MORE
COMMUNITY VOICES

Adventist Health Glendale

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

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

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

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You’re made for more

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

Executive Summary

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

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

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

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

Access to Care

Community Infrastructure

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

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

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

Identity of Steering Committee Hospital & Partner Organizations

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

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

Mr. Onnig Bulanikian
City of Glendale, Director of Community Services & Parks

Arbi Ghazarian, MD
Adventist Health Glendale, Family Medicine Chair

Mr. Roubik Golanian
City of Glendale, City Manager

Alice Issai, MBA
Adventist Health Glendale/Simi Valley Service Area, President

Sirvard Khanoyan, MD
Adventist Health Glendale, Director Family Medicine Residency Program

Sylvia Kotikian, MD
Adventist Health Glendale, ED Medical Director

Elizabeth LaBorde
Adventist Health Glendale and Simi Valley Foundations, President

Eric Markarian
Adventist Health Glendale, Volunteer Services

Ramella Markarian, PhD
Adventist Health Glendale, Business Development Executive

Lilian Mehrabians
Adventist Health Glendale, Volunteer Services

Sara Neal
Adventist Health Glendale, Community Outreach, Business Development

Douglas C. Nies, PhD
Board Member, Adventist Health Glendale Community Board, Clinical Psychologist

Charles Peterson, MD
Adventist Health Glendale, Family and Addiction Medicine Physician

Sandy Schutz, RN, BSN
Board Member, Adventist Health Glendale Foundation

A. CHNA Community Defined

Getting to Know Our Community

Located in the heart of Los Angeles County, we proudly serve a vibrant and diverse urban community that spans all walks of life, from affluent individuals to those facing economic challenges. Our commitment to inclusivity ensures everyone has access to high-quality, compassionate care.

Adventist Health Glendale serves 549,627 residents from over 20 zip codes, with 27.95% of the population identifying as Hispanic and 24.61% identifying as multiple races. Together, we build a healthier future for all, bridging gaps and celebrating our unique cultural identities.

Research indicates that up to 80% of health outcomes are shaped by social determinants of health (SDOH), the vital, yet often overlooked, nonmedical factors that influence our lives. In our service area, challenges such as housing instability and transportation barriers significantly affect our residents' health and quality of life. For additional community context, below are a few SDOH data points:

- 23.30% have limited English proficiency and speak a different language at home.
- The unemployment rate is 7.67%.
- More than one in four households experience a severe housing cost burden where housing costs are 50% or more of the total household income.
- Based on the Area Median Income, residents spend 48.08% of their income on housing and transportation alone.

We acknowledge the challenges our community faces and are committed to fostering a culture of optimism and proactive engagement in improving overall well-being. This report will reflect on our key accomplishments and valuable lessons learned from the past three years, emphasizing our dedication to continuous improvement in healthcare services. By closely examining the high-priority needs identified through our Community Health Needs Assessment process, this report summarizes the health issues that matter most to our residents.

Defining the Community We Serve

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

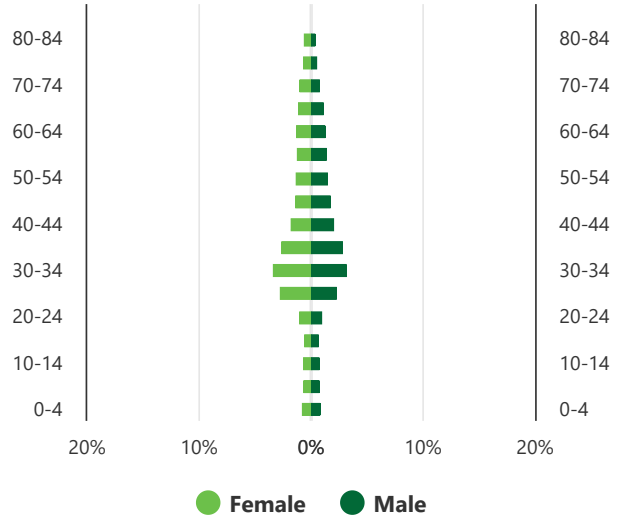
The report area is located in the state of California and includes a total population of 549,627 (based on the 2020 Decennial Census). The largest city in the report area is Glendale, with a population of 196,543. The report area is comprised of the following ZIP codes: 90027, 90039, 90041, 90042, 90065, 91011, 91020, 91040, 91042, 91201, 91202, 91203, 91204, 91205, 91206, 91207, 91208, 91210, 91214, 91501, 91502, 91504.

Total Population
549,627

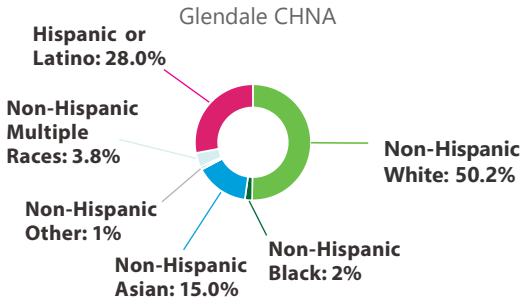
The largest city in the service area is
Glendale, CA
with a population of
196,543

Demographic Profile

Population by Age Group



Total Population by Combined Race and Ethnicity



Data Source: US Census Bureau, American Community Survey. 2018-22.

Students Experiencing Homelessness, Percent
3.00%
California: 3.89%

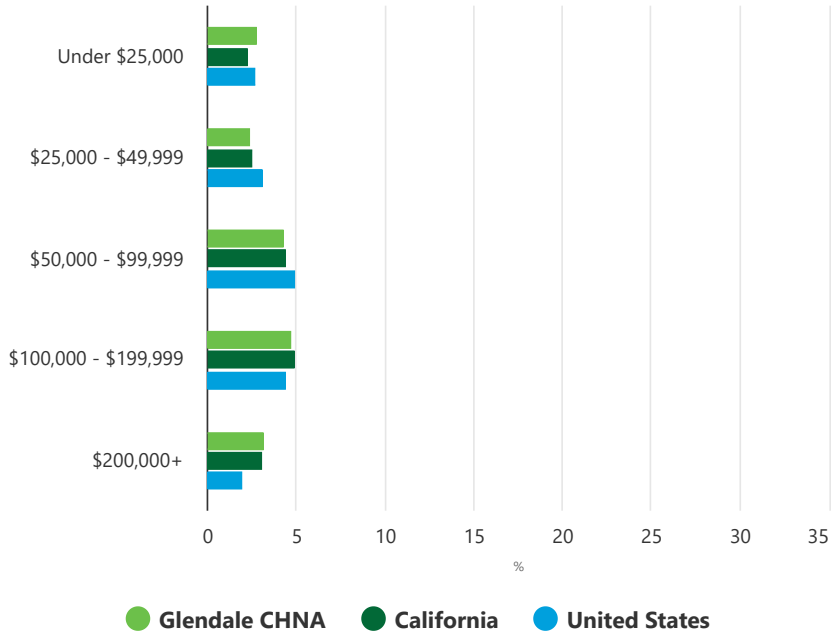
Associate's Degree or Higher
53.53%
California: 43.82%

Labor Force Participation Rate
65.45%
California: 63.82%

41.97%
California: 55.63%
of the population **owns** their home

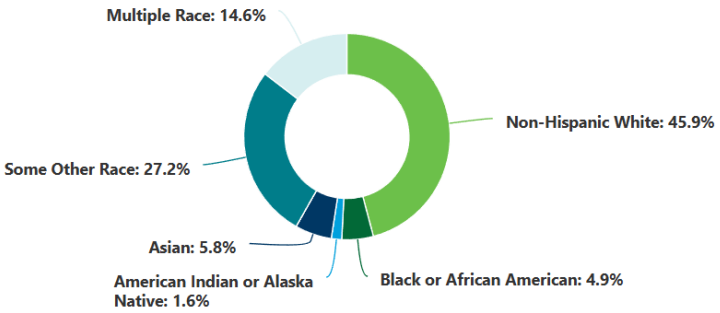
58.03%
California: 44.37%
of the population **rents** their home

Households by Household Income Levels, Percent



Data Source: US Census Bureau, American Community Survey. 2018-22.

Children in Poverty by Race, Total
Glendale CHNA



Childhood Poverty Rate
13.00%
California: 15.61%

II. About Us

Adventist Health

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

Adventist Health Glendale

Adventist Health Glendale is a nonprofit, 515-bed medical center nationally recognized for clinical excellence and patient safety. For over a century, our 30-acre hillside hospital has delivered world-class, patient-centered care to Glendale, Northeast Los Angeles, the San Fernando Valley, and surrounding communities.

Adventist Health Glendale is committed to delivering medical excellence, emergency care, outpatient services and wellness programs to all individuals regardless of insurance or ability to pay. We understand that health is not just about treating illnesses, it's about nurturing the whole person regardless of their socioeconomic status. Our network of healthcare resources and expertise allows us to provide patients with seamless coordination and access to specialized services.

Specialties Brought to our Community

- World class Heart & Vascular Institute
- Comprehensive Breast Center
- Comprehensive Stroke Center & Neuroscience Institute
- Comprehensive Cancer Services
- Diabetes Care
- Family Medicine Residency Program
- Interventional and Advanced Gastroenterology
- Interventional Pulmonology
- Labor & Delivery with level IIIA NICU
- Live Well Senior Program
- Orthopedics, Sports Medicine and Spine Program
- Pharmacy Residency Program
- Go Heart Wellness Program
- STEMI Receiving Center
- Behavioral Health Hospitalist Program
- Women's Health

A Look Back: Activities Since 2022 CHNA

CHNA Successes

Over the past three years, Adventist Health Glendale has focused its outreach efforts to address access to care, health conditions and mental health. Our 2023 Community Health Implementation Strategy (CHIS) serves as a foundation for this work, allowing us to monitor, evaluate, and document our impact through annual updates. In collaboration with our CHNA Steering Committee, staff, and department leaders, we addressed each high-priority need through a variety of educational programs and initiatives that benefit our community.

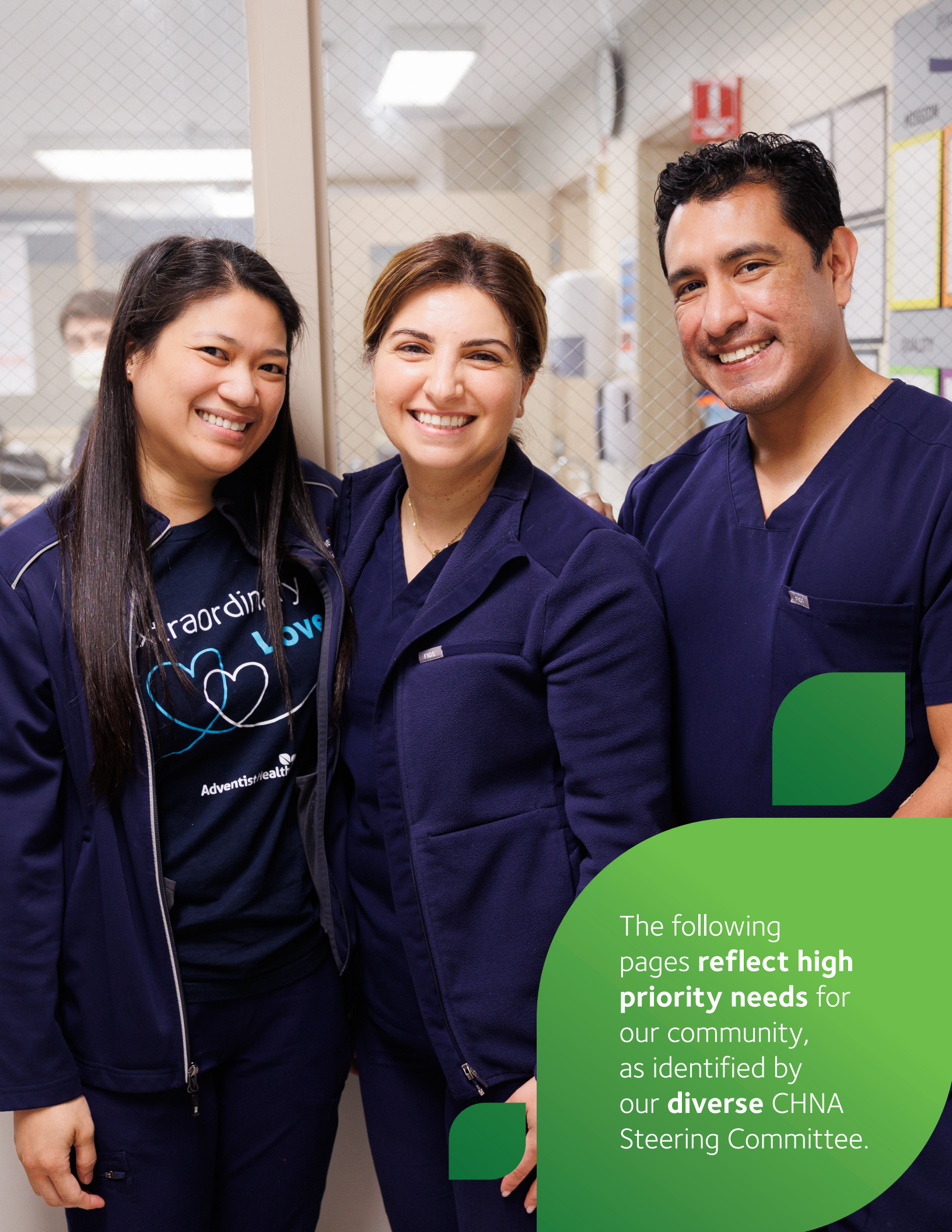
Adventist Health Glendale increased our partnerships with community organizations to extend vital mental health support to our unhoused population upon their discharge and launched our Behavioral Health Hospitalist program in 2024 to facilitate early discharge to our patients. Our "Go Heart Wellness" program was fully launched in 2023 to emphasize the importance of heart health. Additionally, we were proud to collaborate with local high schools to create safe spaces for our youth, prioritizing their mental health and well-being.

These efforts are fostering a healthier, more resilient community. With faith and dedication, we strive to uplift our community. For a complete reporting on this vital mission and to learn about our collaborative efforts since the 2022 Community Health Needs Assessment, please visit this link: https://www.adventisthealth.org/glendale/about-us/community-benefit/

A Look Forward: After the CHNA Report

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

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



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

III. High Priority Health Needs

Access to Care

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

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

One of the many challenges in accessing health care is ensuring that people can reach a service provider. In the Glendale service area, 23.30% of the population has limited English proficiency and key informants described that "It's people that don't speak the language, [the elderly], they don't have anyone at home that can connect the dots for them. It's that kind of vulnerability." In Glendale, one barrier to getting care is a lack of access to a vehicle or a reliable mode of transportation, where almost one in ten households (9.15%) have no motor vehicle. A community survey showed that 14% of individuals did not receive all the medical care they needed, and 27.3% attributed their lack of care to transportation-related barriers. Focus group participants noted that some patients "don't have transportation [and] it's hard to put them in and out of a car in a wheelchair."

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

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

Data Highlights

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

"They [people] don't seek the doctor as needed because they don't have the availability or the knowledge to know how to get that information or where they can go, who they can see…it's difficult for some of the people living in our community to find their way to adequate health care."

"There's no preventative care because they don't even know how to engage in that."

"…unfortunately, the healthcare system is really crumbling in many aspects because people don't see a doctor when they need to, which is then causing the ER rooms to be overcrowded. And we're just causing people to not get the care they need and then not be happy with the facility."

"…[the] healthcare system is just so complicated. People don't understand it and I find it a little bit more with patients that are less educated. Even patients [that] are educated, they still have problems or issues navigating the healthcare system."

"The problem is it's hard to get to the doctor. You may have insurance, you may be able to pay, but you don't have transportation…It's hard to put them [patients] in and out of a car in a wheelchair…so then that access doesn't happen. So the provider doesn't get the patient and the patient doesn't get the care…"

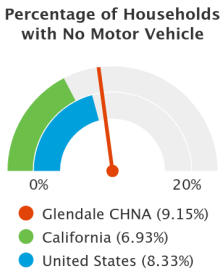
"What we're finding in the ED in terms of [patients] who need to be admitted is there's nowhere to send them. So we've had patients for many days in our ER while we're trying to get them somewhere because they're not okay to go home, they're a danger to themselves for example, or sometimes a danger to their family, they're that sick."

"It's people that don't speak their language, [the elderly], they don't have anyone at home that can connect the dots for them. It's that kind of vulnerability."

"…health insurance is expensive…it doesn't matter who you are…"

"I'd say the accessibility, availability of healthcare still continues to be…a challenge. And even for those that have a job, [it] depends on how much their employer covers, what's the coverage, what's their deductibles, how high are their deductibles?"

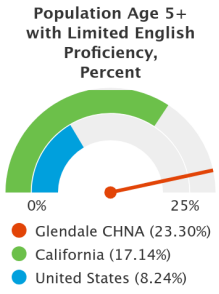
"…for my in-laws that are Spanish speaking, even the doctors that they're finding that are bilingual are really not bilingual. They speak enough Spanish to get by, that will classify them as bilingual. But the context of what is being communicated is lost in translation…"



Glendale Community Health Needs Survey

27.4%

When asked about the reasons for not getting all the medical care needed, selected transportation related barriers keeping them from accessing the care they need.



Community Resources

Administration for Community Living
acl.gov/programs/aging-and-disability-networks
800-677-1116

County Medical Services Program
tuolumnecounty.ca.gov/295/County-Medical-Services-Program
209-533-5711

Healthcare Enrollment Services
coveredca.com
800-300-1506

Glendale Continuum of Care Resource Guide
glendaleca.gov/government/departments/community-services-parks/human-services/homeless-services/glendale-continuum-of-care-social-service-agencies
818-550-4400

Community Health Needs Assessment Full Report

Location

Glendale CHNA

Health Needs: Access to Care

Availability - Primary Care - Primary Care Shortage Areas

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

Types of HPSA

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

This indicator reports the total population in the report area that is living in a primary care Health Professional Shortage Area, regardless of the degree of shortage, or whether the HPSA covers the entire geographic area or a population subgroup.

Indicator data are based on the following calculation:

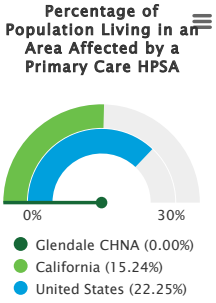
Percentage = [HPSA Population] / [Report Area Population] * 100

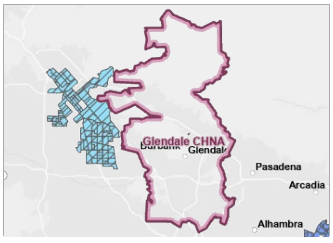
The population figures used in this calculation are from the 2019 American Community Survey 5-year Estimates.

Within the report area, there are 0 people living in a primary care Health Professional Shortage Area. This represents 0.00% of the total population.

Report Area	Total Population (ACS 2122 5-Year Estimates)	Population Living in an Area Affected by a HPSA	Percentage of Population Living in an Area Affected by a Primary Care HPSA	Percentage of HPSA Population Underserved
Glendale CHNA	548,415	0	0.00%	No data
Los Angeles County, CA	10,081,570	1,934,091	19.18%	40.08%
California	39,283,497	5,988,716	15.24%	45.23%
United States	324,697,795	72,230,619	22.25%	51.64%

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





View larger map

Primary Care HPSA Components, Type and Degree of Shortage by Tract / County, HRSA HPSA Database 2024

- Population Group; Over 20.0 FTE Needed
- Population Group; 1.1 - 20.0 FTE Needed
- Population Group; Under 1.1 FTE Needed
- Geographic Area; Over 20.0 FTE Needed
- Geographic Area; 1.1 - 20.0 FTE Needed
- Geographic Area; Under 1.1 FTE Needed
- Glendale CHNA

Availability - Mental Health Care - Mental Health Professional Shortage Areas

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

Types of HPSA

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

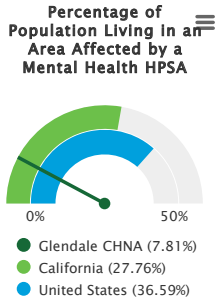
This indicator reports the total population in the report area that is living in a mental health care Health Professional Shortage Area, regardless of the degree of shortage, or whether the HPSA covers the entire geographic area or a population subgroup. Indicator data are based on the following calculation:

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

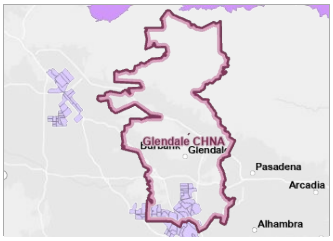
The population figures used in this calculation are from the 2019 American Community Survey 5-year Estimates. This indicator is relevant because a shortage of health professionals contributes to access and health status issues.

Within the report area, there are 42,813 people living in a mental health care Health Professional Shortage Area. This represents 7.81% of the total population.

Report Area	Total Population (ACS 2122 5-Year Estimates)	Population Living in an Area Affected by a HPSA	Percentage of Population Living in an Area Affected by a Mental Health HPSA	Percentage of HPSA Population Underserved
Glendale CHNA	548,415	42,813	7.81%	100.00%
Los Angeles County, CA	10,081,570	2,405,339	23.86%	66.13%
California	39,283,497	10,907,014	27.76%	69.55%
United States	324,697,795	118,818,005	36.59%	62.78%



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



View larger map

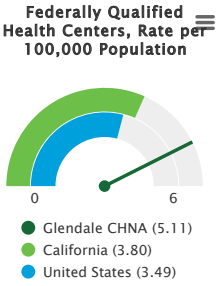
Mental Health Care HPSA Components, Type and Degree of Shortage by Tract / County, HRSA HPSA Database 2024

- Population Group; Over 20.0 FTE Needed
- Population Group; 1.1 - 20.0 FTE Needed
- Population Group; Under 1.1 FTE Needed
- Geographic Area; Over 20.0 FTE Needed
- Geographic Area; 1.1 - 20.0 FTE Needed
- Geographic Area; Under 1.1 FTE Needed
- Glendale CHNA

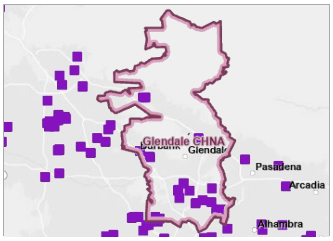
Availability - Hospitals & Clinics - FQHCs, Rate Per Low-Income Population

This indicator reports the number of Federally Qualified Health Centers (FQHCs) in the community. This indicator is relevant because FQHCs are community assets that provide health care to vulnerable populations; they receive extra funding from the federal government to promote access to ambulatory care in areas designated as medically underserved.
Within the report area, there are 28 Federally Qualified Heath Centers. This means there is a rate of 5.11 Federally Qualified Health Centers per 100,000 total population.

Report Area	Total Population (2020)	Number of Federally Qualified Health Centers	Rate of Federally Qualified Health Centers per 100,000 Population
Glendale CHNA	548,415	28	5.11
Los Angeles County, CA	10,014,009	383	3.82
California	39,538,223	1,504	3.80
United States	334,735,149	11,680	3.49



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



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Federally Qualified Health Centers, POS December 2023

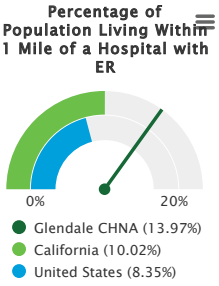
Federally Qualified Health Centers, POS December 2023
Glendale CHNA

Availability - Hospitals & Clinics - Proximity to Hospitals with ER

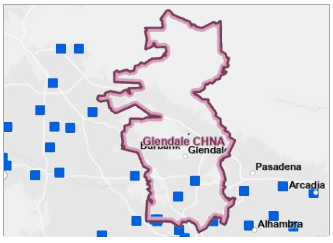
This indicator reports the percentage of the total population living within 1 mile of a hospital with an emergency room. Having good access to hospitals with an emergency room is important for community health because these hospitals play an important role in rapid and serious medical conditions.

As of 2023, of the report area's 548,415 total population, 76,587 or 13.97% live within 1 mile of a hospital with an emergency room. This is greater than the state's reported rate of 10.02%.

Report Area	Total Population	Population Within 1 Mile of a Hospital with ER	Percent Within 1 Mile of a Hospital with ER
Glendale CHNA	548,415	76,587	13.97%
Los Angeles County, CA	10,014,009	1,168,349	11.67%
California	39,538,223	3,961,644	10.02%
United States	334,735,155	27,942,571	8.35%



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



View larger map

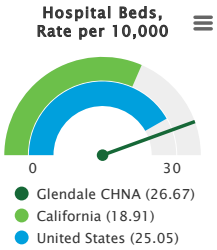
All Hospitals, POS December 2023

All Hospitals, POS December 2023
Glendale CHNA

Availability - Hospitals & Clinics - Hospital Beds Per Capita

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

Report Area	Hospital Beds, Total	Total Population (2020)	Hospital Beds, Rate per 10,000
Glendale CHNA	1,462	548,415	**26.67**
Los Angeles County, CA	21,932	10,014,009	21.90
California	74,762	39,538,223	18.91
United States	830,171	331,449,281	25.05



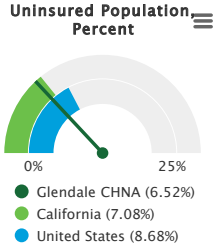
Note: This indicator is compared to the state average.
Data Source: Centers for Medicare & Medicaid Services, Hospital Service Area. 2023.

Barriers - Medical Insurance - Population without Medical Insurance

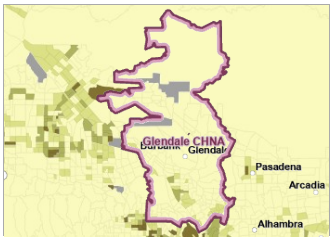
The lack of health insurance is considered a *key driver* of health status.

In the report area 6.52% of the total civilian non-institutionalized population are without health insurance coverage. The rate of uninsured persons in the report area is less than the state average of 7.08%. 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	545,295	35,545	**6.52%**
Los Angeles County, CA	9,866,623	888,735	9.01%
California	38,874,540	2,752,067	7.08%
United States	326,147,510	28,315,092	8.68%



Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2018-22.



View larger map

Uninsured Population, Percent by Tract, ACS 2018-22

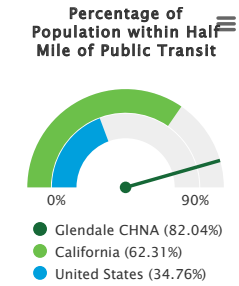
- Over 20.0%
- 15.1 - 20.0%
- 10.1 - 15.0%
- Under 10.1%
- No Data or Data Suppressed
- Glendale CHNA

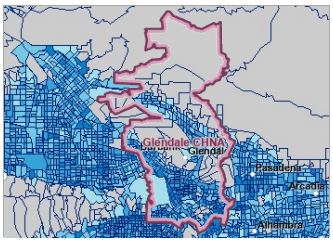
Barriers - Transportation - Distance to Public Transit

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

Report Area	Total Population	Population Within 0.5 Miles of Public Transit	Percentage of Population within Half Mile of Public Transit
Glendale CHNA	503,530	413,104	82.04%
Los Angeles County, CA	10,098,052	7,965,689	78.88%
California	39,148,760	24,391,714	62.31%
United States	322,903,030	112,239,342	34.76%

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





View larger map

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

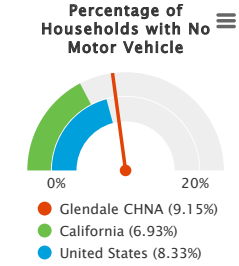
- 800 - 1200 Meters (0.5 - 0.75 Miles)
- 400 - 800 Meters (0.25 - 0.5 Miles)
- 200 - 400 Meters (0.125 - 0.25 Miles)
- Closer than 200 Meters (< 0.125 Miles)
- Further than 1200 Meters (> 0.75 Miles)
- Glendale CHNA

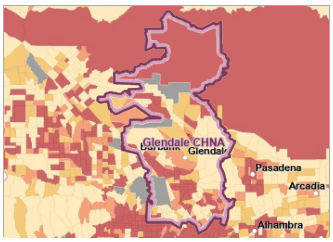
Barriers - Transportation - Households with No Vehicle

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 208,382 total households in the report area, 19,069 or 9.15% are without a motor vehicle.

Report Area	Total Occupied Households	Households with No Motor Vehicle	Households with No Motor Vehicle, Percent
Glendale CHNA	208,382	19,069	9.15%
Los Angeles County, CA	3,363,093	291,082	8.66%
California	13,315,822	922,535	6.93%
United States	125,736,353	10,474,870	8.33%

Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2018-22.





View larger map

Households with No Vehicle, Percent by Tract, ACS 2018-22

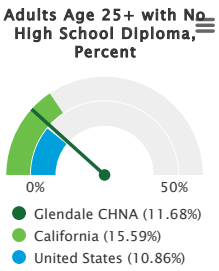
- Over 8.0%
- 6.1 - 8.0%
- 4.1 - 6.0%
- Under 4.1%
- No Data or Data Suppressed
- Glendale CHNA

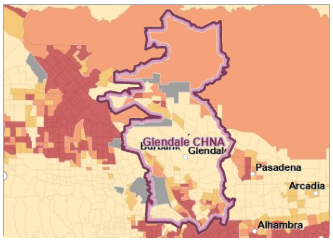
Barriers - Health Literacy - Educational Attainment

Within the report area there are 47,976 persons aged 25 and older without a high school diploma (or equivalency) or higher. This represents 11.68% of the total population aged 25 and older. This indicator is relevant because educational attainment is linked to positive health outcomes (Freudenberg & Ruglis, 2007).

Report Area	Total Population Age 25+	Adults Age 25+ with No High School Diploma	Adults Age 25+ with No High School Diploma, Percent
Glendale CHNA	410,706	47,976	**11.68%**
Los Angeles County, CA	6,909,650	1,364,653	19.75%
California	26,842,698	4,185,710	15.59%
United States	226,600,992	24,599,698	10.86%

Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2018-22.





View larger map

Population with No High School Diploma (Age 25+), Percent by Tract, ACS 2018-22

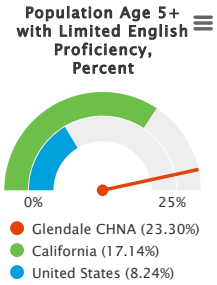
- Over 21.0%
- 16.1 - 21.0%
- 11.1 - 16.0%
- Under 11.1%
- No Data or Data Suppressed
- Glendale CHNA

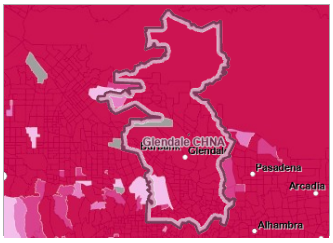
Barriers - Health Literacy - Limited English Proficiency

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 521,204 total population aged 5 and older in the report area, 121,464 or 23.30% 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	521,204	121,464	**23.30%**
Los Angeles County, CA	9,398,060	2,154,616	22.93%
California	37,097,796	6,358,142	17.14%
United States	312,092,668	25,704,846	8.24%

Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2018-22.





View larger map

Population with Limited English Proficiency, Percent by Tract, ACS 2018-22

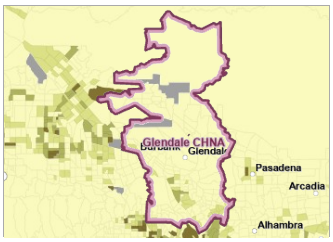
- Over 4.0%
- 2.1 - 4.0%
- 1.1 - 2.0%
- Under 1.1%
- No Data or Data Suppressed
- Glendale CHNA

Barriers - Medical Insurance - Health Insurance Disparities

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

Report Area	Non-Hispanic White	Hispanic or Latino	Non-Hispanic Black	Non-Hispanic Other Race	Disparity Index Score
Glendale CHNA	4.62%	10.90%	7.41%	8.07%	15.32
Los Angeles County, CA	4.35%	13.24%	6.41%	10.85%	12.94
California	3.69%	11.60%	5.75%	8.84%	16.41
United States	5.87%	17.56%	9.76%	13.09%	20.71

Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2018-22.



View larger map

Uninsured Population, Percent by Tract, ACS 2018-22

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

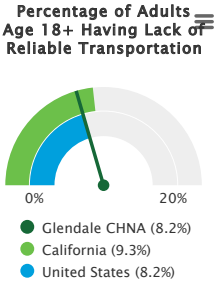
Barriers - Transportation - Lack of Reliable Transportation

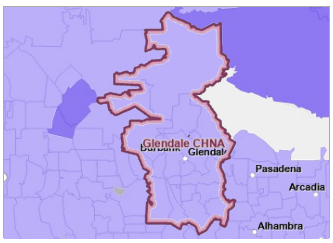
This indicator reports the percentage of adults age 18 and older who report having a lack of reliable transportation in the past 12 months.

Within the report area, there were 8.2% of adults 18 and older who report having a lack of reliable transportation in the past 12 months of the total population age 18 and older.

Report Area	Total Population	Adults Age 18+ Having Lack of Reliable Transportation (Crude)	Adults Age 18+ Having Lack of Reliable Transportation (Age-Adjusted)
Glendale CHNA	548,415	8.2%	No data
Los Angeles County, CA	9,721,138	9.6%	9.6%
California	39,029,342	9.3%	9.5%
United States	333,287,557	8.2%	8.7%

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





View larger map

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

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

Community Infrastructure

Community infrastructure refers to the physical and organizational structures that support the health, safety and well-being of residents. This encompasses essential services that people depend on daily such as schools, transportation systems and internet access as well as infrastructure that prioritizes public health including walkability, expanding green spaces and water systems. Community infrastructure is a foundation for equitable access to services and resources. Community infrastructure contributes to healthier living conditions, reduces health disparities and promotes social determinants of health, such as stable housing, employment opportunities and environmental quality. When community infrastructure is accessible, safe, and well-maintained, it can reduce chronic illnesses, improve mental health and enhance social connections within a community.

An important community infrastructure need in Glendale is access to childcare services. In Glendale, 45.58% of children live in a childcare desert, which is defined as a census tract without a child daycare center. Additionally, expanding internet access to bridge the digital divide is an important need as demonstrated by the primary and secondary data.

One in ten (10.89%) people are only able to access the internet through their cellular plan, and 5.63% of households don't own any type of computer. Key informants described how "children in school [are] not being successful [because] when they get back home [...] they're not completing their homework, [...] they don't have access to the internet." Without internet access, carrying out everyday tasks can become quite challenging.

Given that many Glendale residents live in underserved areas, investing in infrastructure that fosters health and well-being can transform communities, improve health outcomes and reduce disparities. For additional data, see the following pages.

Scan QR Code to explore the full live data report on Community Infrastructure or visit: cares.page.link/vrdL

Data Highlights

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

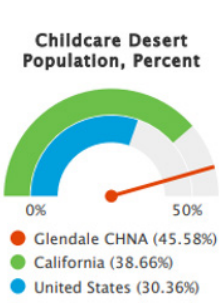
"...if I remember the conversation, they [focus group] were talking specifically about children in school not being successful... when they get back home, why is it that they're not completing their homework?... they don't have access to those resources [internet] that others do."

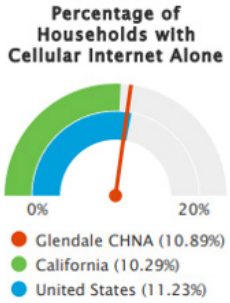
"... they don't have the resources. I'm not saying that the internet is the end all be all, but it's a resource."

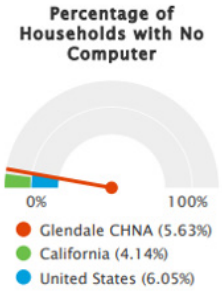
"...it's up to our leadership to do a better job because the leadership has more resources. All the taxes that are being paid goes into a big pot that they can spend wisely to take care of some of the issues."

"...I also see a lot of people walking... in the afternoons and in the evenings...the city can as a community...create more robust paths."

"...we hope that you do feel safe when you come here. That you do feel like it's a walkable city..."







Community Resources

City of Glendale Community Development Department
Glendaleca.gov/government/departments/community-development
818-548-2140

Community Health Needs Assessment Full Report

Location

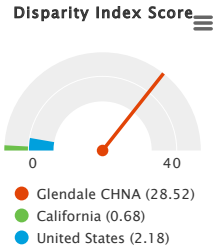
Glendale CHNA

Social Needs: Community Infrastructure

Access to Childcare - Childcare Access Disparities

This indicator reports the percentage of the report area population living in a childcare desert by population race and ethnicity. A childcare desert is defined as a neighborhood (census tract) without a child daycare center. The disparity index score is a relative measure which expresses the magnitude of disparity across population groups, with a score of 0 representing perfect equality, and a score of 100 representing perfect disparity.
Note: The dataset only includes center based child day care locations (including those located at schools and religious institutes) and does not include group, home, and family based child day cares.

Report Area	Non-Hispanic White	Hispanic or Latino	Non-Hispanic Black	Non-Hispanic Other Race	Disparity Index Score
Glendale CHNA	3.27%	0.55%	0.94%	1.42%	**28.52**
Los Angeles County, CA	43.07%	45.92%	38.61%	40.91%	2.43
California	38.86%	39.90%	40.18%	38.82%	0.68
United States	32.00%	31.37%	25.50%	31.56%	2.18



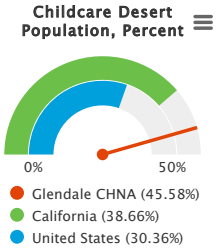
Note: This indicator is compared to the state average.
Data Source: Department of Homeland Security, Homeland Infrastructure Foundation-Level Data. Additional data analysis by CARES. 2020.

Access to Childcare - Childcare Scarcity

In July of 2020, 13,127 or 45.58% of children were living in a childcare desert, defined as a neighborhood (census tract) without a child daycare center. Data for this indicator are obtained from analysis of the Homeland Infrastructure Foundation-Level Data (HIFLD) Child Care Centers database.

Note: The dataset only includes center based child day care locations (including those located at schools and religious institutes) and does not include group, home, and family based child day cares.

Report Area	Total Population Age 0-4	Total Child Care Centers	Childcare Desert Population	Childcare Desert Population, Percent
Glendale CHNA	28,800	138	13,127	**45.58%**
Los Angeles County, CA	611,485	2,113	271,458	44.39%
California	2,451,528	8,502	947,824	38.66%
United States	19,911,293	101,202	6,044,269	30.36%



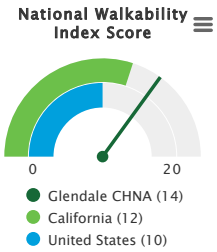
Note: This indicator is compared to the state average.
Data Source: Department of Homeland Security, Homeland Infrastructure Foundation-Level Data. Additional data analysis by CARES. 2020.

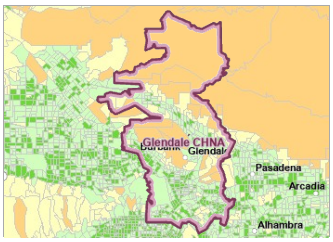
Community Amenities - Walkability

The National Walkability Index (2021) is a nationwide index score developed by EPA that ranks block groups according to their relative walkability using selected variables on density, diversity of land uses, and proximity to transit from the Smart Location Database. The block groups are assigned their final National Walkability Index scores on a scale of 1 to 20 where the higher a score, the more walkable the community is.

Report Area	Total Population (2018)	Walkability Index Score
Glendale CHNA	562,910	14
Los Angeles County, CA	10,098,052	13
California	39,148,760	12
United States	322,903,030	10

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





View larger map

National Walkability Index, National Walkability Index Score by Block Group, EPA SLD 2021

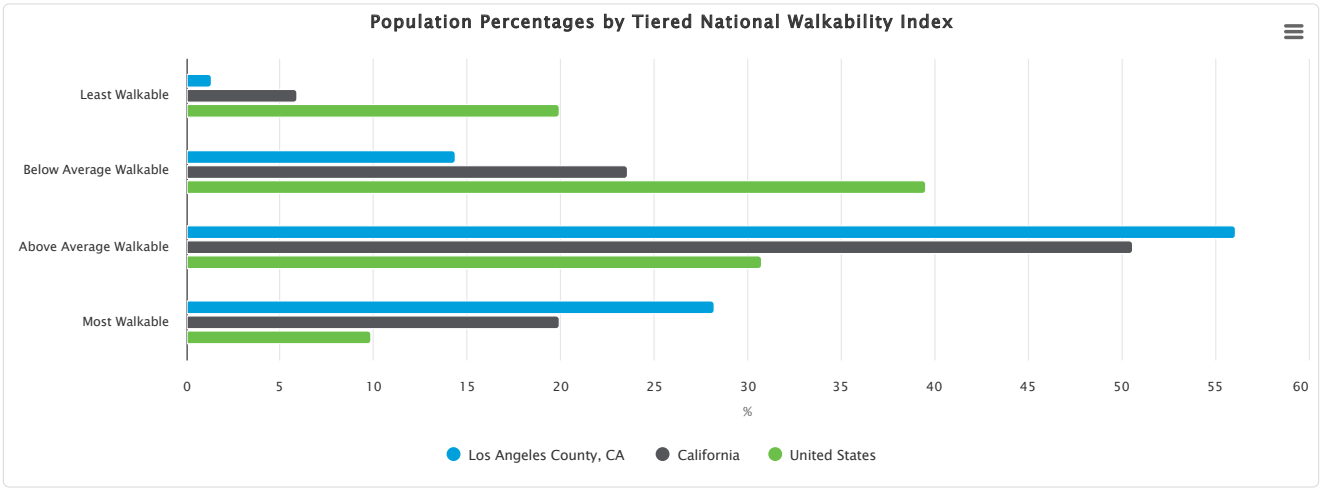
- 1.00 - 5.75 (Least Walkable)
- 5.76 - 10.50 (Below Average)
- 10.51 - 15.25 (Above Average)
- 15.26 - 20.00 (Most Walkable)
- Glendale CHNA

Population Percentages by Tiered National Walkability Index

This indicator reports the percentages of population living in a neighborhood of one of four walkability levels: least walkable, below average walkable, above average walkable, and most walkable. The walkability level is categorized based on the National Walkability Index (NWI) value, i.e., least walkable (NWI 1.0-5.75), below average walkable (NWI 5.76-10.5), above average walkable (NWI 10.51-15.25), most walkable (NWI 15.26-20.0).

Report Area	Least Walkable	Below Average Walkable	Above Average Walkable	Most Walkable
Los Angeles County, CA	1.33%	14.34%	56.09%	28.23%
California	5.89%	23.60%	50.60%	19.90%
United States	19.92%	39.51%	30.74%	9.84%

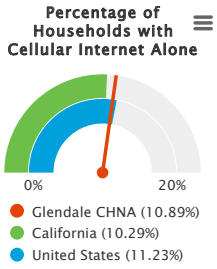
Data Source: Environmental Protection Agency, EPA - Smart Location Database. 2021.



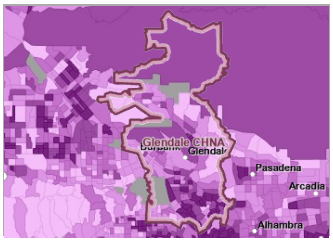
Internet & Technology - Cellular Plan Only

This indicator reports the percentage of households who report having access to the internet through a mobile or cellular data plan with no other type of internet subscription. Of the 208,382 total households in the report area, 22,702 or 10.89% have internet access through a mobile or cellular plan only.
Note: The ACS 2018-22 questions about internet/computer usage are not asked for the group quarters population, so data do not include people living in housing such as dorms, prisons, nursing homes, etc.

Report Area	Total Households	Households with Cellular Internet Only	Households with Cellular Internet Only, Percent
Glendale CHNA	208,382	22,702	**10.89%**
Los Angeles County, CA	3,363,093	371,628	11.05%
California	13,315,822	1,370,203	10.29%
United States	125,736,353	14,120,561	11.23%



Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2018-22.



View larger map

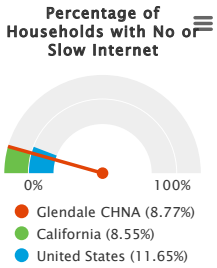
Households with Cellular Internet Alone, Percent by Tract, ACS 2018-22

- Over 16.0%
- 12.1 - 16.0%
- 8.1 - 12.0%
- 4.1 - 8.0%
- Under 4.1%
- No Data or Data Suppressed
- Glendale CHNA

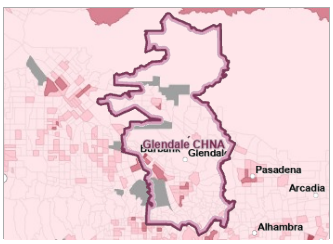
Internet & Technology - No High-Speed Internet

This indicator reports the percentage of households who either use dial-up as their only way of internet connection, or have internet access but don't pay for the service, or have no internet access in their home, based on the 2018-2022 American Community Survey estimates. Of the 208,382 total households in the report area, 18,275 or 8.77% have no or slow internet.
Note: The ACS2018-22 questions about internet/computer usage are not asked for the group quarters population, so data do not include people living in housing such as dorms, prisons, nursing homes, etc.

Report Area	Total Households	Households with No or Slow Internet	Households with No or Slow Internet, Percent
Glendale CHNA	208,382	18,275	**8.77%**
Los Angeles County, CA	3,363,093	329,279	9.79%
California	13,315,822	1,138,238	8.55%
United States	125,736,353	14,652,439	11.65%



Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2018-22.



View larger map

Households with No or Slow Internet, Percent by Tract, ACS 2018-22

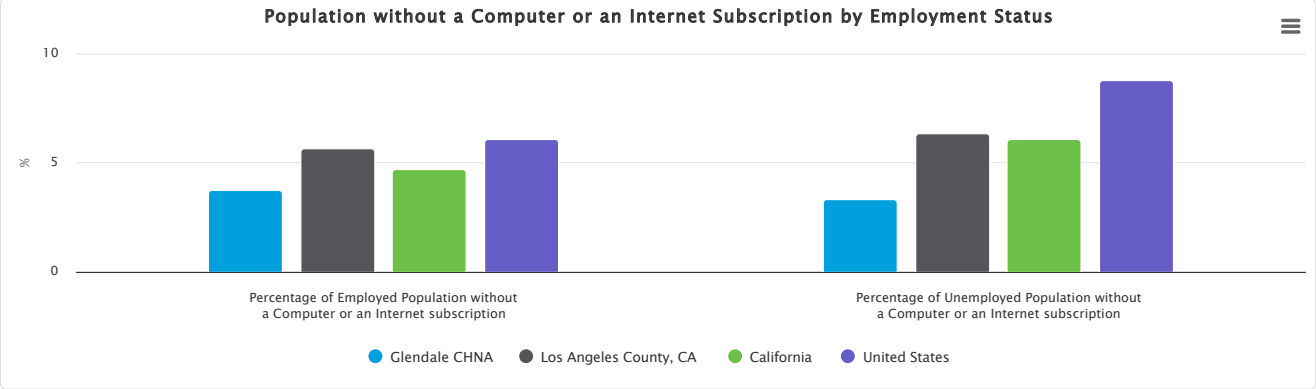
- Over 36.0%
- 28.1 - 36.0%
- 20.1 - 28.0%
- 12.1 - 20.0%
- Under 12.1%
- No Data or Data Suppressed
- Glendale CHNA

Population without a Computer or an Internet Subscription by Employment Status

This indicator reports the total and percentage of population that have no computer or Internet subscription by employment status based on the 2018-2022 American Community Survey estimates. Of the report area's 275,386 employed population, 10,266 or 3.73% have no computer or Internet subscription while of its 22,896 unemployed population, 753 or 3.29% have no computer or Internet subscription. Notice that the universe of this indicator is all civilian household population 16 years and over, including population in labor force (i.e., the employed population and the unemployed population) and population not in labor force (not listed in this table).

Report Area	Total Employed Population	Employed with No Computer or Internet Subscription, Total	Employed with No Computer or Internet Subscription, Percent	Total Unemployed Population	Unemployed with No Computer or Internet Subscription, Total	Unemployed with No Computer or Internet Subscription, Percent
Glendale CHNA	275,386	10,266	3.73%	22,896	753	3.29%
Los Angeles County, CA	4,836,102	272,643	5.64%	357,828	22,577	6.31%
California	18,600,340	869,375	4.67%	1,255,384	76,384	6.08%
United States	157,611,582	9,572,893	6.07%	8,743,936	766,903	8.77%

Data Source: US Census Bureau, American Community Survey. 2018-22.

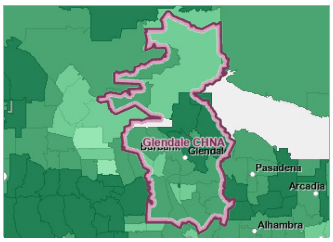


Internet & Technology - Internet Access Disparities

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

Report Area	Non-Hispanic White	Hispanic or Latino	Non-Hispanic Black	Non-Hispanic Other Race	Disparity Index Score
Glendale CHNA	93.32%	92.06%	93.75%	94.76%	0.45
Los Angeles County, CA	94.01%	90.93%	89.04%	92.61%	0.63
California	94.26%	91.86%	90.69%	93.79%	0.56
United States	91.70%	89.97%	86.89%	92.28%	0.68

Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2018-22.



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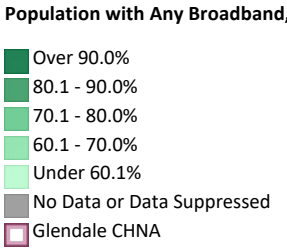


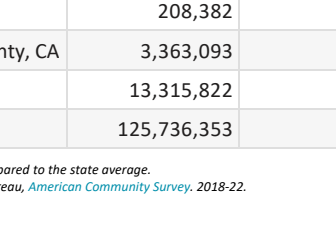
Internet & Technology - No Computer

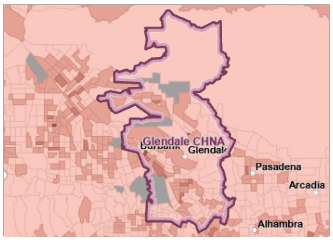
This indicator reports the percentage of households who don't own or use any types of computers, including desktop or laptop, smartphone, tablet or other portable wireless computer, and some other type of computer, based on the 2018-2022 American Community Survey estimates. Of the 208,382 total households in the report area, 11,722 or 5.63% are without a computer.

Note: The ACS 2018-22 questions about internet/computer usage are not asked for the group quarters population, so data do not include people living in housing such as dorms, prisons, nursing homes, etc.

Report Area	Total Households	Households with No Computer	Households with No Computer, Percent
Glendale CHNA	208,382	11,722	5.63%
Los Angeles County, CA	3,363,093	156,060	4.64%
California	13,315,822	551,910	4.14%
United States	125,736,353	7,603,749	6.05%

Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2018-22.





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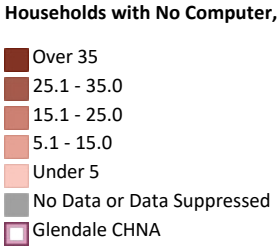
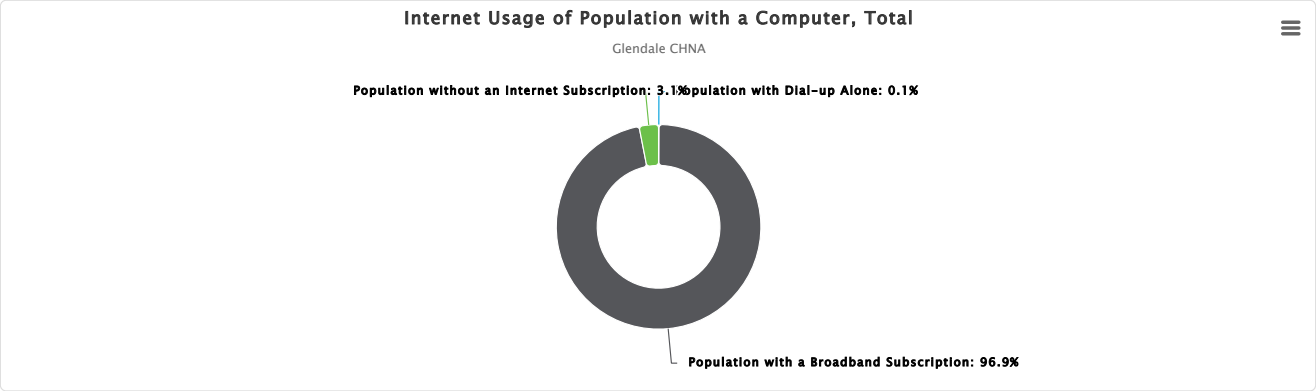


Internet Usage of Population with a Computer, Total

This indicator reports the Internet usage of household population with a computer, including Internet access with dial-up alone, with a broadband subscription, and without Internet subscription, based on the 2018-2022 American Community Survey estimates.

Report Area	Total Population	Population with Any Computer	Population with Dial-up Alone	Population with A Broadband Subscription	Population without An Internet Subscription
Glendale CHNA	538,592	520,349	405	503,985	15,959
Los Angeles County, CA	9,735,169	9,466,257	8,816	8,980,664	476,777
California	38,493,079	37,570,668	35,030	35,945,378	1,590,260
United States	322,994,302	310,986,833	432,346	293,957,068	16,597,419

Data Source: US Census Bureau, American Community Survey. 2018-22.

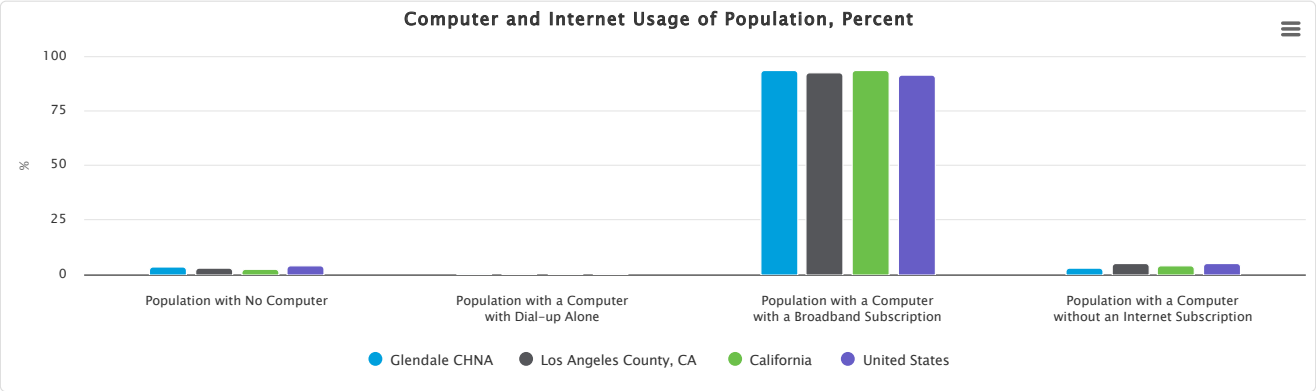


Computer and Internet Usage of Population, Percent

This indicator reports the computer and Internet usage of household population, including not using or owning a computer, with a computer and using dial-up alone for Internet access, with a computer and with a broadband subscription, and with a computer but without an Internet subscription, based on the 2018-2022 American Community Survey estimates.

Report Area	Population with No Computer	Population with Any Computer	Population with Any Computer with Dial-up Alone	Population with Any Computer with A Broadband Subscription	Population with Any Computer without An Internet Subscription
Glendale CHNA	3.39%	96.61%	0.08%	93.57%	2.96%
Los Angeles County, CA	2.76%	97.24%	0.09%	92.25%	4.90%
California	2.40%	97.60%	0.09%	93.38%	4.13%
United States	3.72%	96.28%	0.13%	91.01%	5.14%

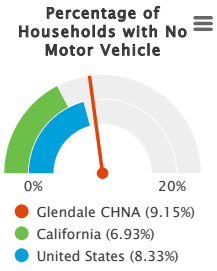
Data Source: US Census Bureau, American Community Survey. 2018-22.



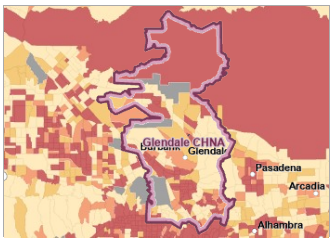
Transportation - Transportation Access

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 208,382 total households in the report area, 19,069 or 9.15% are without a motor vehicle.

Report Area	Total Occupied Households	Households with No Motor Vehicle	Households with No Motor Vehicle, Percent
Glendale CHNA	208,382	19,069	9.15%
Los Angeles County, CA	3,363,093	291,082	8.66%
California	13,315,822	922,535	6.93%
United States	125,736,353	10,474,870	8.33%



Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2018-22.



View larger map

Households with No Vehicle, Percent by Tract, ACS 2018-22

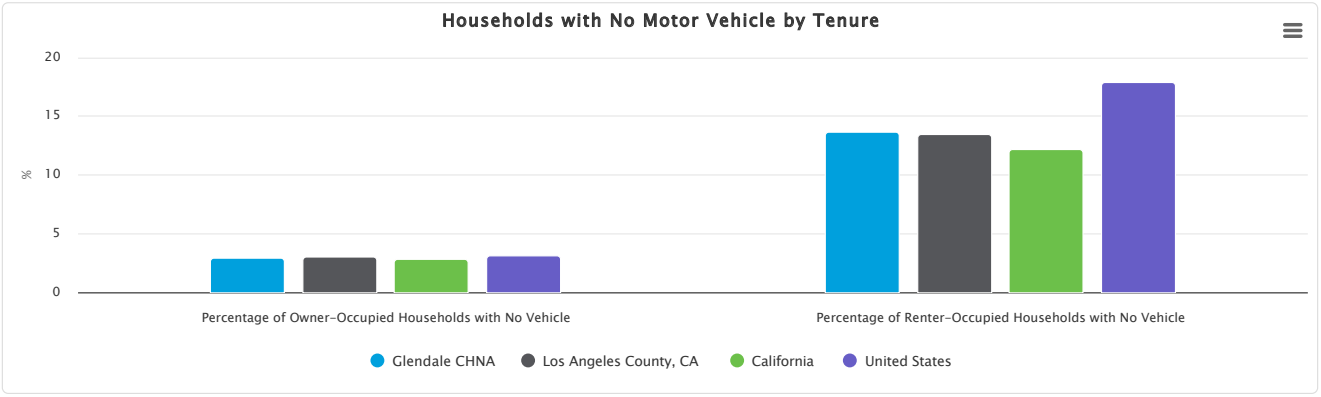
- Over 8.0%
- 6.1 - 8.0%
- 4.1 - 6.0%
- Under 4.1%
- No Data or Data Suppressed
- Glendale CHNA

Households with No Motor Vehicle by Tenure

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

Report Area	Owner-Occupied Households	Owner-Occupied Households, Percent	Renter-Occupied Households	Renter-Occupied Households, Percent
Glendale CHNA	2,581	2.95%	16,488	13.63%
Los Angeles County, CA	47,371	3.05%	243,711	13.46%
California	204,739	2.76%	717,796	12.15%
United States	2,560,689	3.14%	7,914,181	17.89%

Data Source: US Census Bureau, American Community Survey. 2018-22.



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

A. Identified Significant Health Needs

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

High Priority Needs

Access to Care

Dhs.lacounty.gov/glendale

glendaleca.gov/government/departments/community-services-parks/human-services/homeless-services/glendale-continuum-of-care-social-service-agencies

Nearly one in four (23.3%) people have limited English proficiency (U.S. Census Bureau, 2022) and key informants described that there's a vulnerability to getting care when there's a language barrier. Almost one in ten residents (9.15%) lack access to a reliable mode of transportation without a motor vehicle (U.S. Census Bureau, 2022).

Community Infrastructure

glendaleca.gov/government/departments/community-development

Nearly half (45.58%) of children live in a childcare desert, defined as a census tract without a child daycare center (Department of Homeland Security, 2020). Additionally, one in ten (10.89%) people are only able to access the internet through their cellular plan (U.S. Census Bureau, 2022), and key informants described how without internet access, carrying out everyday tasks can be quite challenging.

Lower Priority Needs

Climate & Natural Environment

glendaleca.gov/government/departments/management-services/office-of-sustainability/programs-and-services

Based on the Respiratory Hazard Index Score, the Glendale service area is exposed to air and water toxic risks at a higher rate than the California average (Environmental Protection Agency, 2019), which indicates a higher potential for adverse health effects.

Financial Stability

glendaleca.gov/government/departments/glendale-water-and-power/covid-19-response/financial-assistance-programs

The senior poverty rate is 14.87%, higher than the California average of 11.01% (U.S. Census Bureau, 2022) and more than one in five (22.27%) people are in debt (Debt in America, 2022). Both focus group participants and key informants group participants described how inflation is affecting the ability to afford basic needs, health needs and social needs.

Housing

ascenciaca.org/programs-and-services

glendaleca.gov/government/departments/community-development/housing

Focus group participants raised concerns over how people are affected by different mental health problems and not getting the care they need. The mental health provider rate is 191.49 per 100,000 people, lower than the California average of 327.49 (Centers for Medicare and Medicaid Services, 2024).

Mental Health

namiglendale.org

The median household income is $58,329, compared to $91,905 in California (U.S. Census Bureau, 2022). With a low labor force participation rate of 51.73%, focus group participants attributed this to a lack of employment opportunities, with some individuals taking on second and third jobs to make ends meet.

Social & Economic Context

glendaleca.gov/government/departments/economic-development/glendale-successor-agency/economic-development-is-the-future

Key informants and focus group participants mentioned the need for more social services and organizations that are able to provide resources. For adults 65+, 32.47% live alone (US Census Bureau, 2022) and may have challenges accessing basic needs, including health needs.

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

B. Description of Focus Groups & Key Informant Interviews

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

Logistics

Four (4) focus groups with thirty-nine (39) people participating. Focus groups were in-person, typically running 90 minutes.

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

Participating Organizations

- Adventist Health Glendale Emergency Department and Behavior Health Unit
- Armenian Relief Society
- City of Glendale
- Glendale Healthy Community Coalition
- Glendale Police Department
- Los Angeles and Glendale Pastors and Chaplains

Represented Race/Ethnicity

- African American
- Armenian
- Asian
- Latinx
- Multi-Race
- White

Represented Populations

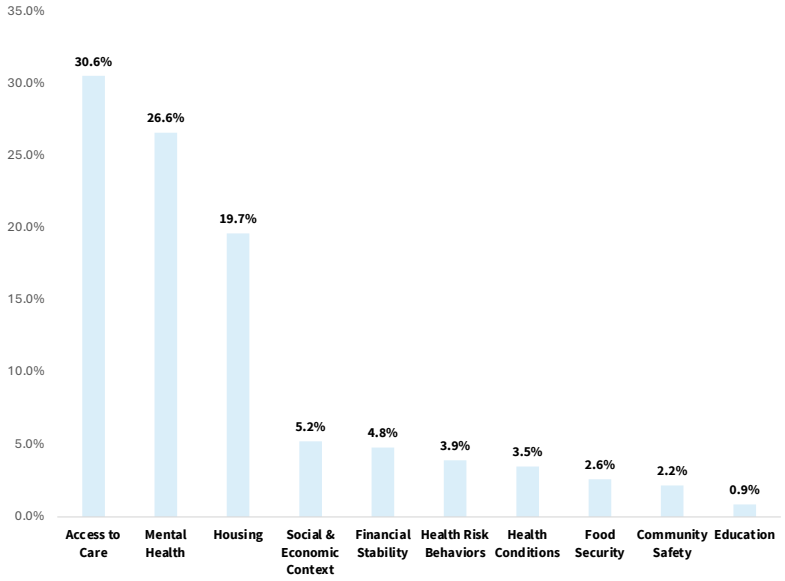
- Healthcare Consumer
- Healthcare Workforce
- Human Services
- Low-income
- LGBTQ Community
- Medically Underserved
- Minority Populations
- Older Adults
- Persons with Disability
- Public Health
- Substance Use Disorder
- Unhoused population
- Young Adults

C. Focus Groups & Key Informant Interviews Results

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

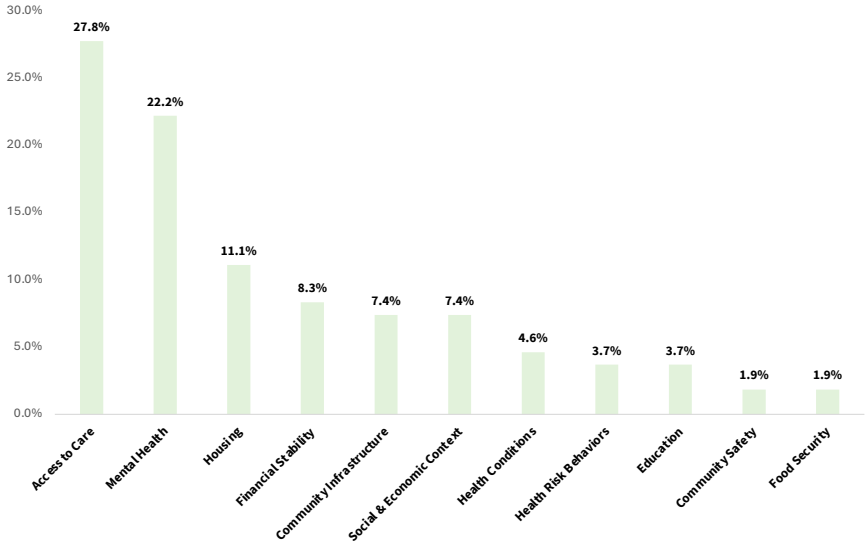
Focus Groups

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



Key Informant Interviews

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



D. Secondary Data Results

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

Priority Health Needs

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

Adults Age 18+ with Poor or Fair General Health (Crude)
17.4%
California: 18.8%

Life Expectancy at Birth (2010-2015)
82.18
California: 80.32

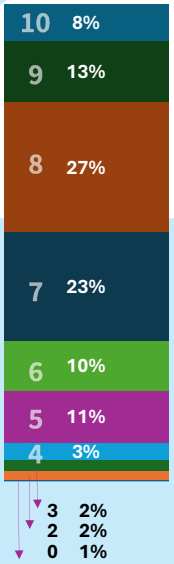
Financial Stability	Climate & Natural Environment	Mental Health	Housing	Access to Care	Food Security
61	52	52	51	49	47

Health Risk Behaviors	Social & Economic Context	Community Infrastructure	Education	Health Conditions	Community Safety
47	43	38	34	32	31

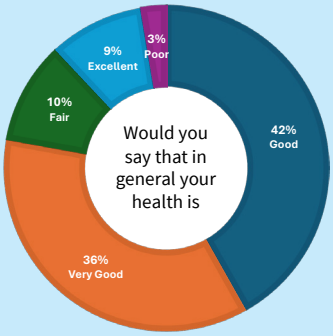
Legend: Excellent · Very Good · Good · Fair · Poor

E. Survey Results

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



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

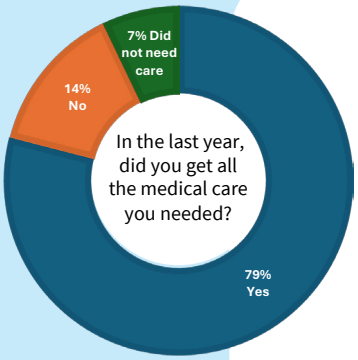


Select 3-5 things that you believe make it hard to live and be well in this community.

High cost of living	25.9%
Lack of affordable housing	18.4%
Access to affordable healthy food	7.8%
Bad air and/ or water quality	7.3%
Unsafe community	6.5%
High risk for natural disasters (fire, floods, earthquakes)	5.6%
Not enough good jobs	5.3%
Lack of safe roads, sidewalks, bike lanes	4.1%
Racism	3.4%
Limited childcare options	3.2%
Lack of transportation	2.8%
No friends or connection to community	2.8%
Can't get medical care	2.7%
Limited access to social services for me or my family members	2.4%
Lack of good schools	1.7%
Grand Total	**100.00%**

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

Aging problems (e.g. arthritis, hearing/vision loss, dementia, etc.)	15.6%
Being overweight	14.0%
No health problems	12.6%
High blood pressure	9.6%
Mental health problems (e.g. extreme sadness, fear, worry, anger or stress)	8.9%
Poor eating habits	8.1%
Vision/hearing problems	5.8%
Teeth problems	5.2%
Diabetes/Kidney Disease	4.1%
Problems with mobility	3.5%
Heart Disease/ Stroke	3.0%
Illness that spreads (like flu, COVID, TB)	2.8%
Asthma/ COPD	1.9%
Cancer	1.8%
Respiratory/Lung Disease	1.1%
Mother-Bay care	0.7%
Alcohol and/or drug misuse	0.6%
Sexually Transmitted Disease (STDs)	0.4%
Learning problems	0.3%
Child/Partner Abuse	0.2%
Grand Total	**100.0%**



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

Inconvenient hours of operation	14.5%
It costs too much	13.3%
Poor quality of doctors/nurses	13.3%
Specialist not covered by insurance	12.7%
I did not know where to get care	9.1%
Location of medical care	7.3%
There was no doctor that accepted my insurance	5.5%
Getting to the clinic was too hard	5.5%
I do not have a primary care doctor	5.5%
Holistic treatments not available	4.2%
I do not have health insurance	4.2%
Doctor or clinic (health provider) did not understand my language, culture, or identity	2.4%
I'm uncomfortable speaking with a doctor	2.4%
Grand Total	**100.0%**

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

Housing Options	16.1%
Managing Stress and Depression	11.8%
Neighborhood Safety	11.1%
Healthcare & Prescription Costs	10.8%
Social/Community Events	10.1%
Parks, Recreation and Outdoor Activities	8.9%
Personal Safety	8.0%
Childcare or Senior Care	7.9%
Utilities/ Internet	7.1%
Legal Services	4.2%
Local Food Banks	4.0%
Grand Total	**100.0%**

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

V. Process & Methods to Conduct the CHNA

A. Introduction

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

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

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

B. Community Impact Framework

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

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

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

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

C. Data Overview: Description, Benefits & Limitations

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

Description

Key Informant Interviews

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

Focus Group

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

Survey

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

Secondary Public Data

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

Benefits

Key Informant Interviews

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

Focus Group

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

Survey

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

Secondary Public Data

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

Limitations

Key Informant Interviews

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

Focus Group

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

Survey

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

Secondary Public Data

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

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D. Focus Group & Key Informant Interview Methodology

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

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

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

E. Survey Methodology

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

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

F. Secondary Data Methodology

Basic Approach

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

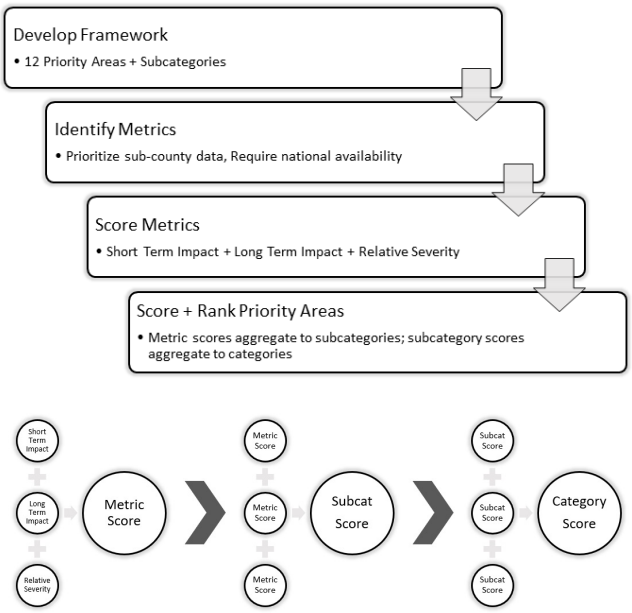

Figure 1. A. Approach to framework and scoring methodology development. B. Diagram of scoring approach.

Metric Scoring

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

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

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

Transformation of Correlation Scores

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

Category Scores

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

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

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

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

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

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

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

Presentation of Results

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

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

Limitations

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

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

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

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

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G. Data Analysis & Identification of Significant Health Needs

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

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

STEP 1: FRAMEWORK & CODEBOOK CREATION

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

STEP 2: DATA COLLECTION

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

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

STEP 3: AGGREGATION

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

STEP 4: SYNTHESIS

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

EVALUATION & HEALTH NEEDS PRIORITIZATION: CHNA Steering Committee

STEP 5: EVALUATION

- Evaluate Significant Health Needs data.

STEP 6: PRIORITIZATION

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

Data Collection to Aggregation

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

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

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

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

For each input text, your goal is:

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

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

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

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

Data Synthesis and Identification of Significant Health Needs

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

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

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

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

Prioritized Criteria

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

Prioritization Process and Selection of High Priority Needs

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

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

I. Written Comments for 2025 CHNA

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

J. CHNA Team Used to Conduct the Assessment

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

Amanjit 'Amy' Lasher
Administrative Director, Community Integration

Sarah Clair, MPA
Manager, Public Affairs

Mitchell Iwahiro, MS
Project Manager, Community Integration

Susan Passalacqua
Manager, Community Benefit Compliance

Lisa Wegley
Program Manager, Community Benefits Operations

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

Matt Gonzales
Salesforce Administrator

Alex McFadyen, PMP
Manager, Consumer Digital Products

Philip Stanley
Digital Marketing Manager

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

Cambria Wheeler
Director, Brand Engagement

CARES

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

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

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


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VI. APPROVAL PAGE

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

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

Alice Issai
President

1509 Wilson Terrace
Glendale, CA 91206

Appendix:

A. Glossary of Terms & Definitions of Health Needs

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

Access to Care

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

Context/Source

Healthy People 2030. "Health Care Access and Quality"

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

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

Climate & Natural Environment

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

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

Context/Source

World Health Organization. "Climate"

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

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

Community Infrastructure

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

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

Context/Source

Robert Wood Johnson Foundation. "Infrastructure is Public Health"

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

Community Safety

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

Context/Source

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

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

Education

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

Context/Source

American Public Health Association. "Education Health"

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

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

Financial Stability

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

Context/Source

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

Food Security

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

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

Context/Source

World Health Organization. "Food Safety"

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

American Public Health Association. "Food and Nutrition"

Health Conditions

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

Context/Source

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

World Health Organization (WHO). "Noncommunicable Diseases"

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

Health Risk Behaviors

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

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

Context/Source

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

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

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

Housing

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

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

Context/Source

Robert Wood Johnson Foundation. "Housing and Health"

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

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

Mental Health

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

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

Context/Source

World Health Organization (WHO). "Mental Health"

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

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

Social & Economic Context

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

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

Context/Source

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

World Health Organization. "Social Determinants of Health"

B. Activity Explanation: Focus Groups & Key Informant Interviews

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

Tallying, Engaging & Asking Questions:

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

ACTIVITY EXPLANATION – Key Informant Interviews

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

Engaging & Asking Questions:

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

B. Focus Group & Key Informant Interview: Question prompter

One of the topics that you identified is _____

Questions:

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

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

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

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

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

Closing question:

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

Conclusion:

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

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

C. Survey Questions:

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

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

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

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

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

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

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

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

D. Prioritization Tools:

1. Health Need – Evaluation Worksheet

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

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

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

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

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

2. Questions to Consider

Do we have any unifying objectives/goals?

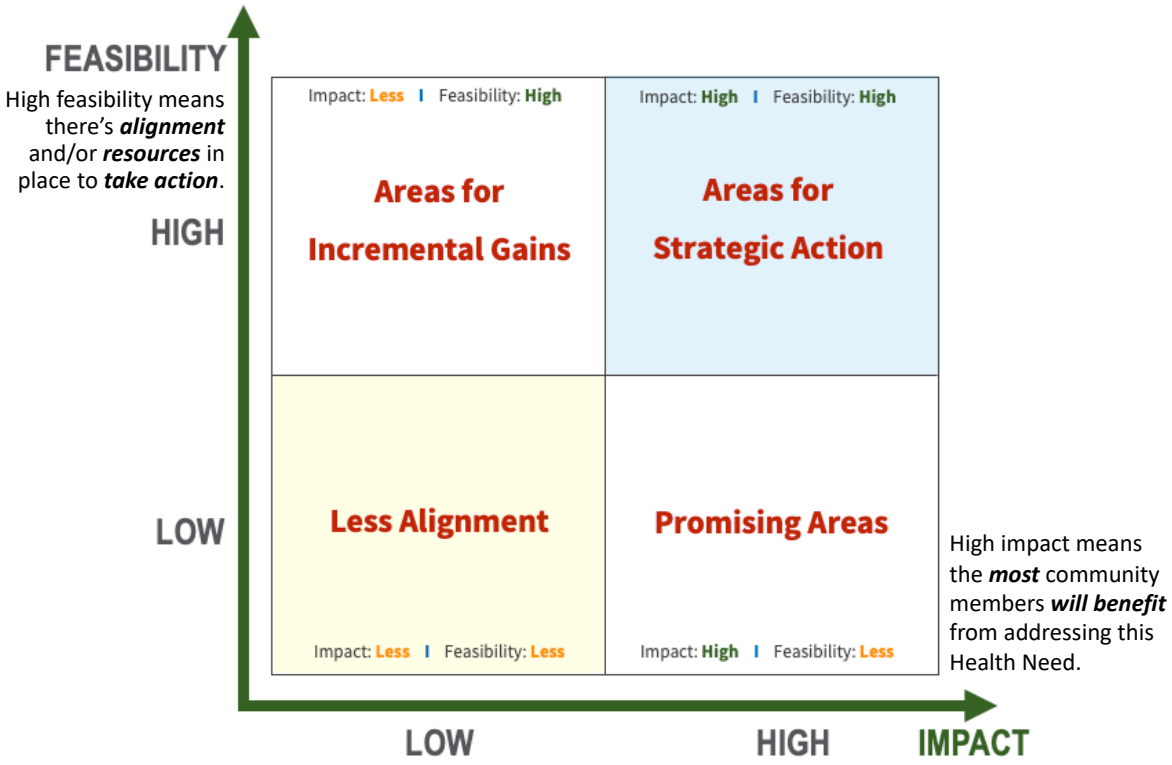
What does immediate success look like (1 - 3yrs)?

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

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

Is this a community-wide or vulnerable population need?

3. Priority Needs Comparison



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