



**ADVENTIST HEALTH  
WHITE MEMORIAL**

2022 COMMUNITY HEALTH  
IMPLEMENTATION STRATEGY

APPROVED APRIL 27, 2023

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# Purpose & Summary

Non-profit health systems, community-based organizations, and public health agencies across the country all share a similar calling: to provide public service to help improve the lives of their community. To live out this calling and responsibility, Adventist Health White Memorial conducts a Community Health Needs Assessment (CHNA) every three years, with our most recent report completed in 2022. Now that our communities' voices, stories, and priority areas are reflected in the CHNA, our next step is to complete a Community Health Improvement Plan (CHIP), or as we refer to it in this report, a Community Health Implementation Strategy (CHIS).

The CHIS consists of a long-term community health improvement plan that strategically implements solutions and programs to address our health needs identified in the CHNA. Together with the Adventist Health Well-Being team, local public health officials, community-based organizations, medical providers, students, parents, and members of selected underserved, low-income, and minority populations, Adventist Health White Memorial intentionally developed a strategic plan to address the needs of our community.

In this CHIS, you will find strategies, tactics, and partnerships that address the following health needs identified in the 2022 Adventist Health White Memorial CHNA:

**Access to Care**

**Financial Stability**

**Food Security**

**Mental Health**

We hope this report is leveraged by all local partners and community members, empowering them to own the potential of healthy living for all. This report was reviewed and approved by our Hospital Board as well as the Adventist Health System Board on April 27, 2023. The entire report is published online and available in print form by contacting [community.benefit@ah.org](mailto:community.benefit@ah.org).



# What if ...

It's not a prescription that changes your health?

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

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

# Getting to know our White Memorial CHNA service area\*

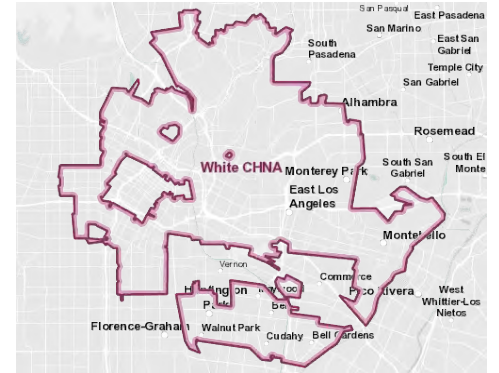
From Mariachi Plaza to Evergreen Cemetery, Boyle Heights is one of Los Angeles' most historic and vibrant communities. Just three miles east of downtown Los Angeles, Boyle Heights is home to generations of immigrants with 76% of the community served by White Memorial Hospital being Hispanic, and the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

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

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

For a more detailed look into community member comments, facts and numbers that are captured in the CHNA, please visit [adventisthealth.org/about-us/community-benefit](http://adventisthealth.org/about-us/community-benefit). The following pages provide a closer look into our community demographic as well as our approach to the CHIS.

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



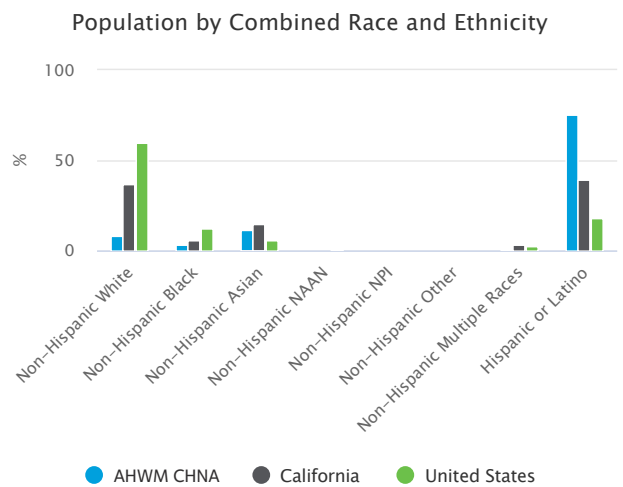
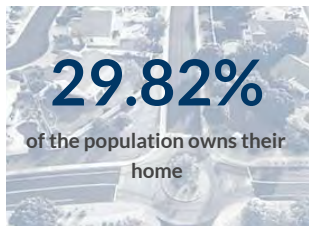
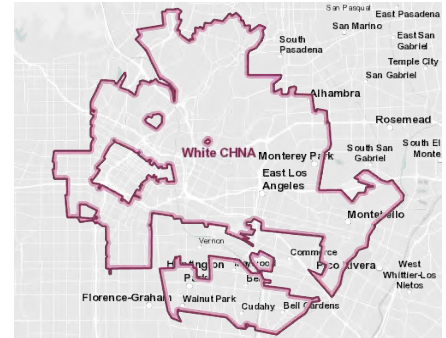
What if our community worked together and made life all-around better? What if we offered various pathways to meet our diverse needs, so every member of our community experienced better health, prosperity and longevity?

# Who We Serve

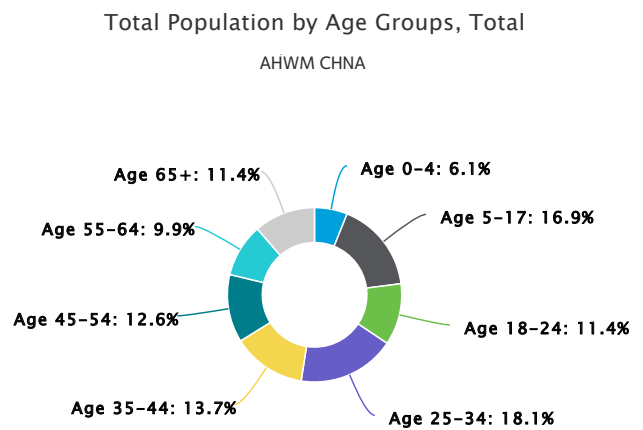
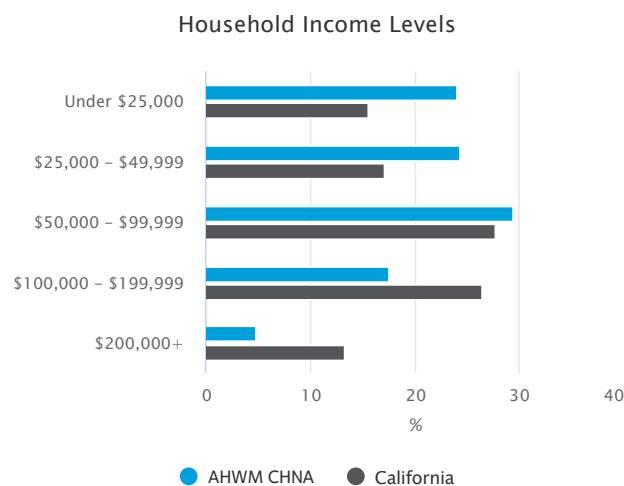
## DEMOGRAPHIC PROFILE

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

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



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





# About Us

## Adventist Health White Memorial

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

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



## Adventist Health

Adventist Health is a faith-inspired, nonprofit integrated health system serving more than 80 communities on the West Coast and Hawaii. Founded on Adventist heritage and values, Adventist Health provides care in hospitals, clinics, home care agencies, hospice agencies and joint-venture retirement centers in both rural and urban communities. Our compassionate and talented team of 34,000 includes associates, medical staff physicians, allied health professionals and volunteers driven in pursuit of one mission: living God’s love by inspiring health, wholeness and hope. Together, we are transforming the American healthcare experience with an innovative, yet timeless, whole-person focus on physical, mental, spiritual and social healing to support community well-being.

## Adventist Health’s Approach to CHNA & CHIS

Adventist Health prioritizes well-being in the communities we serve across our system. We use an intentional, community centered approach when creating our hospital CHNA’s to understand the health needs of each community. After the completion of the community assessment process, we address health needs such as mental health, access to care, health risk behaviors, and others through the creation and execution of a Community Health Implementation Strategy (CHIS) for each of our hospitals and their communities.

The following pages highlight the key findings the Adventist Health White Memorial CHNA Steering Committee (see page 20 for a list

of CHNA Steering Committee sector participants) identified as their top priority health needs, or as we refer to them in this report, their ‘High Priority Needs’. The High Priority Needs are addressed in this Community Health Implementation Strategy.

# High Priority Needs

The following pages highlight the High Priority Needs that will be addressed in this Community Health Implementation Strategy.



# Access to Care

## COMMUNITY VOICES

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



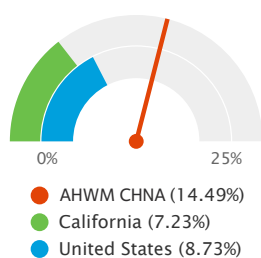
White Memorial residents provided important feedback regarding challenges they face and changes they would like to see. They shared about financial constraints, how these impact language barriers, and their ability to access insurance. Immigrant residents noted that their status limits their ability to receive benefits. The Hispanic community identified healthcare access as a particular problem, referencing concerns about available doctors and the challenges of cultural and linguistic diversity. The provider shortage might require residents to rely on the Emergency Room, and language proficiencies between providers and patients can be challenging.

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

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

## SECONDARY DATA INFOGRAPHIC STATS:

Uninsured Population, Percent



Primary Care Providers, Rate per 100,000 Population

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

# Financial Stability

## COMMUNITY VOICES

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



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

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

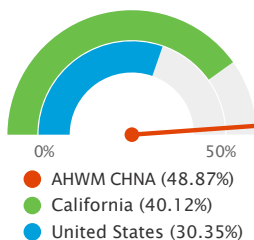
Due to limited time and money many neighborhood members have poor diets as they don't have the resources to get healthy foods. Residents have also noticed a large percentage of neighbors living paycheck to paycheck, unveiling basic financial instability.

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

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

## SECONDARY DATA INFOGRAPHIC STATS:

Percentage of Households where Housing Costs Exceed 30% of Income



## Income - Childhood Poverty Rate

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



# Food Security

## COMMUNITY VOICES

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



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

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

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

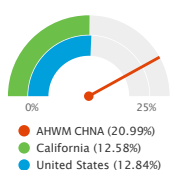
than double the national average and almost 30% higher than the California average.

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

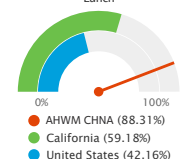
With community collaboration, secure food access, communication and education, families can work toward healthier choices and begin to change futures.

## SECONDARY DATA INFOGRAPHIC STATS:

Population in Poverty, Percent



Percentage of Students Eligible for Free or Reduced Price School Lunch



Population in Poverty Race Alone, Percent

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

# Mental Health

## COMMUNITY VOICES

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



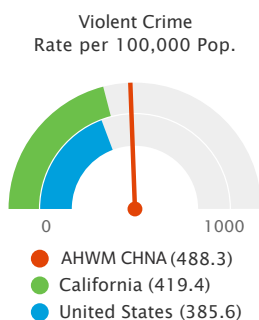
Input from a variety of residents has led to the realization that mental health is a concern that needs to be acknowledged and addressed.

A survey of community residents showed that 48% of those polled shared mental health as a top health concern. Community members commented there is a stigma attached to needing mental health services, and that the Hispanic community is less likely to access mental health care due to this associated stigma.

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

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

## SECONDARY DATA INFOGRAPHIC STATS:



## Mental Health Care Providers, Rate per 100,000 Population

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





# Action Plan for Addressing High Priority Needs

Committee members drew upon a broad spectrum of expertise and possible strategies to improve the health and well-being of vulnerable populations within the community.

The following pages reflect the goals, strategies, actions, and resources identified to address each selected High Priority Need.

**ADDRESSING HIGH PRIORITY: ACCESS TO CARE**

<b>GOAL</b>	Advocate for and collaborate with internal and external partners to identify community members experiencing difficulties accessing care and connect them to support services to increase access to care.				
<b>Priority Area:</b>	Access to Care	<b>Sub-Category:</b>	Availability & Barriers	<b>Defining Metric:</b>	Primary Care clinics shortage areas
<b>Strategy 1:</b>	Utilize stakeholders' existing intake processes to identify individuals experiencing access to care and enroll/direct them to existing services and programs.				
<b>Population Served:</b>	Total population				
<b>Internal Partners:</b>	Limb Preservation Clinic, Director of Finance, Patient Registration Manager, AH Board Members, Community Well-Being Committee, Hospital Board, Medical Staff, President of Foundation,				
<b>External Partners:</b>	FQHC Clinic, Queenscare Mobile Unit				
<b>Actions:</b> Program/Activity/Tactic/Policy		<b>Organization</b>		<b>Lead</b>	
Integrate into intake processes a means to ask people caring for children, 'Do you have difficulty accessing care?' and track responses and direct them to identified community resources.  Enroll person/family into CalAIM, Medi-Cal programs.  Open primary care mega-clinic to open additional access in the community.		Adventist Health - Clinics		Dr. Patel	
		Adventist Health – ED		Olivia Olmos	
		Limb Preservation		Geraldine Loughlin	
		FQHC		Dr. Grace Floutsis	
<b>YEAR ONE</b>	<b>YEAR TWO</b>		<b>YEAR THREE</b>		
Hardwire question ' <i>Do you have difficulty accessing care?</i> ' into partners' initial intake process and refer to identified organization(s).	Track responses to question quarterly and report out to all stakeholders. Collaborate with the organization offering services/programs to track referrals and troubleshoot referral process where needed.		Quarterly internal, external and identified community benefit organizations (CBOs) submit, and review data collected by the collaborative and identify ways to streamline communications.		



<b>Strategy 2:</b>	Meet to identify existing community resources, programs and organizations that can lessen financial burden on parents/care givers and engage them to work collaboratively to streamline offering services to families and children.
<b>Population Served:</b>	All people with diabetes in community (90033 zip code, primary)
<b>Internal Partners:</b>	Limb preservation, Endocrinologist, Diabetes program, Welcome baby program, AH Board Members, Community Well-Being Committee, Hospital Board, Primary care clinic
<b>External Partners:</b>	FQHC Clinic

<b>Actions:</b> Program/Activity/Tactic/Policy	<b>Organization</b>	<b>Lead</b>
Collaborate with internal and external partners to identify and engage existing public and community benefit organizations (CBOs) to receive and enroll families and children with diabetes to their existing services/programs that increase access to care with emphasis on health education.	Adventist Health - Clinics	Dr. Nilem Patel
	Diabetes Clinic	Mary D'Avila
	FQHC	Dr. Grace Floutsis

<b>YEAR ONE</b>	<b>YEAR TWO</b>	<b>YEAR THREE</b>
Identify local CBOs that offer resources, programs or activities that benefit individuals with Diabetes and engage CBOs to partner with.	Meet with all stakeholders and CBOs to review shared data and discuss opportunities to streamline and expand collaborative base.	Meet with all stakeholders and CBOs to review shared data and identify new CBOs to expand offered services/programs for families.

**ADDRESSING HIGH PRIORITY: FINANCIAL STABILITY**

<b>GOAL</b>	Develop systems and programs to aid our community in identifying and addressing key barriers to improving family financial stability.
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<b>Priority Area:</b>	Financial Stability	<b>Sub-Category:</b>	Workforce Development/Employment	<b>Defining Metric:</b>	Labor force participation Rate. Percent completing high school diploma. Percent enrolled in college. Percent obtaining RN degree.
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<b>Strategy:</b>	Enhance current programs in workforce development and MAOF resource connections
<b>Population Served:</b>	Total population
<b>Internal Partners:</b>	CRC, Foundation, Workforce Development
<b>External Partners:</b>	Mexican-American Opportunity Foundation (MAOF), TELACU Education Foundation (TEF), Bank of America

<b>Action:</b> Program/Activity/Tactic/Policy	<b>Organization</b>	<b>Lead</b>
Recruit high school students to complete our Workforce Development program.	Bank of America	Ray Vasquez
	MAOF	Dr Cid Pinedo
	TEF	David Lizarraga
Recruit and provide support mechanisms for local individuals wanting to obtain a nursing degree.		
Provide support mechanisms for local individuals wanting to obtain their 4-year RN degree.		

<b>YEAR ONE</b>	<b>YEAR TWO</b>	<b>YEAR THREE</b>
Identify candidates from the community.	Identify key barriers to program completion.	Monitor advancement rates. Capture key learnings.
Enroll students in program.	Work on removing barriers to diploma attainment.	Build into future program resources.

**ADDRESSING HIGH PRIORITY: FOOD SECURITY**

<b>GOAL</b>	Advocate for and collaborate with internal and external partners to identify community members experiencing food insecurity and connect them to support services and CRC food distribution.				
<b>Priority Area:</b>	Food security	<b>Sub-Category:</b>	Food Access	<b>Defining Metric:</b>	Local food outlets
<b>Strategy:</b>	Utilize stakeholders' existing intake processes to identify those experiencing food insecurities and enroll/direct them to existing services and programs in-house as well as external partners.				
<b>Population Served:</b>	Total population				
<b>Internal Partners:</b>	Prima Pantry, FQHC, Community Resource Center (CRC)				
<b>External Partners:</b>	Food Bank, YMCA				
<b>Actions:</b> Program/Activity/Tactic/Policy	<b>Organization</b>		<b>Lead</b>		
<p>Provide English/Spanish Community Services Resource Guide to local CBOs.</p> <p>Advocate at city or county meetings to create a policy to automatically enroll all people who use receive food subsidy into CalAIM.</p>	Adventist Health - Clinics		Boyle Heights clinic		
	Community Resource Center		Hana Mizban		
	YMCA		Hana Mizban		
	FQHC		Dr. Grace Floutsis		
	Food Bank		Hana Mizban		
<b>YEAR ONE</b>	<b>YEAR TWO</b>		<b>YEAR THREE</b>		
Hardwire question ' <i>Do you have difficulty accessing food?</i> ' into internal (CRC) initial intake process and refer to identified organization(s).	Track responses to question quarterly and report out to all stakeholders. Collaborate with donors and organization offering services/programs to track referrals and troubleshoot referral process when needed.		Quarterly internal, external and identified community benefit organizations (CBOs) submit, and review data collected by the collaborative and identify ways to streamline communications.		



**ADDRESSING HIGH PRIORITY: MENTAL HEALTH**

<b>GOAL</b>	Advocate for and collaborate with internal and external partners to identify community members who may benefit from mental health programs and connect them to these programs.
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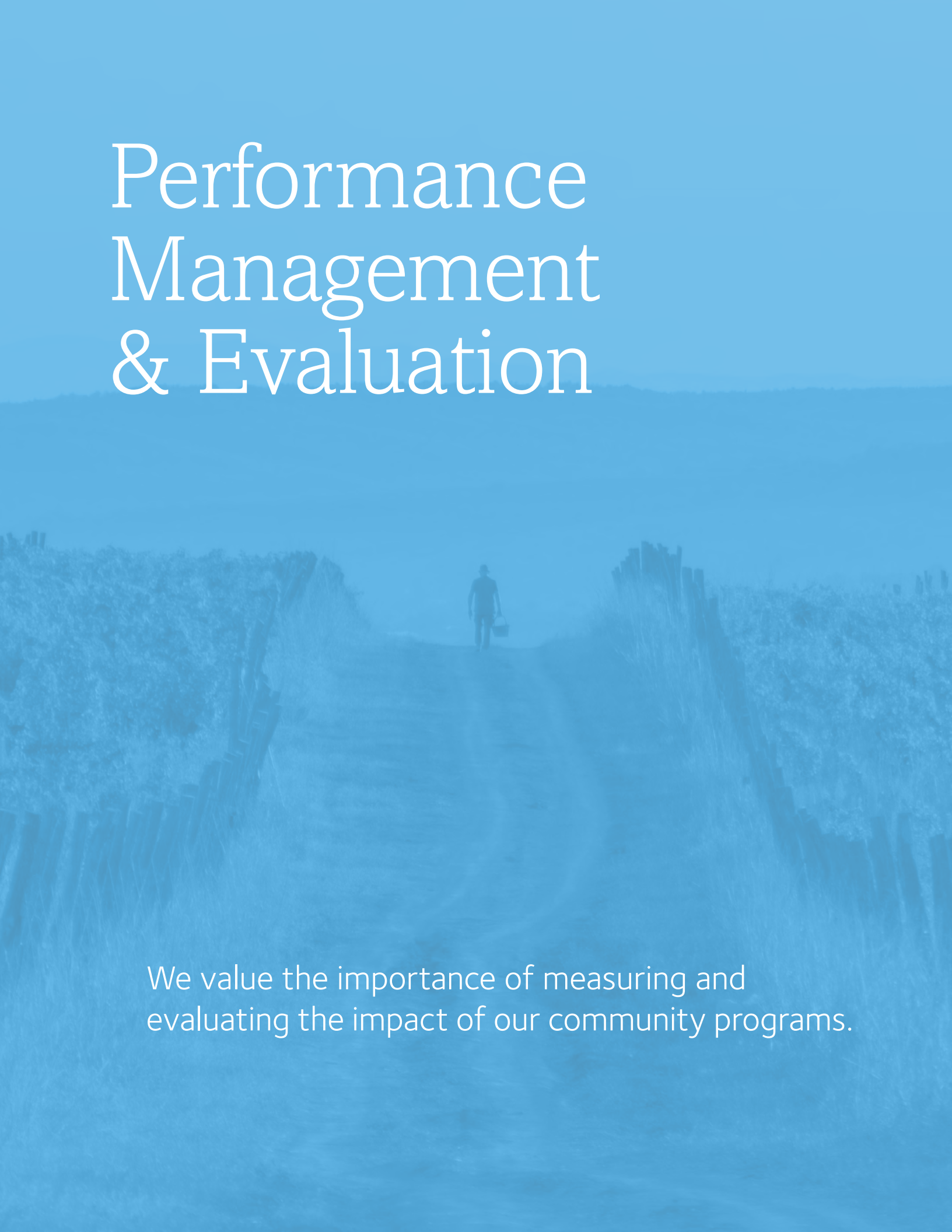
<b>Priority Area:</b>	Mental Health	<b>Sub-Category:</b>	Risk factors	<b>Defining Metric:</b>	Substance use disorders
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<b>Strategy:</b>	Utilize partners existing intake processes to identify those experiencing mental health barriers and enroll/direct them to existing services and programs in-house as well as external partners.
<b>Population Served:</b>	Total population
<b>Internal Partners:</b>	White Memorial Community Health Center (WMCHC) FQHC, Social Workers, Behavioral Medicine Navigator, Community Resource Center (CRC)
<b>External Partners:</b>	WellNest FQHC

<b>Action:</b> Program/Activity/Tactic/Policy	<b>Organization</b>	<b>Lead</b>
Provide English/Spanish Community Services Mental Health Resource Guide to local CBO. Utilize Community Garden for classes. Provide educational classes.	CRC	Hana Mizban
	Community Garden	Hana Mizban
	FQHC	Dr. Grace Floutsis
	WellNest FQHC	Charlene Dimas Peinado

<b>YEAR ONE</b>	<b>YEAR TWO</b>	<b>YEAR THREE</b>
Hardwire question <i>'Do you have difficulty accessing mental health programs?'</i> into intake process and refer to identified organization(s).	Track responses to question quarterly and report out to all stakeholders.  Collaborate with donors and organization offering services/programs to track referrals and troubleshoot referral process where needed.	Quarterly Internal, External and identified community benefit organizations (CBOs) submit, and review data collected by the collaborative and identify ways to streamline communications.

# Performance Management & Evaluation

A person is walking away from the camera on a dirt path that leads through a field of tall, dry grass. The person is carrying a basket. The entire image is overlaid with a semi-transparent blue color. The text 'Performance Management & Evaluation' is written in white, serif font in the upper left quadrant.

We value the importance of measuring and evaluating the impact of our community programs.

# Performance Management & Evaluation

Adventist Health will support the High Priority Need action plans identified in this CHIS by monitoring progress on an ongoing basis and adjusting the approach as needed over the course of the next three years. There are several resources in place to aid in this. All CHIS programs and initiatives will include a completed logic model to identify intended activities, outputs, and short and long-term outcomes. Establishing core metrics for each program or initiative will allow for the ongoing collection of

performance management data. Actively tracking metric performance leads to the identification of strengths and challenges to the work, the local hospital, the Adventist Health Community Benefit team, and external consultants. Together, we will work to share successes and create performance improvement plans when necessary.

In addition, Adventist Health hospitals where High Priority Needs are shared will have the opportunity

to join a collaborative held by the Adventist Health Well-Being team. The collaborative will be centered on building a common approach that aligns and maximizes community benefit, thus reducing the need to manage this work independently at each hospital. Along with that, where appropriate, evaluation activities designed to measure the overall strength and success of this work at the community level will be incorporated into performance management tracking.

## CHIS Development

The development of the CHIS was directly built from the CHNA, whose goal focused on leveraging community stakeholders and data to address the most significant health needs of our community over the next three years. Members of the CHNA Steering Committee—comprised of healthcare, civic, public, and business leaders—led the process of identifying and addressing health needs for a healthier community, completing the final report in fall of 2022.

Collaborating with CHNA Steering Committee members again in early

2023, Adventist Health Community Well-Being Directors facilitated a multi-step process to outline goals and strategies for the CHIS that foster change and positive impact in each of the High Priority Need areas. Each community relied on existing programs and services, and, where necessary, identified new opportunities to pursue collectively.

Once an approach received a consensus, the Community Well-Being Directors worked with Adventist Health leadership and expert consultants to set major

annual milestones for each approach, generating outputs and outcomes that allow for ongoing performance management of this work. For further information on how success will be tracked, refer to the Performance Management and Evaluation section above.

Finally, the CHIS was presented to Adventist Health local Hospital Boards for review and feedback. In addition to this collaborative effort, we also welcome feedback at [community.benefit@ah.org](mailto:community.benefit@ah.org).



Scan the QR code for the full Secondary Data Report





# Significant Identified Health Needs

The Adventist Health Community Well-Being team and community partners collectively reviewed all relevant significant health needs identified through the CHNA process. Using a community health framework developed for this purpose, 12 significant health needs were initially considered. The list of significant needs are as follows:

- Access to Care
- Community Safety
- Community Vitality
- Education
- Environment & Infrastructure
- Financial Stability
- Food Security
- Health Conditions
- Health Risk Behaviors
- Housing
- Inclusion & Equity
- Mental Health

From this group of 12, several high priority health needs were established for Adventist Health White Memorial. High priority health needs were chosen as they had demonstrated the greatest need based on severity and prevalence, intentional alignment around common goals, feasibility of potential interventions, and opportunities to maximize available resources over a three-year period.

Using the criteria mentioned above, we were able to determine which needs were high priority, as compared to those that were significant needs. The High Priority Needs are the focus of this CHIS. The remaining significant health needs are not addressed directly but will likely benefit from the collective efforts defined in this report. The following table provides additional information on all the significant health needs that were considered.

**TABLE OF SIGNIFICANT IDENTIFIED HEALTH NEEDS**

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



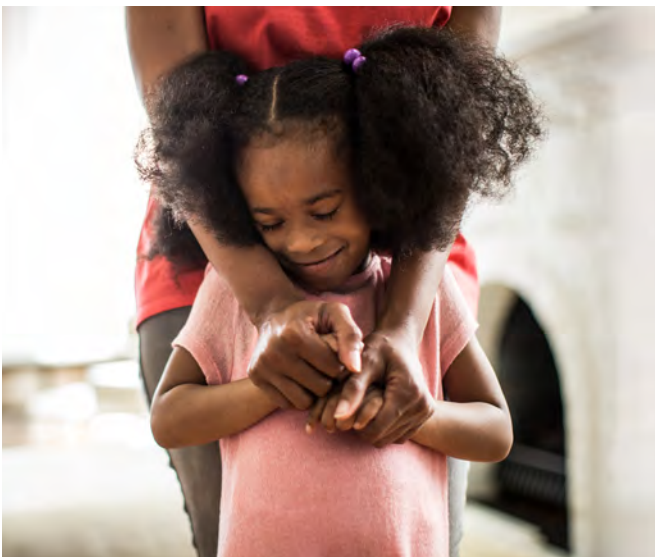
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## Community Health Financial Assistance for Medically Necessary Care Commitment

Adventist Health understands that community members may experience barriers in paying for the care they need. That is why we are committed to providing financial assistance to those who may need support in paying their medical expense(s).

Community members can find out if they qualify for financial aid in paying medical bills by completing a financial assistance application. Applications can be filled out at the time care is received or after the bill has been administered. To access the financial assistance policy for more information or contact a financial assistant counselor, please visit <https://www.adventisthealth.org/patient-resources/financial-services/financial-assistance/>.



# Glossary of Terms

**COMMUNITY ASSET**

refers to community organizations, programs, policies, activities or tactics that improves the quality of community life.

**DEFINING METRIC**

this is the metric used to define the extent of the problem faced by the target population.

**FUNDING**

can be provided by (but not limited to) government agencies, public organizations, grants and philanthropic giving.

**GOAL**

there may be several overarching goals to address each prioritized health need. This is the overarching impact we want to achieve.

**PARTNERS**

describe any planned collaboration between the hospital and other facilities or organizations in addressing health needs.

**POPULATION SERVED**

who is included within the group to receive services of the program.

**PRIORITIZED HEALTH NEED/  
PRIORITY AREA/SIGNIFICANT  
HEALTH NEEDS**

a health need that was identified in a community health needs assessment and was then selected by committee as a high priority need to be addressed.

**STAKEHOLDER- INTERNAL**

colleagues and or board members who work for or with the hospital.

**STAKEHOLDER- EXTERNAL**

community members or organizations who regularly collaborate with the hospital.

**STRATEGY**

a specific action plan designed to achieve the expected outcome.

**SUB-CATEGORY**

If needed, a more granular focus within the identified priority area may be called out.



# Approval Page

## 2023 CHIS Approval

In response to the 2022 Community Health Needs Assessment, this Community Health Implementation Strategy was adopted on April 27, 2023 by the Adventist Health System/West Board of Directors.

The final report was made widely available on May 31, 2023.

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Thank you for reviewing our 2023 Community Health Implementation Strategy.  
We are proud to serve our local community and are committed to making it a healthier place for all.

**John Raffoul, DPA, FACHE**  
Adventist Health White Memorial

