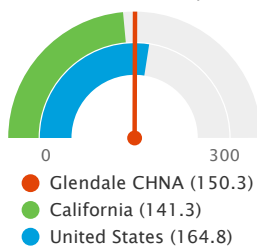
COMMUNITY VOICES

- Poor health and dietary choices, often driven by expense, are seen as major contributors to health problems, noted community members.
- Social isolation, driven by COVID, has led some to avoid medical care, which will likely have long-term consequences. This was a concern expressed by community leaders.
- People reported increased consumption of processed foods, resulting in higher incidences of cardiac cases and diabetes.
- Increased rates of substance abuse are seen as drivers of poor health.

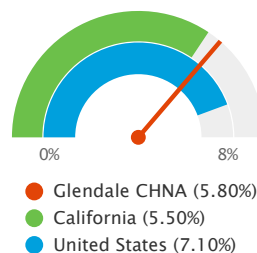


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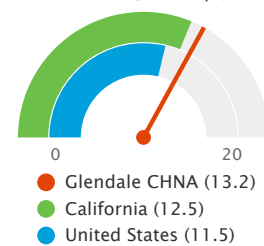
Heart Disease Mortality,
Age-Adjusted Death Rate
(Per 100,000 Pop.)



Percentage of Adults with Cancer



Liver Disease Mortality,
Age-Adjusted Death Rate
(Per 100,000 Pop.)



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

City of Glendale

glendaleca.gov/government/departments/community-services-parks/recreation-programs

Get Connected Get Help with 211, Powered by people in your community, available 24/7, 818-981-4491, unitedway.org

Glendale faces challenges, as residents struggle with poor food choices and chronic conditions are seen as major contributors to health concerns.

Residents shared concerns, including a focus on affordable fast food that can lead to diabetes, high cholesterol and higher incidences of cardiac cases. It was also shared that residents dealing with social isolation, driven by COVID, have avoided care, resulting in long-term consequences.

The death rate from health disease and stroke is 150.3 per 100k people. The percentage of adults with cancer (5.8%) is slightly elevated as well, from that of California (5.5%). The percentage of Medicare beneficiaries

with Alzheimer's disease is 14.6%, which is higher than the California rate (10.5%) and the nation (10.8%).

Postponing care, and specialty care shortages, can mean some residents will be more ill when they begin treatment than they may have been otherwise. School closures limit sports participation, which can impact students' quality of life.

Yet, despite these genuine concerns, residents are eager to roll up their sleeves and find solutions to reduce the health conditions in their community. Together with the community, we can tackle these issues to ensure a future full of health, wholeness and hope.

Percentage of Medicare Beneficiaries with Alzheimer's Disease

Report Area	Total Medicare Fee-for-Service Beneficiaries	Beneficiaries with Alzheimer's Disease	Beneficiaries with Alzheimer's Disease, Percent
Glendale CHNA	18,032	2,639	14.6%
Los Angeles County, CA	574,246	84,048	14.6%
California	2,859,642	299,482	10.5%
United States	33,499,472	3,610,640	10.8%

Mental Health

COMMUNITY VOICES

- The limited socialization caused by COVID is seen as a driver of depression, especially in youth, per focus group participants.
- There are worries that housing instability and the high cost of living increases anxiety levels for many.
- Mental health services are seen as stigmatized, causing some not to seek services.
- Mental health issues are seen as taboo in some cultures, leading to less access to care.
- Teen mental health is seen as a large and growing problem.
- There is a deficiency in the number of mental health providers that are accessible for those who are uninsured or underinsured, an interviewee indicated.



SECONDARY DATA INFOGRAPHIC STATS:

Violent Crime Rate

Report Area	Violent Crimes	Violent Crime Rate (Per 100,000 Pop.)
Glendale CHNA	1,556	488.3
Los Angeles County, CA	49,549	488.3
California	327,327	419.4
United States	2,445,671	385.6

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
Glendale CHNA	314,462	36	242	77.11
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.

Helpful research is opening doors on how to address mental health among residents of all ages.

Residents shared concerns regarding teen mental health; a growing problem made more concerning by the depression and isolation created by COVID. Overall, inadequate mental health care is seen as a major problem. The older adult population is another area of concern, due to the shortage of physical and mental health care.

Many residents receiving services are stigmatized, which causes some to avoid seeking care. Insurance status affects the ability to get mental health care and shortages of providers prevent residents from receiving needed care.

A survey indicated that 48 percent of residents feel their top health concern and their top concern overall is mental health. Access to mental health care providers is limited, with 77.11 mental

health providers per 100k people, which is significantly less than the rate in California (150.31) and in the US (132.27). The violent crime rate is 488.3 per 100k people, higher than that of California (419.4) and the US (385.6).

With commitment, numbers can be replaced with healing and hope.

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

Boys & Girls Club- Elmwood

818-433-8390, bgcburbank.org

Didi Hirsch Mental Health Services

818-244-7257, didihirsch.org

Get Connected Get Help with 211, Powered by people in your community, available 24/7, 818-981-4491, unitedway.org

Unemployment by Race, Total

Report Area	Non-Hispanic White	Black or African American	Native American or Alaska Native	Asian	Some Other Race	Multiple Race
Glendale CHNA	6,355	513	47	1,488	1,889	1,290
Los Angeles County, CA	90,253	40,186	3,069	38,198	68,876	30,601
California	402,121	110,197	13,728	144,492	193,399	115,127
United States	4,432,807	1,853,375	115,397	421,021	541,963	564,122

Risk Factors – Stress & Trauma – Unemployment

Report Area	Labor Force	Number Unemployed	Unemployment Rate
Glendale CHNA	177,852	13,375	7.52%
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 Glendale 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.

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II. About Us

A. Adventist Health Glendale

Located in the center of beautiful mountain ranges, Adventist Health Glendale is a 515-bed medical center and acts as an active and devoted leader in promoting a healthy lifestyle and the highest quality of medical care. Key services include our heart and vascular institute, neurology institute, spine institute and more. We are proud to serve a section of Los Angeles County.



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.

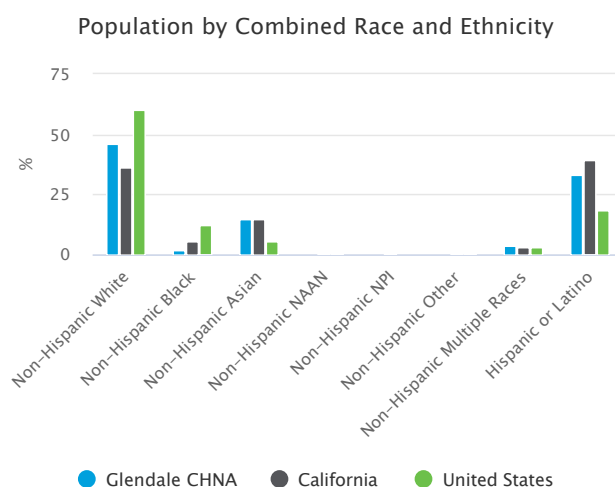
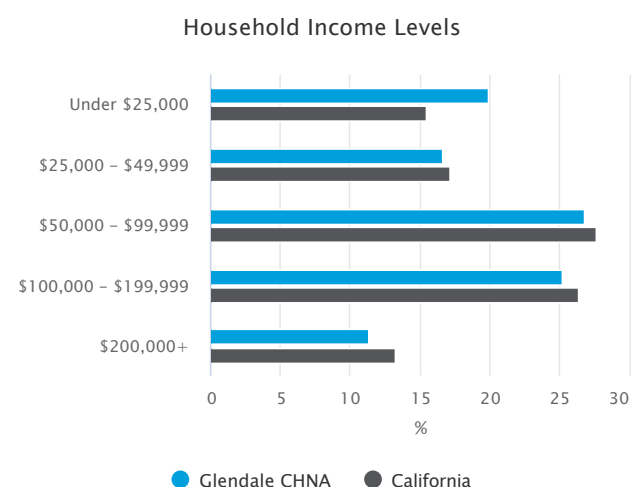
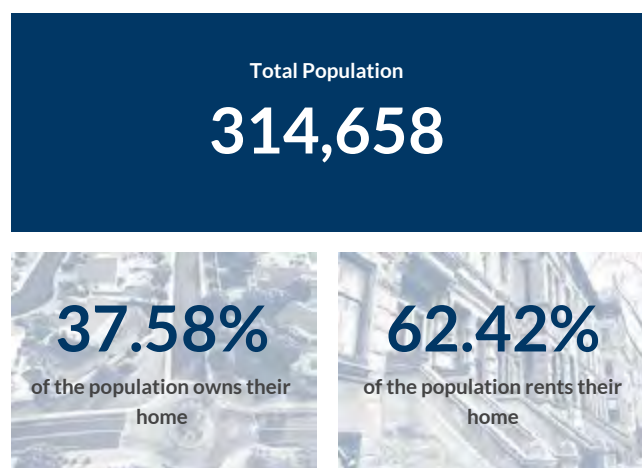
The conditions in which we live, work and play have an enormous impact on our health long before we ever see a doctor—these are the principles of well-being. A key aspect of our strategy to support individual, organizational and community well-being is our relationship with Blue Zones®, a pioneer in 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

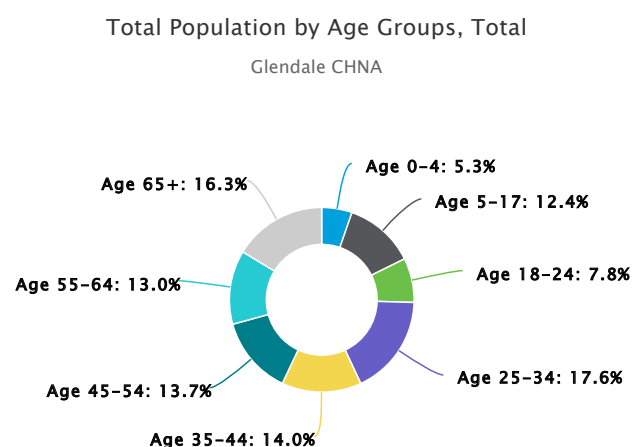
DEMOGRAPHIC PROFILE

The following zip codes represent Adventist Health Glendale'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 Glendale CHNA market has a total population of 314,658 (based on the 2020 Decennial Census). The largest city in the service area is Glendale, with a population of 191,761. The service area is comprised of the following zip codes: 91020, 91201, 91206, 91203, 91205, 90065, 91207, 90041, 91204, 90042, 91208, 91202.



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
Housing	See Sections III.C - E
Lower Priority Needs	
Community Safety 211info.org/get-help/employment/	This community has higher rates of unemployed and out-of-school youth aged 16-19 than the state or the US, major vehicle crash mortality, and injury mortality.
Housing-Unhoused 211info.org/get-help/housing-shelter/	The limited number of available housing units and the overall high cost of living are critical drivers to homelessness. 57% of those surveyed identified homelessness as a health need in the community.
Health Risk Behaviors 211info.org/get-help/mental-behavioral-health/	This community has higher rates of adulting smoking, teen birth rates, and low birthweight births than the rest of the state. There are concerns among interviewees that illicit drug use is a pervasive problem as well.
Health Conditions 211info.org/get-help/health-care/	The prevalence rates of diabetes, heart disease, and cancer are higher than the state average. Similarly, mortality rates for liver and lung disease are also elevated compared to Oregon as a whole.
Education 211info.org/get-help/education/	Difficulty recruiting and retaining teachers, coupled with limited afterschool options, hamper educational opportunities for students. Adequate and reasonably priced childcare access is also a problem for many families.
COVID 211info.org/get-help/health-care/	Around 60% of those surveyed identified COVID as a community health need.
Environment & Infrastructure 211info.org/get-help/transportation/	With limited public transportation in a rural area it is often difficult for many to access needed services. Land use also affects housing and recreational opportunities.
Mental Health 211info.org/get-help/mental-behavioral-health/	The need for mental health services has grown during COVID while the number of providers and the overall range of services has either been reduced or not matched the expanded need. Around 60% of those surveyed consider mental health a community health need.

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 locals involved in the healthcare and public health system. These were conducted in-person and virtually. This information was collected by the Adventist Health Community Well-Being team, Biel Consulting, Inc. 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, 7 focus groups were conducted with 61 participants, and 23 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

- ▶ Seven (7) focus groups
- ▶ Sixty-one (61) people participated

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

KEY INFORMANTS

- ▶ Twenty-three (23) 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 Glendale, Armenian Society, Ascencia, Bold Law, City of Glendale, City of Glendale Community Services & Parks Department, City of Glendale Fire Department, Dignity Health, Glendale City College District, Glendale City Seventh-day Adventist Church, Glendale Unified School District, Family Promise of the Verdugos, IPA Preferred, Kids' Community Dental Clinic, Korean Americans Family Services, Los Angeles Department of Public Health, Los Angeles LGBT Center, National Alliance of Mental Illness Glendale, Police Department, State Senate, and YMCA Glendale & Pasadena

REPRESENTED RACE/ETHNICITIES

Armenian, Korean, Hispanic, Multi-Race and White

REPRESENTED POPULATIONS

Civic government and community-based organizations focusing on children, education, faith, healthcare, higher education, law enforcement, LGBT community, low-income, medically underserved, mental health, minority populations, providers, and public health 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	Glendale	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	15%	15%





C. Access to Care

Glendale residents face a number of large 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. Glendale has a limited number of mental health care providers — about half that of California and the US. Additionally, 7.9% of the population is uninsured as compared to 7.2% in California. This rate is much higher for Native Americans or Alaska Native people in the community (15.7%), as well as those of some other race (14.6%).

Of households in Glendale, 9.9% have no motor vehicle as compared to 7% in California and 8.5% in the US. This rate is mitigated by the extremely high rate of the population living close to public transit (87.1%) as compared to both California (62.3%) and the US (34.8%).

The adult population in Glendale without a high school diploma is 14.85% and is above that of the US (11.47%). In addition, 28.57% of the population age five and older have limited English proficiency, creating barriers to healthcare access, provider communications, and health literacy/education. This rate is significantly higher than that of California (17.41%) and the US (8.25%).



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PRIMARY COMMENTS

FOCUS GROUPS COMMENTS (PARAPHRASED FROM PRIMARY DATA INTERVIEW NOTES)

- People with inadequate insurance and who don't speak English as a first language struggle to access good quality care, interviewees noted.
- Residents will forgo some medical care if they can't afford it, with dental visits being one cited example.
- There is a strong desire by interviewees to ensure equal care regardless of insurance status.
- Trust is seen as a critical, but difficult to establish, part of the patient/provider relationship by community members.
- People noted cultural barriers to care exist for many groups in the community.
- During focus groups it was stated that public transportation availability, such as bus schedules, can make it hard to get to the doctor.
- Even those who have insurance often pay excessively to get care, it was stated.

KEY INFORMANT COMMENTS

- Interviewees said the inadequate number of providers makes it difficult for everyone to get appointments.
- Inconsistent access to care leads to chronic diseases becoming major medical problems, in the eyes of some.
- Translation services, especially in Spanish and Armenian, are seen as critically important to community members.
- Experience with the healthcare system is largely defined by the type of insurance you have, interviewees stated.
- People interviewed said many patients are confused about their healthcare options due to the complicated rules of their insurance.
- Interviewees noted legal status as a problem in accessing care.
- Older residents are seen as being financially limited when it comes to getting the healthcare they need.
- Housing insecurity, food insecurity, lack of being able to navigate the health care system, discrimination, stigma surrounding mental health, and financial barriers are limiting quality of life and health for many residents, it was noted during interviews.
- Home nursing is seen as a way to ensure more residents get timely care, according to those interviewed.

Secondary Data Summary

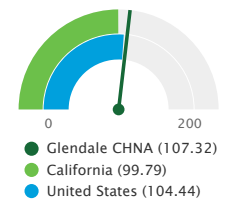
Access to Care

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 number of 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.

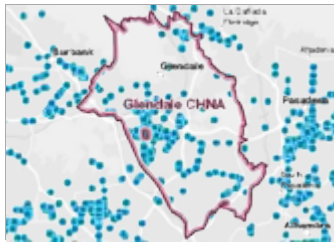
Report Area	Total Population (2020)	Number of Facilities	Number of Providers	Providers, Rate per 100,000 Population
Glendale CHNA	314,462	202	337	107.32
Los Angeles County, CA	10,014,009	4,193	10,158	101.44
California	39,538,223	12,051	39,455	99.79
United States	334,735,155	117,465	349,603	104.44

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
- Glendale CHNA

Barriers - Medical Insurance - Population without Medical Insurance

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

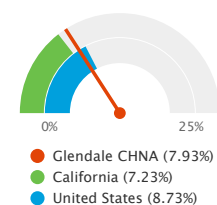
In the report area 7.93% of the total civilian non-institutionalized population are without health insurance coverage. The rate of uninsured persons in the report area is greater than the state average of 7.23%. This indicator is relevant because lack of insurance is a primary barrier to healthcare access 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
Glendale CHNA	323,468	25,657	7.93%
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%

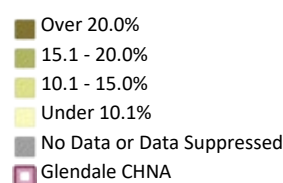
Note: This indicator is compared to the state average.

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

Uninsured Population, Percent



Uninsured Population, Percent by Tract, ACS 2016-20



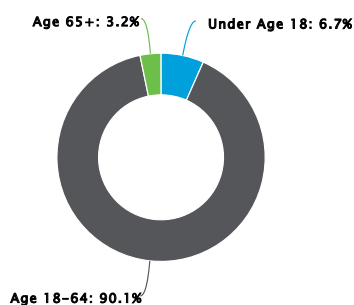
Uninsured Population by Age Group, Total

This indicator reports the total uninsured population by age group.

Report Area	Under Age 18	Age 18-64	Age 65+
Glendale CHNA	1,707	23,120	830
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

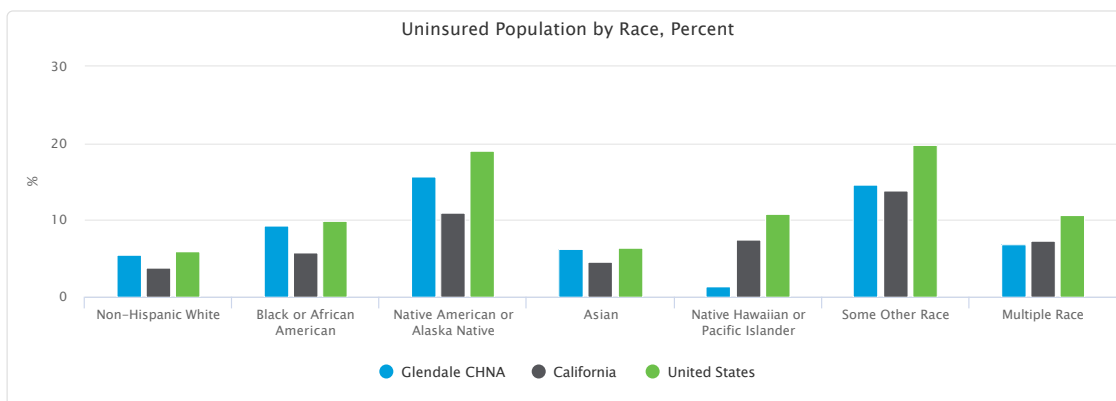
Glendale CHNA



Uninsured Population by Race, Percent

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

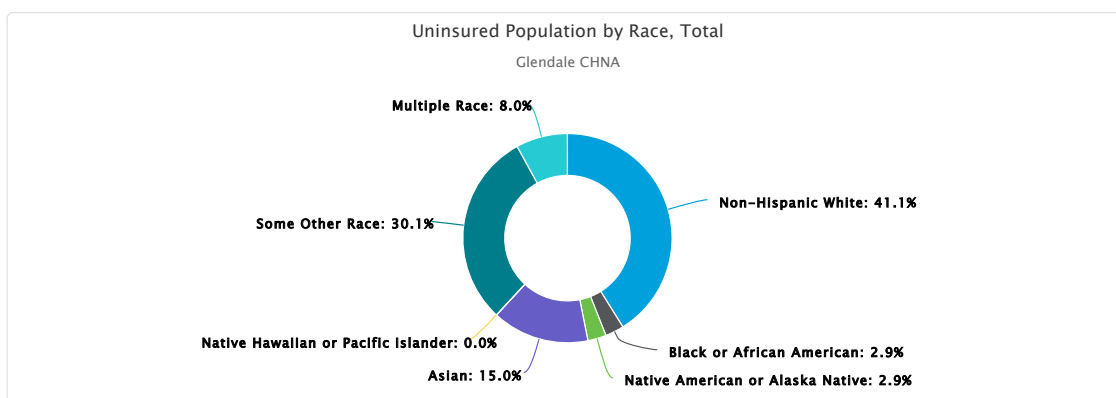
Report Area	Non-Hispanic White	Black or African American	Native American or Alaska Native	Asian	Native Hawaiian or Pacific Islander	Some Other Race	Multiple Race
Glendale CHNA	5.48%	9.22%	15.69%	6.21%	1.40%	14.59%	6.81%
California	3.87%	5.85%	11.02%	4.50%	7.47%	13.82%	7.24%
United States	5.93%	9.94%	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.

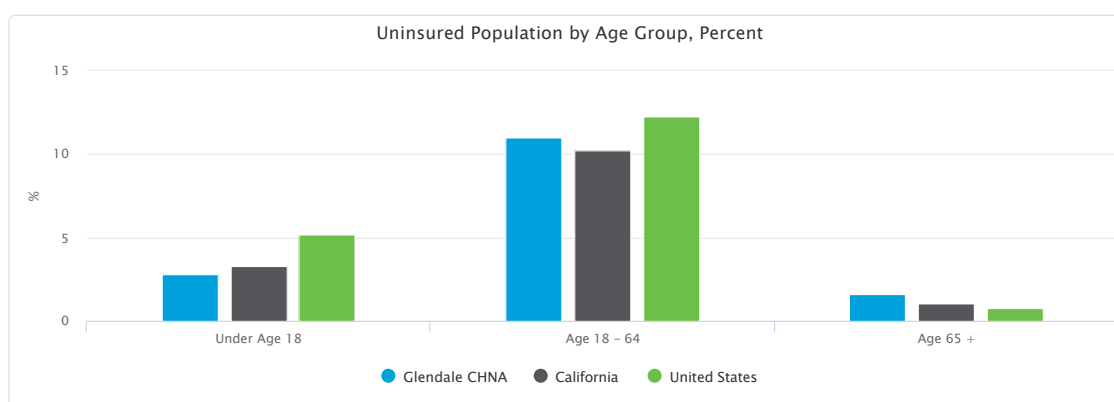
Report Area	Non-Hispanic White	Black or African American	Native American or Alaska Native	Asian	Native Hawaiian or Pacific Islander	Some Other Race	Multiple Race
Glendale CHNA	8,204	579	569	2,995	6	6,008	1,591
California	547,635	126,535	33,530	261,111	10,979	768,688	223,444
United States	11,475,294	3,972,510	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.

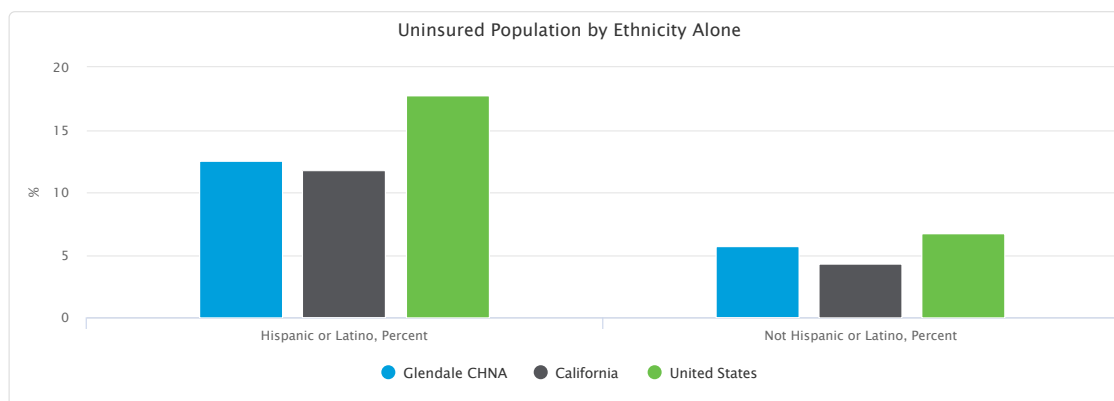
Report Area	Under Age 18	Age 18 - 64	Age 65 +
Glendale CHNA	2.80%	10.98%	1.60%
Los Angeles County, CA	3.64%	12.81%	1.52%
California	3.26%	10.24%	1.06%
United States	5.18%	12.26%	0.79%



Uninsured Population by Ethnicity Alone

This indicator reports the uninsured population by ethnicity alone.

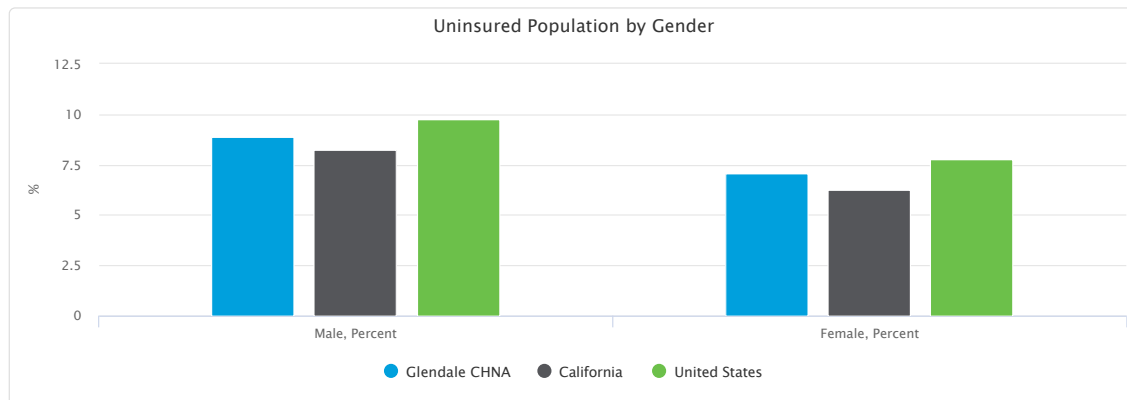
Report Area	Hispanic or Latino	Not Hispanic or Latino	Hispanic or Latino, Percent	Not Hispanic or Latino, Percent
Glendale CHNA	13,375	12,282	12.48%	5.68%
California	1,793,633	1,012,540	11.79%	4.29%
United States	10,382,464	17,676,439	17.72%	6.72%



Uninsured Population by Gender

This indicator reports the uninsured population by gender.

Report Area	Male	Female	Male, Percent	Female, Percent
Glendale CHNA	13,883	11,774	8.89%	7.04%
California	1,580,869	1,225,304	8.25%	6.23%
United States	15,300,004	12,758,899	9.74%	7.76%

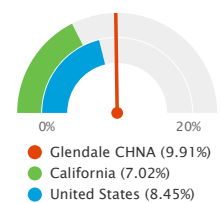


Barriers - Transportation - Households with No Vehicle

This indicator reports the number and percentage of households with no motor vehicle based on the latest 5-year American Community Survey estimates. Of the 118,810 total households in the report area, 11,780 or 9.91% are without a motor vehicle

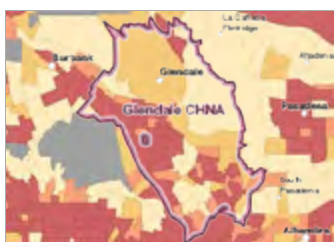
Report Area	Total Occupied Households	Households with No Motor Vehicle	Households with No Motor Vehicle, Percent
Glendale CHNA	118,810	11,780	9.91%
Los Angeles County, CA	3,332,504	293,326	8.80%
California	13,103,114	920,362	7.02%
United States	122,354,219	10,344,521	8.45%

Percentage of Households with No Motor Vehicle

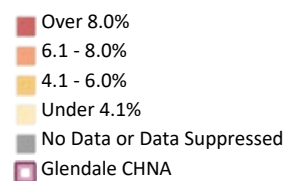


Note: This indicator is compared to the state average.

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

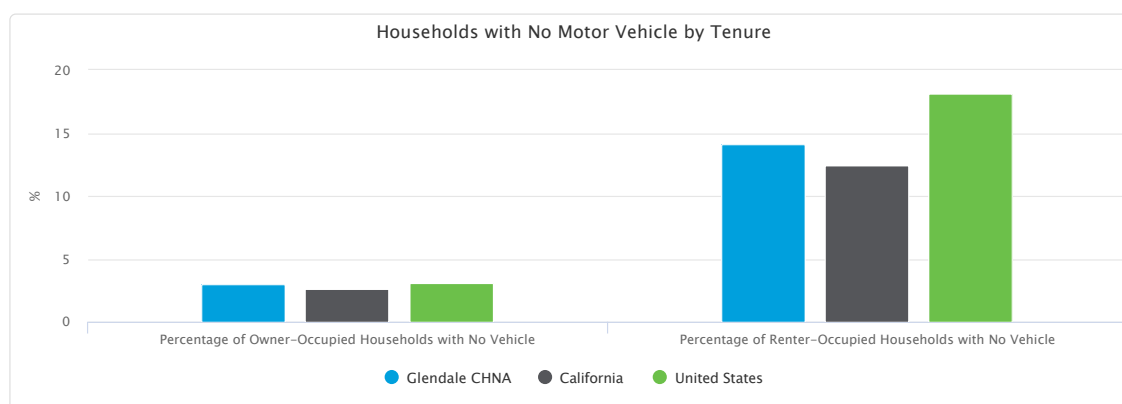


Households with No Vehicle, Percent by Tract, ACS 2016-20



Households with No Motor Vehicle by Tenure

Report Area	Owner-Occupied Households	Owner-Occupied Households, Percent	Renter-Occupied Households	Renter-Occupied Households, Percent
Glendale CHNA	1,341	3.00%	10,439	14.08%
Los Angeles County, CA	45,352	2.96%	247,974	13.79%
California	192,132	2.65%	728,230	12.42%
United States	2,457,633	3.12%	7,886,888	18.11%

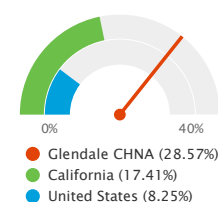


Barriers - Health Literacy - Limited English Proficiency

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 307,991 total population aged 5 and older in the report area, 88,001 or 28.57% have limited English proficiency.

Report Area	Population Age 5+	Population Age 5+ with Limited English Proficiency	Population Age 5+ with Limited English Proficiency, Percent
Glendale CHNA	307,991	88,001	28.57%
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

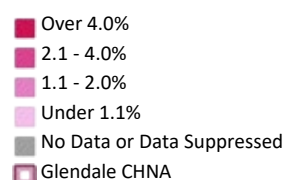


Note: This indicator is compared to the state average.

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



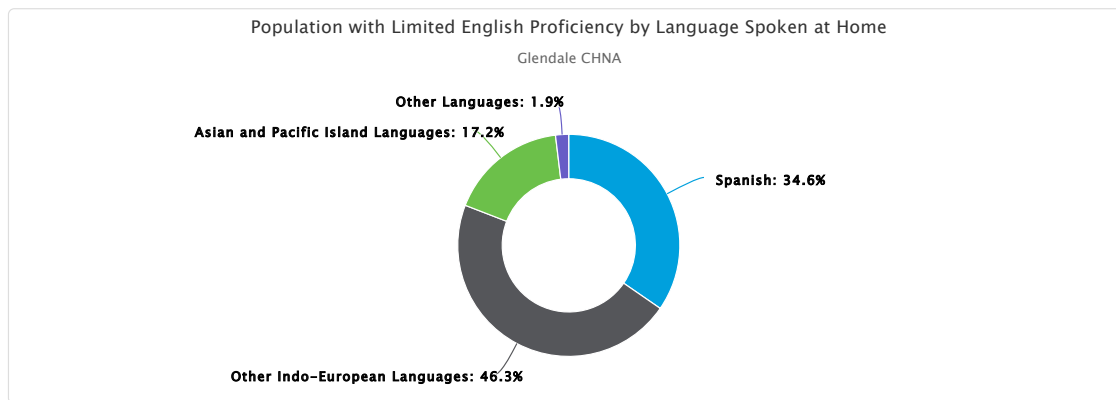
Population with Limited English Proficiency, Percent by Tract, ACS 2016-20



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.

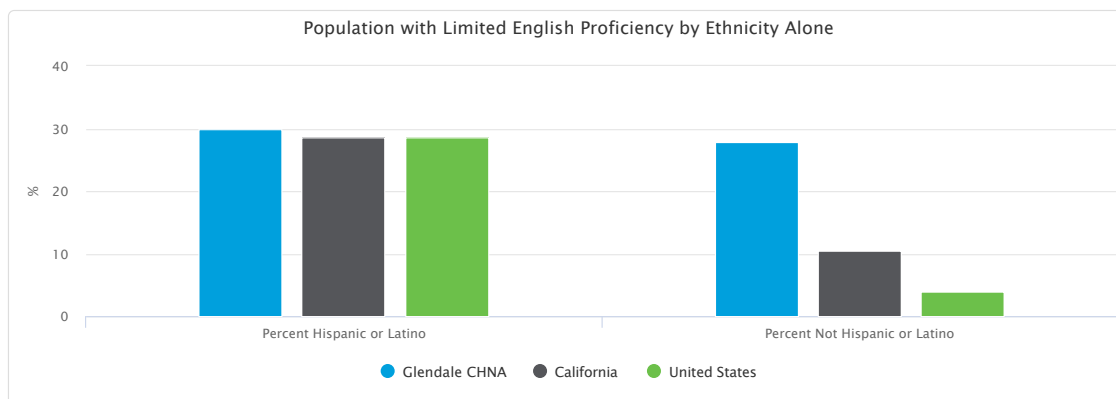
Report Area	Spanish	Other Indo-European Languages	Asian and Pacific Island Languages	Other Languages
Glendale CHNA	30,462	40,711	15,142	1,686
Los Angeles County, CA	1,458,177	180,483	521,211	31,213
California	4,083,013	499,656	1,720,073	129,360
United States	15,949,582	3,422,525	4,886,876	1,053,041



Population with Limited English Proficiency by Ethnicity Alone

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 ethnicity alone in the report area.

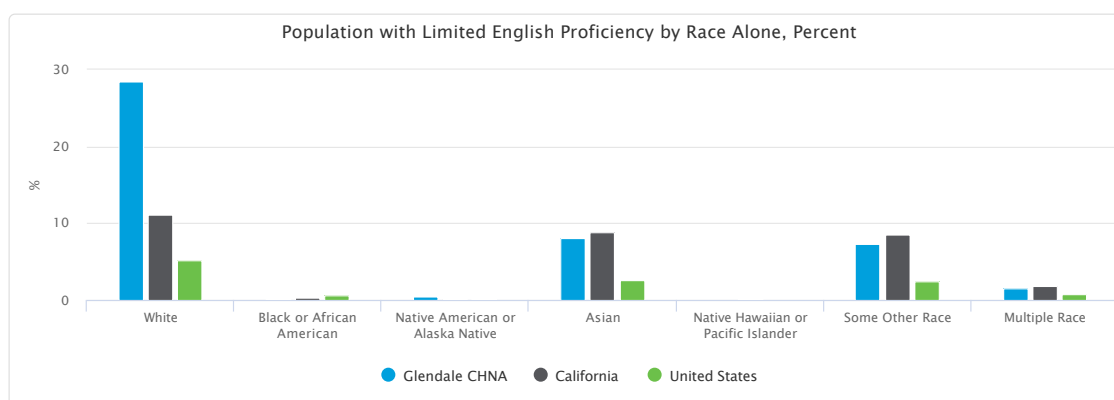
Report Area	Total Hispanic or Latino	Total Not Hispanic or Latino	Percent Hispanic or Latino	Percent Not Hispanic or Latino
Glendale CHNA	30,244	57,757	29.94%	27.91%
Los Angeles County, CA	1,447,678	743,406	32.07%	15.07%
California	4,048,196	2,383,906	28.56%	10.47%
United States	15,590,137	9,721,887	28.69%	3.85%



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.

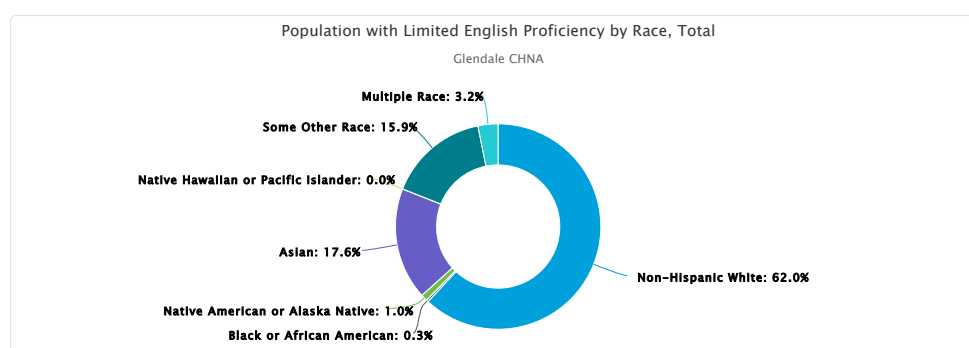
Report Area	White	Black or African American	Native American or Alaska Native	Asian	Native Hawaiian or Pacific Islander	Some Other Race	Multiple Race
Glendale CHNA	28.47%	0.15%	0.48%	8.10%	0.01%	7.29%	1.45%
Los Angeles County, CA	17.61%	0.32%	0.39%	11.82%	0.05%	15.44%	2.59%
California	11.14%	0.23%	0.21%	8.84%	0.08%	8.58%	1.77%
United States	5.12%	0.55%	0.09%	2.55%	0.03%	2.48%	0.82%

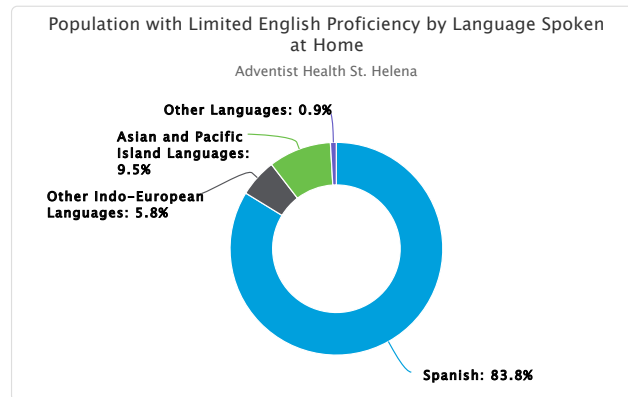


Population with Limited English Proficiency by Race, Total

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

Report Area	Non-Hispanic White	Black or African American	Native American or Alaska Native	Asian	Native Hawaiian or Pacific Islander	Some Other Race	Multiple Race
Glendale CHNA	54,535	279	915	15,515	10	13,967	2,780
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

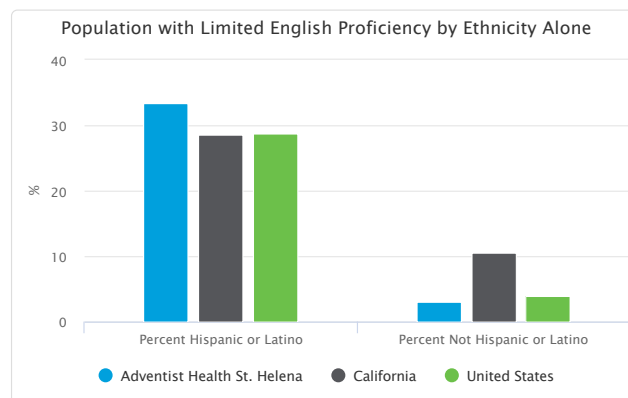




Population with Limited English Proficiency by Ethnicity Alone

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 ethnicity alone in the report area.

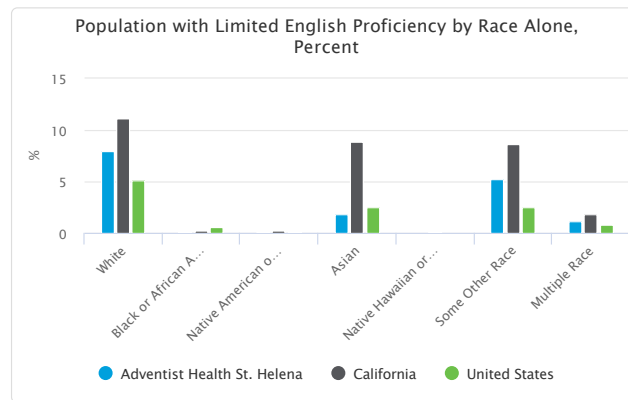
Report Area	Total Hispanic or Latino	Total Not Hispanic or Latino	Percent Hispanic or Latino	Percent Not Hispanic or Latino
Adventist Health St. Helena	18,696	4,034	33.40%	2.98%
Lake County, CA	2,915	596	23.67%	1.24%
Napa County, CA	15,781	3,438	36.05%	3.91%
Sonoma County, CA	41,972	9,588	33.95%	2.75%
California	4,048,196	2,383,906	28.56%	10.47%
United States	15,590,137	9,721,887	28.69%	3.85%



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.

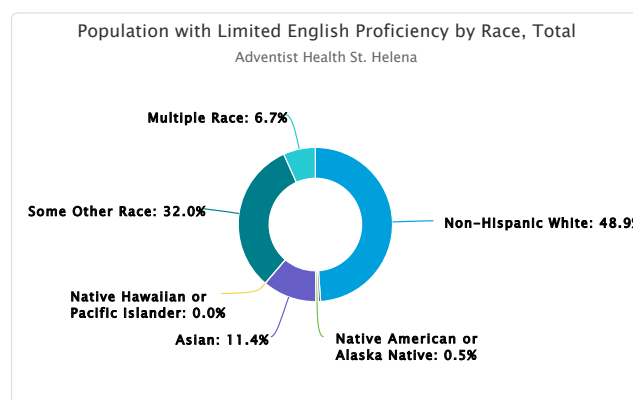
Report Area	White	Black or African American	Native American or Alaska Native	Asian	Native Hawaiian or Pacific Islander	Some Other Race	Multiple Race
Adventist Health St. Helena	7.95%	0.08%	0.09%	1.85%	0.00%	5.20%	1.09%
Lake County, CA	3.36%	0.08%	0.00%	0.48%	0.00%	3.13%	0.49%
Napa County, CA	10.14%	0.08%	0.13%	2.50%	0.00%	6.17%	1.38%
Sonoma County, CA	3.82%	0.24%	0.19%	1.85%	0.04%	7.87%	0.91%
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%



Population with Limited English Proficiency by Race, Total

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

Report Area	Non-Hispanic White	Black or African American	Native American or Alaska Native	Asian	Native Hawaiian or Pacific Islander	Some Other Race	Multiple Race
Adventist Health St. Helena	11,121	107	119	2,582	2	7,272	1,527
Lake County, CA	1,564	36	0	223	2	1,459	227
Napa County, CA	9,557	71	119	2,359	0	5,813	1,300
Sonoma County, CA	13,198	824	648	6,394	134	27,220	3,142
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



D. Health Conditions

Having a population with a higher than average burden of major health conditions, especially chronic conditions, is a social, environmental, and healthcare difficulty for any community. The presence of one or more chronic conditions in particular is a driver of lower quality of life and greater healthcare expenditures. Glendale faces some important challenges in this regard.

The death rate from health disease and stroke is 150.3 per 100k people and is slightly elevated than that of California at 141.3. The percentage of adults with cancer (5.8%) is slightly elevated as well from that of California (5.5%). The percentage of Medicare beneficiaries with Alzheimer's disease is 14.6% and is higher than both the rate in California (10.5%) and in the nation (10.8%). Liver disease mortality rate is slightly elevated (13.2 per 100k people) than in California (12.5) and in the US (11.5).



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PRIMARY COMMENTS

FOCUS GROUPS

- Poor health and dietary choices, often driven by expense, are seen as major contributors to health problems by community members spoken to.
- It's hard to get affordable food, per interviewees.
- During interviews it was stated that people walk around parks and exercise to beat diabetes.

KEY INFORMANT COMMENTS

- Social isolation, driven by COVID, has led some to avoid medical care, which will likely have long-term consequences. This was a concern expressed by community leaders.
- People reported increased consumption of processed foods, resulting in higher incidences of cardiac cases and diabetes.
- "Increased rates of substance abuse are seen as drivers of poor health."
- Deferred preventative services and limited specialty care means that some will be much more ill when they begin treatment than they would be otherwise, interviewees stated.
- Community leaders stated school closures limited sports participation for many youth.
- Some interviewees stated patients with diabetes not managing their blood sugars and patients with heart disease who are still smoking will have worse health outcomes over time.
- During lockdown, people were less active. Opportunities to be physically active declined with the pandemic, some interviewees noted.
- Interviewees were concerned that often people can only afford fast food and that leads to diabetes and high cholesterol.
- During the pandemic, the food pantries would be accessible to the community twice a month and just starting a couple of months ago, they reduced it down to once a month. So there is a reduction in the free food that people have access to.



Secondary Data Summary

Health Conditions

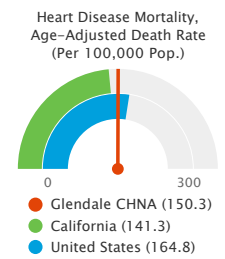
Heart Disease & Stroke - Heart Disease & Stroke Mortality

This indicator reports the 2016-2020 five-year average rate of death due to heart disease (ICD10 Codes I00-I09, I11, I13, I20-I25) per 100,000 population. Figures are reported as crude rates, and as rates age-adjusted to year 2000 standard. Rates are resummized for report areas from county level data, only where data is available. This indicator is relevant because heart disease is a leading cause of death in the United States.

Within the report area, there are a total of 2,652 deaths due to heart disease. This represents an age-adjusted death rate of 150.3 per every 100,000 total population.

Note: Data are suppressed for counties with fewer than 20 deaths in the time frame.

Report Area	Total Population, 2016-2020 Average	Five Year Total Deaths, 2016-2020 Total	Crude Death Rate (Per 100,000 Population)	Age-Adjusted Death Rate (Per 100,000 Population)
Glendale CHNA	316,464	2,652	167.6	150.3
Los Angeles County, CA	10,077,819	84,451	167.6	150.3
California	39,444,803	315,849	160.1	141.3
United States	326,747,554	3,294,101	201.6	164.8

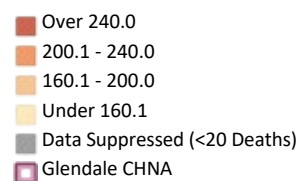


Note: This indicator is compared to the state average.

Data Source: Centers for Disease Control and Prevention, CDC - National Vital Statistics System. Accessed via CDC WONDER. 2016-2020. Source geography: County



Heart Disease Mortality, Age Adj. Rate (Per 100,000 Pop.) by County, CDC NVSS 2016-20

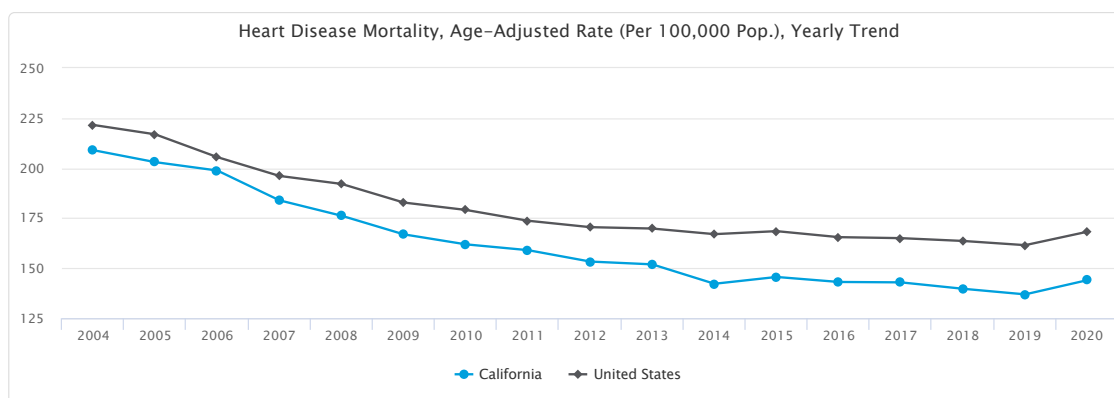


Heart Disease Mortality, Age-Adjusted Rate (Per 100,000 Pop.), Yearly Trend

This indicator reports age-adjusted rate of death due to heart disease per 100,000 people over time.

Report Area	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
California	209.0	203.0	198.8	183.9	176.2	166.9	161.9	159.0	153.3	151.9	142.2	145.6	143.1	142.9	139.7	136.9	144.0
United States	221.6	216.9	205.5	196.1	192.1	182.8	179.1	173.7	170.5	169.8	167.0	168.5	165.5	165.0	163.6	161.5	168.2

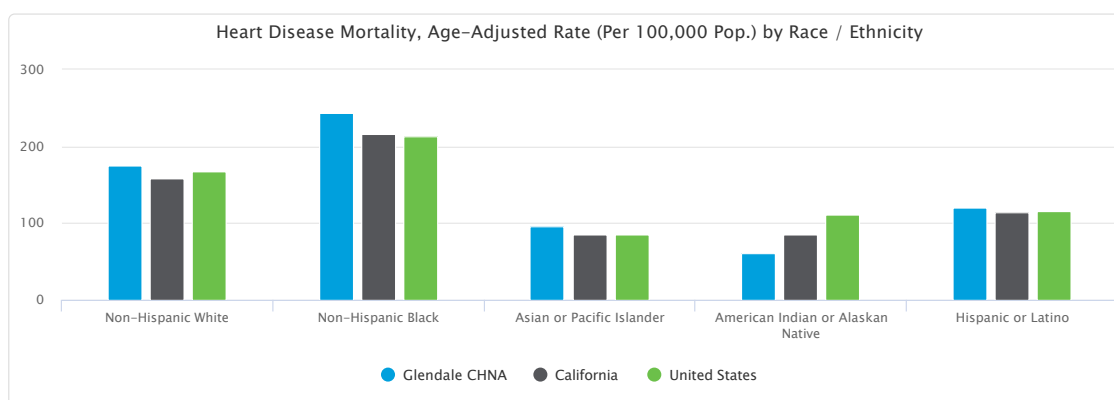
Note: No county data available. See data source and methodology for more details.



Heart Disease Mortality, Age-Adjusted Rate (Per 100,000 Pop.) by Race / Ethnicity

This table reports the age-adjusted rate of death due to heart disease per 100,000 people by race and Hispanic origin.

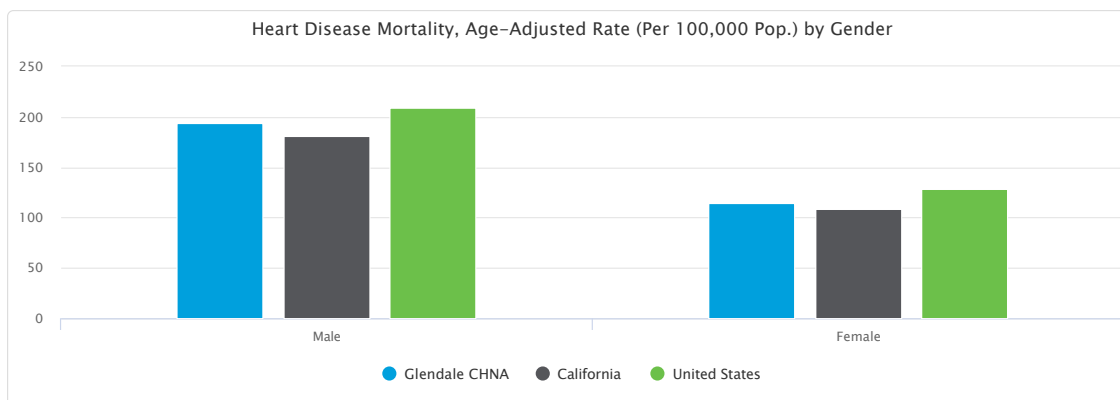
Report Area	Non-Hispanic White	Non-Hispanic Black	Asian or Pacific Islander	American Indian or Alaskan Native	Hispanic or Latino
Glendale CHNA	175.3	244.4	95.8	61.4	119.9
Los Angeles County, CA	175.3	244.4	95.8	61.4	119.9
California	158.4	216.6	86.0	85.3	114.0
United States	168.2	212.6	85.6	111.7	115.3



Heart Disease Mortality, Age-Adjusted Rate (Per 100,000 Pop.) by Gender

This table reports the age-adjusted rate of death due to heart disease per 100,000 people by gender.

Report Area	Male	Female
Glendale CHNA	194.1	115.0
Los Angeles County, CA	194.1	115.0
California	181.0	108.6
United States	208.9	128.8

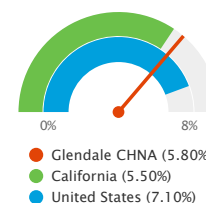


Cancers - Cancer

This indicator reports the number and percentage of adults age 18 and older who report ever having been told by a doctor, nurse, or other health professional that they have any other types (besides skin) of cancer.

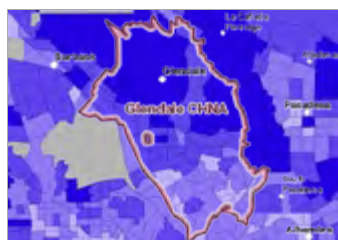
Report Area	Total Population (2019)	Percentage of Adults with Cancer
Glendale CHNA	316,193	5.80%
Los Angeles County, CA	10,039,107	5.00%
California	39,512,223	5.50%
United States	328,239,523	7.10%

Percentage of Adults with Cancer

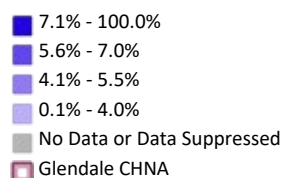


Note: This indicator is compared to the state average.

Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal. 2019. Source geography: Tract



Cancer, Prevalence Among Adults Age 18+ by Tract, CDC BRFSS PLACES Project 2019

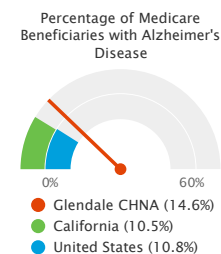


Chronic Brain Disorders - Alzheimer's Disease Prevalence

This indicator reports the number and percentage of Medicare fee-for-service population with Alzheimer's Disease. Data are based upon Medicare administrative enrollment and claims data for Medicare beneficiaries enrolled in the fee-for-service program.

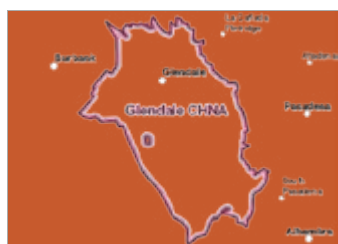
Within the report area, there were 2,639 beneficiaries with Alzheimer's Disease based on administrative claims data in the latest report year. This represents 14.6% of the total Medicare fee-for-service beneficiaries

Report Area	Total Medicare Fee-for-Service Beneficiaries	Beneficiaries with Alzheimer's Disease	Beneficiaries with Alzheimer's Disease, Percent
Glendale CHNA	18,032	2,639	14.6%
Los Angeles County, CA	574,246	84,048	14.6%
California	2,859,642	299,482	10.5%
United States	33,499,472	3,610,640	10.8%

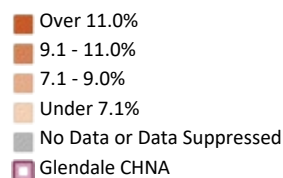


Note: This indicator is compared to the state average.

Data Source: Centers for Medicare & Medicaid Services, CMS - Chronic Conditions Warehouse. 2018. Source geography: County



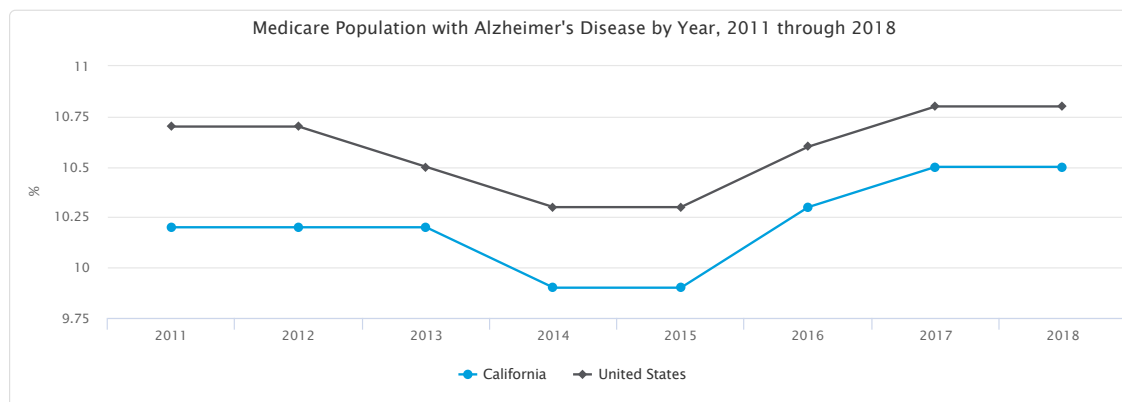
Beneficiaries with Alzheimer's Disease, Percent by County, CMS 2018



Medicare Population with Alzheimer's Disease by Year, 2011 through 2018

This indicator reports the percentage of the Medicare fee-for-service population with Alzheimer's Disease over time.

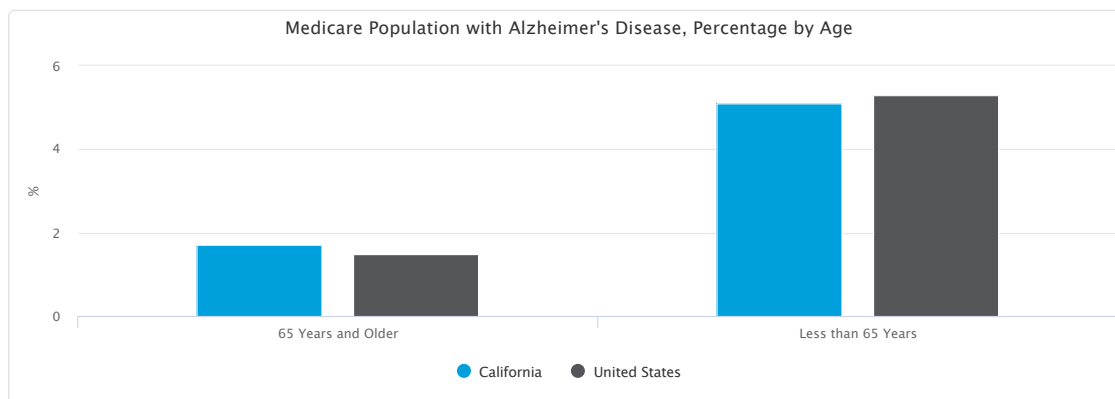
Report Area	2011	2012	2013	2014	2015	2016	2017	2018
Los Angeles County, CA	12.5%	12.9%	13.2%	13.0%	13.0%	13.8%	14.4%	14.6%
California	10.2%	10.2%	10.2%	9.9%	9.9%	10.3%	10.5%	10.5%
United States	10.7%	10.7%	10.5%	10.3%	10.3%	10.6%	10.8%	10.8%



Medicare Population with Alzheimer's Disease, Percentage by Age

This indicator reports the prevalence of Alzheimer Disease among Medicare beneficiaries by age.

Report Area	65 Years and Older	Less than 65 Years
Los Angeles County, CA	1.4%	4.9%
California	1.7%	5.1%
United States	1.5%	5.3%



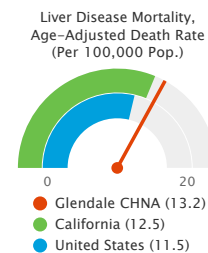
Kidney & Liver Diseases - Liver Disease Mortality

This indicator reports the 2016-2020 five-year average rate of death due to liver disease per 100,000 population. Figures are reported as crude rates, and as rates age-adjusted to year 2000 standard. Rates are resummized for report areas from county level data, only where data is available. This indicator is relevant because liver disease is a leading cause of death in the United States.

Within the report area, there are a total of 231 deaths due to liver disease. This represents an age-adjusted death rate of 13.2 per every 100,000 total population.

Note: Data are suppressed for counties with fewer than 20 deaths in the time frame.

Report Area	Total Population, 2016-2020 Average	Five Year Total Deaths, 2016-2020 Total	Crude Death Rate (Per 100,000 Population)	Age-Adjusted Death Rate (Per 100,000 Population)
Glendale CHNA	316,464	231	14.6	13.2
Los Angeles County, CA	10,077,819	7,362	14.6	13.2
California	39,444,803	27,757	14.1	12.5
United States	326,747,554	221,126	13.5	11.5



Note: This indicator is compared to the state average.

Data Source: Centers for Disease Control and Prevention, CDC - National Vital Statistics System. Accessed via CDC WONDER. 2016-2020. Source geography: County

E. Mental Health

Glendale has a limited number of mental health care providers, and with 77.11 mental health providers per 100k people, it is significantly less than the rate in California (150.31) and in the US (132.27).

The violent crime rate, including homicide, rape, robbery, and aggravated assault is 488.3 per 100k people and is elevated than both that of California (420.9) and the US (386.5). Living in an unsafe community elevates stress and the need for mental health services.

7.52% of the civilian non-institutionalized age 16 and older population of Glendale is unemployed compared to 6.18% in California and 5.38% in the United States. The rate is higher for Black people in the community (12.28%) and for people of multiple races (10.36%).



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PRIMARY COMMENTS

FOCUS GROUPS

- The limited socialization caused by COVID is seen as a driver of depression, especially in youth, per focus group participants.
- There are worries that housing instability and the high cost of living increase anxiety levels for many.
- Mental health services are seen as stigmatized, causing some not to seek services.
- Unstably housed community members, the older adult population, and people with substance use problems are seen as more likely to experience mental health problems.
- Inadequate mental health care overall, and for specific populations like new mothers, is seen as a major problem.
- Access to mental health professionals is not believed to be possible for all community residents.
- Integrated care is seen as the preferred treatment for people with chronic mental health needs.
- Insurance status greatly affects the ability get mental health care.

KEY INFORMANT COMMENTS

- Mental health issues are seen as taboo in some cultures, leading to less access to care.
- Teen mental health is seen as a large and growing problem.
- There is a deficiency in the number of mental health providers that are accessible for those who are uninsured or underinsured, an interviewee indicated.
- With mental health, no one is exempt. Some might hide it better than others, but mental health concerns impact people across the spectrum of income and class, as stated by one interviewee.
- People are seen as experiencing more mental health issues with the pandemic.
- Interviewees noted that many mental health professionals are seen as not accepting insurance.
- Substance abuse problems are seen as a symptom of mental health challenges for many.
- Religion was noted as a possible barrier to mental health care, with people seeking support from spiritual leaders rather than professionals.
- Pediatric mental health has become significantly worse with the pandemic community members believe.
- It was stated that there are no LGBTQ identified mental illness or substance abuse homes and inpatient treatment centers in the area.
- It is believed having to share living spaces due to financial constraints can contribute to mental health challenges.
- People note there are never enough senior resources for physical or mental health.

Secondary Data Summary

Mental Health

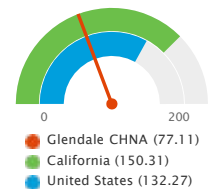
Risk Factors - Access to Care - Access to Mental Health Providers

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 242 mental health providers with a CMS National Provider Identifier (NPI). This represents 77.11 providers per 100,000 total population.

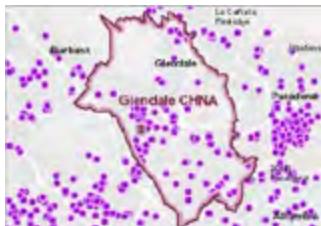
Report Area	Total Population (2020)	Number of Facilities	Number of Providers	Providers, Rate per 100,000 Population
Glendale CHNA	314,462	36	242	77.11
Los Angeles County, CA	10,014,009	1,493	13,419	134.00
California	39,538,223	5,078	59,430	150.31
United States	334,735,155	56,424	442,757	132.27

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
- Glendale 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.

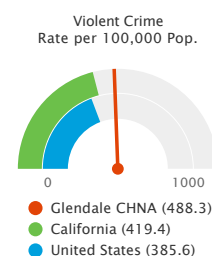
In the report area, 1,556 violent crimes occurred in 2014 and 2016 (two years). The violent crime rate of 488.3 per 100,000 residents is higher than the statewide rate of 419.4 per 100,000.

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.)
Glendale CHNA	1,556	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, *for Political and Social Research*. 2014.

Additional analysis by the National Archive of Criminal Justice Data. Accessed via the Inter-university Consortium



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
- Glendale CHNA

Risk Factors - Stress & Trauma - Unemployment

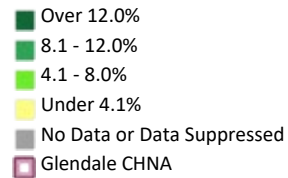
According to the most recent the American Community Survey estimates, total unemployment in the report area is 13,375, or 7.52% of the civilian non-institutionalized population age 16 and older. This indicator is relevant because unemployment creates financial instability and barriers to access including insurance coverage, health services, healthy food, and other necessities that contribute to poor health status.

Report Area	Labor Force	Number Unemployed	Unemployment Rate
Glendale CHNA	177,852	13,375	7.52%
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



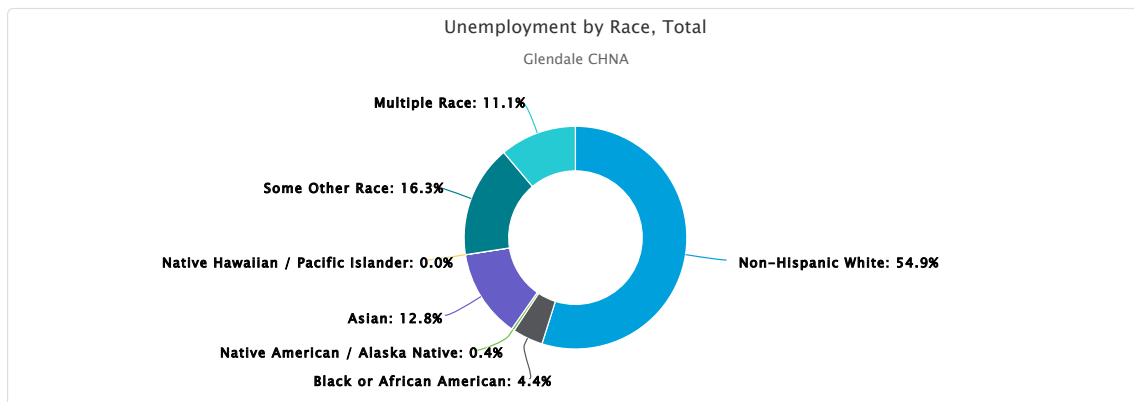
Unemployed Workers, Percent by Tract, ACS 2016-20



Unemployment by Race, Total

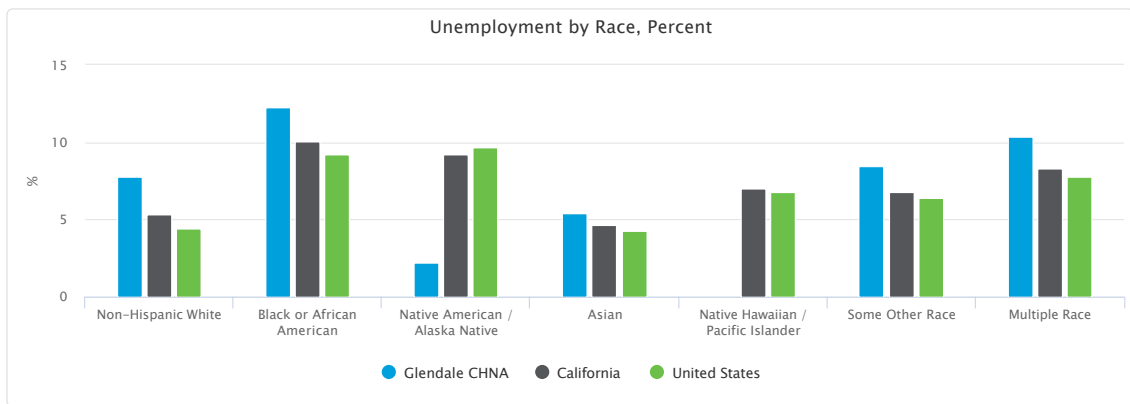
Data Source: US Census Bureau, American Community Survey. 2016-20. Source geography: Tract

Report Area	Non-Hispanic White	Black or African American	Native American / Alaska Native	Asian	Native Hawaiian / Pacific Islander	Some Other Race	Multiple Race
Glendale CHNA	6,355	513	47	1,488	0	1,889	1,290
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
Glendale CHNA	7.79%	12.28%	2.22%	5.41%	0.00%	8.42%	10.36%
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%



F. 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.

G. 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.

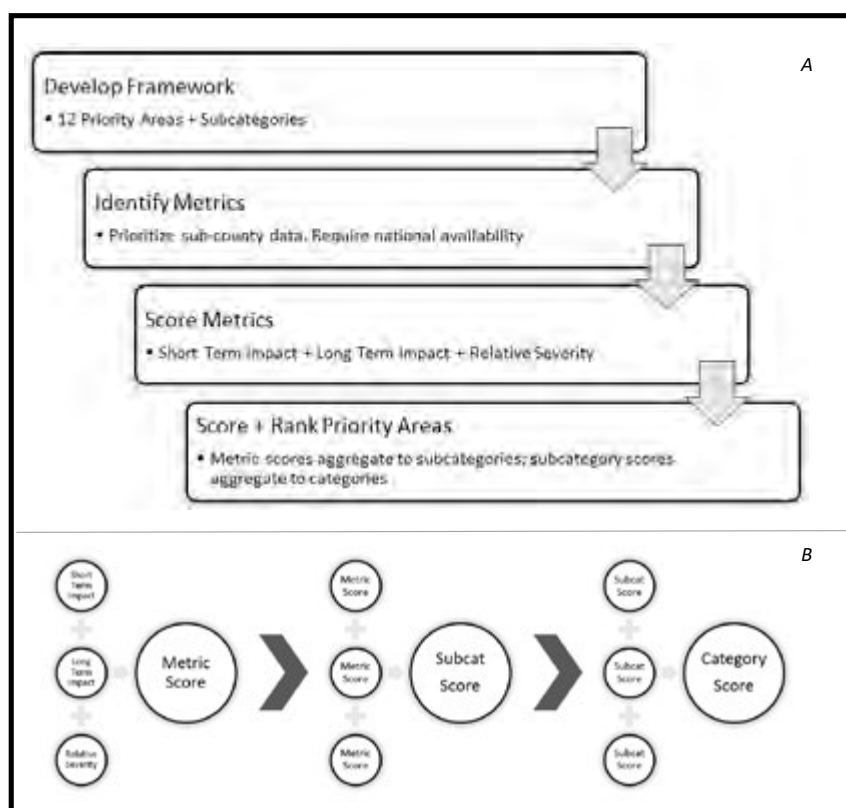


Figure 1. A. Approach to framework and scoring methodology development. B. Diagram of scoring approach.

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.

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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 participants included a broad range of stakeholders concerned with health and wellbeing. 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 health and wellbeing stakeholders in the community 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.

Key Informant interviews were conducted by a local Glendale consultant. Interviews with community stakeholders involved in health and wellness efforts were asked very similar questions to focus group participants in order to understand their opinions on community health needs and how to address them. This interview data was combined with focus group data and analyzed in the manner.

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 were 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.

FOCUS GROUP 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).
- ▶ 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 Glendale 2019 Implementation Strategy Evaluation of Impact



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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)

Berkley 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

BIEL CONSULTING, INC.

Biel Consulting, Inc. assisted with primary data collection. Biel Consulting, Inc. has over 25 years of experience conducting CHNAs and working with hospitals on developing, implementing, and evaluating

community benefit programs.
www.bielconsulting.com

Melissa Biel, MSN, DPA
Biel Consulting, Inc.
(805) 994-7039
melissabiel@bielconsulting.com
www.Bielconsulting.com

“Giving data meaning”
www.communitybenefitconnect.org

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 policy makers 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 support 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, safe people and safe children.

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 requires 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 preferred affordable healthy foods, 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 that 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 manners range from abuse of drugs and alcohol, to smoking, to misuse of medications. Relying on unhealthy food choices is another example of 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 make it so all individuals in a community have equal opportunities to live good lives.

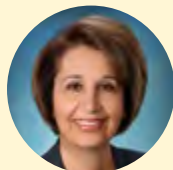
MENTAL HEALTH:

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.

Alice Issai, MBA
Adventist Health Glendale

COMMUNITY HEALTH NEEDS ASSESSMENT