2021

Community Health Needs ASSESSMENT REPORT

Goshen Health

Table of Contents

Executive Summary of Findings for Goshen Health Communities 4
- Introduction 4
- Community Health Needs in Goshen Health Communities 5
- Prioritized Community Health Needs 6

Introduction 7
- Goshen Health 7
- CHNA Process and Leadership 8
- Consultants 9

Community Served 10
- Goshen Health Communities 10
- Demographics 11
  - Population and Age 11
  - Race/Ethnicity 13
- Social Determinants of Health 14
  - Employment 14
  - Income 14
  - Poverty 15
  - Education 16
  - Medically Underserved Areas 17

Progress since Prior CHNA 18
- 2018 Implementation Plan Priorities and Outcomes 19
- Community Feedback from 2018 CHNA Report and Implementation Plan 19

Data Methodology and Analysis 20
- Secondary Data: Methodology and Findings 20
- Primary Data: Methodology and Findings 22
  - Focus Groups and Key Informant Interviews 22
  - Community Surveys 23

Data Coding and Integration 29

Methodology 29

Results 30

Barriers to Care 31

Prioritization of Community Health Needs 33

Health Needs Prioritized and Those Not Prioritized: Methodology and Results 33

Prioritized Community Health Needs: Methodology and Results 34

Resources Available and Not Available to Address Community Health Needs 34

Appendices 35

Appendix I: 2021 Secondary Data Report: University of Wisconsin Population Health Institute 2020 County Health Rankings 35

Part 1: National Key Findings Report 35

Part 2: Indiana Key Findings Report 52

Part 3: Snapshot of Communities Served by Goshen Health 64

Appendix II: 2021 Secondary Data Report: United For ALICE. (2020). *ALICE in Indiana: A financial hardship study.* Retrieved from https://unitedforalice.org/indiana 85

Appendix III: Community Health Needs Survey 130

Appendix IV: Community Health Needs Survey Findings 136

Appendix V: Community Resources 140

Resources Needed: Focus Group and Key Informants 141

Community Resources 142

Appendix VI: Organizations Represented by Focus Group and Individual Interview Participants 143

Appendix VII: Frequency Rankings of Community Health Needs 145

Appendix VIII: CHNA Leadership Groups 147

Appendix IX: Strategies that Addressed 2021 Community Health Needs 149

Executive Summary of Findings for Goshen Health Communities

Introduction

In 2021, Goshen Health completed an evaluation of its communities' healthcare needs as required by the Patient Protection and Affordable Care Act. This process continues Goshen Health's long-standing practice of regularly identifying and addressing health needs within its communities.

To identify the health needs for the 2021 community health needs assessment (CHNA), data were collected from secondary sources and from a community survey, Latino and non-Latino parents of school age parents and guardians, community leaders, focus groups and key informants from business, not-for-profit and service organizations, healthcare and mental health workers, and those from or representing vulnerable populations. These data were analyzed to identify and prioritize health needs in the Goshen Health communities. These sequential steps are illustrated in the figure below.

The findings of this report will enable Goshen Health to develop initiatives that focus on improving the health of those it serves.

Figure 1: *Data and the Prioritization of Community Health Needs*

Community Health Needs in Goshen Health Communities

The health needs were identified after an extensive analysis of secondary and primary data that included surveys, focus groups and key informants.

Health Needs Identified

- Advocacy for seniors
- Air pollution
- Cancer
- Cardiovascular health
- Child abuse
- Child mortality
- Combined/comorbid health issues
- Culture and lifestyle
- Diabetes treatment and prevention
- Disinformation around health issues caused by political polarization
- Family and social support
- Formal education
- Health education
- Immigrant health
- Infant mortality
- Insurance coverage
- Lack of access to health care
- Mental health
- Nutrition
- Obesity/Weight management
- Physical fitness/Exercise
- Poverty
- Social Isolation
- Substance abuse/Addictions
- Teen births
- Tobacco use/Smoking
- Transportation
- Treatment of chronic diseases
- Violence

Prioritized Community Health Needs

The Goshen Health Community Advisory Council met on July 16, 2021, to prioritize the community health needs that had been identified. Members of the committee are listed in Appendix VIII. The committee included broad representation from the community as well as Goshen Health leadership. The health needs identified as priorities and their rank order were determined after consideration of various criteria.

Rank Order	Prioritized Health Need
1	Mental health
2	Diabetes treatment and prevention
3	Poverty
4	Obesity/Weight management
5	Lack of access to health care
6	Substance abuse/Addictions
7	Health education

Table 1: *Prioritized Health Needs*

The Goshen Health implementation strategies will identify which of these prioritized health needs it will address and the plan for doing so.

Introduction

Goshen Health

Goshen Health has proudly served as a community-owned not-for-profit health system for over 100 years. With 36 locations across four counties, they offer specialized cancer care; heart and vascular care; and a physician's network with primary and specialty care. Their mission of improving the health of our communities is the driving force behind their nearly 2,000 Colleagues and providers.

Every three years, Goshen Health takes a close look at the communities' healthcare needs. They use the methods outlined in this report to gain deeper insight into what matters the most to who they serve: their patients, their communities and their Colleague base. As they listen, learn and collaborate with key partners, they recognize ways they can make a difference in the lives of people who live, work and play in Goshen and the surrounding area.

CHNA Process and Leadership

As noted in the schematic below, the CHNA process consists of two phases:

- Development of the community health needs assessment (CHNA) report
- Implementation plan/strategies to address selected prioritized health needs

The CHNA report is Phase I of the CHNA process.

PHASE 1: Community Health Needs Assessment (CHNA) Report

DATA COLLECTION		ANALYSIS	PRIORITIZATION	CHNA REPORT
Secondary Data	Primary Data	Analyze Data	Identify & Prioritize data	Prepare CHNA Report
Goshen Health	Goshen Health Venture International Community Advisory Committee	Venture International	Community Advisory Committee	Venture International Community Advisory Committee

PHASE 2: Implementation

IMPLEMENTATION PLAN — Goshen Health

Health Need Addressed
Health Need Unaddressed
Implement Strategy

Figure 2: *The Two Phases of the CHNA Process*

INTRODUCTION

Goshen Health appointed three groups to oversee, guide or participate in the CHNA process:

- Goshen Health Steering Committee
- Goshen Health Planning Team
- Goshen Health Community Advisory Council

The steering committee was appointed by the Goshen Health CEO to oversee both the community health needs assessment report process and the development of the implementation plan. The committee is accountable to the Goshen Health CEO and ensures that the CHNA report and implementation plan are submitted to the CEO for adoption by the Goshen Health board.

The planning team implemented the CHNA process as defined by the steering committee. The team ensured that the day-to-day details required for a successful CHNA process were adequately addressed.

The Goshen Health Community Advisory Council (CAC) included community members, as well as steering committee and planning team members. CAC responsibilities were to:

- Serve as advocates in the community for the CHNA process and outcomes
- Provide counsel regarding the membership of focus group and key informants to be interviewed
- Assist in interpreting the data gathered during the CHNA process
- Identify and prioritize the health needs of the community

Members of steering committee, planning team, and community advisory council are listed in Appendix VIII.

Consultants

Venture International LLC (VI) was retained by Goshen Health to provide consultation for the 2021 community needs assessment, and includes the following participants: Dr. Curt Bechler, Chief Executive Officer; Justin Weaver, Managing Partner and Tamra Ummel, Partner.

Venture International's headquarter is in Hudsonville, Michigan, and provides data-driven products and services to improve outcomes, enhance the sustainability and ensure best practices in health systems and other organizations. Venture International has been involved in community health needs assessment processes since 2002. To learn more about Venture International LLC, visit: http://vianswers.com.

Community Served

Goshen Health Communities

Goshen Health's communities consist of four counties in northern Indiana: Elkhart County, in which Goshen Health is located, and the secondary service areas of LaGrange, Noble, and Kosciusko Counties.

Figure 3: *Goshen Health Communities*

Demographics

The following demographic data is from the US Census Bureau population estimates, vintage 2002, 2006, 2010, 2016 and 2019.

Population and Age

Elkhart County is the most populated county and has the highest growth rate in its four-county service area.

Population (not graphed)	2002 Data	2006 Data	2010 Data	2012 Data	2016 Data	2019 Data
Indiana	6,148,648	6,300,341	6,445,295	6,597,000	6,619,680	6,732,219
Elkhart County	185,148	196,691	197,558	199,619	203,474	206,341
4-county region				362,331	368,636	373,155

Population 4-Year Growth Rate	2002 Data	2006 Data	2010 Data	2012 Data	2016 Data	2020 Data
Indiana		2.5%	2.3%	2.4%	0.3%	N/A
Elkhart County		6.2%	0.4%	1.0%	1.9%	N/A
4-county region					1.7%	N/A

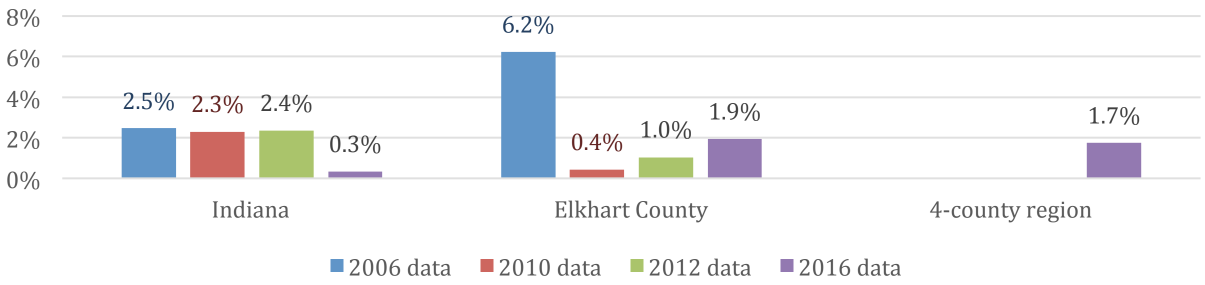


***Figure 4:** Population and Growth Rates*

COMMUNITY SERVED

Demographics

Population and Age

While the majority of the population in LaGrange, Noble and Kosciusko Counties is rural, only 20.6% of Elkhart County's population was rural as indicated in the 2010 U.S. Census.

The population in Elkhart County's service area is younger than that of Indiana as a whole.

Population by Age Group	2012 <18	2012 65+	2015 <18	2015 65+	2019 <18	2019 65+
Indiana	24.3%	13.6%	23.9%	14.6%	23.3%	16.1%
Elkhart County	28.1%	12.7%	28.0%	13.6%	27.4%	15.1%
4-county region	28.4%	13.2%	27.9%	14.2%	26.9%	15.7%

Largest Segment (not graphed)	2012 Age 18-64	2015 Age 18-64	2019 Age 18-64
Indiana	62.1%	61.5%	60.6%
Elkhart County	59.2%	58.4%	57.5%
4-county region	58.4%	57.9%	57.4%

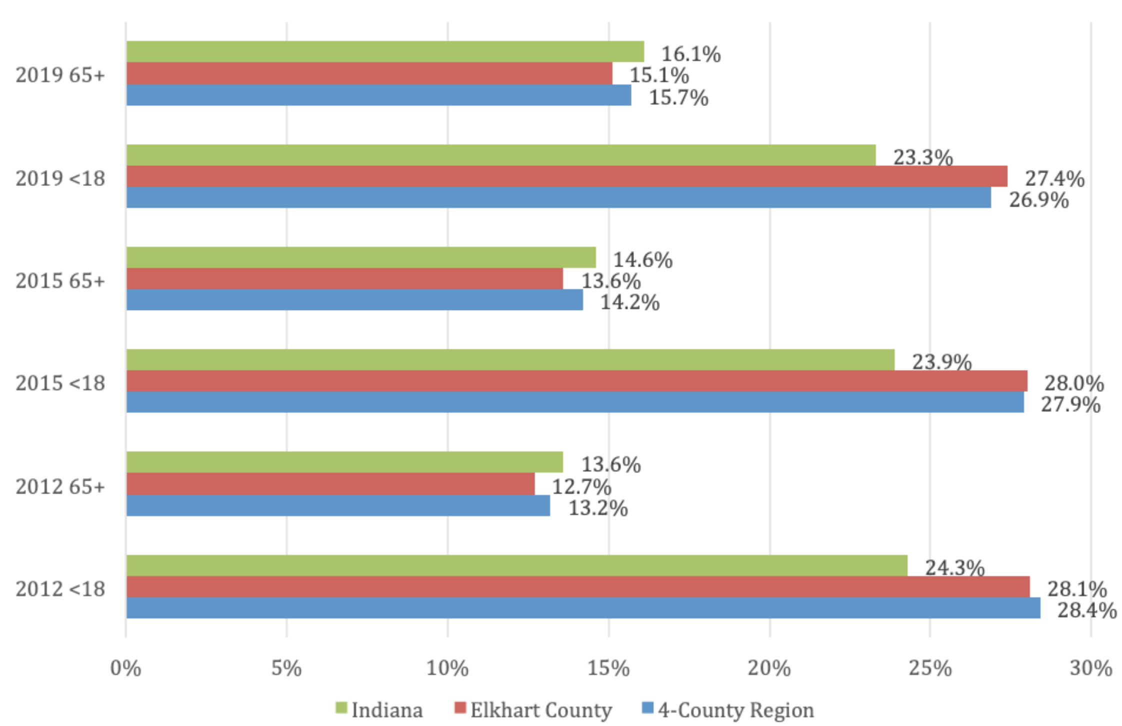


Figure 5: *Population by Age Groups*

COMMUNITY SERVED

Demographics

Race/Ethnicity

The percentage of African Americans in the Goshen Health service area is smaller than the state of Indiana, although the percentage of Latinos is significantly higher. In the four-county service area, Elkhart County has the highest percentage of Latinos (16.8% compared to 9.4% in the four-county area). In the City of Goshen, Latino students currently make up over 53% of the students in Goshen Community Schools.

Population by Race & Ethnicity

		Indiana	Elkhart	4-County Region
Race	2+ races	2.2%	2.5%	1.5%
	White	84.8%	89.5%	94.8%
	Black or African American	9.9%	6.1%	2.2%
	American Indian and Alaska Native	0.4%	0.6%	0.4%
	Asian	2.6%	1.2%	1.0%
	Native Hawaiian and Other Pacific Islander	0.1%	0.1%	0.1%
Ethnicity	White alone, not Hispanic	78.4%	74.1%	85.6%
	Hispanic or Latino	7.3%	16.8%	9.9%

0% 20% 40% 60% 80% 100%

Figure 6: *Population by Race and Ethnicity*

Social Determinants of Health

Employment

Currently there are many job openings in Goshen Health's four-county area of service as unemployment has dropped substantially since the last recession.

Unemployment	2009 Data	2011 Data	2015 Data	2020 Data
Indiana	9.2%	8.4%	4.8%	3.4%
Elkhart County	13.6%	9.6%	3.8%	2.6%
4-counties' AVERAGE %		8.5%	3.9%	2.7%

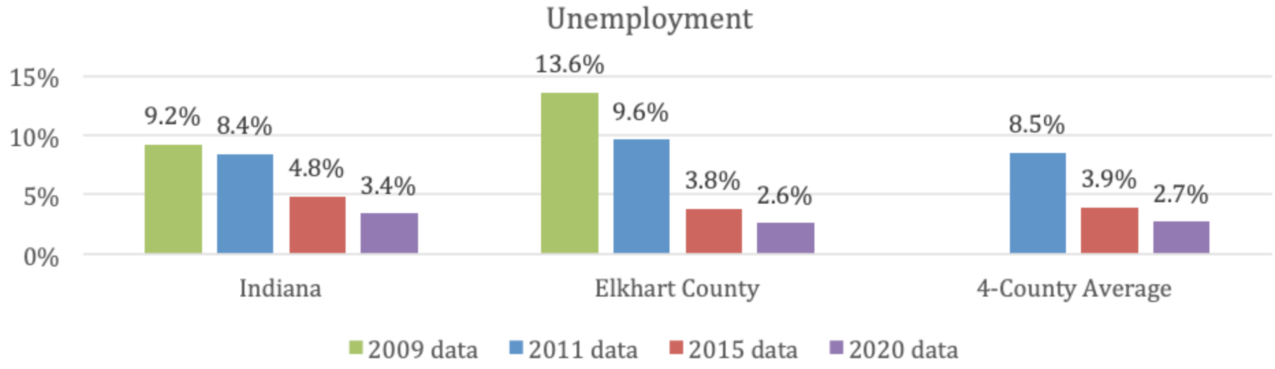


Figure 7: *Unemployment*

Income

Low unemployment is slowly translating into wage increases since the recession, although median household income in Goshen Health's communities remains lower than in Indiana.

Median Household Income	2009 data	2012 data	2015 data	2019 data
Indiana	$45,427	$46,954	$51,721	$56,303
Elkhart County	$43,531	$45,806	$49,448	$57,021
4-county region average		$47,005	$50,439	$59,919

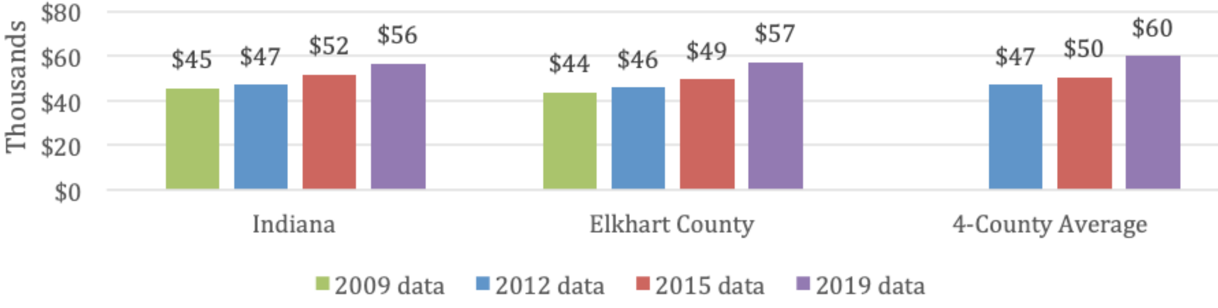


Figure 8: *Median House Income*

COMMUNITY SERVED

Social Determinants of Health

Poverty

Children living in poverty is one indicator of health vulnerability of a population. Child poverty in Elkhart County rose between 2000 and 2009 and levels are like those in Indiana, but higher than in the other three counties served by Goshen Health. Child poverty improved after 2012.

Children Living in Poverty	2000 Data	2009 Data	2012 Data	2015 Data	2020 Data
Indiana	11.7%	18.2%	22.1%	20.4%	17.5%
Elkhart County	10.2%	19.7%	21.2%	19.4%	16.0%
4-county region average			19.9%	15.3%	12.9%

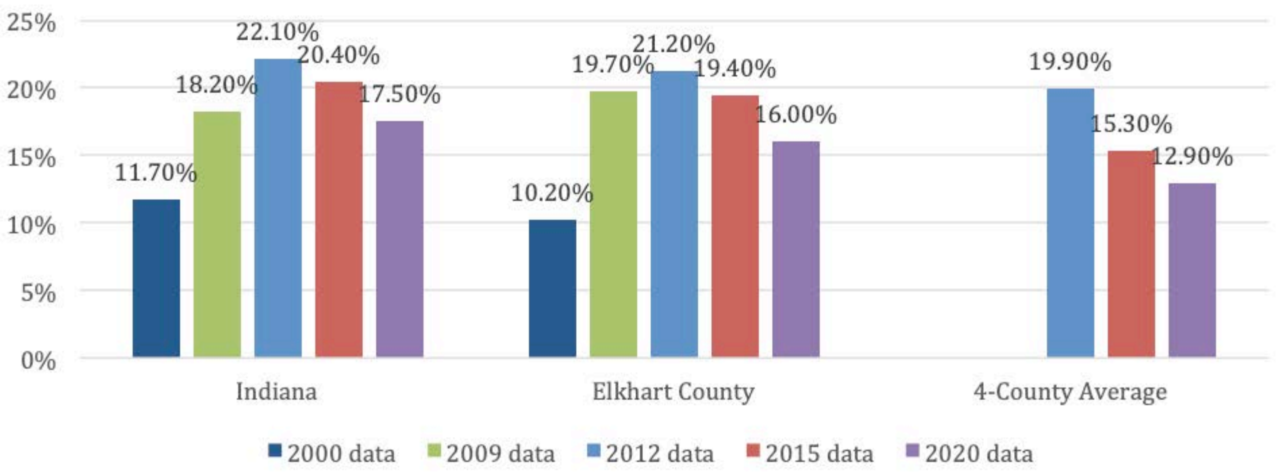


Figure 9: *Children Living in Poverty*

Education

In 2009, the percentage of high school graduates in Elkhart County is for the adult population. After 2009, the percentage indicates the graduation rate. While high school graduation rates in the Goshen Health communities are comparable to Indiana in 2012 and 2016, and significantly better in 2020, postsecondary education in the four-county region is below that of Indiana.

High School Graduates	2009 Data	2012 Data	2016 Data	2020 Data
Indiana		86.5%	86.5%	83.8%
Elkhart County	36.6%	85.4%	85.4%	91.0%
4-counties' AVERAGE %		85.4%	85.4%	91.8%

High School Graduates

100%
80%
60%
40%
20%
0%

Indiana: 86.5% 86.5% 83.8%
Elkhart County: 36.6% 85.4% 85.4% 91.0%
4-County Average: 85.4% 85.4% 91.8%

2009 data | 2012 data | 2016 data | 2020 data

Figure 10: *High School Graduates*

Medically Underserved Areas

The primary medically underserved areas in the Goshen Health communities are in Elkhart County with an area also located in Warsaw, Kosciusko County.

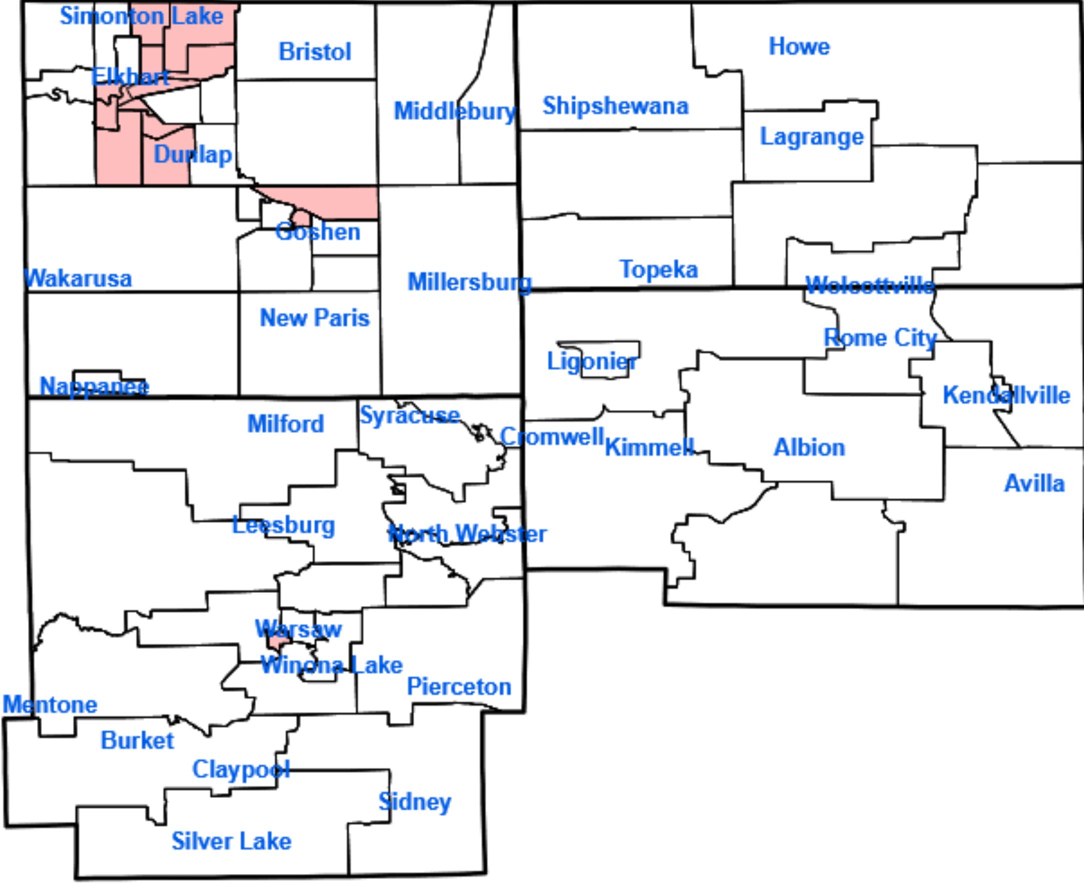


Figure 11: *Medically Underserved Areas (MUAs) by County Census Tract =*

COMMUNITY SERVED

Progress Since Prior CHNA

The CHNA process identifies and prioritizes the health needs of the community. The implementation strategies for addressing selected community health needs are then developed. As noted in the diagram below, an important aspect of the process is to review the outcomes of the implementation strategies so that the action plan can be strengthened.

CHNA

Implementation Plan

Expected Improved Health Outcomes

Monitor/Evaluate Actual Outcomes

Modify Action Plans

Ongoing Assessment and Improvement

Figure 12: *CHNA Implementation Plan*

2018 Implementation Plan Priorities and Outcomes

In 2018, Goshen Health identified several key community health need priority areas and corresponding implementation strategies.

The first priority area included obesity, physical fitness, nutrition and health education. Three strategies were designed and implemented to address this area:

1. Goshen Health led a community coalition to improve and expand broad access obesity initiatives with outcome measures, focusing on high-risk populations and cultural minorities.

2. Goshen Health established an evidence-based survey to connect obese patients screened in Accountable Care Organizations with health coaches or other resources.

3. Goshen Health launched a pilot intervention program for obese pediatric patients which took into account social determinants of health.

The second priority area included diabetes, nutrition and health education. One strategy was designed and implemented to address this area:

1. Goshen Health established an intervention platform for uncontrolled diabetes, using a community-developed, evidence-based education tool to provide diabetic patients with ongoing education alongside the use of an evidence-based survey instrument to link diabetic patients with appropriate resources.

The full 2019-2021 Goshen Health CHNA Action Plan is available in Appendix IX.

Community Feedback from 2015 CHNA Report and Implementation Plan

Although the 2018 CHNA report and implementation plan were made available to the public via Goshen Health's website, https://goshenhealth.com/home, or by paper copy as requested, no comments were received.

Data Methodology and Analysis

Two secondary and six primary data sets were analyzed for the 2021 Goshen Health CHNA.

Secondary data

- University of Wisconsin Population Health Institute 2020 County Health Rankings
  - National Key Findings
  - Indiana Key Findings
  - Snapshot of Communities Served by Goshen Health
- United for ALICE 2020 National Report

Primary data

- Focus Groups
- Key Informant Interviews
- Surveys
  - Latino and Non-Latino Parents and Guardians of School-Age Children
  - Amish Community Leaders
  - Latino and Non-Latino Community Members
  - Individual Focus Group and Key Informant Interview Participants

Findings were integrated to provide a comprehensive overview of health needs in the Goshen Health communities.

Secondary Data: Methodology and Findings

The University of Wisconsin Population Health Institute's 2020 County Health Rankings were consulted to create a secondary data report. This report included the University of Wisconsin's National Key Findings and Indiana Key Findings, as well as a trend report created by Goshen Health with data from the 2018, 2019 and 2020 County Health Rankings on the four counties (Elkhart, Kosciusko, LaGrange, and Noble) served by Goshen Health. The report developed a community health profile from existing health, social, and economic indicators for Goshen Health communities.

In addition to the County Health Ranking data, the secondary data report also integrates information from United Way's United for ALICE 2020 National Report. United for ALICE measures the number of households who classify as ALICE: Asset Limited, Income-Constrained and Employed. Households are classified as ALICE if their income is above the Federal Poverty Level, but below the basic cost of living.

The most significant health issues identified in the secondary data include:

- Air pollution
- Availability of health services
- Child mortality
- Formal education
- Infant mortality
- Insurance coverage
- Obesity/Weight management
- Physical fitness/Exercise
- Substance abuse/Addiction
- Unsafe sex

Health issues from the County Health Rankings (CHR) were considered to be significant if they passed two of the following four tests:

1. According to the last three years' CHR reports*, is the health issue trending in the wrong direction** in Elkhart County?
2. According to the 2020 CHR data, is the health issue more prevalent in Elkhart County than in Indiana?
3. According to the last three years' CHR reports, is the health issue trending in the wrong direction in at least two counties of the three-county region?
4. According to the 2020 CHR data, is the health issue more prevalent in at least two counties of the three-county region than in Indiana?

**Data in the 4-county region snapshot document is drawn from the 2018, 2019 and 2020 CHR yearly reports. As each report collects several years of past data, the reports do not reflect the condition of the region in a specific year.*

***A health factor/outcome is "trending in the wrong direction" if it is a negative factor and is increasing across the three reports or is a positive factor and is decreasing across the three reports.*

Health issues deemed significant were placed into a health need category determined by the issue's County Health Ranking categorization and the 2018 CHNA's health need categories.

A summary of health-related trends is provided in the table below. Health factors and outcomes which consistently increased or decreased for two counties of the four-county region across the 2018, 2019 and 2020 CHR reports are included. When considering these trends, a key issue to remember is that the data in these secondary trend reports are not fully current but reflect several years of prior data.

Increasing Trends*

- **Arrests for the possession of synthetic and other drugs**
- **Child mortality**
- **Children in single-parent households**
- College attendance
- Food environment index
- **Sexually transmitted infections**
- **Injury deaths**
- **Long commute driving alone**
- Median household income
- **Premature mortality**
- **Years lost to death**

Decreasing Trends*

- Children in poverty
- Disconnected youth
- Income inequality
- Population per non-physician primary care provider
- Severe housing problems
- Teen births
- Unemployment
- Uninsured children

***Table 1:** Increasing and Decreasing Health-Related Trends*

**Trends which are bolded will likely have a negative impact on community health. Trends are listed alphabetically, not by magnitude or importance.*

Data sources, findings and methodology for the secondary data reports are described in Appendix I.

Primary Data: Methodology and Findings

The primary data collection process included focus groups, key informant interviews and surveys, providing a contemporary perspective of health-related needs in Goshen Health communities.

Focus Groups and Key Informant Interviews

Focus Groups

During the spring of 2021, three community focus groups (22 participants) from across the Goshen Health service area met. These groups included healthcare providers, senior care personnel, and representatives from faith-based and other nonprofit organizations. The organizations represented in these focus groups are listed in the Appendix VI.

Focus group discussions identified the most significant health needs in the community, barriers to meeting these needs, and resources available. The relative importance of a health-related need was determined by the frequency with which the need was identified, and included:

- Mental health
- Obesity
- Substance abuse: addictions, alcohol, drugs
- Culture and lifestyle
- Disinformation around health issues caused by political polarization
- Family dysfunctionality
- Lack of access to affordable quality health care
- Acute care for mental health/Mobile crisis unit to respond to dysfunction
- Lack of health education
- Combined or comorbid health issues
- Transportation
- Advocacy for seniors
- Support for chronic conditions

Key Informant Interviews

Seven key informants were interviewed during the month of May 2021. They represented a broad cross-section of community leaders from the organizations listed in the Appendix VI. The relative importance of the health-related need was determined by the frequency with which the need was identified, and included:

- Diabetes
- Obesity
- Mental health
- Access: Lack of healthcare education, Lack of physicians and mental health providers
- Poverty
- Social isolation
- Cancer
- Child abuse
- Chronic disease management
- Drugs
- Smoking
- Chronic mental illness
- Immigrant health
- Lack of physicians

Community Focus Groups and Key Informants: Selection Criteria and Demographics

Focus group members and key informants were selected based on their expertise in public health, special knowledge of community health needs, ability to represent the broad interests of the community served by the hospital or were a member of or could speak to the needs of medically underserved or vulnerable populations. Appendix VI provides information on the organizational affiliations of these participants.

Community Surveys

Survey: Focus Groups and Key Informants

Prior to each focus group meeting and key informant interview, each participant was asked to complete a brief survey. The purpose of the survey was to stimulate the thinking of focus group members and key informants for the conversations that followed. In addition, the survey provided a systematic method of gathering the individual perspectives of participants. A total of 21 surveys were completed.

The survey included:

- Perceptions of health in the community served by Goshen Health
- Four multiple choice questions, in which participants selected the top three health needs, health education needs, barriers to these needs, and resources to address these needs
- Two multi-statement Likert scale questions regarding community social health and support for specific groups
- A request for demographic information

Participants selected their top three options from a list of twenty-two health needs. The percentage of participants who selected each need was then calculated and needs which were in the top third of options selected by percentage were considered significant.

The most significant health needs identified in the survey included:

- Mental health/Depression
- Obesity/Weight management
- Substance abuse/Addictions
- Availability to health services
- Health education
- Family and social support
- Treatment of chronic diseases
- Diet and healthy eating
- Diabetes treatment and prevention
- Poverty
- Cardiovascular health

Survey: Latino and Non-Latino Parents and Guardians of School-Age Children

Three-hundred and ninety-five (395) Goshen Community Schools (GCS) parents and guardians participated in an online survey in Spanish or English in the spring of 2021. Ninety-five (95) survey respondents were Latino and 300 were non-Latino. The purpose of the survey was to provide a snapshot of health perceptions of the parents of schoolchildren in the Goshen, Indiana area.

The survey included:

- Perceptions of health in the community served by Goshen Health
- Four multiple choice questions, in which participants selected the top three health needs, health education needs, barriers to these needs, and resources to address these needs
- Two multi-statement Likert scale questions regarding community social health and support for specific groups
- A request for demographic information

The ethnicity of participants and their age ranges are shown in the graphs below.

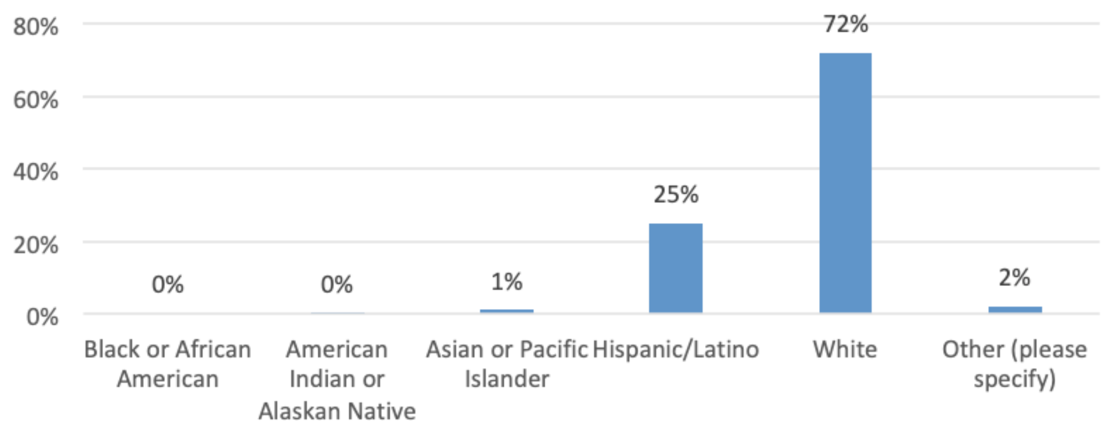


Figure 13: *Ethnicity of GCS Parents and Guardians*

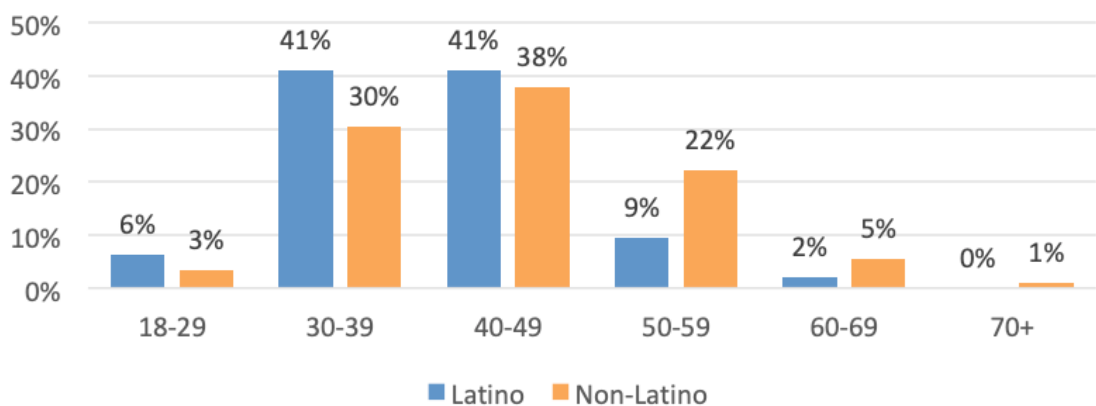


Figure 14: *Age of GCS Latino and non-Latino Parents and Guardians*

Participants selected their top three options from a list of twenty-two health needs. The percentage of participants who selected each need was then calculated and needs which were in the top third of options selected by percentage were considered significant. The most significant health needs identified are noted in the table below. See Appendix III for the ranking of all health needs identified by Latino and non-Latino parents and guardians.

Significant Health Concerns Among Latino Parents and Guardians	Significant Health Concerns in Non-Latino Parents and Guardians
Mental health/Depression	Mental health/Depression
Obesity/Weight management	Obesity/Weight management
Health education	Poverty
Availability of health services	Substance abuse/Addictions
Insurance coverage	Insurance coverage
Substance abuse/Addictions	Diet and healthy eating
Physical fitness/Exercise	Availability of health services
Diet and healthy eating	Family and social support
Diabetes treatment and prevention	Physical fitness/Exercise
Tobacco use/Smoking	

Table 2: *Significant Health Concerns of Latino and Non-Latino Parents and Guardians*

While many of the health needs are identical for each group, Latino respondents are more concerned about health education, diabetes treatment and prevention and tobacco use/smoking than non-Latino respondents, for whom poverty and family and social support are of greater concern.

Data Considerations

The purpose of the survey was to provide a snapshot of health perceptions and needs of the parents and guardians of Latino and non-Latino schoolchildren in the Goshen, Indiana, area. Over half of the students enrolled in Goshen Community Schools are Latino. Fewer Latino parents and guardians completed the survey than was the case for non-Latino parents and guardians (95 Latinos to 300 non-Latinos). Yet, 24% of respondents to the GCS survey were reportedly Latino which is comparable to the percentage (25%) of Latino families served by Goshen Community Schools. As such, it cannot be extrapolated across the entire demographic population or necessarily to other schools in the Goshen Health communities.

Survey: Amish Community Leaders
Four Amish community leaders completed a paper survey in English sent to them by mail in the spring of 2021. These leaders were selected to represent the broader Amish community served by Goshen Health.

The survey included:

- Perceptions of health in the community served by Goshen Health
- Four multiple choice questions, in which participants ranked the top three health needs, health education needs, barriers to these needs, and resources to address these needs
- Two multi-statement Likert scale questions regarding community social health and support for specific groups.
- A request for demographic information

Participants selected their top three options from a list of twenty-two health needs. The percentage of participants who selected each need was then calculated and needs which were in the top third of options selected by percentage were considered significant.

The most significant health needs identified in the survey included:

- Diet and healthy eating
- Substance abuse/Addictions
- Tobacco use/Smoking
- Cancer
- Obesity/Weight management
- Violence
- Cardiovascular health

Survey: General Community
Seven-hundred and ninety-two (792) residents of the region Goshen Health serves participated in an online survey in Spanish or English in the spring of 2021. Thirty-six (36) survey respondents were Latino and 756 were non-Latino. The purpose of the survey was to provide a snapshot of health perceptions of those served by Goshen Health. (Appendix III)

The survey included:

- Perceptions of health in the community served by Goshen Health
- Four multiple choice questions, in which participants ranked the top three health needs, health education needs, barriers to these needs, and resources to address these needs
- Two multi-statement Likert scale questions regarding community social health and support for specific groups.
- A request for demographic information

The ethnicity of participants and their age ranges are shown in the graphs below.

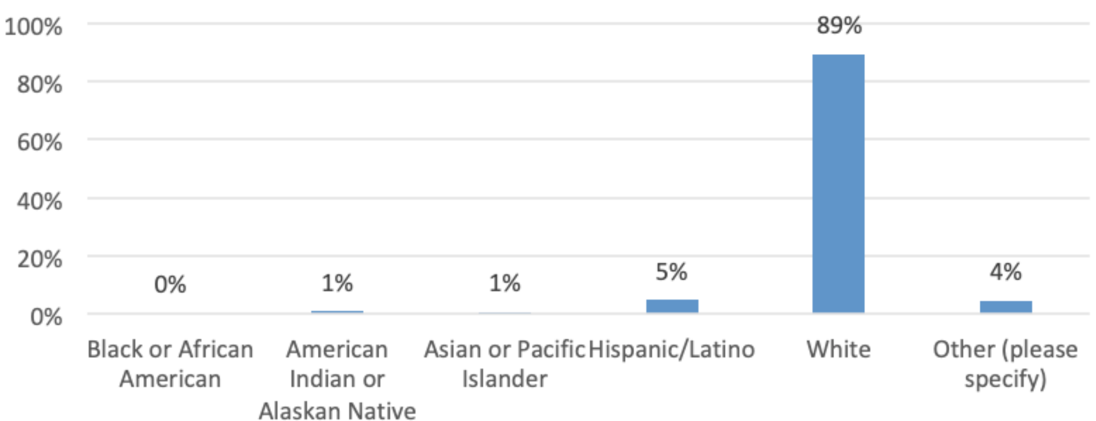


Figure 15: *Ethnicity of General Community Respondents*

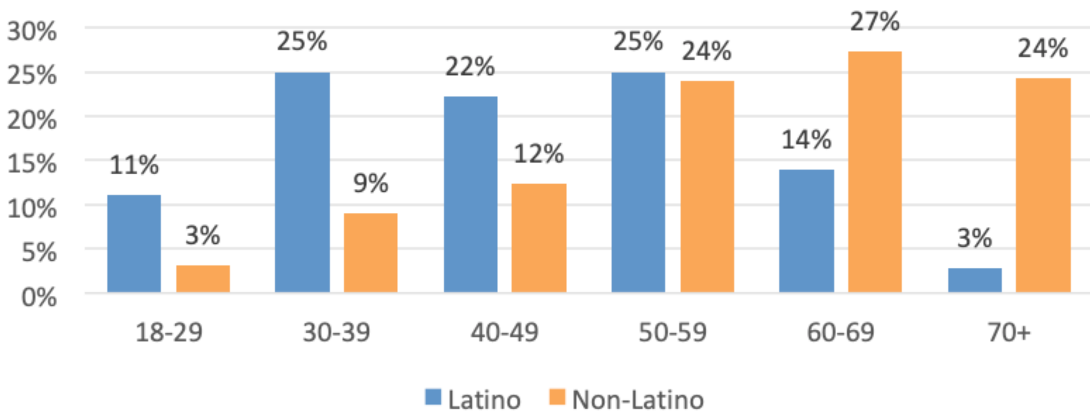


Figure 16: *Age of General Community Respondents*

Participants selected their top three options from a list of twenty-two health needs. The percentage of participants who selected each need was then calculated and needs which were in the top third of options selected by percentage were considered significant. The most significant health needs identified in the survey are noted in the table below.

Significant Health Concerns Among Latino Parents and Guardians	Significant Health Concerns in Non-Latino Parents and Guardians
Mental health/Depression	Mental health/Depression
Obesity/Weight management	Obesity/Weight management
Health education	Poverty
Availability of health services	Substance abuse/Addictions
Insurance coverage	Insurance coverage
Substance abuse/Addictions	Diet and healthy eating
Physical fitness/Exercise	Availability of health services
Diet and healthy eating	Family and social support
Diabetes treatment and prevention	Physical fitness/Exercise
Tobacco use/Smoking	

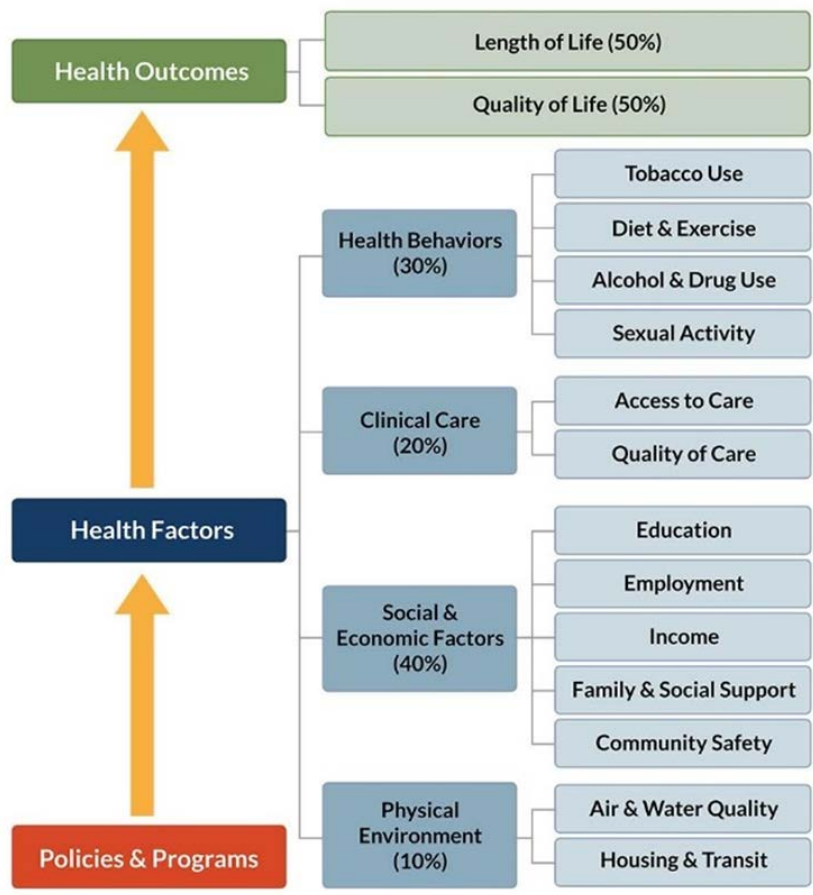
Table 3: *Significant Health Concerns of Latino and Non-Latino General Community Respondents*

While many of the health needs are identical for each group, Latino respondents are more concerned about poverty and diabetes than non-Latino respondents, for whom physical fitness/exercise is of greater concern.

Data Coding and Integration

Methodology

The health needs identified in the data from the primary and secondary data were coded and analyzed based on the County Health Rankings Model (http://www.countyhealthrankings.org/).



This model identifies key factors that drive health outcomes.

- Health outcomes (mortality and morbidity) can be understood in terms of the length and quality of life.
- Health factors include:
  - Health behaviors
  - Clinical care
  - Social and economic factors
  - Physical environment

The four contributors to the health factors are shown in the center blue rectangles. Contributors to each of the four factors are indicated in the far-right light blue rectangles. To further define the process, there are also contributors to categories noted in the light blue rectangles.

- Policies and programs, noted in the lower left-hand red rectangle at the bottom of the county health rankings schematic, impact community health and can include those initiated by the hospital/health system and those at the federal, state and local levels.

Results

Using the Community Health Rankings Model, the significant health needs identified in all data sets could be integrated, creating coherence, and are summarized in the table below.

		Primary Groups and Individuals Surveyed								Secondary Data
		Focus Group Meetings	Key Informant Interviews	Community Survey: Latino Respondents	Community Survey: Non-Latino Respondents	GCS Survey: Latino Parents/ Guardians	GCS Survey: Non-Latino Parents/ Guardians	Focus Group & Key Informant Survey	Amish Community Leader Survey	Secondary Data
Health Outcomes		Mental health	Diabetes treatment and prevention	Mental health/ Depression	Mental health/ Depression	Mental health/ Depression	Mental health/ Depression	Mental health/ Depression	Cancer	Child mortality
Health Outcomes		Acute care for mental health/Mobile crisis unit to respond to dysfunction	Mental health	Diabetes treatment and prevention	Cancer	Diabetes treatment and prevention		Treatment of chronic diseases	Cardiovascular health	Infant mortality
Health Outcomes		Combined/ comorbid health issues	Cancer	Treatment of chronic diseases	Treatment of chronic diseases			Diabetes treatment and prevention		
Health Outcomes		Treatment of chronic diseases	Chronic mental illness	Cancer				Cardiovascular health		
Health Outcomes			Treatment of chronic diseases							
Health Factors	Healthy Behaviors	Obesity/Weight management	Obesity/Weight management	Obesity/Weight management	Obesity/Weight management	Obesity/Weight management	Obesity/Weight management	Obesity/Weight management	Nutrition	Obesity/Weight management
Health Factors	Healthy Behaviors	Substance abuse/ Addictions	Substance abuse/ Addictions	Substance abuse/ Addictions	Substance abuse/ Addictions	Substance abuse/ Addictions	Substance abuse/ Addictions	Substance abuse/ Addictions	Substance abuse/ Addictions	Substance abuse/ Addictions
Health Factors	Healthy Behaviors		Tobacco use/ Smoking	Nutrition	Nutrition	Physical fitness/ Exercise	Nutrition	Nutrition	Tobacco use/ Smoking	Physical fitness/ Exercise
Health Factors	Healthy Behaviors				Physical fitness/Exercise	Nutrition	Physical fitness/ Exercise		Obesity/Weight management	Teen births
Health Factors	Healthy Behaviors					Tobacco use/ Smoking				
Health Factors	Clinical Care	Lack of access to affordable quality health care	Lack of physicians	Availability of health services	Availability of health services	Health education	Availability of health services	Availability of health services		Lack of physicians
Health Factors	Clinical Care	Health education	Health education	Health education	Health education	Availability of health services		Health education		
Health Factors	Social & Economic	Culture and lifestyle	Poverty	Poverty	Insurance coverage	Insurance coverage	Poverty	Poverty	Violence	Insurance coverage
Health Factors	Social & Economic	Disinformation around health issues	Social isolation	Insurance coverage			Insurance coverage			Formal education
Health Factors	Social & Economic	Family and social support	Child abuse				Family and social support			
Health Factors	Social & Economic	Advocacy for seniors	Immigrant health							
Health Factors	Physical Environment	Transportation								Air Pollution
Policies & Programs										

Table 4: Integration of Significant Health Needs identified in Primary and Secondary Data

Barriers to Care

Significant barriers to positive health outcomes were identified by the general community survey respondents, the Goshen Community Schools survey respondents, the Amish community leader survey, the community focus groups, and the key informants.

Each survey respondent group's responses were coded and correlated with the critical health factors using the Community Health Rankings Model and summarized in the table below:

Barriers to Addressing Significant Health Needs

Data Set		Community Survey: Latino Respondents	Community Survey: Non-Latino Respondents	GCS Survey: Latino Parents/ Guardians	GCS Survey: Non-Latino Parents/ Guardians	Focus Group & Key Informant Survey	Amish Community Leader Survey
Health Factors	Healthy Behaviors	Nutritional habits	Nutritional habits	Lack of initiative	Lack of initiative		Nutritional habits
		Lack of initiative	Lack of initiative	Nutritional habits	Nutritional habits		Lack of initiative
	Clinical Care	Lack of mental health providers	Lack of mental health providers		Lack of mental health providers	Lack of mental health providers	
		Ability to navigate the healthcare system	Ability to navigate the healthcare system		Ability to navigate the healthcare system	Ability to navigate the healthcare system	
	Social & economic	Lack of insurance	Income inequality	Lack of insurance	Income inequality	Lack of health education	Lack of health education
		Income inequality	Lack of insurance	Language and cultural differences	Lack of insurance	Income inequality	Lack of family and social support
		Language and cultural differences	Lack of health education	Income inequality	Stigma associated with health issue	Language and cultural differences	Cultural health attitudes
			Cultural health attitudes	Lack of health education			
			Stigma associated with health issue				
	Physical Environment					Lack of transportation	Work Environment
Policies & programs							

Table 5: Barriers to Meeting Healthcare Needs Identified by Survey Respondent

As the focus groups and key informants identified barriers for specific health needs, the barriers they identified are not coded and are displayed separately in the following two tables:

Focus Groups — Barriers to Addressing Significant Health Needs

Mental health
- Lack of access to care
- Stigma
- Cost of care
- Lack of provider cultural competence
- Lack of mental health education/Understanding

Obesity
- Lack of access to/Cost of healthy food
- Lack of time to prepare healthy food/Exercise
- Lack of food preparation/Nutritional knowledge

Substance abuse: addictions, alcohol, drugs
- Lack of detox centers
- Stigma to getting help
- Lack of access/Cost of treatment

Culture and lifestyle
- Socioeconomic/Financial concerns
- Individual habits

Family dysfunctionality
- Lack of financial and parenting skills/Education
- Lack of external/Social support

Lack of health education
- Lack of access to educational resources/Platforms
- Lack of educator cultural competency/Credibility

Transportation
- Lack of service providers/Service areas
- Lack of social connections

Advocacy for seniors
- No payment for advocacy
- Lack of local funds

Support for chronic conditions
- Lack of affordable quality care
- Lack of insurance
- Current healthcare payment system

Table 6: *Barriers Identified by Focus Groups*

Key Informants — Barriers to Addressing Significant Health Needs

Diabetes and Obesity
- Culture and language barriers
- Lack/Cost of healthy food
- Awareness of issue/Access to treatment

Mental Health
- Stigma attached to mental health
- Lack of mental health providers
- Awareness of issue/Access to treatment

Access: Lack of Healthcare Education, Lack of Physicians and Mental Health Providers
- Lack of provider cultural competence

Poverty
- Lack of education
- Fear of healthcare costs

Social Isolation
- Political polarization
- Racism

Cancer
- Diet
- Workplace environment

Chronic Disease Management
- Lack of follow-up programs

Drug Abuse
- Lack of mental health support
- Normalization of drug use
- Lack of effective treatments

Smoking
- Family and peer influence

Immigrant Health
- Lack of outreach

Lack of Physicians
- Lack of community appeal for new physicians
- Current healthcare payment system

Table 7: *Barriers Identified by Key Informants*

Prioritization of Community Health Needs

Health Needs Prioritized and Those Not Prioritized: Methodology and Results

On July 16, 2021, members of the Community Advisory Council (CAC) met to prioritize the community health needs identified in the primary and secondary data. The data was organized in a frequency table (Appendix IX). The number of data sets that identified a health need, as well as disparities between population groups, were then considered. Of the 30 health needs identified in the various data sets, 14 were considered during prioritization.

Health Needs Considered During Prioritization

- Cancer
- Diabetes treatment and prevention
- Family and social support
- Health education
- Insurance coverage
- Lack of access to health care
- Mental health
- Nutrition
- Obesity/Weight management
- Physical fitness/Exercise
- Poverty
- Substance abuse/Addictions
- Tobacco use/Smoking
- Treatment of chronic diseases

Health Needs Not Considered During Prioritization

- Advocacy for seniors
- Air pollution
- Cardiovascular health
- Child abuse
- Child mortality
- Combined or comorbid health issues
- Culture and lifestyle
- Disinformation around health issues caused by political polarization
- Formal education
- Immigrant health
- Infant mortality
- Social isolation
- Teen births
- Transportation
- Violence

Prioritized Community Health Needs: Methodology and Results

The prioritization of the health needs to be prioritized was based on six criteria:

- **Disparities within subgroups:** Are there health-related needs of the medically underserved, low income, and minority populations that need special focus?
- **Feasibility of intervention:** Does the community have adequate resources to address the health-related problem?
- **Impact on the community/magnitude:** Does this health-related problem have a significant impact on many people in the community?
- **Importance to the community:** Is this health-related problem of importance to the community? (High levels of interest in the community for addressing a health-related need usually lead to higher levels of community engagement.)
- **Severity:** What do the morbidity and mortality rates indicate?
- **Trends:** Is the health-related need improving or getting worse in the community, and does this trend indicate a need for a greater or lesser level of intervention?

Each health need was evaluated with each criterion, using a scale of 1-4, with 1 indicating that the criterion was not met, and 4 indicating that the criterion was fully met. The scores of all participants for each health need were averaged and the health needs were ranked based on the average score for each health need that was prioritized. The rank order of the prioritized health needs is noted in the table below:

COMMUNITY
HEALTH NEEDS

Rank Order	Prioritized Health Need
1	Mental health
2	Diabetes treatment and prevention
3	Poverty
4	Obesity/Weight management
5	Lack of access to health care
6	Substance abuse/Addictions
7	Health education

Table 8: *Rank Order of Prioritized Health Needs*

Resources Available and Not Available to Address Community Health Needs

See Appendix V for listings of resources available and not available for addressing community health needs identified by survey respondent groups and Goshen Health.

Appendices

The appendices include information and data that informed and guided the identification of health needs in Goshen Health Communities. Surveys and questionnaires are included.

Appendix I: 2021 Secondary Data Report:
University of Wisconsin Population Health Institute 2020 County Health Rankings

Part 1: National Key Findings Report

County Health
Rankings & Roadmaps
Building a Culture of Health, County by County

A Robert Wood Johnson Foundation program

2020 County Health Rankings
Key Findings Report

A collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute.

APPENDICES

Introduction

Since the first release in 2010, the County Health Rankings have helped the nation understand that where you live matters for your health. Fair access to jobs, quality education, safe, affordable housing, proximity to greenspace, and transportation shape day-to-day life and long-term opportunities for good health. This year, with the 10th anniversary of the Rankings, we highlight signs of improvement and recognize the challenges that remain to create a fair and just opportunity for everyone to be as healthy as possible.

We take a careful look at counties among the least healthy and urge consideration of the context. Past and present forms of discrimination matter. There are multiple examples of laws and policies – some that started with the birth of the nation and whose effects are still felt today – that underlie current opportunities for health. For example, this can be seen in the failure to uphold laws and treaties, including the rights of Native people; in discriminatory practices in labor, housing, bank lending, and criminal justice; and in the disinvestment in local and regional economies.

We look at signs of hope among communities doing the hard work for a better tomorrow, recognizing that our actions today affect future generations. Too many children continue to live in poverty. This is a challenge for counties among the least healthy, and even counties among the healthiest in each state.

Often, it is necessary to look backward to understand how to move forward. By pairing data with an acknowledgment of history, we can work together to address the impacts of racism and discrimination. We can move toward healing and optimal health for all. We seek a future where everyone can thrive, no matter who you are, where you live, or how much money you have.

Summary of Findings

- Gaps in life expectancy remain. After a drop in life expectancy in recent years, signs indicate the overall national trend may be leveling off. Yet not all groups of people, everywhere, have experienced the same length of life trends. Among rural counties, more counties worsened than improved since the 2010 Rankings, and nationwide, racial and ethnic disparities in life expectancy persist. Progress is uneven: from the 2010 to 2020 Rankings, there have been gains in some of the key factors that impact health, including education and employment, while others, such as rates of children living in poverty and income inequality showed little progress.
- The past affects the present. The Rankings have shown that from one county to the next, stark differences persist in health and opportunity. This year, we take a closer look at counties that were among the least healthy in the 2010 Rankings. These counties are part of the Deep South, Appalachia, and Tribal Lands – each representing regions of the country with long histories of racism, disinvestment, and discrimination.
- There is work to be done. Counties among the least healthy saw gains in employment and insurance rates in recent years, though a wide gap remains, as the rest of the nation also improved.
- Even the healthiest counties can do better. Since 2010, the Rankings have identified counties performing well overall – that is, ranked at the top within their state. Yet, data show within these counties, obstacles to opportunity exist. Even in the top-ranked county of each state, challenges remain with income inequality and children living in poverty, disproportionately burdening children of color.
- Child poverty remains a formidable barrier to the health of our nation today and in the future. Recent trends show that while a small share of counties made progress post-recession, child poverty remains high in the vast majority of counties. Racial inequities in children living in poverty persist.
- The racial opportunity gap persists. While unemployment rates have declined for all racial and ethnic groups, income for American Indian and Alaska Native, Black, or Hispanic households have largely seen modest gains relative to Asian or White households. These modest gains have not translated into household incomes that keep pace with rising costs of living, such as housing, making it difficult for families with lower incomes to make ends meet and be healthy.

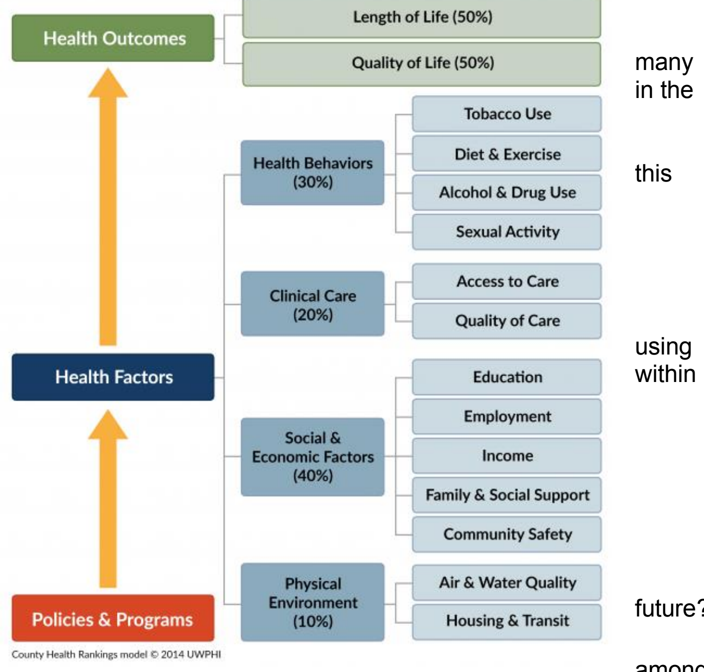
About County Health Rankings & Roadmaps

By ranking the health of nearly every county in the nation, County Health Rankings & Roadmaps (CHR&R) illustrates **what we currently know** when it comes to what is keeping people healthy or making them sick and

shows **what we can do** to create healthier places to live, learn, work, and play. CHR&R brings actionable data, evidence, guidance, and stories to diverse leaders and residents to make it easier for people to be healthier in their communities. The Robert Wood Johnson Foundation collaborates with the University of Wisconsin Population Health Institute to bring this program to communities across the nation.

Rankings

The Rankings are based on a model of population health (see right) that illustrates the many factors that influence health and are measured in the Rankings. We report these ranks at countyhealthrankings.org, along with all the underlying measures and additional data for this year and prior years.



We compile the Rankings using county-level measures from a variety of national data sources, which can be found here. These measures are standardized and combined using scientific weights. We then rank counties within each state, providing two overall ranks that address two key questions:

Health Outcomes: How healthy are community members in a county now?

Health Factors: What are the opportunities for community members to be healthy in the future?

The ranks call attention to the wide gaps among counties within states in what matters for health. These gaps represent disparities in health outcomes and inequities in opportunities to live long and well.

What Works for Health

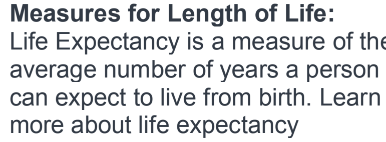
When it comes to developing and implementing solutions to problems that affect communities, evidence matters. What Works for Health is an easy-to-use, online tool that summarizes evidence for policies, programs, and systems changes that can make a difference locally.

Action Center & Community Guidance

We offer many pathways for self-directed and peer learning, web-based content, and virtual interactive forums that are designed to accelerate learning and action to build healthier communities and advance equitable opportunities. Our online Action Center, featuring Action Learning Guides and a Partner Center, offers steps for communities to move forward by working together to engage diverse partner organizations and community members, assess needs and resources, and act on what's important to create positive change that has a lasting impact.

A Decade of Data: Rankings 2010 to 2020

Since 2010, the County Health Rankings have measured the health of communities by examining how long and how well people live. A decade later, trends in length of life – a key measure of the health of a community – show us that health outcomes have improved for some groups of people in some places and worsened in others.



County Health Rankings Measures for Length of Life:
Life Expectancy is a measure of the average number of years a person can expect to live from birth. Learn more about life expectancy at countyhealthrankings.org/life-expectancy.

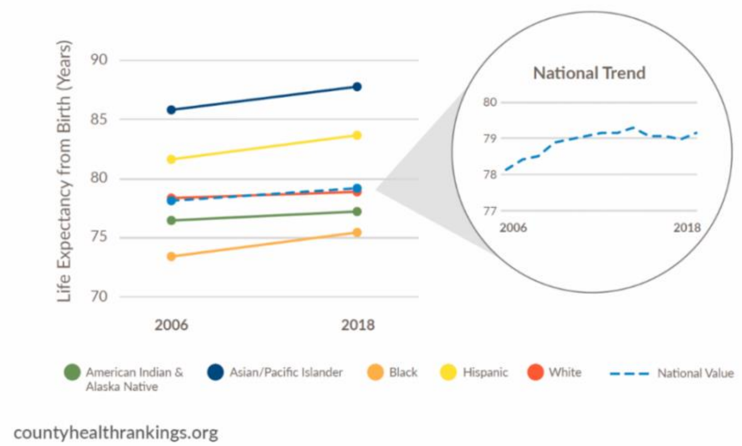
Premature death is measured in Years of Potential Life Lost (YPLL) before age 75 in the Rankings. More years of life are lost when deaths occur among younger age groups. Learn more about YPLL at countyhealthrankings.org/ypll.

Progress in Health Outcomes: Length of Life

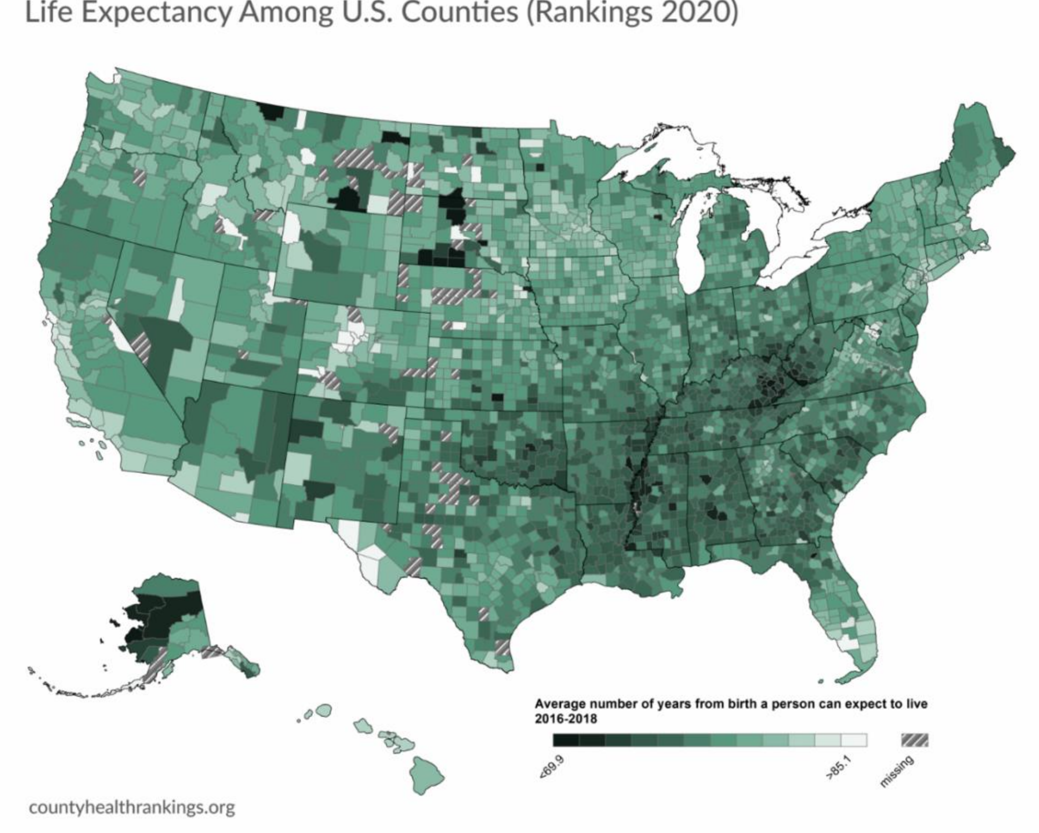
Key Findings

- After a drop in life expectancy in recent years, there are signs that the overall negative trend in life expectancy may be leveling off (see dashed blue line).
- Nationwide, not all groups of people have experienced the same trends in health outcomes. The gap in life expectancy across racial and ethnic groups in our country continues to be about 12 years.
- Life expectancy from birth varies across U.S. counties by over 40 years, with a low of 61.6 years on average. Recent data show that counties on the West and Northeast coasts have higher average life expectancy, while residents of the Deep South, Appalachia, and Tribal Lands live shorter lives.
- From the 2010 to 2020 Rankings, most counties have seen progress or held steady in measures of length of life. However, there are disparities by community type. More metropolitan counties improved than worsened (n=127 vs. n=98, respectively) in premature death, while, among rural counties, more worsened than improved (n=190 vs. n=90, respectively).* Life expectancy from birth in rural counties is 78.2 years, while those born in metropolitan counties can expect to live at least one year longer on average.

**See Technical Note #1 and Technical Note #2.*



APPENDICES



Progress in Health Factors: Key Improvements

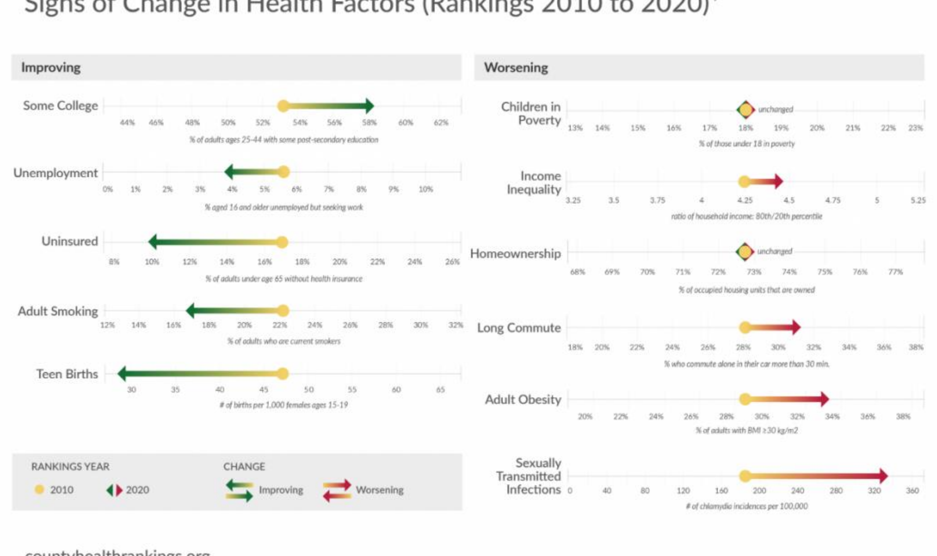
Over the course of a decade, the Rankings have helped to deepen our understanding of the conditions that shape our opportunities to live long and well. In the Rankings, we examine four factors that influence the health of counties: health behaviors, clinical care, social and economic factors, and the physical environment. In turn, each of these factors is based on several measures – the full list of factors and measures is provided here. Social and economic factors impact health more than any other group of factors.

While there is work to be done to create communities where everyone can be their healthiest, the 2020 Rankings show us there are signs of progress in key factors. We highlight the direction health factors in U.S. counties have shifted from the 2010 to 2020 Rankings using the most recently available data for key measures of health behaviors, clinical care, social and economic factors, and the physical environment.

- From the 2010 to 2020 Rankings, there were signs of progress in social and economic factors, including more educational attainment and lower unemployment rates.
- Though data for the most recent years are not available, there were also signs of progress in uninsured rates for U.S. counties overall.
- Counties have also seen improvements in health behaviors, such as lower rates of adult smoking and teen births.

Worsening in Health Factors: Key Challenges that Remain

- Rates of children living in poverty have shown little indication of meaningful progress in the past decade and income inequality is rising.
- Rates of homeownership have changed little over a decade. There were also signs that more adults have long commutes, spending more time to get to work.
- Rates of adult obesity and sexually transmitted infections showed signs of worsening.



**See Technical Note #3.*

The Journey to Thrive for Counties Among the Least Healthy

The County Health Rankings have shown that stark disparities persist in the opportunity to live long and well across U.S. counties. Not all groups of people, everywhere, have experienced the same progress in health factors and outcomes. Here we describe the challenges and signs of positive change for the counties among the least healthy* – scoring in the lowest decile for health outcomes measures.

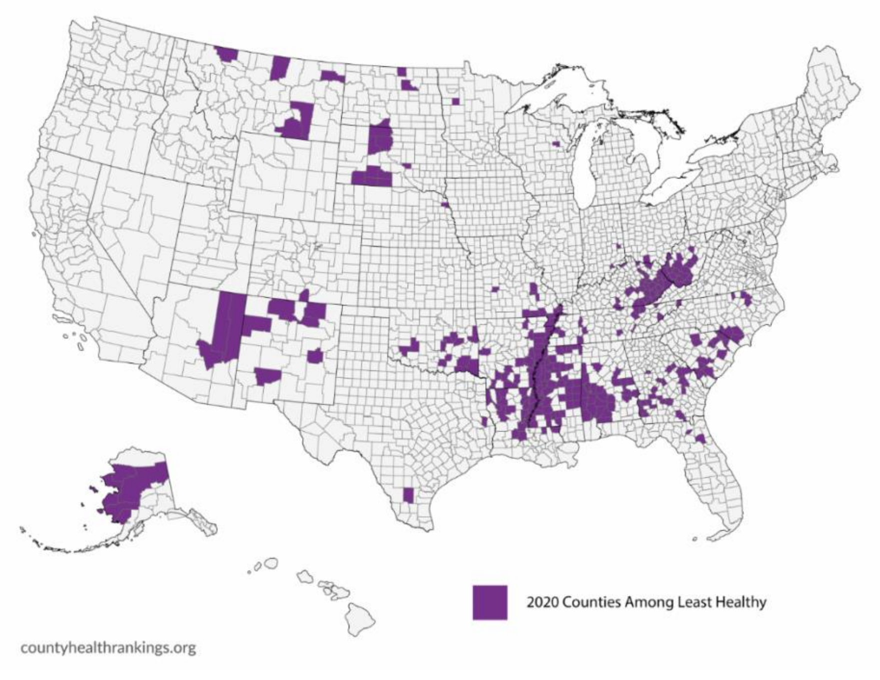
**See Technical Note #1 and Technical Note #4.*

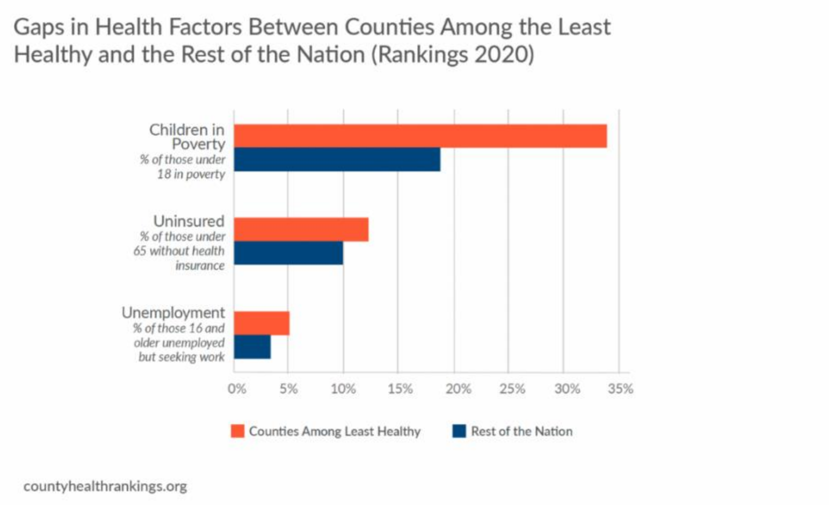
Key Findings

- Counties that are among the least healthy in the 2020 Rankings* are a part of the Deep South, Appalachia, and Tribal Lands.
- Nearly a decade ago, the pattern was largely the same, as the majority of counties among the least healthy in 2020 were among the least healthy in the 2010 Rankings.
- These counties represent all community types, though they are largely rural. They generally have smaller populations and have seen slow population decline over the course of a decade.
- In addition to experiencing poor health outcomes, these counties also face barriers to opportunity. Counties among the least healthy in the 2020 Rankings had higher rates of poverty, uninsured, and unemployment than the rest of the nation's counties.

**See Technical Note #4.*

Counties Among the Least Healthy for Outcome Measures (Rankings 2010)
2010 Counties Among Least Healthy
countyhealthrankings.org


Counties Among the Least Healthy for Outcome Measures (Rankings 2020)
2020 Counties Among Least Healthy
countyhealthrankings.org



Too often, these places are only recognized because they are where people experience the worst health outcomes. Yet, many of these places have achieved progress despite challenges, for example, by building from their strengths and engaging residents in decision making to improve their communities so that everyone can thrive. Following the Great Recession, more than half of counties among the least healthy in the 2010 Rankings improved in rates of unemployment and uninsured.

Many communities have found a way forward through obstacles to opportunities. Past and present discriminatory policies and practices – such as racial segregation through redlining, legal actions to terminate tribal culture and land rights, and disinvestment in rural economies – have contributed to many communities consistently landing among the least healthy in measures of health and opportunity.

However, there is work that remains. Where counties among the least healthy in the 2010 Rankings made progress, so did the rest of the nation. Other counties nationwide started ahead and outpaced counties among the least healthy, particularly for rates of children living in poverty.

Addressing the Past to Create Future Opportunity

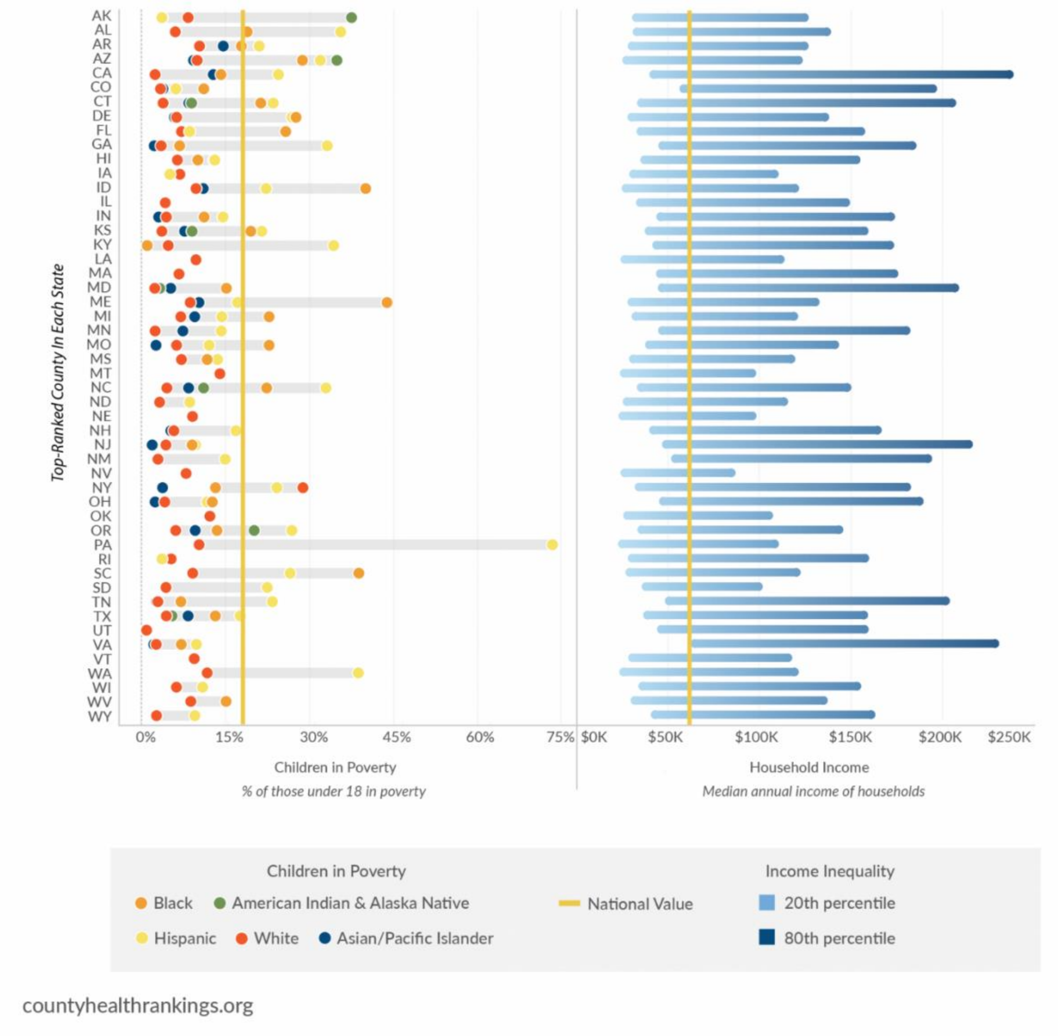
© 2017 Josh Kohanek. Photo courtesy of the Robert Wood Johnson Foundation.

Richmond, Virginia – where nearly 60% of the 227,000 residents are people of color – is a city that recognizes that to change its future and improve health for all, it must understand its past. For many that call this former capital of the Confederacy home, decades of discriminatory policies and practices have left a heavy, lasting footprint, but now Richmond is striving to create a city of inclusion and opportunity. Historically ranked among the least healthy counties in Virginia, Richmond employs a comprehensive approach to addressing social and economic barriers, such as poverty, through the city's Office of Community Wealth Building (OCWB). OCWB's strategy includes systems transformation and a focus on direct services. Its workforce initiatives, which assisted over 870 people in 2019 connect residents to jobs through training, mentorship, wrap around services, and apprenticeships in efforts to address the racial gap in income – median household income is nearly $33K for Black households, $35K for Hispanic households, and $58K for White households. The city's Building Lives to Self-Sufficiency program offers targeted support to heads of households to help them identify barriers to their success and connect them to the resources needed to overcome them.

Honoring Values and Traditional Knowledge for Stronger Families and Healthier Communities

© 2019 Brian Adams. Photo courtesy of the Robert Wood Johnson Foundation.

Sitka, Alaska – a community with a population under 10,000 – realized that achieving better health for all meant honoring the social, cultural, and political fabric of this place. A vital shift in the city among local leaders, city and state agencies, and organizations working with the indigenous Tlingit people and the Sitka Tribe of Alaska (STA) is helping Sitka emerge from a painful history. Russian colonization and decades of U.S. government policies separated Native families, suppressed their culture and language, and brought about disparities in education, employment, and health. Strengthening families for the health of children has been at the core of the partnership between the Alaska Office of Children's Services and STA in their work to better enforce the federal Indian Child Welfare Act of 1978. It affirms tribes' jurisdiction over custody cases involving Native children and aims to keep children from being severed from their culture and identity. The state and tribal social services and courts personnel have trained and planned together, including helping non-Native state staff better understand the history and impact of trauma on tribal citizens. The collaboration has created a more culturally sensitive process for keeping Native families intact and has fundamentally shifted outcomes. Sitka now has Alaska's lowest per capita rate of Native children removed from their homes in child welfare cases.



Racial and Ethnic Gaps for Children in Poverty & Income Inequality within the Top-Ranked County in Each State (2020 Rankings)
Top-Ranked County In Each State
AK
AL
AR
AZ
CA
CO
CT
DE
FL
GA
HI
IA
ID
IL
IN
KS
KY
LA
MA
MD
ME
MI
MN
MO
MS
MT
NC
ND
NE
NH
NJ
NM
NV
NY
OH
OK
OR
PA
RI
SC
SD
TN
TX
UT
VA
VT
WA
WI
WV
WY
0%
15%
30%
45%
60%
75%
Children in Poverty
% of those under 18 in poverty
$0K
$50K
$100K
$150K
$200K
$250K
Household Income
Median annual income of households
Children in Poverty
Black
American Indian & Alaska Native
Hispanic
White
Asian/Pacific Islander
National Value
Income Inequality
20th percentile
80th percentile
countyhealthrankings.org

APPENDICES

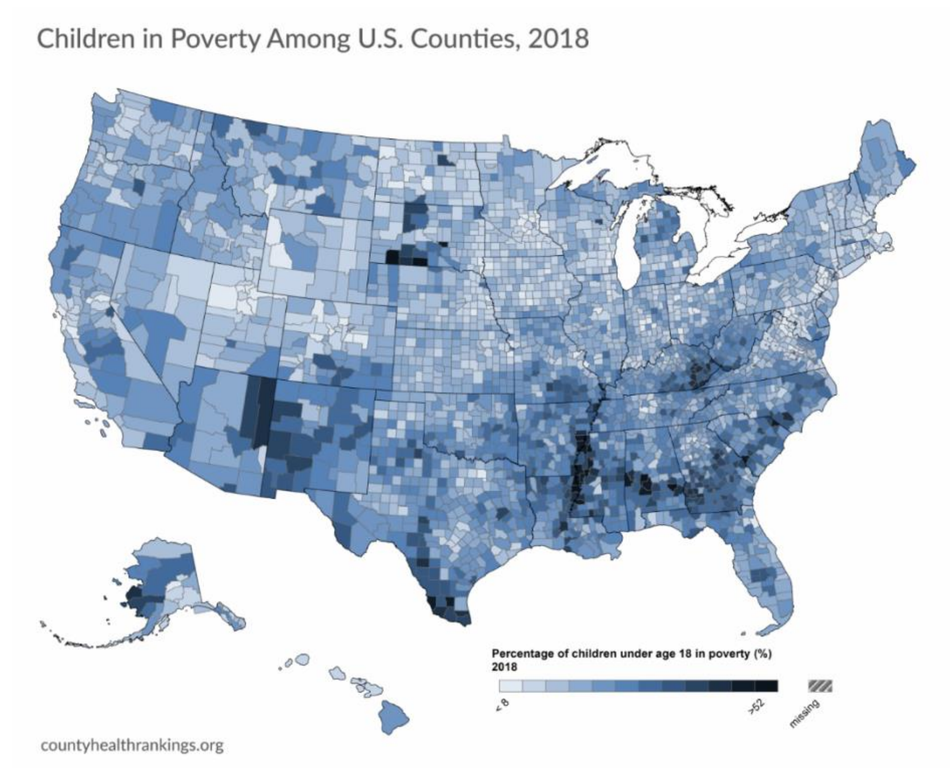
A Closer Look: Income, Poverty, and Unemployment

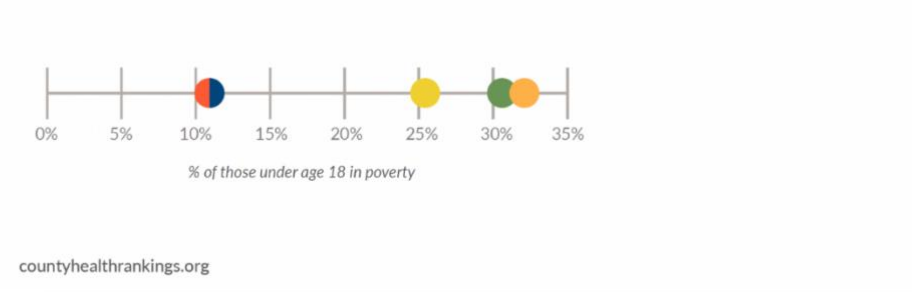
Household income and jobs that pay a living wage shape our opportunities and choices about housing, education, child care, food, medical care, and more. Opportunities for better health erode for households with lower income or in poverty who often face less access to good jobs with livable wages, affordable housing, and grocery stores with healthy foods. Due to various manifestations of structural racism, including redlining and discriminatory hiring practices, families of color are disproportionately represented among households of lower income and in neighborhoods segregated from economic opportunities, quality goods, and services. Systematic disinvestment in rural economies, including reduction of manufacturing sector jobs, has also affected social and economic conditions across regions of our country. Children are particularly vulnerable to the adverse effects of a lack of family income that allows enough money to cover basic needs and save for setbacks. Nearly 13 million – 1 in 6 – children in the U.S. live in poverty, a marker of both current and future health.

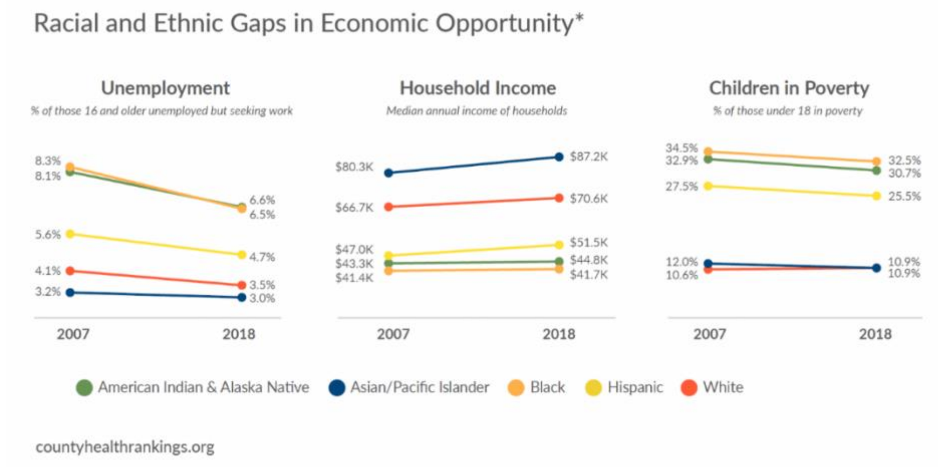
Key Findings

- Though unemployment declined for households of all racial and ethnic groups over the past decade, American Indian and Alaska Native, Black, or Hispanic people continue to have higher unemployment rates. These households largely saw modest gains in household income* compared to White or Asian households.
- Annual income for White or Asian households continues to be almost $20K higher than for American Indian and Alaska Native, Black, or Hispanic households.
- National trends show 18% of children lived in poverty in 2018, levels comparable to a decade ago. A closer examination of post-Recession trends from 2014 to 2018 show that these rates have remained static in the majority of counties nationwide (57%), while 41% of counties improved.*
- Recent data show the highest rates of children in poverty are in counties in the Southwest and Southeast regions, as well as parts of Appalachia, the Mississippi Delta, and Tribal Lands.
- Racial inequities persist, as poverty rates are higher for American Indian and Alaska Native, Black, or Hispanic children*; often twice as high as rates for White children. Where data are available, this pattern holds true across a majority of U.S. counties.

*See Technical Note #2 and Technical Note #6.







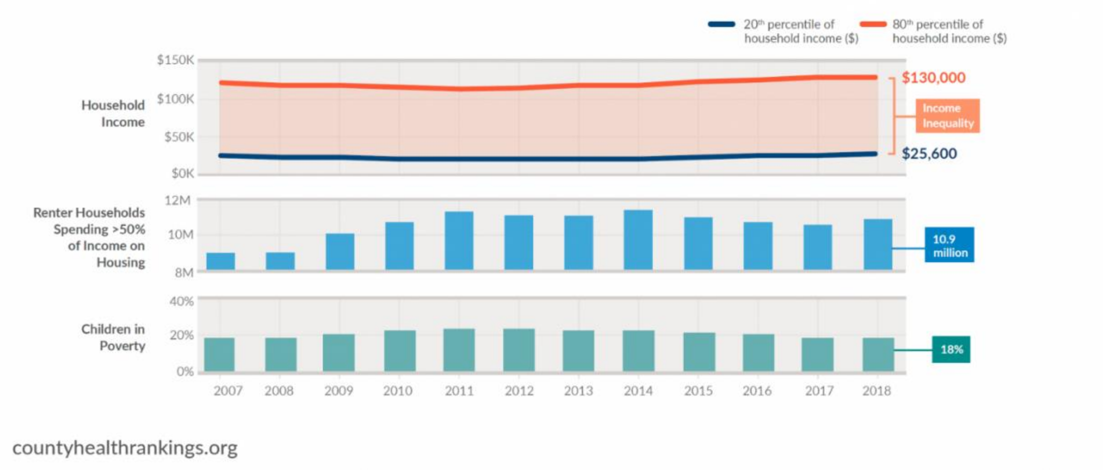
*See Technical Note #2 and Technical Note #6.

APPENDICES

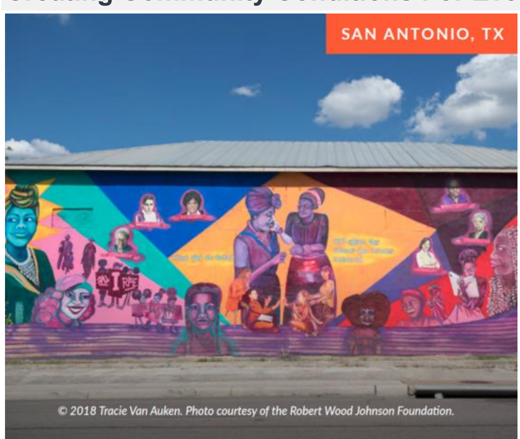
Making Ends Meet for Households with Lower Income

- Much like the stalled progress for rates of children living in poverty, over the past decade, there has been little change in income for households* in the lower income tiers (20th percentile of incomes). Meanwhile, incomes at the top (80th percentile) continued to grow.
- Household income, particularly for those in the lower tiers, has not kept pace with the cost of basic needs, such as housing – the single largest expense for most families. In 2018, 16.7 million households were severely housing cost burdened, paying 50% or more of their income for housing. Renters make up the majority of these cost burdened households.
- Over the decade, severely cost burdened renter households grew by almost two million to nearly 10.9 million in 2018. Renter households with incomes under $15K, the approximate annual income for minimum wage earners, continue to face the highest burden rates with nearly three out of four spending half or more of their income on rent.
- In 2018, nearly seven million children in poverty lived in a household that spent half or more of their income on housing, leaving little else for other basic needs like food, transportation, or child care.

*See *Technical Note #6*



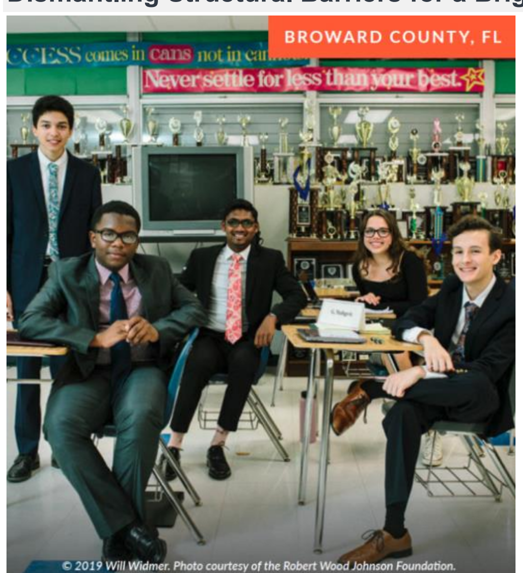
Creating Community Conditions For Everyone's Health



© 2018 Tracie Van Auken. Photo courtesy of the Robert Wood Johnson Foundation.

San Antonio, Texas – Home to 1.5 million people, San Antonio, Texas is the seventh largest U.S. city by population, 60% of whom are Hispanic. San Antonio offers reminders of its past, like the Mission San Juan Capistrano from 1731, and glimpses of its future, seen in the new shops and residences in the upscale Pearl District. Community partners are taking a hard look at entrenched problems to provide all with greater opportunity. The city's Office of Equity is leading with equity in all policies to reduce health disparities and the city's budget prioritizes the needs of residents in historically excluded neighborhoods as demonstrated by the parks and trail development in several low-income communities. UP Partnership aligns the efforts of 16 local school districts countywide to improve educational outcomes in everything from early grade reading to high school completion. Some of the greatest gains have been in reducing the uninsured rate for children and youth. Most recent data show that Bexar County has a rate of uninsured children of 8.2%, compared to the state's uninsured rate of 11.2% and Texas is the only state with a double digit uninsured rate for children in the country. San Antonio's Food Bank, which distributed 63 million pounds of food in 2016, goes beyond food distribution by seeking to address the root causes of food insecurity through free job training.

Dismantling Structural Barriers for a Brighter Economic Future



© 2019 Will Widmer. Photo courtesy of the Robert Wood Johnson Foundation.

Broward County, Florida – In the demographically diverse community of Broward County, Florida, with a population of 1.9 million – where nearly 60% of the population are people of color – local government is leading the charge in addressing unfair and reinforcing structures that have led to disparities. The county-led Dismantling Racism Initiative is creating space for difficult conversations through interracial dialogue and bias trainings for nearly 3,500 people within government agencies, schools, public health, and social service providers. The school system – sixth largest in the nation – is bridging the racial achievement gap with equity liaisons in every school, and efforts to increase participation from students of color in activities like computer coding and debate are helping students succeed. Broward's intentional education focus is yielding results – graduation rates for Black students have climbed from 66% in 2013 to 81.6% in 2019, while in the same year graduation rates for Hispanic students was 86.9% and White students 91.6%. Broward is among the most expensive places to live in the country – more than half of nearly 681,500 households have work, but due to the high cost of living, struggle to afford basic needs like housing, food, child care, and transportation. To address these challenges, government, business, and nonprofit leaders work together through the Coordinating Council of Broward to pursue policy changes in partnership with residents. Together, they rallied voter support of new taxes to fund the construction of more affordable housing and transportation improvements.

For information on these approaches and other specific strategies that can make a difference, visit What Works for Health.

Taking Action to Improve Social and Economic Opportunity and Reduce Child Poverty

No child should have to grow up in poverty. Our nation's youth should have the chance for a healthy start to life, regardless of where they live, how they look, or their family circumstances. Taking action to help children and their families today and prepare our future leaders will require a commitment to dismantling racism and all forms of discrimination backed by political will and equitable investments in strategies that can make a difference, including:

Invest in education from early childhood through adulthood – such as publicly-funded prekindergarten or career and technical education – to create environments that support learning and boost employment and career prospects.

Increase or supplement income and support asset development in low-income households such as through expanded earned income tax credits, jobs that pay a living wage, or subsidized asset accumulation programs.

Support inclusive community development, reduce displacement, and ensure access to secure and affordable housing, for example, through zoning, tax credits and other government affordable housing subsidies, housing choice vouchers for low-income households, and fair housing laws and enforcement.

Ensure that everyone has adequate, affordable health care coverage and receives culturally competent services and care by increasing accessibility such as through community health workers and school-based health centers, and training health care professionals on cultural diversity.

Foster social connections within communities, adopt trauma-informed approaches to community building and support, and cultivate empowered and civically engaged youth and adults through leadership development and peer mentoring.

Technical Notes and Glossary of Terms

What is health equity? What are health disparities? And how do they relate?

Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty and discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.

Health disparities are differences in health or in the key determinants of health, such as education, safe housing, and discrimination, which adversely affect marginalized or excluded groups.

Health equity and health disparities are closely related to each other. Health equity is the ethical and human rights principle or value that motivates us to eliminate health disparities. Reducing and ultimately eliminating disparities in health and its determinants of health is how we measure progress toward health equity.

Structural or institutional racism is race-based unfair treatment built into policies, laws, and practices. It often is rooted in intentional discrimination that occurred historically, but it can exert its effects even when no individual currently intends to discriminate.

Braveman P, Arkin E, Orleans T, Proctor D, and Plough A. What is Health Equity? And What Difference Does a Definition Make? Robert Wood Johnson Foundation. May 2017.

Note: In this report, we use the terms disparities, differences, and gaps interchangeably.

Technical Notes:

1. Metropolitan and rural counties were categorized according to the 2013 NCHS Urban-Rural Classification Scheme for Counties. We define metropolitan counties (n=1166) as those belonging to metropolitan statistical areas with a population greater than 50,000. The remaining non-metropolitan counties are considered rural (n=1976).
2. The percentages of counties that improved, remained static, or worsened on measures were determined by examining the statistical significance of the linear trend across the time period.
3. Values in the figure are the median value of counties for each measure at the time of the 2010 and 2020 Rankings except for Uninsured and Children in Poverty, which are the national values at both time points. There are different data year spans and differential missingness between 2010 and 2020 data. The magnitude of change from 2010 to 2020 was determined by the calculation of paired samples t-tests and Cohen's D using county-level data.
4. Counties among the least healthy in 2010 and 2020 scored among the 10th percentile of counties nationwide for health outcomes z-score in at least two of the three Rankings between 2010-12 or 2018-2020, respectively.
5. Top-ranked counties are those within states that have had the top Health Outcomes rank, on average, over the three most recent Rankings releases. Extreme and missing values for Children in Poverty can occur in counties with small sub-group populations. Values with 95% confidence intervals widths >40% were suppressed. See analytic files at www.countyhealthrankings.org for unsuppressed values and 95% confidence intervals.
6. Values for household income are adjusted for inflation to 2018 dollars. Households are defined as all people living in a housing unit. Members of a household can be related or unrelated.

How did we select evidence-informed approaches?

Evidence-informed approaches included in this report represent those backed by strategies that have demonstrated consistently favorable results in robust studies or reflect recommendations by experts based on early research. To learn more about evidence analysis methods and evidence-informed strategies that can improve health and decrease disparities, visit What Works for Health.

How do we define racial and ethnic groups?

We recognize that "race" or "ethnicity" are social categories, meaning the way society may identify individuals based on their cultural ancestry, not a way of characterizing individuals based on biology or genetics. A strong and growing body of empirical research provides support for the fact that genetic factors are not responsible for racial differences in health factors and very rarely for health outcomes.

We are bound by data collection and categorization of race and ethnicity according to the U.S. Census Bureau definitions, in adherence with the 1997 Office of Management and Budget standards as follows:

- Hispanic includes those who identify themselves as Mexican, Puerto Rican, Cuban, Central or South American, other Hispanic, or Hispanic of unknown origin and can be of any racial background.
- White includes people who identify themselves as White and do not identify as Hispanic.
- Black includes people who identify themselves as Black or African American and do not identify as Hispanic.
- American Indian and Alaska Native includes people who identify themselves as American Indian or Alaska Native and do not identify as Hispanic.
- Asian includes people who identify themselves as Asian or Pacific Islander and do not identify as Hispanic.

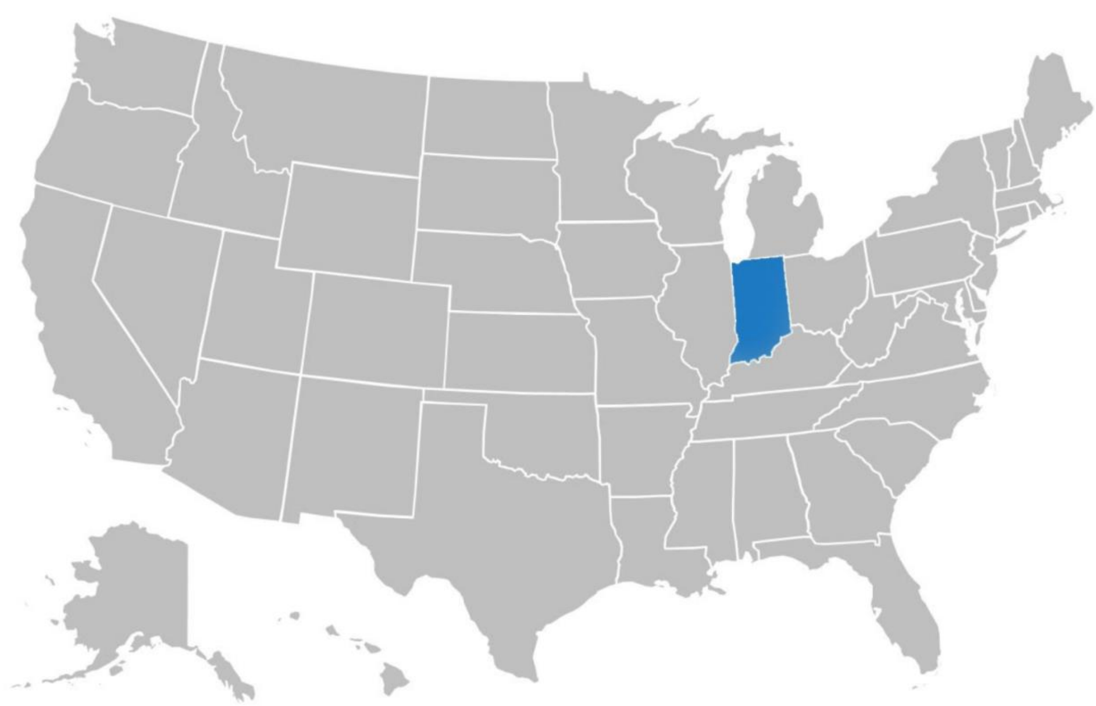
Our analyses by race and ethnicity use several different sources that are inconsistent in how data for those who identify as Hispanic are included or excluded from racial groups. Our analyses also do not capture those reporting more than one race, of "some other race", or who do not report their race. This categorization can mask variation within racial and ethnic groups and can hide historical context that underlies health differences.

County Health Rankings & Roadmaps

Building a Culture of Health, County by County

A Robert Wood Johnson Foundation program

Indiana



2020 County Health Rankings Report

A collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute.

2020 County Health Rankings for the 92 Ranked Counties in Indiana

County	Health Outcomes	Health Factors	County	Health Outcomes	Health Factors	County	Health Outcomes	Health Factors	County	Health Outcomes	Health Factors
Adams	40	39	Franklin	11	24	Lawrence	46	51	Rush	47	56
Allen	55	52	Fulton	62	49	Madison	83	81	Scott	90	80
Bartholomew	26	15	Gibson	49	11	Marion	72	87	Shelby	50	53
Benton	19	29	Grant	91	82	Marshall	24	61	Spencer	10	10
Blackford	76	57	Greene	52	74	Martin	33	45	St. Joseph	54	62
Boone	3	2	Hamilton	1	1	Miami	57	83	Starke	73	84
Brown	29	14	Hancock	6	5	Monroe	16	19	Steuben	9	17
Carroll	22	27	Harrison	36	40	Montgomery	37	18	Sullivan	61	88
Cass	79	58	Hendricks	2	3	Morgan	43	32	Switzerland	77	91
Clark	80	60	Henry	65	42	Newton	78	71	Tippecanoe	34	23
Clay	68	68	Howard	81	77	Noble	21	43	Tipton	28	12
Clinton	53	48	Huntington	39	26	Ohio	5	25	Union	60	44
Crawford	88	92	Jackson	59	36	Orange	58	69	Vanderburgh	82	65
Daviess	41	59	Jasper	38	50	Owen	64	64	Vermillion	48	75
Dearborn	30	38	Jay	86	66	Parke	35	79	Vigo	75	85
Decatur	27	28	Jefferson	66	76	Perry	45	63	Wabash	63	34
DeKalb	25	22	Jennings	89	78	Pike	56	46	Warren	4	20
Delaware	85	67	Johnson	12	7	Porter	23	31	Warrick	13	6
Dubois	8	4	Knox	70	54	Posey	15	13	Washington	67	72
Elkhart	32	47	Kosciusko	17	21	Pulaski	69	33	Wayne	87	73
Fayette	92	86	LaGrange	7	37	Putnam	18	30	Wells	20	9
Floyd	51	41	Lake	74	90	Randolph	84	70	White	31	16
Fountain	44	55	LaPorte	71	89	Ripley	42	35	Whitley	14	8

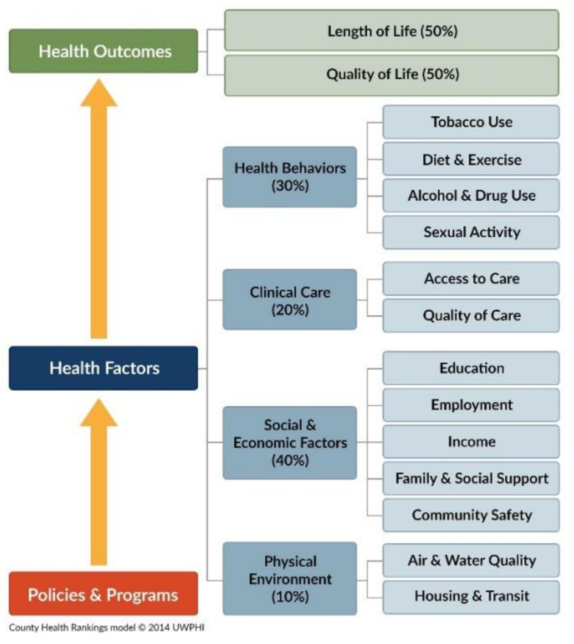
For more information on how these ranks are calculated, view the tables at the end of this report and visit **www.countyhealthrankings.org**

The County Health Rankings & Roadmaps (CHR&R) lifts up actionable data, evidence, guidance, and stories for communities to make it easier for people to be healthy in their neighborhoods, schools, and workplaces. Ranking the health of nearly every county in the nation (based on the model below), CHR&R illustrates what we currently know when it comes to what is keeping people healthy or making them sick and shows what we can do to create healthier places to live, learn, work, and play.

What are the County Health Rankings?

Published online at **www.countyhealthrankings.org**, the Rankings help us understand what influences our health and how long and well we live. The Rankings are unique in their ability to provide measures of the current overall health of each county in all 50 states. They also look at a variety of measures that affect the future health of communities, such as high school graduation rates, access to healthy foods, rates of smoking, children in poverty, and teen births.

For the past 10 years, communities have used the Rankings to garner support for local health improvement initiatives by engaging government agencies, health care providers, community organizations, business leaders, policymakers, and the public.



Moving with Data to Action

The **Take Action to Improve Health** section of our website helps communities join together to look at the many factors influencing health, select strategies that work, and make changes that can have a lasting impact. Take Action to Improve Health is a hub for information to help any community member or leader who wants to improve their community's health and foster health equity. You will find:

- **What Works for Health**, a searchable menu of evidence-informed strategies that can make a difference locally;
- **The Action Center**, your home for step-by-step guidance and tools to help you move with data to action;
- **Action Learning Guides**, self-directed learning modules combining guidance, tools, and hands-on practice and reflection activities on specific topics;
- **The Partner Center**, information to help you identify the right partners and explore tips to engage them.

Ensuring Healthy Places for All

Communities thrive when all people can be healthy in their neighborhoods, schools, and workplaces. CHR&R brings actionable data and strategies to communities working to ensure that healthy places are available to all. Pages 49 and 50 of this report highlights how health outcomes and health factors differ by place within your state. On pages 51 and 52, we illustrate how health differs among racial/ethnic groups within places.

The Robert Wood Johnson Foundation (RWJF) collaborates with the University of Wisconsin Population Health Institute (UWPHI) to bring this program to cities, counties, and states across the nation.

What are Health Outcomes?

Everyone wants to experience long and healthy lives, yet places have different resources and opportunities. To understand the health outcomes in a community, we measure both length and quality of life by county within Indiana.

Length of Life

- Premature death *(years of potential life lost before age 75)*

Quality of Life

- Self-reported health status
- Percent of low birthweight newborns

How Do Counties Rank for Health Outcomes?

The green map shows the distribution of Indiana's **health outcome ranks** across counties. The map is divided into four quartiles with less color intensity indicating better health outcomes in the respective summary rankings. Specific county ranks can be found in the table on page 49.

Detailed information on the measures and their associated weights is available on page 55. You can also learn about how we calculate health outcome ranks at www.countyhealthrankings.org.

What Do Differences Between Ranks Mean?

Counties are ordered by the health outcome rank, with a top-ranked county (rank = 1) having the best health outcome score. Ranks are easy to communicate, but they mask differences in health within counties and from one ranked county to the next. The chart next to the map shows the spread of health outcome scores (ranks) for each county (green circles) in Indiana. This graphic shows the size of the gap *between* ranked counties. The different background colors correspond to the four quartiles used in the map.

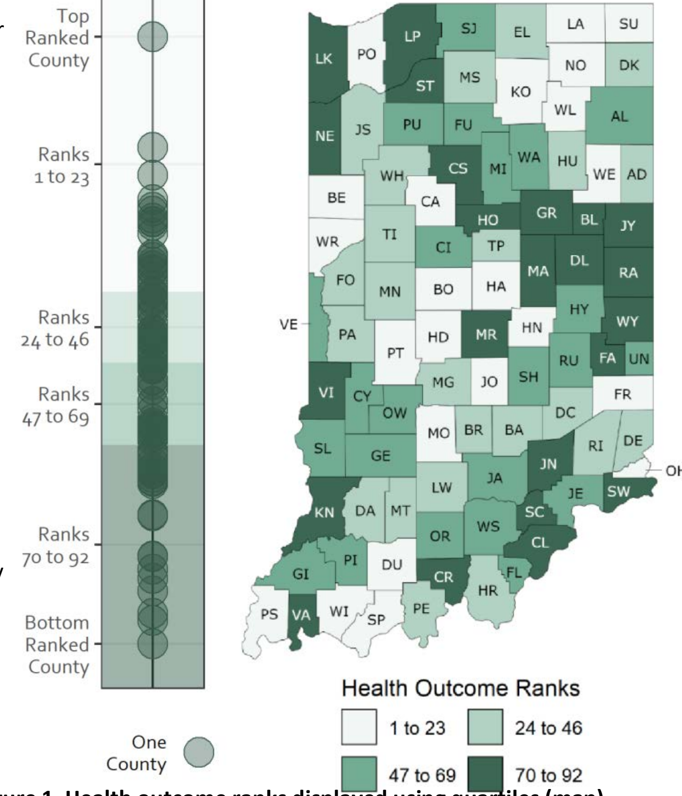
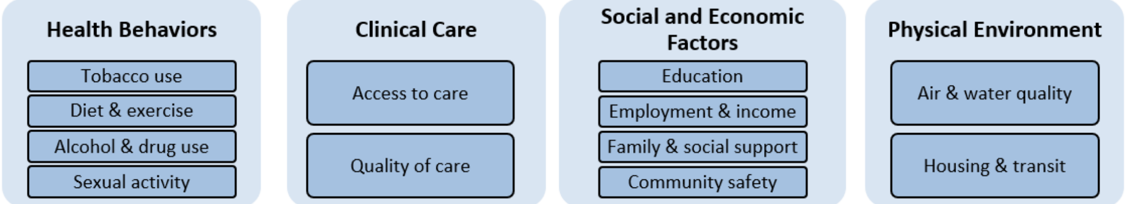


Figure 1. Health outcome ranks displayed using quartiles (map) and underlying health outcome scores (chart)

What are Health Factors?

Many factors shape our opportunities to be healthy and influence how well and how long we live. Health factors represent the things we can change to improve health for all, like opportunities for quality education, good paying jobs, access to quality clinical care, healthy foods, green spaces, and secure and affordable housing. We measure four health factor areas.



How Do Counties Rank for Health Factors?

The blue map shows the distribution of Indiana's **health factor ranks** across counties. The map is divided into four quartiles with less color intensity indicating better health factors in the respective summary rankings. Specific county ranks can be found in the table on page 49.

Detailed information on the measures and their associated weights is available on page 55. You can also learn about how we calculate health factor ranks, at www.countyhealthrankings.org.

What Do Differences Between Ranks Mean?

Counties are ordered by the health factor rank, with a top-ranked county (rank = 1) having the best health factor score. As previously noted, ranks mask differences in the opportunity for health within counties and from one county to the next. The chart next to the map shows the spread of health factor scores (ranks) for each ranked county (blue circles) in Indiana. This graphic shows the size of the gap *between* ranked counties. The different background colors correspond to the four quartiles used in the map.

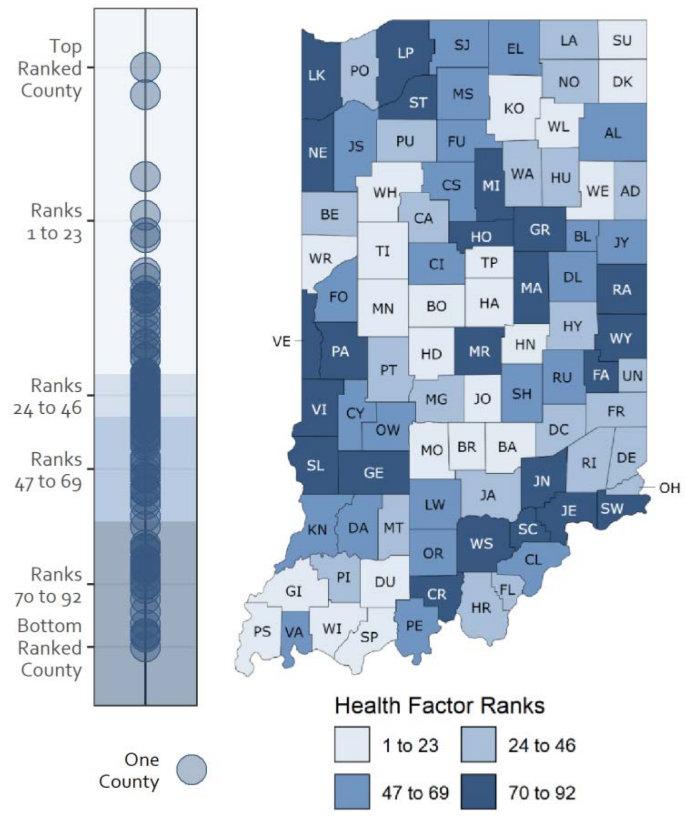


Figure 2. Health factor ranks displayed using quartiles (map) and underlying health outcome scores (chart)

APPENDICES

Growing Healthy Places Means Ensuring Opportunities for All

Health is influenced by every aspect of how and where we live. Access to secure and affordable housing, safe neighborhoods, good paying jobs and quality early childhood education are examples of important factors that can put people on a path to a healthier life. But access to these opportunities often looks different based on where you live, the color of your skin, or the circumstances you were born into. Data show a persistent pattern in barriers to opportunity for people with lower incomes and for communities of color across the United States. Patterned differences in a range of health factors emerge from unfair policies and practices at many levels and over many decades.

Copyright 2019 Brian Adams. Photo courtesy of the Robert Wood Johnson Foundation.

A Pattern of Unfair Differences Exists for People with Lower Incomes and Communities of Color in:

Access to Care

Air and Water Quality

Availability of Healthy Foods

Community Safety

Educational Supports

Employment Opportunities

Housing Opportunities

Income

Quality of Care

Using Data for Action

Achieving health equity means reducing and ultimately eliminating unjust and avoidable differences in opportunity and health. Our progress toward health equity will be measured by how health disparities change over time. Visit **www.countyhealthrankings.org** to learn more about:

1. Health outcome and factor measures for your state and county;
2. Measures that have data available for racial and ethnic groups to illuminate differences in opportunities for health in your state and county;
3. Additional data resources for Indiana that provide information about health and opportunity among other subgroups, such as gender, age, or zip code.

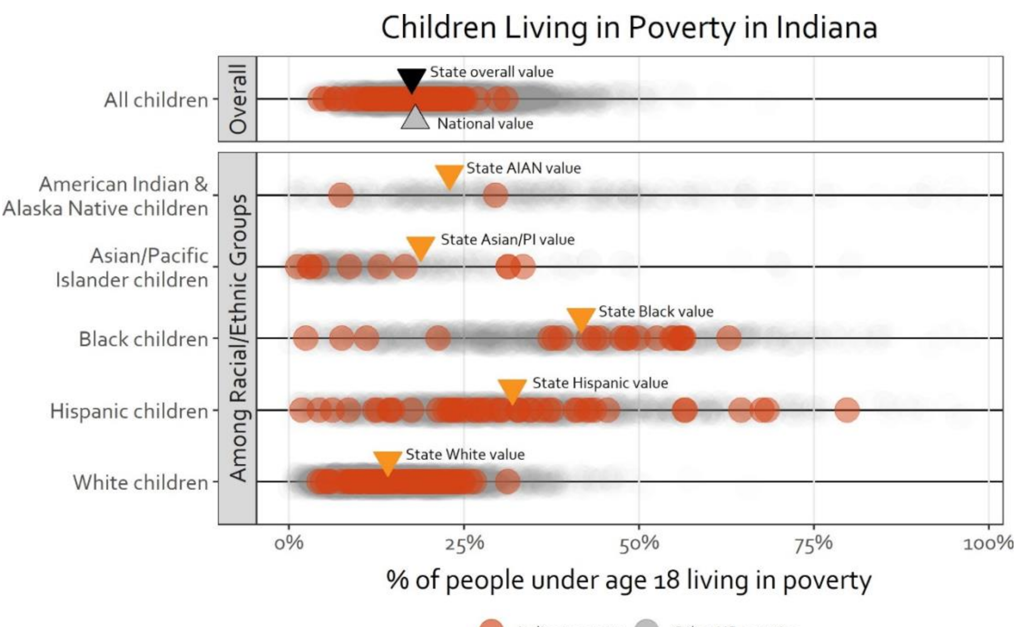
What Has Been Done Can Be Undone

Many communities are mobilizing state and local efforts to harness the collective power of community members, partners, and policymakers – working together to dismantle unfair patterns and ensure the growth of healthy places for all. To learn from others who are igniting possibilities and inspiring action, visit our **Learn from Others** page at www.countyhealthrankings.org.

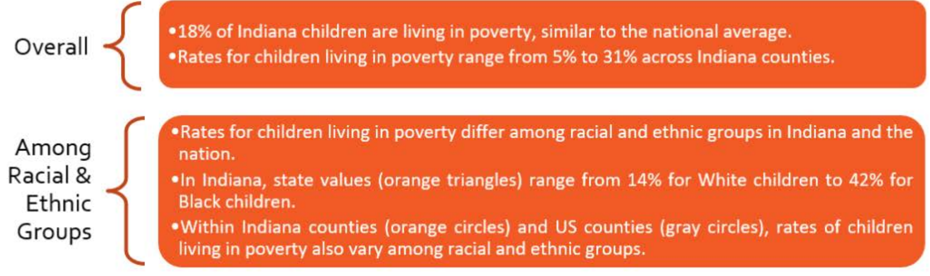
Opportunities for Health Within Indiana Counties

A healthy beginning is essential to a healthy future for our children and our communities. **Children in poverty** is a measure of both current and future opportunities for the health of the community. Patterns of unfair and avoidable differences at the local, state, and national level exist among racial and ethnic groups for children living in poverty.

The graphic below shows the patterns of children living in poverty for individual counties in Indiana and among racial and ethnic groups within counties of Indiana. It also shows the data for all counties across the nation in the gray circles beneath the Indiana data.



Key Takeaways for Children Living in Poverty in Indiana



Want to learn more? Visit our State Reports page at *www.countyhealthrankings.org* to interact with the data and explore patterns in other measures by place and among racial and ethnic groups.

2020 County Health Rankings for Indiana: Measures and National/State Results

Measure	Description	US	IN	IN MIN	IN MAX
HEALTH OUTCOMES					
Premature death*	Years of potential life lost before age 75 per 100,000 population (age-adjusted).	6,900	8,300	4,100	13,600
Poor or fair health	Percentage of adults reporting fair or poor health (age-adjusted).	17%	20%	11%	23%
Poor physical health days	Average number of physically unhealthy days reported in past 30 days (age- adjusted).	3.8	4.2	3.0	4.7
Poor mental health days	Average number of mentally unhealthy days reported in past 30 days (age-adjusted).	4.0	4.7	3.5	5.2
Low birthweight*	Percentage of live births with low birthweight (< 2,500 grams).	8%	8%	5%	10%
HEALTH FACTORS					
HEALTH BEHAVIORS					
Adult smoking	Percentage of adults who are current smokers.	17%	22%	13%	24%
Adult obesity	Percentage of the adult population (age 20 and older) that reports a body mass index (BMI) greater than or equal to 30 kg/m2.	29%	33%	25%	43%
Food environment index	Index of factors that contribute to a healthy food environment, from 0 (worst) to 10 (best).	7.6	7.1	6.5	9.0
Physical inactivity	Percentage of adults age 20 and over reporting no leisure-time physical activity.	23%	27%	17%	40%
Access to exercise opportunities	Percentage of population with adequate access to locations for physical activity.	84%	75%	24%	92%
Excessive drinking	Percentage of adults reporting binge or heavy drinking.	19%	18%	14%	20%
Alcohol-impaired driving deaths	Percentage of driving deaths with alcohol involvement.	28%	20%	0%	46%
Sexually transmitted infections	Number of newly diagnosed chlamydia cases per 100,000 population.	524.6	514.2	53.2	1,109.0
Teen births*	Number of births per 1,000 female population ages 15-19.	23	27	6	49
CLINICAL CARE					
Uninsured	Percentage of population under age 65 without health insurance.	10%	10%	6%	25%
Primary care physicians	Ratio of population to primary care physicians.	1,330:1	1,510:1	28,440:1	480:1
Dentists	Ratio of population to dentists.	1,450:1	1,780:1	12,410:1	1,130:1
Mental health providers	Ratio of population to mental health providers.	400:1	620:1	14,010:1	210:1
Preventable hospital stays*	Rate of hospital stays for ambulatory-care sensitive conditions per 100,000 Medicare enrollees.	4,535	5,006	2,505	7,678
Mammography screening*	Percentage of female Medicare enrollees ages 65-74 that received an annual mammography screening.	42%	42%	30%	53%
Flu vaccinations*	Percentage of fee-for-service (FFS) Medicare enrollees that had an annual flu vaccination.	46%	49%	26%	60%
SOCIAL & ECONOMIC FACTORS					
High school graduation	Percentage of ninth-grade cohort that graduates in four years.	85%	84%	75%	98%
Some college	Percentage of adults ages 25-44 with some post-secondary education.	66%	63%	30%	87%
Unemployment	Percentage of population ages 16 and older unemployed but seeking work.	3.9%	3.4%	2.5%	5.5%
Children in poverty*	Percentage of people under age 18 in poverty.	18%	18%	5%	31%
Income inequality	Ratio of household income at the 80th percentile to income at the 20th percentile.	4.9	4.4	3.2	6.1
Children in single-parent households	Percentage of children that live in a household headed by single parent.	33%	34%	15%	47%
Social associations	Number of membership associations per 10,000 population.	9.3	12.3	4.7	21.5
Violent crime	Number of reported violent crime offenses per 100,000 population.	386	385	16	1,251
Injury deaths*	Number of deaths due to injury per 100,000 population.	70	77	42	130
PHYSICAL ENVIRONMENT					

Air pollution - particulate matter	Average daily density of fine particulate matter in micrograms per cubic meter (PM2.5).	8.6	11.8	10.4	14.3
Drinking water violations	Indicator of the presence of health-related drinking water violations. 'Yes' indicates the presence of a violation, 'No' indicates no violation.	N/A	N/A	No	Yes
Severe housing problems	Percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities.	18%	13%	6%	21%
Driving alone to work*	Percentage of the workforce that drives alone to work.	76%	83%	56%	90%
Long commute - driving alone	Among workers who commute in their car alone, the percentage that commute more than 30 minutes.	36%	31%	15%	57%

*Indicates subgroup data by race and ethnicity is available

2020 County Health Rankings: Ranked Measure Sources and Years of Data

	Measure	Weight	Source	Years of Data
HEALTH OUTCOMES				
Length of Life	Premature death*	50%	National Center for Health Statistics - Mortality Files	2016-2018
Quality of Life	Poor or fair health	10%	Behavioral Risk Factor Surveillance System	2017
	Poor physical health days	10%	Behavioral Risk Factor Surveillance System	2017
	Poor mental health days	10%	Behavioral Risk Factor Surveillance System	2017
	Low birthweight*	20%	National Center for Health Statistics - Natality files	2012-2018
HEALTH FACTORS				
HEALTH BEHAVIORS				
Tobacco Use	Adult smoking	10%	Behavioral Risk Factor Surveillance System	2017
Diet and Exercise	Adult obesity	5%	United States Diabetes Surveillance System	2016
	Food environment index	2%	USDA Food Environment Atlas, Map the Meal Gap from Feeding America	2015 & 2017
	Physical inactivity	2%	United States Diabetes Surveillance System	2016
	Access to exercise opportunities	1%	Business Analyst, Delorme map data, ESRI, & US Census Tigerline Files	2010 & 2019
Alcohol and Drug Use	Excessive drinking	2.5%	Behavioral Risk Factor Surveillance System	2017
	Alcohol-impaired driving deaths	2.5%	Fatality Analysis Reporting System	2014-2018
Sexual Activity	Sexually transmitted infections	2.5%	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention	2017
	Teen births*	2.5%	National Center for Health Statistics - Natality files	2012-2018
CLINICAL CARE				
Access to Care	Uninsured	5%	Small Area Health Insurance Estimates	2017
	Primary care physicians	3%	Area Health Resource File/American Medical Association	2017
	Dentists	1%	Area Health Resource File/National Provider Identification file	2018
	Mental health providers	1%	CMS, National Provider Identification	2019
Quality of Care	Preventable hospital stays*	5%	Mapping Medicare Disparities Tool	2017
	Mammography screening*	2.5%	Mapping Medicare Disparities Tool	2017
	Flu vaccinations*	2.5%	Mapping Medicare Disparities Tool	2017
SOCIAL & ECONOMIC FACTORS				
Education	High school graduation	5%	Indiana Department of Education	2016-2017
	Some college	5%	American Community Survey, 5-year estimates	2014-2018
Employment	Unemployment	10%	Bureau of Labor Statistics	2018
Income	Children in poverty*	7.5%	Small Area Income and Poverty Estimates	2018
	Income inequality	2.5%	American Community Survey, 5-year estimates	2014-2018
Family and Social Support	Children in single-parent households	2.5%	American Community Survey, 5-year estimates	2014-2018
	Social associations	2.5%	County Business Patterns	2017

Community Safety	Violent crime	2.5%	Uniform Crime Reporting - FBI	2014 & 2016
	Injury deaths*	2.5%	National Center for Health Statistics - Mortality Files	2014-2018
PHYSICAL ENVIRONMENT				
Air and Water Quality	Air pollution - particulate matter⁺	2.5%	Environmental Public Health Tracking Network	2014
	Drinking water violations	2.5%	Safe Drinking Water Information System	2018
Housing and Transit	Severe housing problems	2%	Comprehensive Housing Affordability Strategy (CHAS) data	2012-2016
	Driving alone to work*	2%	American Community Survey, 5-year estimates	2014-2018
	Long commute - driving alone	1%	American Community Survey, 5-year estimates	2014-2018

*Indicates subgroup data by race and ethnicity is available
⁺ Not available for AK and HI

2020 County Health Rankings: Additional Measure Sources and Years of Data

	Measure	Source	Years of Data
HEALTH OUTCOMES			
Length of Life	Life expectancy*	National Center for Health Statistics - Mortality Files	2016-2018
	Premature age-adjusted mortality*	National Center for Health Statistics - Mortality Files	2016-2018
	Child mortality*	National Center for Health Statistics - Mortality Files	2015-2018
	Infant mortality*	National Center for Health Statistics - Mortality Files	2012-2018
Quality of Life	Frequent physical distress	Behavioral Risk Factor Surveillance System	2017
	Frequent mental distress	Behavioral Risk Factor Surveillance System	2017
	Diabetes prevalence	United States Diabetes Surveillance System	2016
	HIV prevalence	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention	2016
HEALTH FACTORS			
HEALTH BEHAVIORS			
Diet and Exercise	Food insecurity	Map the Meal Gap	2017
	Limited access to healthy foods	USDA Food Environment Atlas	2015
Alcohol and Drug Use	Drug overdose deaths*	National Center for Health Statistics - Mortality Files	2016-2018
	Motor vehicle crash deaths*	National Center for Health Statistics - Mortality Files	2012-2018
Other Health Behaviors	Insufficient sleep	Behavioral Risk Factor Surveillance System	2016
CLINICAL CARE			
Access to Care	Uninsured adults	Small Area Health Insurance Estimates	2017
	Uninsured children	Small Area Health Insurance Estimates	2017
	Other primary care providers	CMS, National Provider Identification	2019
SOCIAL & ECONOMIC FACTORS			
Education	Disconnected youth	American Community Survey, 5-year estimates	2014-2018
	Reading scores*⁺	Stanford Education Data Archive	2016
	Math scores*⁺	Stanford Education Data Archive	2016
Income	Median household income*	Small Area Income and Poverty Estimates	2018
	Children eligible for free or reduced price lunch	National Center for Education Statistics	2017-2018
Family and Social Support	Residential segregation - Black/White	American Community Survey, 5-year estimates	2014-2018
	Residential segregation - non-White/White	American Community Survey, 5-year estimates	2014-2018
Community Safety	Homicides*	National Center for Health Statistics - Mortality Files	2012-2018
	Suicides*	National Center for Health Statistics - Mortality Files	2014-2018
	Firearm fatalities*	National Center for Health Statistics - Mortality Files	2014-2018
	Juvenile arrests⁺	Easy Access to State and County Juvenile Court Case Counts	2017
PHYSICAL ENVIRONMENT			
Housing and Transit	Traffic volume	EJSCREEN: Environmental Justice Screening and Mapping Tool	2018
	Homeownership	American Community Survey, 5-year estimates	2014-2018
	Severe housing cost burden	American Community Survey, 5-year estimates	2014-2018

*Indicates subgroup data by race and ethnicity is available.
⁺ Not available in all states

See additional contextual demographic information and measures online at www.countyhealthrankings.org

APPENDICES

Technical Notes and Glossary of Terms

What is health equity? What are health disparities? And how do they relate?

Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty and discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.

Health disparities are differences in health or in the key determinants of health such as education, safe housing, anddiscrimination, which adversely affect marginalized or excluded groups.

Health equity and health disparities are closely related to each other. Health equity is the ethical and human rights principle orvalue that motivates us to eliminate health disparities. Reducing and ultimately eliminating disparities in health and its determinants of health is how we measure progress toward health equity.

Braveman P, Arkin E, Orleans T, Proctor D, and Plough A. What is Health Equity? And WhatDifference Does a Definition Make? Robert Wood Johnson Foundation. May 2017

How do we define racial and ethnic groups?

In our analyses by race and ethnicity we define each category as follows:

- Hispanic includes those who identify themselves as Mexican, Puerto Rican, Cuban, Central or South American, otherHispanic, or Hispanic of unknown origin and can be of any racial background.
- American Indian & Alaska Native (AIAN) includes people who identify themselves as American Indian or AlaskaNative.
- Asian/Pacific Islander (Asian/PI) includes people who identify themselves as Asian or Pacific Islander.
- Black includes people who identify themselves as Black or African American.
- White includes people who identify themselves as White and do not identify as Hispanic.

Our analyses do not include people reporting more than one race, as this category was not measured uniformly across the data sources used in the County Health Rankings. These racial and ethnic categories can mask variation within groups and can hide historical context that underlies health differences.

We recognize that "race" is a social category, meaning the way society may identify individuals based on their cultural ancestry, not a way of characterizing individuals based on biology or genetics. A strong and growing body of empirical research provides support for the fact that genetic factors are not responsible for racial differences in health factors and very rarely for health outcomes.

How do we rank counties?

To calculate the ranks, we first standardize each of the measures using z-scores. Z-scores allow us to combine multiple measures because the measures are now on the same scale. The ranks are then calculated based on weighted sums of the measure z-scores within each state to create an aggregate z-score. The county with the best aggregate z-score (healthiest) gets a rank of #1 for that state. The aggregate z-scores are graphed next to the maps for health outcomes and health factors on pages 4 and 5 to show the distribution of the values that contribute to the rank. To see more detailed information on rankcalculation please visit our methods in **Explore Health Rankings** on our website: www.countyhealthrankings.org.

Technical Notes:

- In this report, we use the terms disparities, differences, and gaps interchangeably.
- We follow basic design principles for cartography in displaying color spectrums with less intensity for lower valuesand increasing color intensity for higher values. We do not intend to elicit implicit biases that "darker is bad".
- Overall county level values of children in poverty are obtained from one-year modeled estimates from the Small Area Income and Poverty Estimates (SAIPE) Program. Because SAIPE does not provide estimates by racial and ethnic groups, data from the 5-year American Community Survey (ACS) was used to quantify children living in poverty by racial and ethnic groups.
- County-level data for children in poverty among racial and ethnic groups are not shown if the estimate was considered to be unreliable (confidence interval width was greater than 40% or value was 0% or 100%). Unreliableestimates are often due to a very small sample size.
- Given the suppression of data for small sample sizes particularly for county data by race, there may be a gap betweenthe state value and the data for the county data that are available.
- In many of the images using one circle to depict a county the values are very close causing overlapping circles. Inthese cases, greater color intensity indicates overlapping of multiple counties.

Report Authors

Courtney Blomme, MS, RD
Anne Roubal, PhD, MS
Marjory Givens, PhD, MSPH
Sheri Johnson, PhD
Lawrence Brown, PhD

Suggested citation: University of Wisconsin Population Health Institute. County Health Rankings State Report 2020.

Research Assistance:

Molly Burdine
Amanda Gatewood, PhD
Keith Gennuso, PhD

Joe Hinton, MA Hannah
Olson-Williams
Eunice Park, MIS

Elizabeth Pollock, PhD
Jennifer Robinson
Matthew Rodock, MPH

With contributions from our CHR&R team including:
What Works for Health
Community Transformation
Operations
RWJF Culture of Health Prize

This work could not be done without our partnerships with:
The Centers for Disease Control and Prevention for providing us with key health indicators
Burness for supporting our communication efforts
Forum One for website design and support

This work is possible thanks to a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute.

County Health Rankings & Roadmaps
Building a Culture of Health, County by County
A Robert Wood Johnson Foundation program

University of Wisconsin Population Health Institute
610 Walnut St, #524, Madison, WI 53726 | (608) 265-8240 | info@countyhealthrankings.org

Snapshot of Communities Served by Goshen Health, 2018–2020*

Source: countyhealthrankings.org as of 12/1/2020

Publicly available data are gathered annually by University of Wisconsin Population Health Institute to reflect county-level health performance by state, across the nation. This document collects data from the 2018, 2019 and 2020 County Health Rankings, providing a summary of health trends in the communities served by Goshen Health, Elkhart, Kosciusko, LaGrange and Noble counties.

The following tables and graphs present the metrics as laid out in the ranking studies:

1) County rankings across Indiana
2) Weighted health outcomes used in rankings
3) Weighted health factors used in rankings
4) Demographics
5) Unweighted health outcomes not used in rankings
6) Unweighted health factors not used in rankings
7) Arrests for possession and sale/manufacture of drugs**

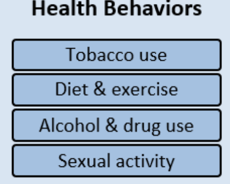
In sections 1 and 2, the weight assigned to each metric by the University of Wisconsin Population Health Institute is provided in each metric's graph and table title.

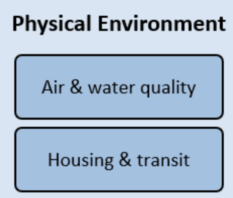
Weighted Health Outcomes

Length of Life
Premature death
(years of potential life lost before age 75)

Quality of Life
Self-reported health status
Percent of low birthweight newborns

Weighted Health Factors



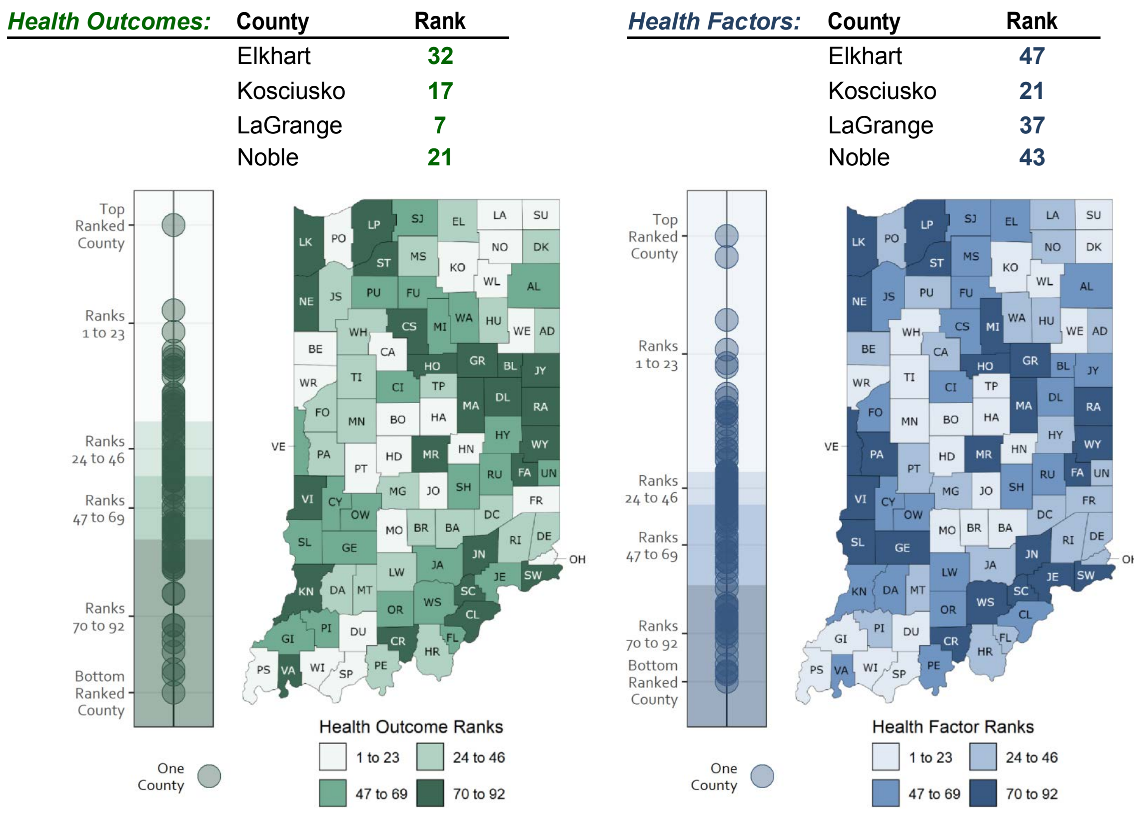


The years provided denote the year of the County Health Ranking Report from which the data was gathered, NOT the time of original data collection. Please refer to the* ***2020 County Health Rankings: Ranked Measure Sources and Years of Data* *chart in the Indiana Key Findings section for 2020 data collection sources and years, or to the County Health Rankings Website page https://www.countyhealthrankings.org/app/indiana/2021/downloads for previous years' data sourcing information.*

***This data was not collected by the University of Wisconsin. It was collected from the FBI's 2012, 2014 and 2016 Uniform Crime Reporting Program data. Full citations are provided at the end of this report.*

Section 1: Goshen Health Communities’ Rankings in Indiana

Source: countyhealthrankings.org as of 12/1/2020



Health Outcomes: County	Rank
Elkhart	32
Kosciusko	17
LaGrange	7
Noble	21

Health Factors: County	Rank
Elkhart	47
Kosciusko	21
LaGrange	37
Noble	43

Figure 1. Health outcome ranks displayed using quartiles (map) and underlying health outcome scores (chart)

Figure 2. Health factor ranks displayed using quartiles (map) and underlying health outcome scores (chart)

Rankings in Health Outcome Building Blocks ***Rankings***

in Health Factor Building Blocks

County	Length of Life (50%)	Quality of Life (50%)
Elkhart	28	44
Kosciusko	21	17
LaGrange	10	8
Noble	33	9

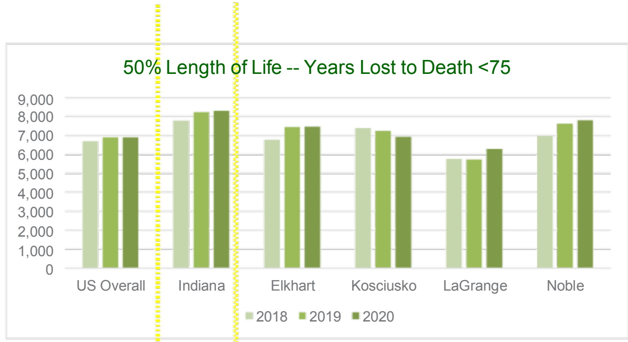
County	Health Behavior (30%)	Clinical Care (20%)	Social & Economic (40%)	Physical Environment (10%)
Elkhart	54	58	28	70
Kosciusko	31	60	9	87
LaGrange	19	92	14	2
Noble	41	75	21	75

Section 2: Weighted Health Outcomes

50% Length of Life -- Years Lost to Death <75

Source: countyhealthrankings.org annual reports 2018 to 2020 *Years of potential life lost before age 75 per 100,000 population (age-adjusted).*

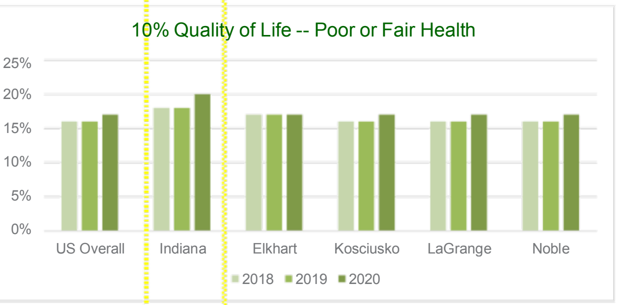
			Goshen Health Community County			
	US Overall	**Indiana**	**Elkhart**	**Kosciusko**	**LaGrange**	**Noble**
2018	**6,700**	**7,794**	**6,783**	**7,386**	**5,769**	**6,961**
2019	**6,900**	**8,238**	**7,445**	**7,236**	**5,733**	**7,622**
2020	**6,900**	**8,306**	**7,468**	**6,926**	**6,290**	**7,803**



10% Quality of Life -- Poor or Fair Health

Source: countyhealthrankings.org annual reports 2018 to 2020
Percentage of adults reporting fair or poor health (age-adjusted).

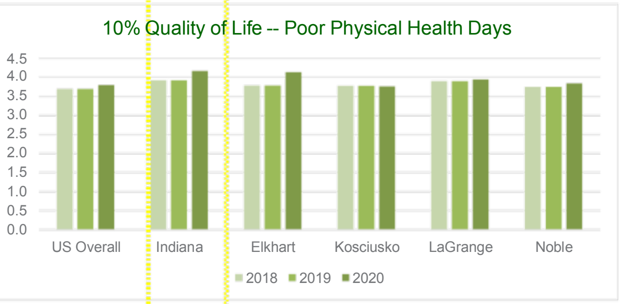
			Goshen Health Community County			
	US Overall	**Indiana**	**Elkhart**	**Kosciusko**	**LaGrange**	**Noble**
2018	**16%**	**18%**	**17%**	**16%**	**16%**	**16%**
2019	**16%**	**18%**	**17%**	**16%**	**16%**	**16%**
2020	**17%**	**20%**	**17%**	**17%**	**17%**	**17%**



10% Quality of Life -- Poor Physical Health Days

Source: countyhealthrankings.org annual reports 2018 to 2020
Average number of physically unhealthy days reported in past 30 days (age-adjusted).

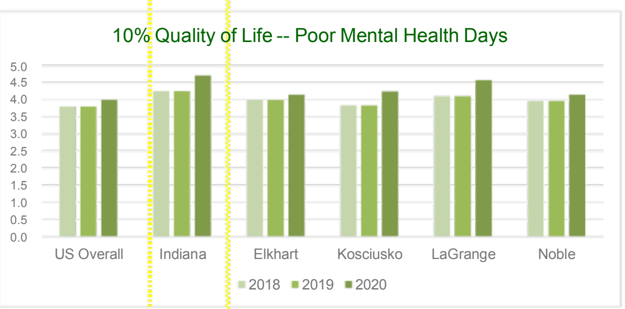
			Goshen Health Community County			
	US Overall	**Indiana**	**Elkhart**	**Kosciusko**	**LaGrange**	**Noble**
2018	**3.7**	**3.9**	**3.8**	**3.8**	**3.9**	**3.8**
2019	**3.7**	**3.9**	**3.8**	**3.8**	**3.9**	**3.8**
2020	**3.8**	**4.2**	**4.1**	**3.8**	**4.0**	**3.8**



10% Quality of Life -- Poor Mental Health Days

Source: countyhealthrankings.org annual reports 2018 to 2020
Average number of mentally unhealthy days reported in past 30 days (age-adjusted).

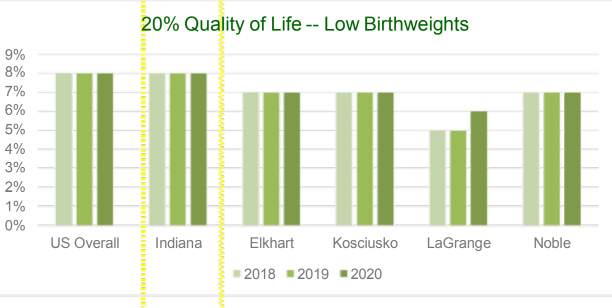
			Goshen Health Community County			
	US Overall	**Indiana**	**Elkhart**	**Kosciusko**	**LaGrange**	**Noble**
2018	**3.8**	**4.3**	**4.0**	**3.8**	**4.1**	**4.0**
2019	**3.8**	**4.3**	**4.0**	**3.8**	**4.1**	**4.0**
2020	**4.0**	**4.7**	**4.2**	**4.2**	**4.6**	**4.1**



20% Quality of Life -- Low Birthweights

Source: countyhealthrankings.org annual reports 2018 to 2020
Percentage of live births with low birthweight (< 2,500 grams).

			Goshen Health Community County			
	US Overall	**Indiana**	**Elkhart**	**Kosciusko**	**LaGrange**	**Noble**
2018	**8%**	**8%**	**7%**	**7%**	**5%**	**7%**
2019	**8%**	**8%**	**7%**	**7%**	**5%**	**7%**
2020	**8%**	**8%**	**7%**	**7%**	**6%**	**7%**



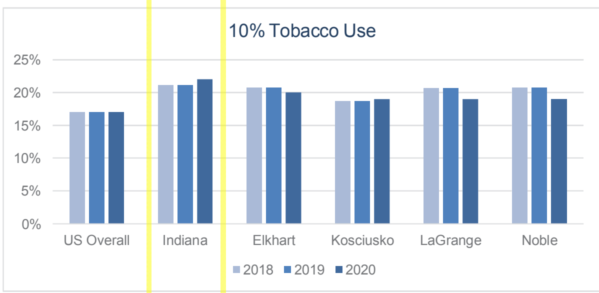
Section 3: Weighted Health Factors -- Health Behaviors (Tobacco, Diet and Exercise)

10% Tobacco Use

Source: countyhealthrankings.org annual reports 2018 to 2020

Percentage of adults who are current smokers.

	US Overall	Indiana	Goshen Health Community County Elkhart	Kosciusko	LaGrange	Noble
2018	17%	21%	21%	19%	21%	21%
2019	17%	21%	21%	19%	21%	21%
2020	17%	22%	20%	19%	19%	19%

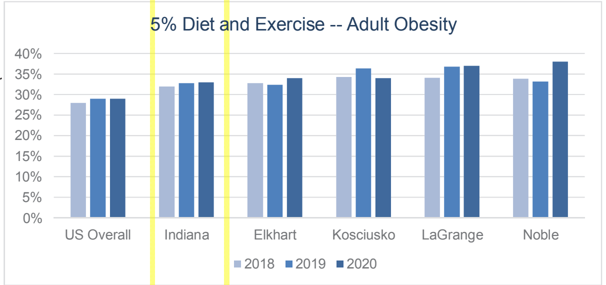


5% Diet and Exercise -- Adult Obesity

Source: countyhealthrankings.org annual reports 2018 to 2020

Percentage of the adult population (age 20 and older) that reports a body mass index (BMI) greater than or kg/m2.

	US Overall	Indiana	Goshen Health Community County Elkhart	Kosciusko	LaGrange	Noble
2018	28%	32%	33%	34%	34%	34%
2019	29%	33%	32%	36%	37%	33%
2020	29%	33%	34%	34%	37%	38%

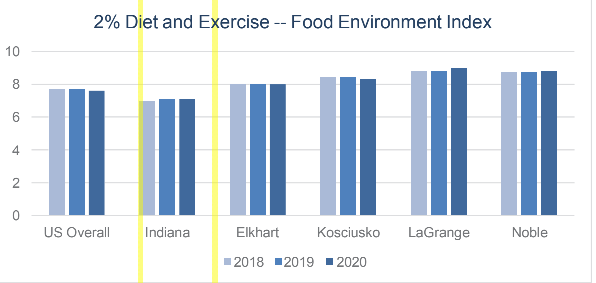


2% Diet and Exercise -- Food Environment Index

Source: countyhealthrankings.org annual reports 2018 to 2020

Index of factors that contribute to a healthy food environment, from 0 (worst) to 10 (best).

	US Overall	Indiana	Goshen Health Community County Elkhart	Kosciusko	LaGrange	Noble
2018	7.7	7.0	8.0	8.4	8.8	8.7
2019	7.7	7.1	8.0	8.4	8.8	8.7
2020	7.6	7.1	8.0	8.3	9.0	8.8

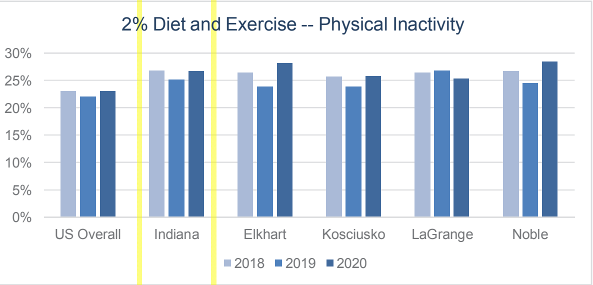


2% Diet and Exercise -- Physical Inactivity

Source: countyhealthrankings.org annual reports 2018 to 2020

Percentage of adults age 20 and over reporting no leisure-time physical activity.

	US Overall	Indiana	Goshen Health Community County Elkhart	Kosciusko	LaGrange	Noble
2018	23%	27%	26%	26%	26%	27%
2019	22%	25%	24%	24%	27%	25%
2020	23%	27%	28%	26%	25%	29%

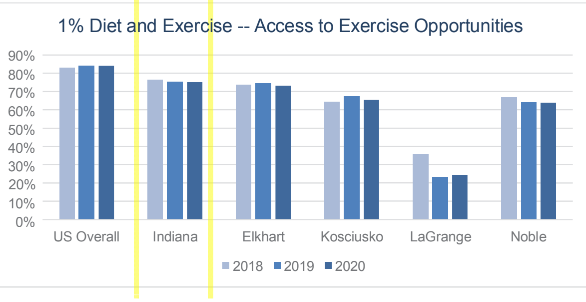


1% Diet and Exercise -- Access to Exercise Opportunities

Source: countyhealthrankings.org annual reports 2018 to 2020

Percentage of population with adequate access to locations for physical activity.

	US Overall	Indiana	Goshen Health Community County Elkhart	Kosciusko	LaGrange	Noble
2018	83%	77%	74%	65%	36%	67%
2019	84%	75%	74%	67%	23%	64%
2020	84%	75%	73%	65%	24%	64%



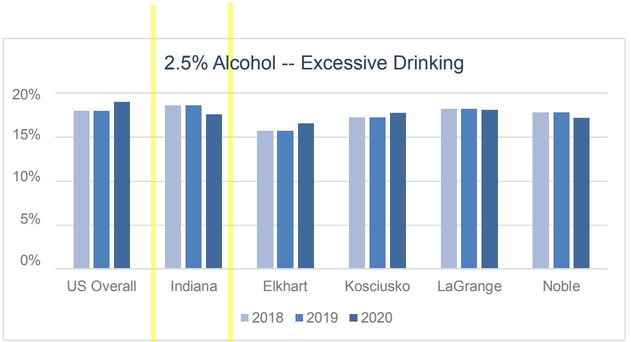
Section 3: Weighted Health Factors -- Health Behaviors (Alcohol and Sexual Activity)

2.5% Alcohol -- Excessive Drinking

Source: countyhealthrankings.org annual reports 2018 to 2020

Percentage of adults reporting binge or heavy drinking.

			Goshen Health Community County			
	US Overall	Indiana	Elkhart	Kosciusko	LaGrange	Noble
2018	18%	19%	16%	17%	18%	18%
2019	18%	19%	16%	17%	18%	18%
2020	19%	18%	17%	18%	18%	17%

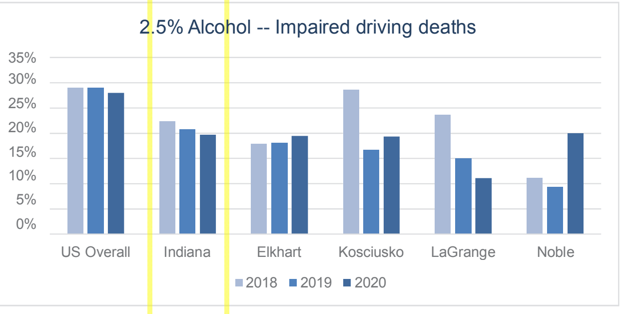


2.5% Alcohol -- Impaired driving deaths

Source: countyhealthrankings.org annual reports 2018 to 2020

Percentage of driving deaths with alcohol involvement.

			Goshen Health Community County			
	US Overall	Indiana	Elkhart	Kosciusko	LaGrange	Noble
2018	29%	22%	18%	29%	24%	11%
2019	29%	21%	18%	17%	15%	9%
2020	28%	20%	19%	19%	11%	20%

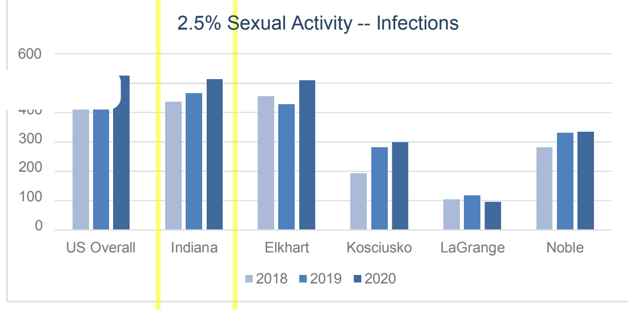


2.5% Sexual Activity -- Infections

Source: countyhealthrankings.org annual reports 2018 to 2020

Number of newly diagnosed chlamydia cases per 100,000

			Goshen Health Community County			
	US Overall	Indiana	Elkhart	Kosciusko	LaGrange	Noble
2018	478.8	437.9	456.0	193.5	104.1	281.4
2019	497.3	466.0	427.6	281.1	118.5	331.0
2020	524.6	514.2	509.7	299.2	96.7	335.1

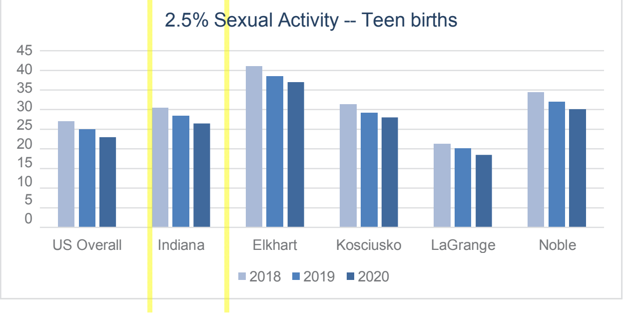


2.5% Sexual Activity -- Teen births

Source: countyhealthrankings.org annual reports 2018 to 2020

Number of births per 1,000 female population ages 15-19.

			Goshen Health Community County			
	US Overall	Indiana	Elkhart	Kosciusko	LaGrange	Noble
2018	27	30	41	31	21	34
2019	25	28	38	29	20	32
2020	23	27	37	28	18	30



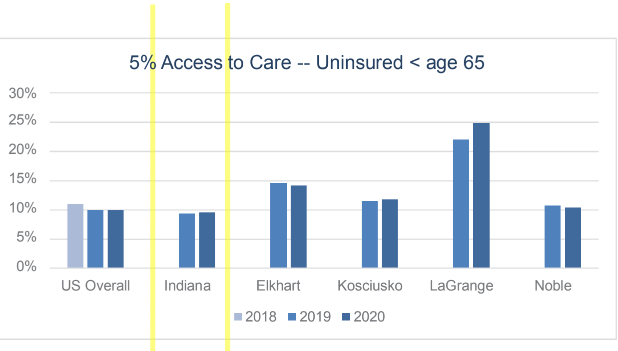
Section 3: Weighted Health Factors -- Clinical Care (Access)

5% Access to Care -- Uninsured < age 65

Source: countyhealthrankings.org annual reports 2018 to 2020

Percentage of population under age 65 without health insurance.

			Goshen Health Community County			
	US Overall	**Indiana**	**Elkhart**	**Kosciusko**	**LaGrange**	**Noble**
2018	**11%**					
2019	**10%**	**9%**	**15%**	**11%**	**22%**	**11%**
2020	**10%**	**10%**	**14%**	**12%**	**25%**	**10%**

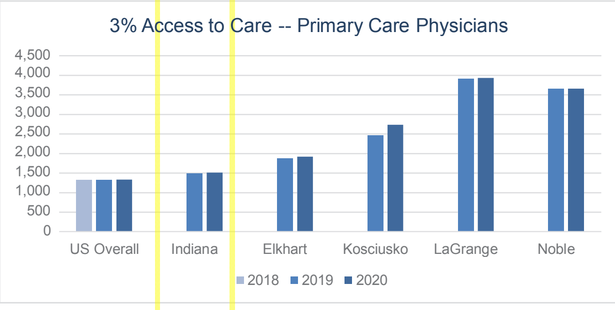


3% Access to Care -- Primary Care Physicians

Source: countyhealthrankings.org annual reports 2018 to 2020

Ratio of population to primary care physicians.

			Goshen Health Community County			
	US Overall	**Indiana**	**Elkhart**	**Kosciusko**	**LaGrange**	**Noble**
2018	**1,320**					
2019	**1,330**	**1,495**	**1,870**	**2,472**	**3,911**	**3,664**
2020	**1,330**	**1,511**	**1,916**	**2,731**	**3,930**	**3,650**

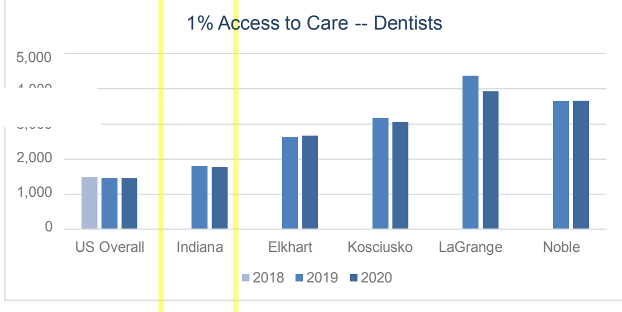


1% Access to Care -- Dentists

Source: countyhealthrankings.org annual reports 2018 to 2020

Ratio of population to dentists.

			Goshen Health Community County			
	US Overall	**Indiana**	**Elkhart**	**Kosc**		
2018	**1,480**					
2019	**1,460**	**1,810**	**2,629**	**3,168**	**4,367**	**3,650**
2020	**1,450**	**1,777**	**2,670**	**3,052**	**3,933**	**3,656**

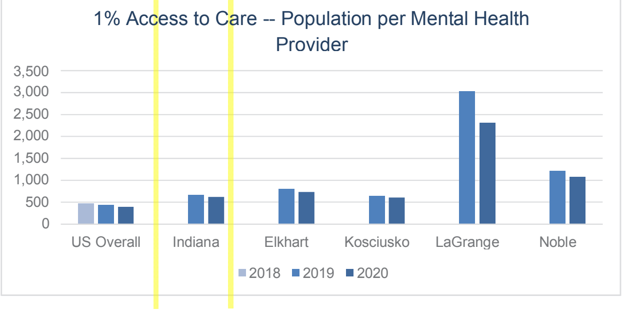


1% Access to Care -- Population per Mental Health Provider

Source: countyhealthrankings.org annual reports 2018 to 2020

Ratio of population to mental health providers.

			Goshen Health Community County			
	US Overall	**Indiana**	**Elkhart**	**Kosciusko**	**LaGrange**	**Noble**
2018	**470**					
2019	**440**	**669**	**804**	**649**	**3,023**	**1,217**
2020	**400**	**623**	**732**	**606**	**2,314**	**1,080**



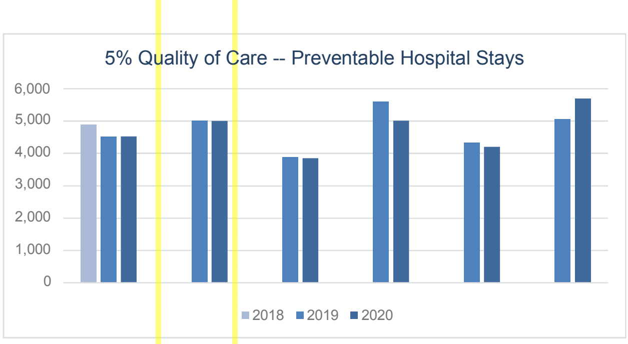
Section 3: Weighted Health Factors -- Clinical Care (Quality)

5% Quality of Care -- Preventable Hospital Stays

Source: countyhealthrankings.org annual reports 2018 to 2020

Rate of hospital stays for ambulatory-care sensitive conditions per 100,000 Medicare enrollees.

			Goshen Health Community County			
	US Overall	**Indiana**	**Elkhart**	**Kosciusko**	**LaGrange**	**Noble**
2018	**4,900**					
2019	**4,520**	**5,023**	**3,887**	**5,606**	**4,344**	**5,073**
2020	**4,535**	**5,006**	**3,859**	**5,017**	**4,213**	**5,699**

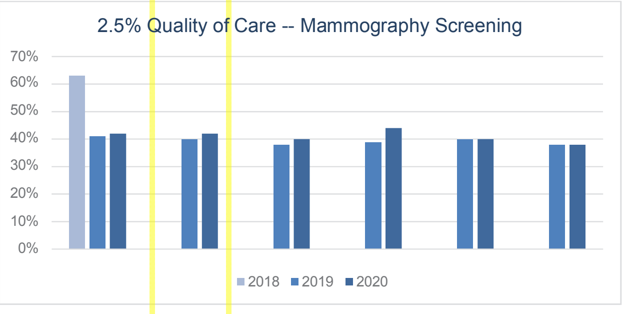


2.5% Quality of Care -- Mammography Screening

Source: countyhealthrankings.org annual reports 2018 to 2020

Percentage of female Medicare enrollees ages 65-74 that received an annual mammography screening.

			Goshen Health Community County			
	US Overall	**Indiana**	**Elkhart**	**Kosciusko**	**LaGrange**	**Noble**
2018	**63%**					
2019	**41%**	**40%**	**38%**	**39%**	**40%**	**38%**
2020	**42%**	**42%**	**40%**	**44%**	**40%**	**38%**

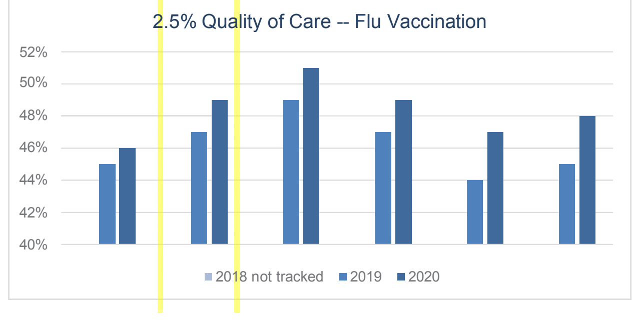


2.5% Quality of Care -- Flu Vaccination

Source: countyhealthrankings.org annual reports 2018 to 2020

Percentage of fee-for-service (FFS) Medicare enrollees that had an annual flu vaccination.

			Goshen Health Community County			
	US Overall	**Indiana**	**Elkhart**	**Kosciusko**	**LaGrange**	**Noble**
2018 not tracked						
2019	**45%**	**47%**	**49%**	**47%**	**44%**	**45%**
2020	**46%**	**49%**	**51%**	**49%**	**47%**	**48%**



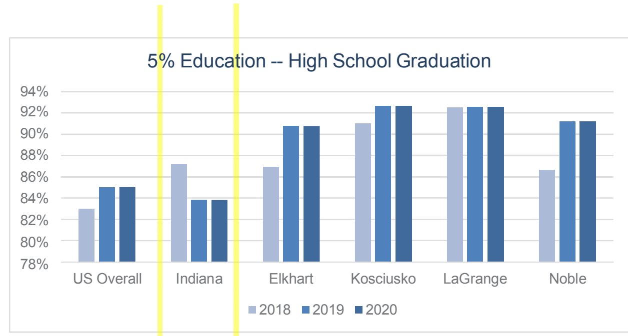
Section 3: Weighted Health Factors -- Social & Economic (Education, Employment, Income)

5% Education -- High School Graduation

Source: countyhealthrankings.org annual reports 2018 to 2020

Percentage of ninth-grade cohort that graduates in four years.

			Goshen Health Community County			
	US Overall	**Indiana**	**Elkhart**	**Kosciusko**	**LaGrange**	**Noble**
2018	**83%**	**87%**	**87%**	**91%**	**93%**	**87%**
2019	**85%**	**84%**	**91%**	**93%**	**93%**	**91%**
2020	**85%**	**84%**	**91%**	**93%**	**93%**	**91%**

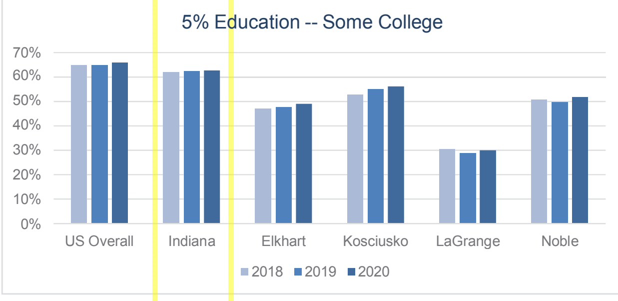


5% Education -- Some College

Source: countyhealthrankings.org annual reports 2018 to 2020

Percentage of adults ages 25-44 with some post-secondary education.

			Goshen Health Community County			
	US Overall	**Indiana**	**Elkhart**	**Kosciusko**	**LaGrange**	**Noble**
2018	**65%**	**62%**	**47%**	**53%**	**30%**	**51%**
2019	**65%**	**62%**	**48%**	**55%**	**29%**	**50%**
2020	**66%**	**63%**	**49%**	**56%**	**30%**	**52%**

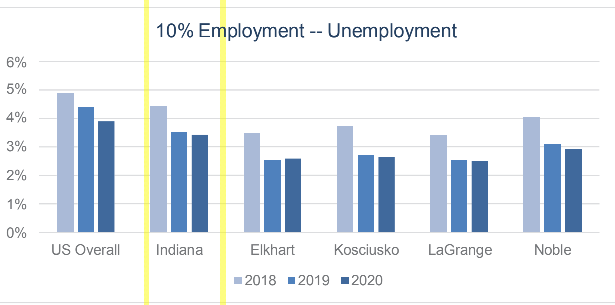


10% Employment -- Unemployment

Source: countyhealthrankings.org annual reports 2018 to 2020

Percentage of population ages 16 and older unemployed but seeking work.

			Goshen Health Community County			
	US Overall	**Indiana**	**Elkhart**	**Kosciusko**	**LaGrange**	**Noble**
2018	**4.9%**	**4.4%**	**3.5%**	**3.7%**	**3.4%**	**4.1%**
2019	**4.4%**	**3.5%**	**2.5%**	**2.7%**	**2.6%**	**3.1%**
2020	**3.9%**	**3.4%**	**2.6%**	**2.6%**	**2.5%**	**2.9%**

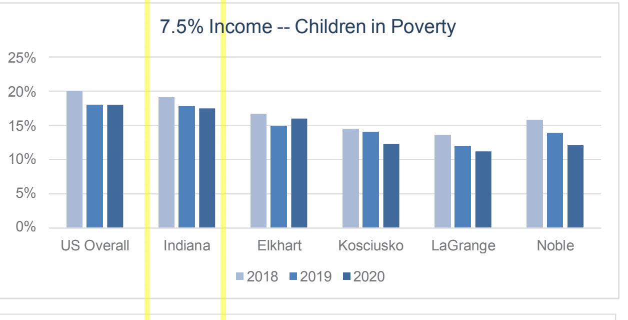


7.5% Income -- Children in Poverty

Source: countyhealthrankings.org annual reports 2018 to 2020

Percentage of people under age 18 in poverty.

			Goshen Health Community County			
	US Overall	**Indiana**	**Elkhart**	**Kosciusko**	**LaGrange**	**Noble**
2018	**20%**	**19%**	**17%**	**15%**	**14%**	**16%**
2019	**18%**	**18%**	**15%**	**14%**	**12%**	**14%**
2020	**18%**	**18%**	**16%**	**12%**	**11%**	**12%**

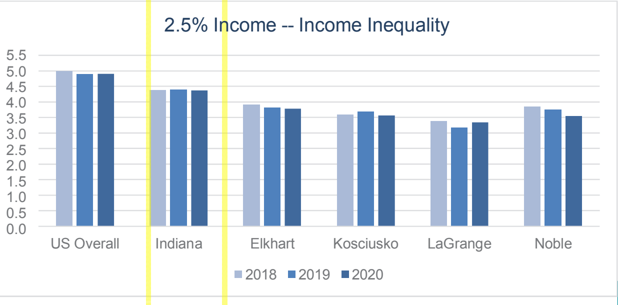


2.5% Income -- Income Inequality

Source: countyhealthrankings.org annual reports 2018 to 2020

Ratio of household income at the 80th percentile to income at the 20th percentile.

			Goshen Health Community County			
	US Overall	**Indiana**	**Elkhart**	**Kosciusko**	**LaGrange**	**Noble**
2018	**5.0**	**4.4**	**3.9**	**3.6**	**3.4**	**3.8**
2019	**4.9**	**4.4**	**3.8**	**3.7**	**3.2**	**3.8**
2020	**4.9**	**4.4**	**3.8**	**3.6**	**3.3**	**3.5**



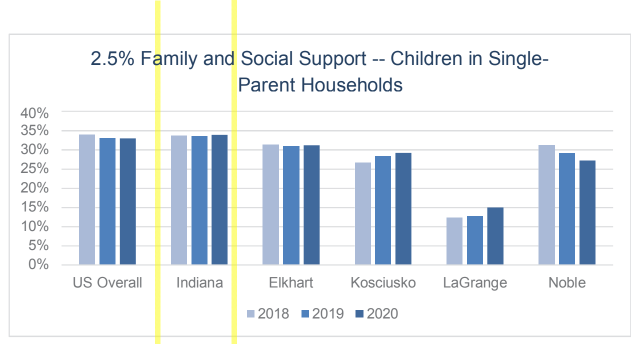
Section 3: Weighted Health Factors -- Social & Economic (Support and Safety)

2.5% Family and Social Support -- Children in Single-Parent Households

Source: countyhealthrankings.org annual reports 2018 to 2020

Percentage of children that live in a household headed by single parent.

			Goshen Health Community County			
	US Overall	Indiana	Elkhart	Kosciusko	LaGrange	Noble
2018	34%	34%	31%	27%	12%	31%
2019	33%	34%	31%	28%	13%	29%
2020	33%	34%	31%	29%	15%	27%

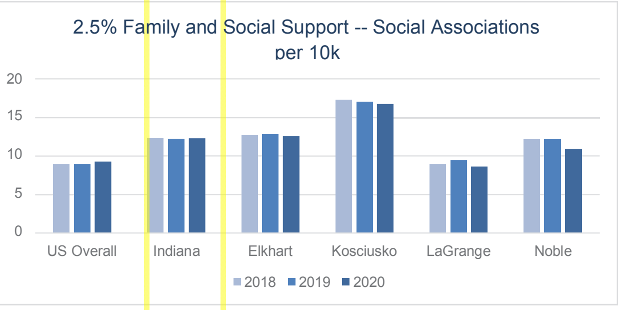


2.5% Family and Social Support -- Social Associations per 10k

Source: countyhealthrankings.org annual reports 2018 to 2020

Number of membership associations per 10,000 population.

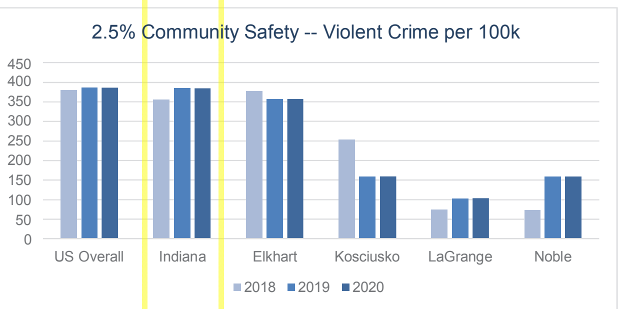
			Goshen Health Community County			
	US Overall	Indiana	Elkhart	Kosciusko	LaGrange	Noble
2018	9.0	12.3	12.7	17.3	9.0	12.2
2019	9.0	12.3	12.8	17.1	9.5	12.2
2020	9.3	12.3	12.6	16.8	8.7	11.0



2.5% Community Safety -- Violent Crime per 100k

Source: countyhealthrankings.org annual reports 2018 to 2020 Number of reported violent crime offenses per 100,000 population.

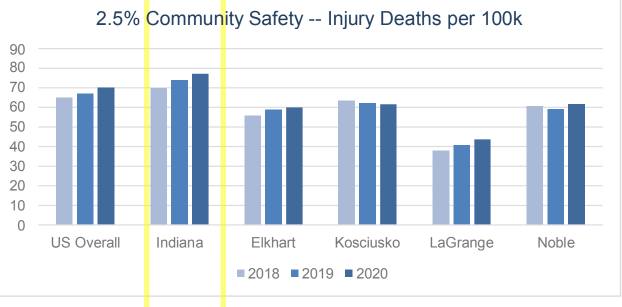
			Goshen Health Community County			
	US Overall	Indiana	Elkhart	Kosciusko	LaGrange	Noble
2018	380	356	378	253	75	73
2019	386	385	357	159	103	158
2020	386	385	357	159	103	158



2.5% Community Safety -- Injury Deaths per 100k

Source: countyhealthrankings.org annual reports 2018 to 2020 Number of deaths due to injury per 100,000 population.

			Goshen Health Community County			
	US Overall	Indiana	Elkhart	Kosciusko	LaGrange	Noble
2018	65	70	56	63	38	60
2019	67	74	59	62	41	59
2020	70	77	60	62	44	62



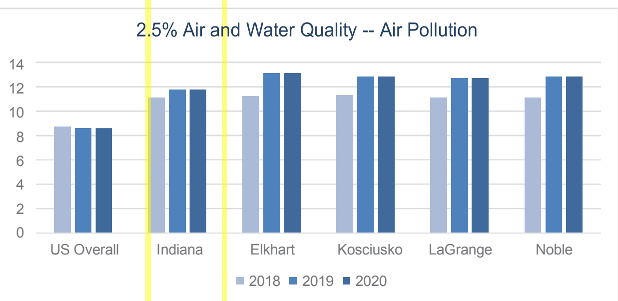
Section 3: Weighted Health Factors -- Physical Environment

2.5% Air and Water Quality -- Air Pollution

Source: countyhealthrankings.org annual reports 2018 to 2020

Average daily density of fine particulate matter in micrograms per cubic meter (PM2.5).

			Goshen Health Community County			
	US Overall	**Indiana**	**Elkhart**	**Kosciusko**	**LaGrange**	**Noble**
2018	**8.7**	**11.1**	**11.2**	**11.3**	**11.1**	**11.1**
2019	**8.6**	**11.8**	**13.1**	**12.8**	**12.7**	**12.8**
2020	**8.6**	**11.8**	**13.1**	**12.8**	**12.7**	**12.8**



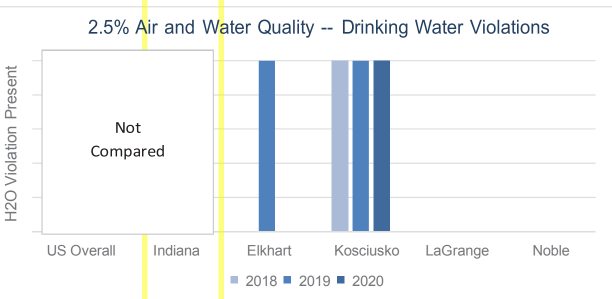
2.5% Air and Water Quality -- Drinking Water Violations

Source: countyhealthrankings.org annual reports 2018 to 2020

Indicator of the presence of health-related drinking water violations. 'Yes' indicates the presence of a violation, 'No' indicates no violation.

			Goshen Health Community County			
	US Overall	**Indiana**	**Elkhart**	**Kosciusko**	**LaGrange**	**Noble**
2018	**n/a**	**n/a**	**0%**	**100%**	**0%**	**0%**
2019	**n/a**	**n/a**	**100%**	**100%**	**0%**	**0%**
2020	**n/a**	**n/a**	**0%**	**100%**	**0%**	**0%**

			Goshen Health Community County			
	US Overall	**Indiana**	**Elkhart**	**Kosciusko**	**LaGrange**	**Noble**
2018			**No**	**Yes**	**No**	**No**
2019			**Yes**	**Yes**	**No**	**No**
2020			**No**	**Yes**	**No**	**No**

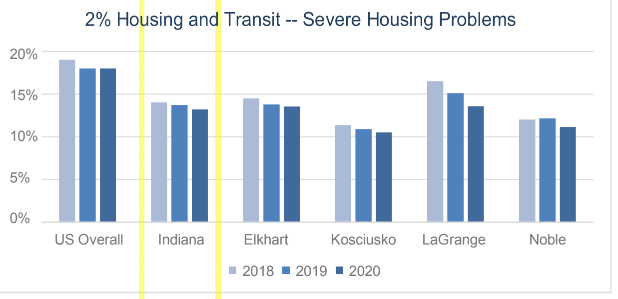


2% Housing and Transit -- Severe Housing Problems

Source: countyhealthrankings.org annual reports 2018 to 2020

Percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities.

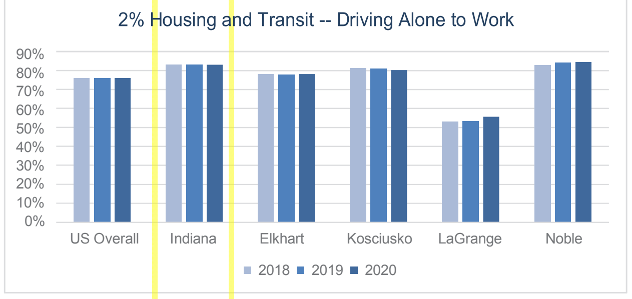
			Goshen Health Community County			
	US Overall	**Indiana**	**Elkhart**	**Kosciusko**	**LaGrange**	**Noble**
2018	**19%**	**14%**	**14%**	**11%**	**16%**	**12%**
2019	**18%**	**14%**	**14%**	**11%**	**15%**	**12%**
2020	**18%**	**13%**	**14%**	**11%**	**14%**	**11%**



2% Housing and Transit -- Driving Alone to Work

Source: countyhealthrankings.org annual reports 2018 to 2020 Percentage of the workforce that drives alone to work.

			Goshen Health Community County			
	US Overall	**Indiana**	**Elkhart**	**Kosciusko**	**LaGrange**	**Noble**
2018	**76%**	**83%**	**78%**	**81%**	**53%**	**83%**
2019	**76%**	**83%**	**78%**	**81%**	**53%**	**84%**
2020	**76%**	**83%**	**78%**	**80%**	**56%**	**84%**

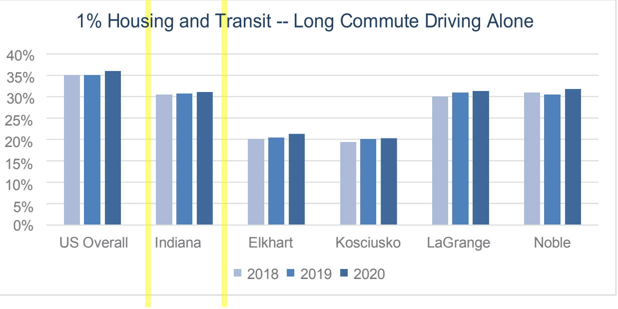


1% Housing and Transit -- Long Commute Driving Alone

Source: countyhealthrankings.org annual reports 2018 to 2020

Among workers who commute in their car alone, the percentage that commute more than 30 minutes.

			Goshen Health Community County			
	US Overall	**Indiana**	**Elkhart**	**Kosciusko**	**LaGrange**	**Noble**
2018	**35%**	**31%**	**20%**	**19%**	**30%**	**31%**
2019	**35%**	**31%**	**20%**	**20%**	**31%**	**31%**
2020	**36%**	**31%**	**21%**	**20%**	**31%**	**32%**



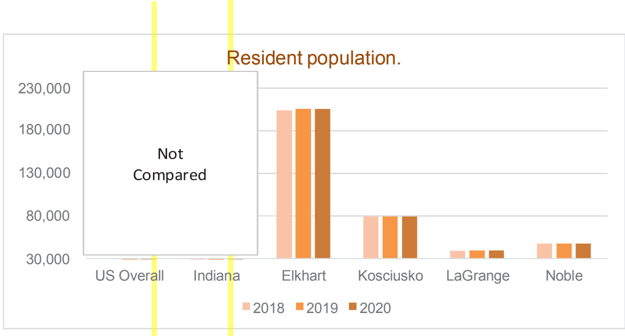
Section 4: Demographics (Population, Age and Gender)

Resident population.

Source: countyhealthrankings.org annual reports 2018 to 2020

Population

			Goshen Health Community County			
	US Overall	Indiana	Elkhart	Kosciusko	LaGrange	Noble
2018		6,666,818	203,781	79,092	39,110	47,638
2019	325,719,178	6,666,818	205,032	79,206	39,303	47,452
2020	327,167,434	6,691,878	205,560	79,344	39,330	47,532

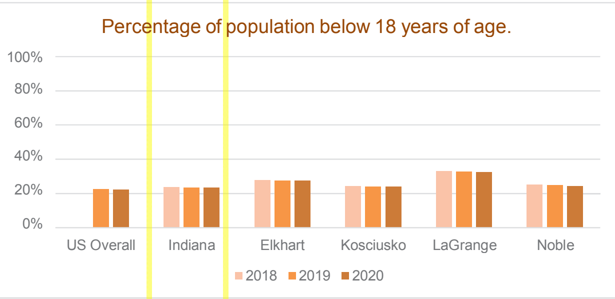


Percentage of population below 18 years of age.

Source: countyhealthrankings.org annual reports 2018 to 2020

% below 18 years of age

			Goshen Health Community County			
	US Overall	Indiana	Elkhart	Kosciusko	LaGrange	Noble
2018		23.8%	27.9%	24.4%	33.1%	25.1%
2019	22.6%	23.6%	27.7%	24.1%	32.9%	25.0%
2020	22.4%	23.4%	27.5%	23.8%	32.5%	24.4%

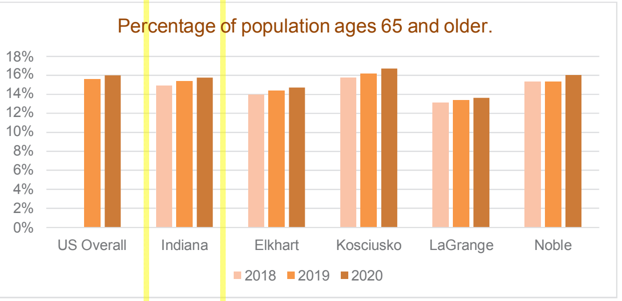


Percentage of population ages 65 and older.

Source: countyhealthrankings.org annual reports 2018 to 2020

% 65 and older

			Goshen Health Community County			
	US Overall	Indiana	Elkhart	Kosciusko	LaGrange	Noble
2018		14.9%	14.0%	15.8%	13.1%	15.3%
2019	15.6%	15.4%	14.4%	16.2%	13.4%	15.3%
2020	16.0%	15.8%	14.7%	16.7%	13.6%	16.0%

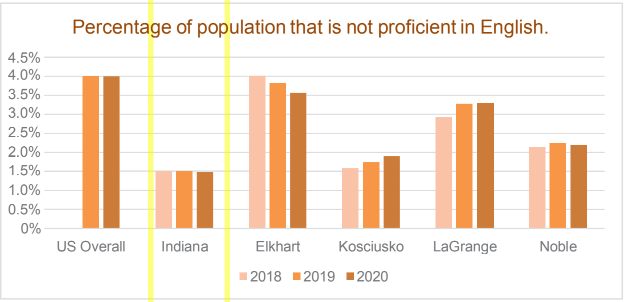


Percentage of population that is not proficient in English.

Source: countyhealthrankings.org annual reports 2018 to 2020

% not proficient in English

			Goshen Health Community County			
	US Overall	Indiana	Elkhart	Kosciusko	LaGrange	Noble
2018		1.5%	4.0%	1.6%	2.9%	2.1%
2019	4.0%	1.5%	3.8%	1.7%	3.3%	2.2%
2020	4%	1.5%	3.6%	1.9%	3.3%	2.2%

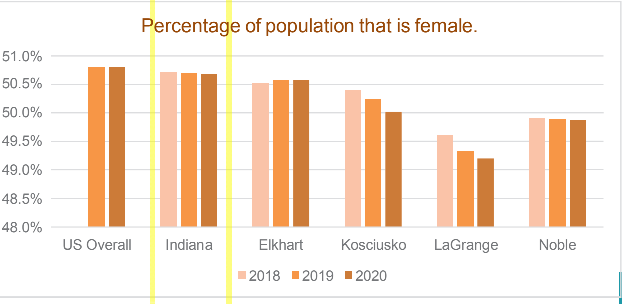


Percentage of population that is female.

Source: countyhealthrankings.org annual reports 2018 to 2020

% Females

			Goshen Health Community County			
	US Overall	Indiana	Elkhart	Kosciusko	LaGrange	Noble
2018		50.7%	50.5%	50.4%	49.6%	49.9%
2019	50.8%	50.7%	50.6%	50.2%	49.3%	49.9%
2020	50.8%	50.7%	50.6%	50.0%	49.2%	49.9%



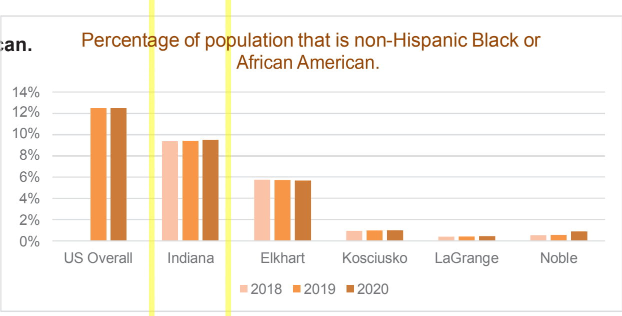
Section 4: Demographics (Race and Ethnicity)

Percentage of population that is non-Hispanic Black or African American.

Source: countyhealthrankings.org annual reports 2018 to 2020

% Non-Hispanic Black

	US Overall	Indiana	Goshen Health Community County			
			Elkhart	Kosciusko	LaGrange	Noble
2018		9.3%	5.8%	1.0%	0.4%	0.5%
2019	12.5%	9.4%	5.7%	1.0%	0.4%	0.5%
2020	12.5%	9.5%	5.7%	1.0%	0.4%	0.9%

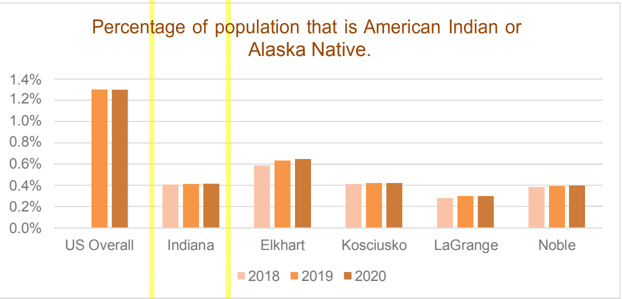


Percentage of population that is American Indian or Alaska Native.

Source: countyhealthrankings.org annual reports 2018 to 2020

% American Indian & Alaska Native

	US Overall	Indiana	Goshen Health Community County			
			Elkhart	Kosciusko	LaGrange	Noble
2018		0.4%	0.6%	0.4%	0.3%	0.4%
2019	1.3%	0.4%	0.6%	0.4%	0.3%	0.4%
2020	1.3%	0.4%	0.6%	0.4%	0.3%	0.4%

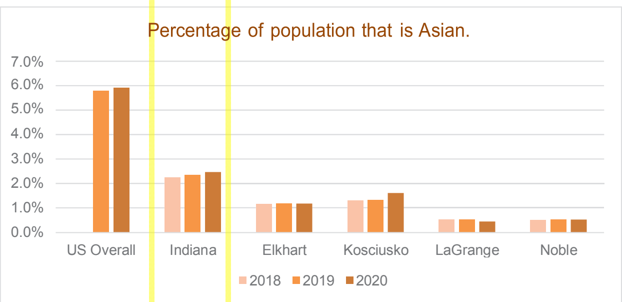


Percentage of population that is Asian.

Source: countyhealthrankings.org annual reports 2018 to 2020

% Asian

	US Overall	Indiana	Goshen Health Community County			
			Elkhart	Kosciusko	LaGrange	Noble
2018		2.25%	1.16%	1.31%	0.53%	0.52%
2019	5.8%	2.36%	1.19%	1.34%	0.54%	0.53%
2020	5.9%	2.47%	1.19%	1.62%	0.45%	0.53%

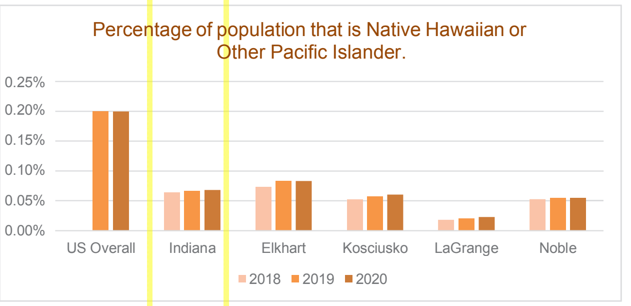


Percentage of population that is Native Hawaiian or Other Pacific Islander.

Source: countyhealthrankings.org annual reports 2018 to 2020

% Native Hawaiian/Other Pacific Islander

	US Overall	Indiana	Goshen Health Community County			
			Elkhart	Kosciusko	LaGrange	Noble
2018		0.06%	0.07%	0.05%	0.02%	0.05%
2019	0.2%	0.07%	0.08%	0.06%	0.02%	0.05%
2020	0.2%	0.07%	0.08%	0.06%	0.02%	0.05%

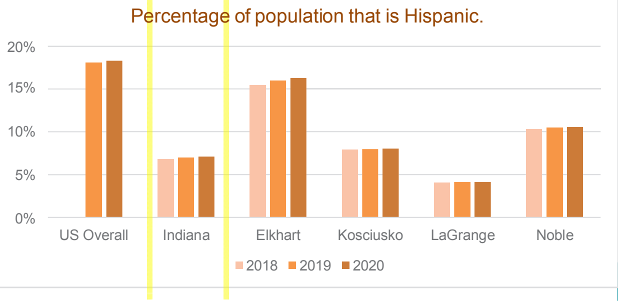


Percentage of population that is Hispanic.

Source: countyhealthrankings.org annual reports 2018 to 2020

% Hispanic

	US Overall	Indiana	Goshen Health Community County			
			Elkhart	Kosciusko	LaGrange	Noble
2018		6.8%	15.5%	7.9%	4.0%	10.3%
2019	18.1%	7.0%	16.0%	8.0%	4.1%	10.4%
2020	18.3%	7.1%	16.3%	8.1%	4.1%	10.5%



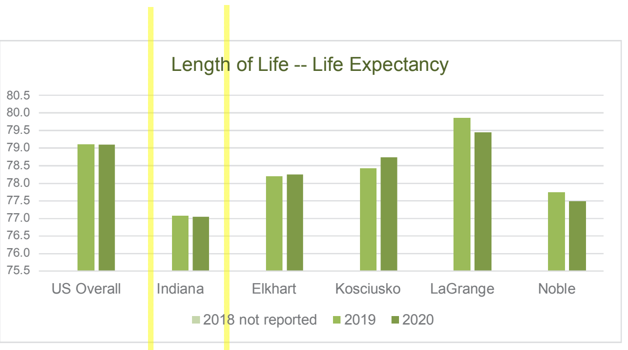
Section 5: Unweighted Health Outcomes -- Length of Life

Length of Life -- Life Expectancy

Source: countyhealthrankings.org annual reports 2018 to 2020

Average number of years a person can expect to live.

	US Overall	Indiana	Goshen Health Community County			
			Elkhart	Kosciusko	LaGrange	Noble
2018 not reported						
2019	79.1	77.1	78.2	78.4	79.9	77.7
2020	79.1	77.0	78.3	78.7	79.5	77.5

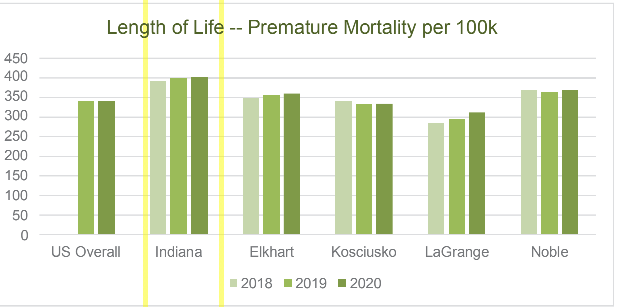


Length of Life -- Premature Mortality per 100k

Source: countyhealthrankings.org annual reports 2018 to 2020

Number of deaths among residents under age 75 per 100,000 population (age-adjusted).

	US Overall	Indiana	Goshen Health Community County			
			Elkhart	Kosciusko	LaGrange	Noble
2018		392	347	341	285	370
2019	340	399	356	333	295	364
2020	340	401	360	334	312	369

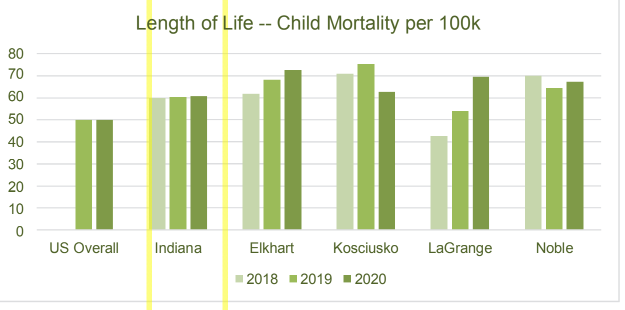


Length of Life -- Child Mortality per 100k

Source: countyhealthrankings.org annual reports 2018 to 2020

Number of deaths among children under age 18 per 100,000 population.

	US Overall	Indiana	Goshen Health Community County			
			Elkhart	Kosciusko	LaGrange	Noble
2018		60	62	71	43	70
2019	50	60	68	75	54	64
2020	50	61	73	63	70	67

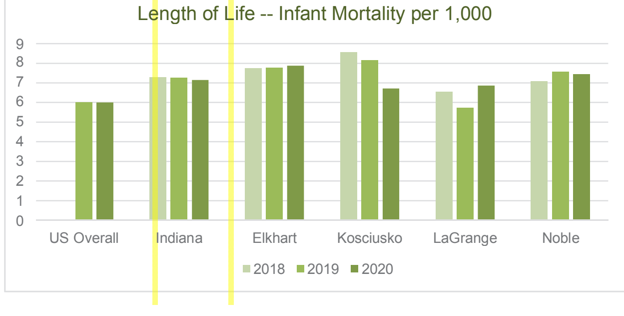


Length of Life -- Infant Mortality per 1,000

Source: countyhealthrankings.org annual reports 2018 to 2020

Number of all infant deaths (within 1 year), per 1,000 live births.

	US Overall	Indiana	Goshen Health Community County			
			Elkhart	Kosciusko	LaGrange	Noble
2018		7.3	7.7	8.6	6.5	7.1
2019	6	7.3	7.8	8.2	5.7	7.6
2020	6	7.1	7.9	6.7	6.9	7.4



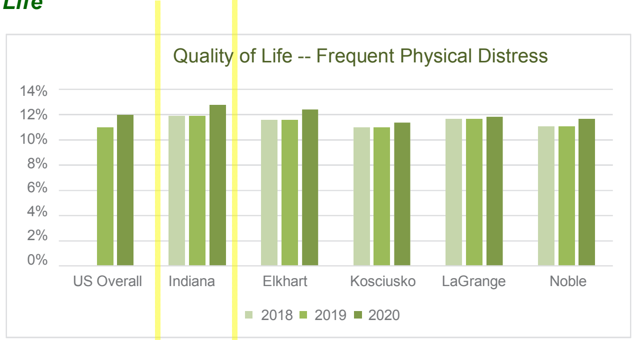
Section 5: Unweighted Health Outcomes -- Quality of Life

Quality of Life -- Frequent Physical Distress

Source: countyhealthrankings.org annual reports 2018 to 2020

Percentage of adults reporting 14 or more days of poor physical health per month.

			Goshen Health Community County			
	US Overall	Indiana	Elkhart	Kosciusko	LaGrange	Noble
2018		11.9%	11.6%	11.0%	11.7%	11.1%
2019	11%	11.9%	11.6%	11.0%	11.7%	11.1%
2020	12%	12.8%	12.4%	11.4%	11.8%	11.7%

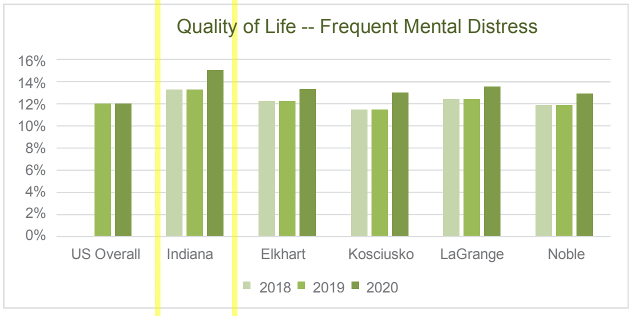


Quality of Life -- Frequent Mental Distress

Source: countyhealthrankings.org annual reports 2018 to 2020

Percentage of adults reporting 14 or more days of poor mental health per month.

			Goshen Health Community County			
	US Overall	Indiana	Elkhart	Kosciusko	LaGrange	Noble
2018		13.3%	12.3%	11.4%	12.4%	11.9%
2019	12%	13.3%	12.3%	11.4%	12.4%	11.9%
2020	12%	15.0%	13.3%	13.0%	13.5%	12.9%

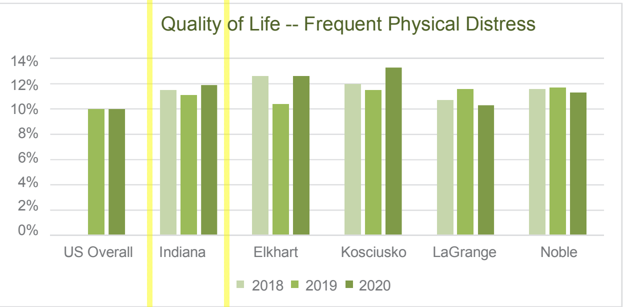


Quality of Life -- Diabetes Prevalence

Source: countyhealthrankings.org annual reports 2018 to 2020

Percentage of adults aged 20 and above with diagnosed diabetes.

			Goshen Health Community County			
	US Overall	Indiana	Elkhart	Kosciusko	LaGrange	Noble
2018		11.5%	12.6%	12.0%	10.7%	11.6%
2019	10%	11.1%	10.4%	11.5%	11.6%	11.7%
2020	10%	11.9%	12.6%	13.3%	10.3%	11.3%

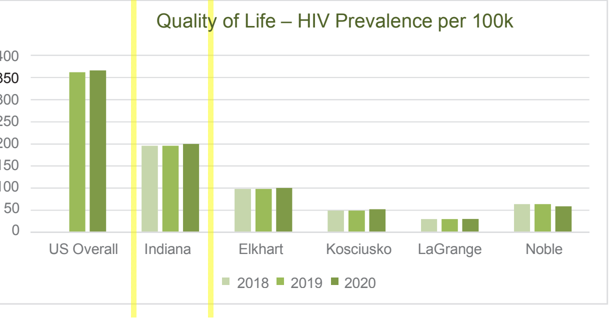


Quality of Life -- HIV Prevalence per 100k

Source: countyhealthrankings.org annual reports 2018 to 2020

Number of people aged 13 years and older living with a diagnosis of human immunodeficiency viru infection per 100,000 population.

			Goshen Health Community County			
	US Overall	Indiana	Elkhart	Kosciusko	LaGrange	Noble
2018		196	98	49	31	64
2019	362	196	98	49	31	64
2020	366	200	101	52	30	59



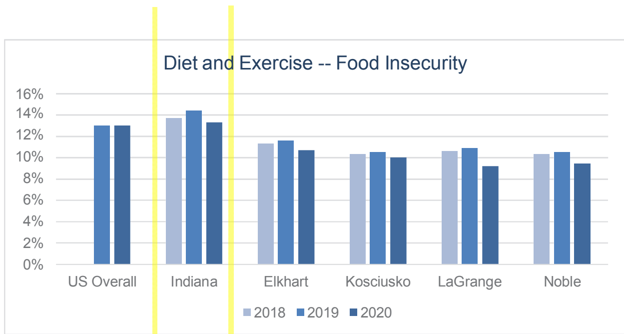
Section 6: Unweighted Health Factors -- Health Behaviors

Diet and Exercise -- Food Insecurity

Source: countyhealthrankings.org annual reports 2018 to 2020

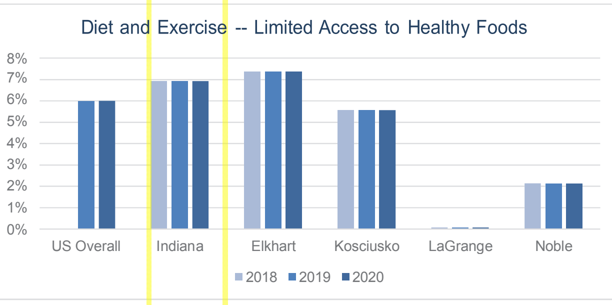
Percentage of population who lack adequate access to food.

			Goshen Health Community County			
	US Overall	**Indiana**	**Elkhart**	**Kosciusko**	**LaGrange**	**Noble**
2018		**13.7%**	**11.3%**	**10.3%**	**10.6%**	**10.3%**
2019	**13%**	**14.4%**	**11.6%**	**10.5%**	**10.9%**	**10.5%**
2020	**13%**	**13.3%**	**10.7%**	**10.0%**	**9.2%**	**9.4%**



Diet and Exercise -- Limited Access to Healthy Foods *Source: countyhealthrankings.org annual reports 2018 to 2020* *Percentage of population who are low-income and do not live close to a grocery store.*

			Goshen Health Community County			
	US Overall	**Indiana**	**Elkhart**	**Kosciusko**	**LaGrange**	**Noble**
2018		**6.9%**	**7.4%**	**5.6%**	**0.1%**	**2.1%**
2019	**6%**	**6.9%**	**7.4%**	**5.6%**	**0.1%**	**2.1%**
2020	**6%**	**6.9%**	**7.4%**	**5.6%**	**0.1%**	**2.1%**

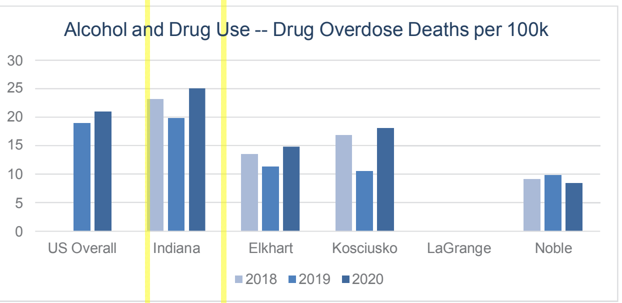


Alcohol and Drug Use -- Drug Overdose Deaths per 100k

Source: countyhealthrankings.org annual reports 2018 to 2020

Number of drug poisoning deaths per 100,000 population.

			Goshen Health Community County			
	US Overall	**Indiana**	**Elkhart**	**Kosciusko**	**LaGrange**	**Noble**
2018		**23**	**14**	**17**		**9**
2019	**19**	**20**	**11**	**11**		**10**
2020	**21**	**25**	**15**	**18**		**8**

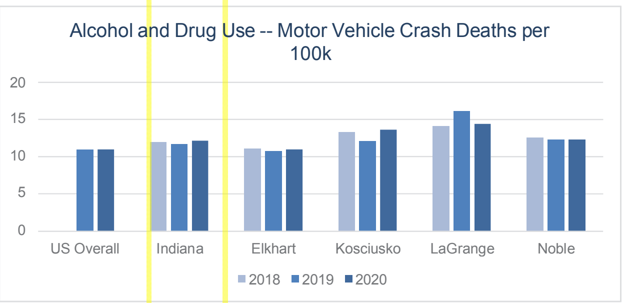


Alcohol and Drug Use -- Motor Vehicle Crash Deaths per 100k

Source: countyhealthrankings.org annual reports 2018 to 2020

Number of motor vehicle crash deaths per 100,000 population.

			Goshen Health Community County			
	US Overall	**Indiana**	**Elkhart**	**Kosciusko**	**LaGrange**	**Noble**
2018		**12**	**11**	**13**	**14**	**13**
2019	**11**	**12**	**11**	**12**	**16**	**12**
2020	**11**	**12**	**11**	**14**	**14**	**12**

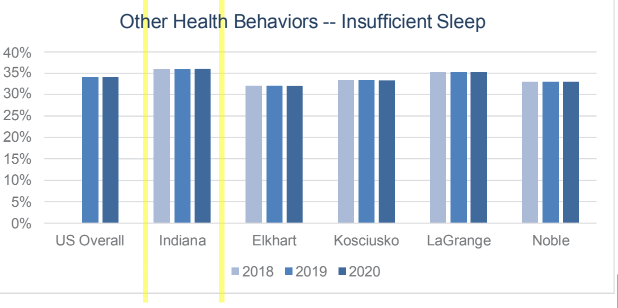


Other Health Behaviors -- Insufficient Sleep

Source: countyhealthrankings.org annual reports 2018 to 2020

Percentage of adults who report fewer than 7 hours of sleep on average.

			Goshen Health Community County			
	US Overall	**Indiana**	**Elkhart**	**Kosciusko**	**LaGrange**	**Noble**
2018		**36.0%**	**32.1%**	**33.3%**	**35.2%**	**33.0%**
2019	**34%**	**36.0%**	**32.1%**	**33.3%**	**35.2%**	**33.0%**
2020	**34%**	**36.0%**	**32.1%**	**33.3%**	**35.2%**	**33.0%**



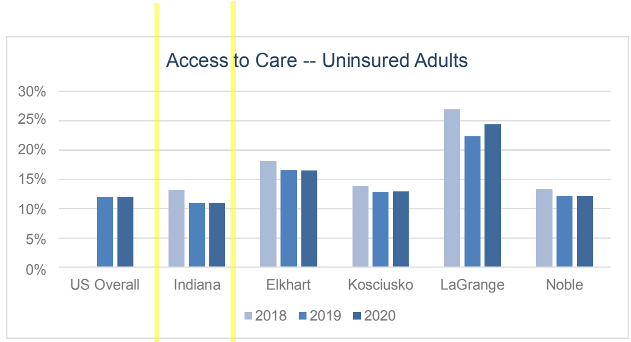
Section 6: Unweighted Health Factors -- Clinical Care

Access to Care -- Uninsured Adults

Source: countyhealthrankings.org annual reports 2018 to 2020

Percentage of adults under age 65 without health insurance.

	US Overall	Indiana	Goshen Health Community County			
			Elkhart	Kosciusko	LaGrange	Noble
2018		13.1%	18.1%	13.9%	26.9%	13.4%
2019	12%	10.9%	16.6%	12.9%	22.3%	12.0%
2020	12%	11.0%	16.5%	13.0%	24.3%	12.0%

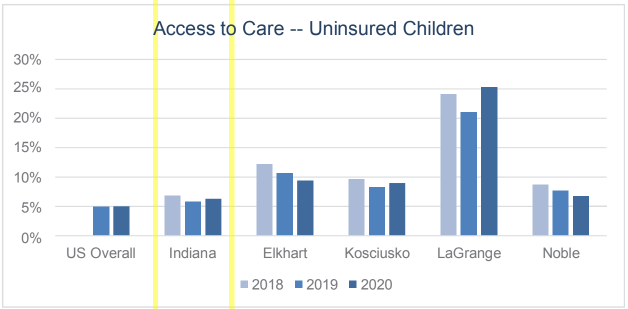


Access to Care -- Uninsured Children

Source: countyhealthrankings.org annual reports 2018 to 2020

Percentage of children under age 19 without health insurance.

	US Overall	Indiana	Goshen Health Community County			
			Elkhart	Kosciusko	LaGrange	Noble
2018		6.9%	12.2%	9.7%	24.1%	8.7%
2019	5%	5.8%	10.7%	8.3%	21.1%	7.7%
2020	5%	6.3%	9.4%	9.0%	25.3%	6.8%

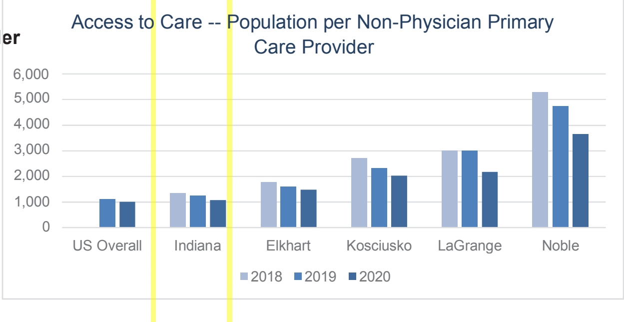


Access to Care -- Population per Non-Physician Primary Care Provider

Source: countyhealthrankings.org annual reports 2018 to 2020

Ratio of population to primary care providers other than physicians.

	US Overall	Indiana	Goshen Health Community County			
			Elkhart	Kosciusko	LaGrange	Noble
2018		1,367	1,772	2,727	3,008	5,293
2019	1,130	1,245	1,614	2,330	3,023	4,745
2020	1,010	1,080	1,490	2,034	2,185	3,656



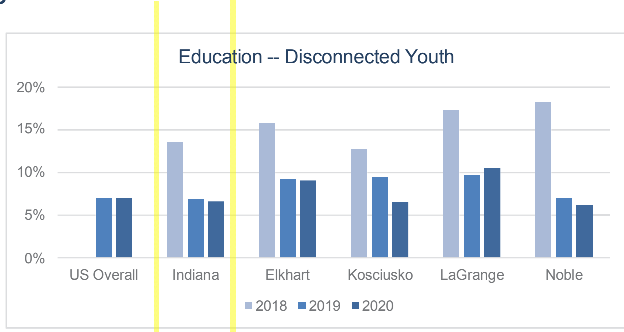
Section 6: Unweighted Health Factors -- Social & Economic (Education & Income)

Education -- Disconnected Youth

Source: countyhealthrankings.org annual reports 2018 to 2020

Percentage of teens and young adults ages 16-19 who are neither working nor in school.

			Goshen Health Community County			
	US Overall	Indiana	Elkhart	Kosciusko	LaGrange	Noble
2018		13.5%	15.7%	12.7%	17.2%	18.3%
2019	7%	6.8%	9.2%	9.4%	9.7%	6.9%
2020	7%	6.6%	9.0%	6.5%	10.5%	6.2%

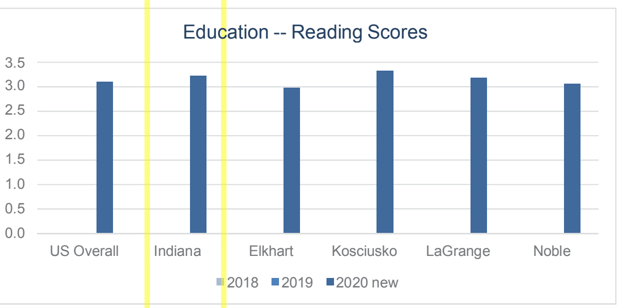


Education -- Reading Scores

Source: countyhealthrankings.org annual reports 2018 to 2020

Average grade level performance for 3rd graders on English Language Arts standardized tests

			Goshen Health Community County			
	US Overall	Indiana	Elkhart	Kosciusko	LaGrange	Noble
2018						
2019						
2020	3.1	3.2	3.0	3.3	3.2	3.1

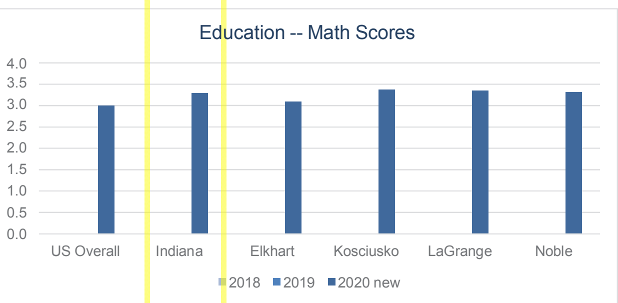


Education -- Math Scores

Source: countyhealthrankings.org annual reports 2018 to 2020

Average grade level performance for 3rd graders on math standardized tests

			Goshen Health Community County			
	US Overall	Indiana	Elkhart	Kosciusko	LaGrange	Noble
2018						
2019						
2020	3.0	3.3	3.1	3.4	3.4	3.3

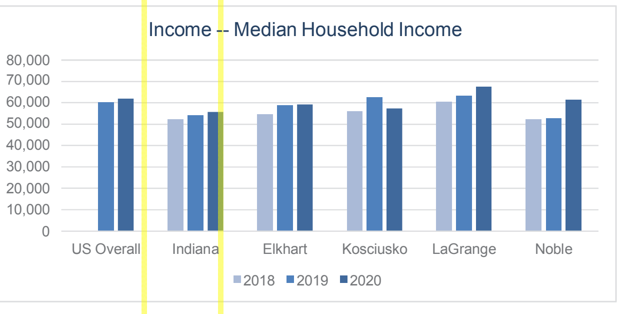


Income -- Median Household Income

Source: countyhealthrankings.org annual reports 2018 to 2020

Number of motor vehicle crash deaths per 100,000 population.

			Goshen Health Community County			
	US Overall	Indiana	Elkhart	Kosciusko	LaGrange	Noble
2018		52,289	54,582	56,010	60,402	52,318
2019	60,300	54,134	58,781	62,666	63,291	52,764
2020	61,900	55,725	59,251	57,367	67,498	61,341

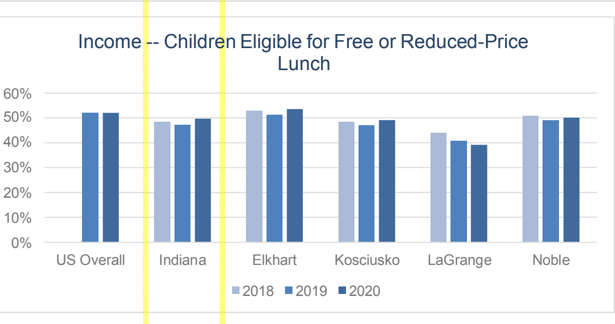


Income -- Children Eligible for Free or Reduced-Price Lunch

Source: countyhealthrankings.org annual reports 2018 to 2020

Percentage of children enrolled in public schools that are eligible for free or reduced price lunch.

			Goshen Health Community County			
	US Overall	Indiana	Elkhart	Kosciusko	LaGrange	Noble
2018		48.3%	52.8%	48.3%	43.9%	50.7%
2019	52%	47.3%	51.2%	47.0%	40.8%	49.2%
2020	52%	49.7%	53.6%	49.1%	39.2%	50.0%



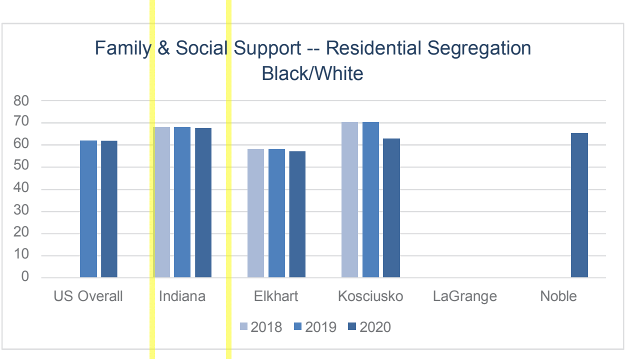
Section 6: Unweighted Health Factors -- Social & Economic (Family & Social Support)

Family & Social Support -- Residential Segregation Black/White

Source: countyhealthrankings.org annual reports 2018 to 2020

Index of dissimilarity where higher values indicate greater residential segregation between Black and White county residents.

			Goshen Health Community County			
	US Overall	**Indiana**	**Elkhart**	**Kosciusko**	**LaGrange**	**Noble**
2018		68	58	71		
2019	62	68	58	71		
2020	62	68	57	63		65

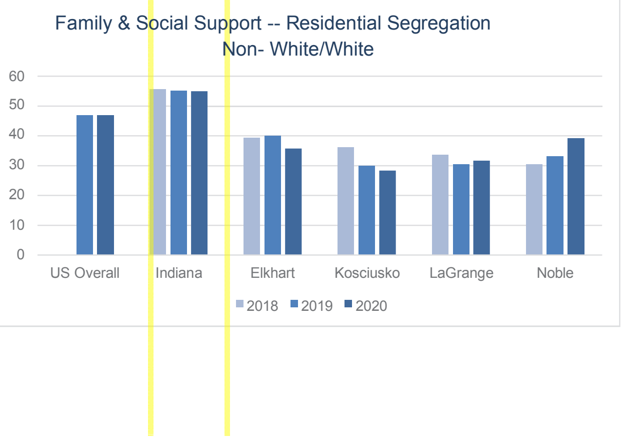


Family & Social Support -- Residential Segregation Non-White/White

Source: countyhealthrankings.org annual reports 2018 to 2020

Index of dissimilarity where higher values indicate greater residential segregation between non-White and White county residents.

			Goshen Health Community County			
	US Overall	**Indiana**	**Elkhart**	**Kosciusko**	**LaGrange**	**Noble**
2018		56	39	36	34	31
2019	47	55	40	30	30	33
2020	47	55	36	28	32	39



APPENDICES

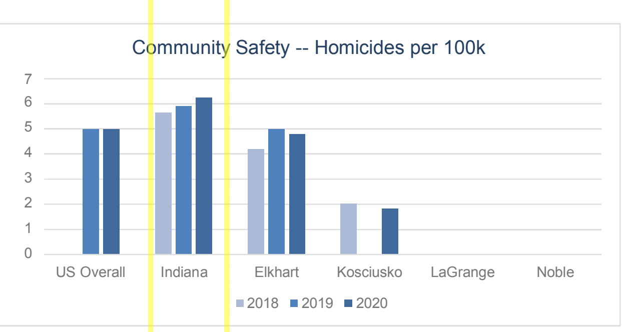
Section 6: Unweighted Health Factors -- Social & Economic (Community Safety)

Community Safety -- Homicides per 100k

Source: countyhealthrankings.org annual reports 2018 to 2020

Number of deaths due to homicide per 100,000 population.

	US Overall	Indiana	Goshen Health Community County			
			Elkhart	Kosciusko	LaGrange	Noble
2018		5.6	4.2	2.0		
2019	5	5.9	5.0			
2020	5	6.3	4.8	1.8		

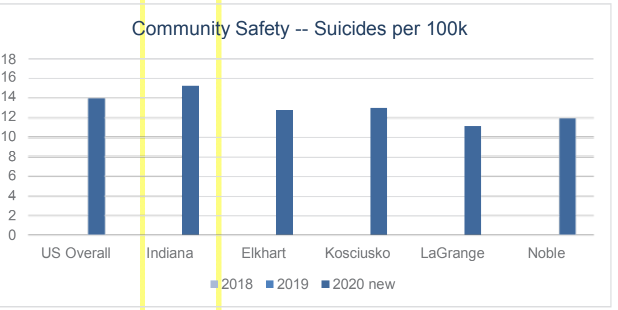


Community Safety -- Suicides per 100k

Source: countyhealthrankings.org annual reports 2018 to 2020

Number of deaths due to suicide per 100,000 population.

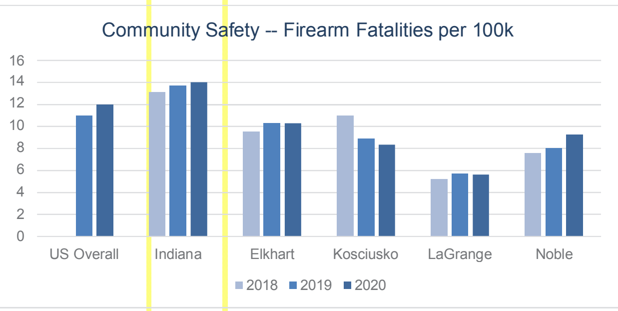
	US Overall	Indiana	Goshen Health Community County			
			Elkhart	Kosciusko	LaGrange	Noble
2018						
2019						
2020 new	14	15.3	12.8	13.0	11.1	11.6



Community Safety -- Firearm Fatalities per 100k

Source: countyhealthrankings.org annual reports 2018 to 2020 Number of deaths due to firearms per 100,000 population.

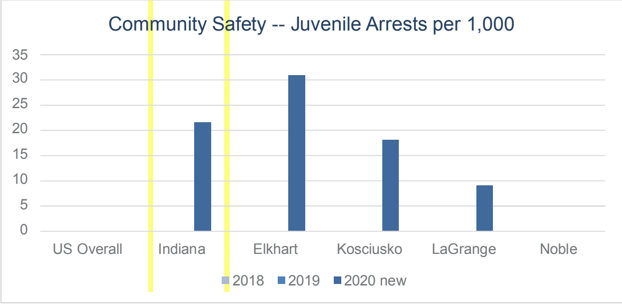
	US Overall	Indiana	Goshen Health Community County			
			Elkhart	Kosciusko	LaGrange	Noble
2018		13.1	9.5	11.0	5.2	7.6
2019	11	13.7	10.3	8.9	5.7	8.0
2020	12	14.0	10.3	8.4	5.6	9.2



Community Safety -- Juvenile Arrests per 1,000

Source: countyhealthrankings.org annual reports 2018 to 2020 Rate of delinquency cases per 1,000 juveniles

	US Overall	Indiana	Goshen Health Community County			
			Elkhart	Kosciusko	LaGrange	Noble
2018						
2019						
2020 new	n/a	22	31	18	9	39



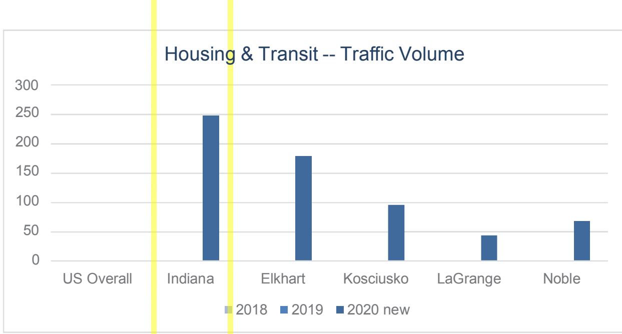
Section 6: Unweighted Health Factors -- Physical Environment (Housing & Transit)

Housing & Transit -- Traffic Volume

Source: countyhealthrankings.org annual reports 2018 to 2020

Average traffic volume per meter of major roadways in the county.

			Goshen Health Community County			
	US Overall	Indiana	Elkhart	Kosciusko	LaGrange	Noble
2018						
2019						
2020 new	n/a	248	179	96	44	68

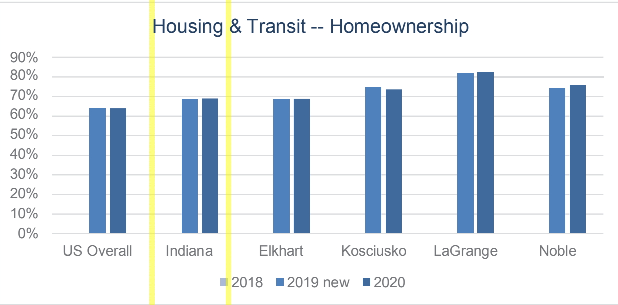


Housing & Transit -- Homeownership

Source: countyhealthrankings.org annual reports 2018 to 2020

Percentage of occupied housing units that are owned.

			Goshen Health Community County			
	US Overall	Indiana	Elkhart	Kosciusko	LaGrange	Noble
2018						
2019	64%	68.9%	68.6%	74.8%	82.0%	74.4%
2020	64%	68.9%	68.8%	73.6%	82.7%	76.0%

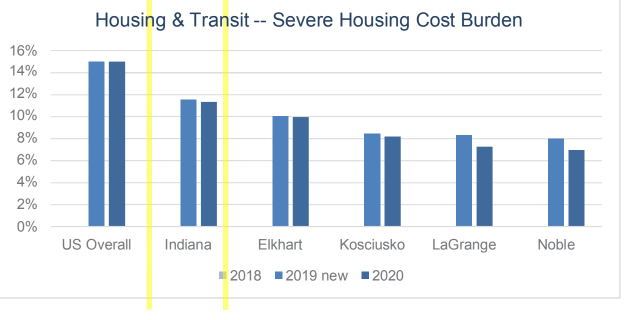


Housing & Transit -- Severe Housing Cost Burden

Source: countyhealthrankings.org annual reports 2018 to 2020

Percentage of households that spend 50% or more of their household income on housing.

			Goshen Health Community County			
	US Overall	Indiana	Elkhart	Kosciusko	LaGrange	Noble
2018						
2019 new	15%	11.5%	10.1%	8.4%	8.4%	8.0%
2020	15%	11.3%	10.0%	8.2%	7.3%	7.0%



Section 7: Arrests for Possession and Sale/Manufacture of Drugs

Arrests for Possession and Sale/Manufacture of Marijuana

Sources: 2012, 2014 and 2016 FBI Uniform Crime Reporting Program Data; 2012 and 2014 US Census Bureau Community Surveys.

Arrests per 1,000 population.

					Goshen Health Community Counties			
	US Overall		**Indiana**		**Elkhart**		**3-county region AVG**	
	Possession	Sale	Possession	Sale	Possession	Sale	Possession	Sale
2012	2.1	0.3	1.7	0.3	1.5	0.0	1.7	0.3
2014	1.9	0.3	1.6	0.3	1.7	0.1	1.2	0.2
2016					3.0	0.2	1.7	0.2

Arrests for Possession and Sale/Manufacture of Cocaine and Opiates

Sources: 2012, 2014 and 2016 FBI Uniform Crime Reporting Program Data; 2012 and 2014 US Census Bureau Community Surveys.

Arrests per 1,000 population.

					Goshen Health Community Counties			
	US Overall		**Indiana**		**Elkhart**		**3-county region AVG**	
	Possession	Sale	Possession	Sale	Possession	Sale	Possession	Sale
2012	0.8	0.3	0.2	0.2	0.2	0.3	0.3	0.7
2014	0.8	0.3	0.3	0.2	0.1	0.1	0.2	0.4
2016					0.5	0.2	0.1	0.3

Arrests for Possession and Sale/Manufacture of Synthetic Drugs

Sources: 2012, 2014 and 2016 FBI Uniform Crime Reporting Program Data; 2012 and 2014 US Census Bureau Community Surveys.

Arrests per 1,000 population.

					Goshen Health Community Counties			
	US Overall		**Indiana**		**Elkhart**		**3-county region AVG**	
	Possession	Sale	Possession	Sale	Possession	Sale	Possession	Sale
2012	0.2	0.1	0.3	0.1	0.1	0.0	0.4	0.2
2014	0.2	0.1	0.3	0.1	0.1	0.1	0.4	0.4
2016					0.7	0.2	0.6	0.1

Arrests for Possession and Sale/Manufacture of Other Drugs

Sources: 2012, 2014 and 2016 FBI Uniform Crime Reporting Program Data; 2012 and 2014 US Census Bureau Community Surveys.

Arrests per 1,000 population.

					Goshen Health Community Counties			
	US Overall		**Indiana**		**Elkhart**		**3-county region AVG**	
	Possession	Sale	Possession	Sale	Possession	Sale	Possession	Sale
2012	0.9	0.2	0.4	0.2	0.1	0.0	0.3	0.2
2014	1.1	0.2	0.4	0.2	0.1	0.0	0.6	0.1
2016					0.5	0.2	1.4	0.2

Section 7 Bibliography:

Federal Bureau of Investigation, United States Department of Justice. (2014). Uniform Crime Reporting Program Data: County-Level Data, United States, 2012.

Federal Bureau of Investigation, United States Department of Justice. (2017). Uniform Crime Reporting Program Data: County-Level Data, United States, 2014.

Federal Bureau of Investigation, United States Department of Justice. (2019). Uniform Crime Reporting Program Data: County-Level Data, United States, 2016.

U.S. Census Bureau (2012). American Community Survey. Retrieved from https://data.census.gov/cedsci/table?q=US%20Population%202012&tid=ACSDT1Y2012.B01003&hidePreview=false

U.S. Census Bureau (2014). American Community Survey. Retrieved from https://data.census.gov/cedsci/table?q=US%20Population%202014&tid=ACSDT1Y2014.B01003&hidePreview=false

Appendix II:

2021 Secondary Data Report: United For ALICE. (2020). ALICE in Indiana: A financial hardship study. Retrieved from https://unitedforalice.org/indiana

ON UNEVEN GROUND

ALICE and Financial Hardship in the U.S.

APPENDICES

WHAT IS UNITED FOR ALICE?

United For ALICE is a center of innovation, research, and action around financial hardship. At its core is **ALICE: A**sset **L**imited, **I**ncome **C**onstrained, **E**mployed — a measure of households that earn above the Federal Poverty Level but below the cost of household basics. The ALICE research drills down to the local level for both household incomes and costs, showing the mismatch between low-paying jobs and what it takes to survive financially, county by county and state by state.

This research is bolstered by external advisory committees of experts in fields ranging from health care and child care to labor and technology. The ALICE research team collaborates with a state-level committee in each partner state, and it draws on those experts nationwide for a biennial Methodology Review. This collaborative model ensures that all ALICE products and tools are based on unbiased data that is transparent, replicable, current, and incorporates local context.

With this data and research, ALICE partners convene, advocate, and innovate in their communities to highlight the issues faced by ALICE households, and to build solutions that promote financial stability.

KEY TERMS

ALICE: Asset **L**imited, **I**ncome **C**onstrained, **E**mployed — households with income above the Federal Poverty Level but below the basic cost of living.

Household Survival Budget: The cost of household basics (housing, child care, food, transportation, health care, and a smartphone plan, plus taxes and a small contingency). Calculated at the county level for various household types, including a **Senior Survival Budget**.

ALICE Threshold: The average income that a household needs to afford the household basics defined by the Household Survival Budget for each county.

Below ALICE Threshold: Includes both poverty-level and ALICE households — all households unable to afford the basics.

ALICE Essentials Index: A national standardized measure of the change over time in the costs of household basics included in the Household Survival Budget.

ALICE ONLINE

Learn more at UnitedForALICE.org

Interactive Maps

Data at the state, county, municipal, ZIP code, and congressional district levels

Research Advisory Committee

Learn about the members and role of this critical group

Additional Reports

Explore The ALICE Essentials Index and The Consequences of Insufficient Household Income

Demographic Data

Information about ALICE households by age, race/ ethnicity, and household type

Data Spreadsheet

Download the ALICE data

Jobs Graphs

Details about where ALICE works

County Profiles

Detailed data about ALICE households in each county

Methodology

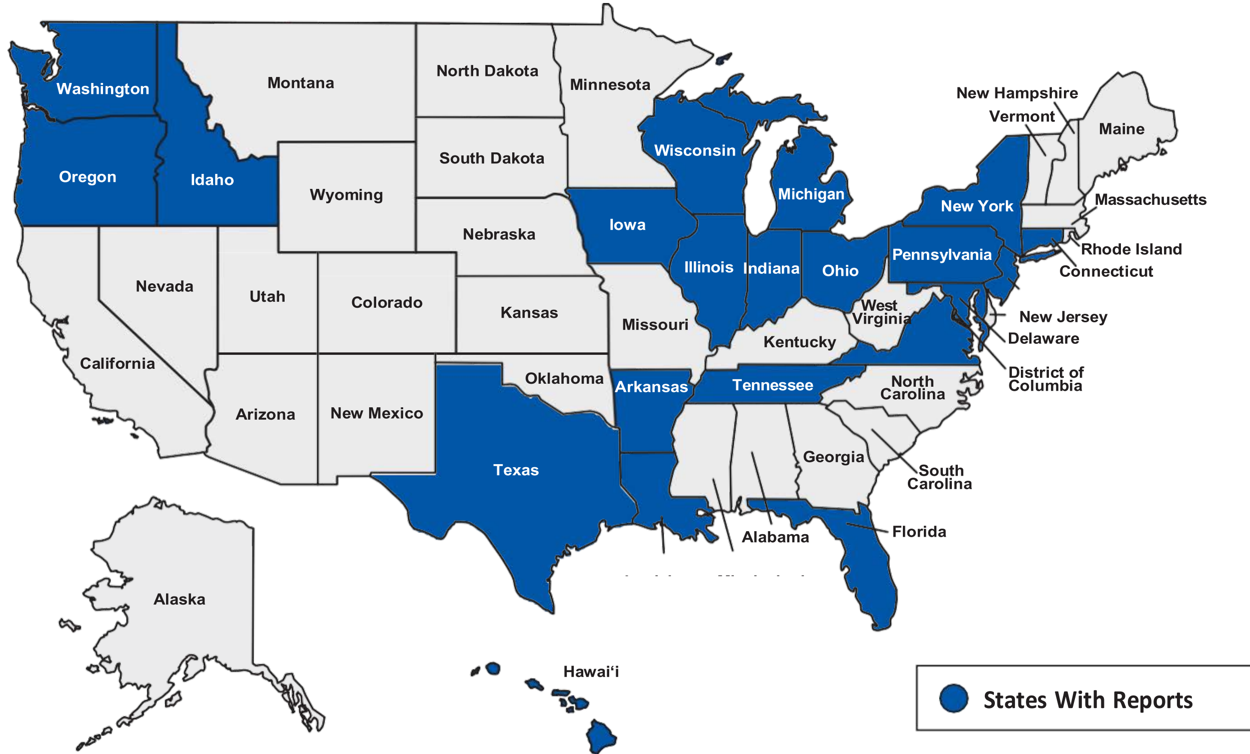
Overview of the sources and calculations used in the ALICE research

More About United For ALICE

See our partners, press coverage, learning communities, etc.

UNITED FOR ALICE STATES AND PARTNERS

The first ALICE study documented financial hardship in Morris County, New Jersey in 2009. A decade later, that spark has grown into a grassroots movement that includes United Ways, corporations, and nonprofits in 21 states: Arkansas,Connecticut, Florida, Hawai‘i, Idaho, Illinois, Indiana, Iowa, Louisiana, Maryland, Michigan, New Jersey, New York, Ohio, Oregon, Pennsylvania, Tennessee, Texas, Virginia, Washington, and Wisconsin. Learn more about our partners at UnitedForALICE.org/Governance



NATIONAL ALICE ADVISORY COUNCIL

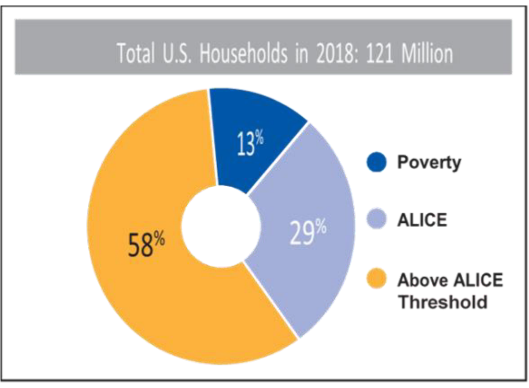
Aetna Foundation • Allergan • Alliant Energy • AT&T • Atlantic Health System Compare.com Deloitte Entergy • Johnson & Johnson • JLL • Kaiser Permanente • RWJBarnabas Health • Robert Wood Johnson Foundation • The Hartford • Thrivent • UPS U.S. Venture • U.S. Venture-Schmidt Family Foundation

PARTNER STATE REPORT SPONSORS

Atlantic Union Bank • Avista Foundation • Bank of Hawaii • Consumers Energy Foundation CSEA, AFSCME Local 1000, AFL-CIO • Entergy • Hawaii Community Foundation • Idaho Community Foundation Idaho Nonprofit Center • Kamehameha Schools • Key Bank • NBT Bank • Providence Health Care Tennessee Afterschool Network • The Ford Family Foundation Virginia Association of Free and Charitable Clinics • Virginia's Community Colleges • WaFd Bank • Washington State Employees Credit Union • Winthrop Rockefeller Foundation • Xerox

ON UNEVEN GROUND

Over the last decade, behind the veneer of a strong economy, conditions have actually gotten worse for millions of families across the U.S. — and that decline set the stage for the dual health and economic crises of the COVID-19 pandemic.



Sources: ALICE Threshold, 2018; American Community Survey, 2018

At the center of these crises is **ALICE:** households that are **A**sset **L**imited, **I**ncome **C**onstrained, **E**mployed, with income above the Federal Poverty Level (FPL) but not high enough to afford essentials in the communities where they live. In 2018, of the 121 million households in the U.S., 16 million (13%) earned below the FPL, while another 35 million (29%) — **more than twice as many** — were ALICE.

That year, 42% of U.S. households could not afford the cost of household basics.[1]

Official economic markers do not measure the realities that low-income families face — which essentials they need to live and work in the modern economy, and how the costs of those goods have changed over time. The most deceptive measure is the official measure of financial hardship, the Federal Poverty Level. The FPL was developed 50 years ago to measure the country's progress in the War on Poverty, and its calculations have failed to keep up with changing conditions in a number of ways. For example, food is no longer 33% of a family budget, as the FPL first assumed, but closer to 15%; and a smartphone, which didn't exist 20 years ago, is now essential.

Because the FPL's methodology never changed, over time the threshold it set for poverty grew impossibly low — far below what any household actually needs to survive. The FPL has also not taken into account the varying costs of goods in different parts of the country (except Alaska and Hawai'i). And increases in the FPL have lagged far behind the rate of increase in the cost of the most essential household items.

The ALICE measures help fill these gaps, providing data to more accurately measure how many households are struggling. The Household Survival Budget and the ALICE Threshold reveal that ALICE households never recovered from the Great Recession. The ALICE Essentials Index shows that the cost of household basics continued to rise, and wages did not keep pace during the "recovery" from 2010 to 2018.

In addition, as work arrangements continue to shift risk to workers, causing shortfalls in hours and dependable benefits, life has become harder for ALICE families and those in poverty. As a result, rather than "recovering," more households have actually moved closer to falling below the ALICE Threshold over the last decade, and ALICE families have not been able to rebuild or replenish their savings.

The year 2020 has been one of overlapping crises — the COVID-19 pandemic and an unfolding national economic slowdown, layered with regional natural disasters ranging from hurricanes, derechos, and tornados to unprecedented wildfires. And that confluence has been a perfect storm for ALICE households, who were already more vulnerable than ever before.

MEET ALICE: WORKING HARD BUT STRUGGLING TO SURVIVE

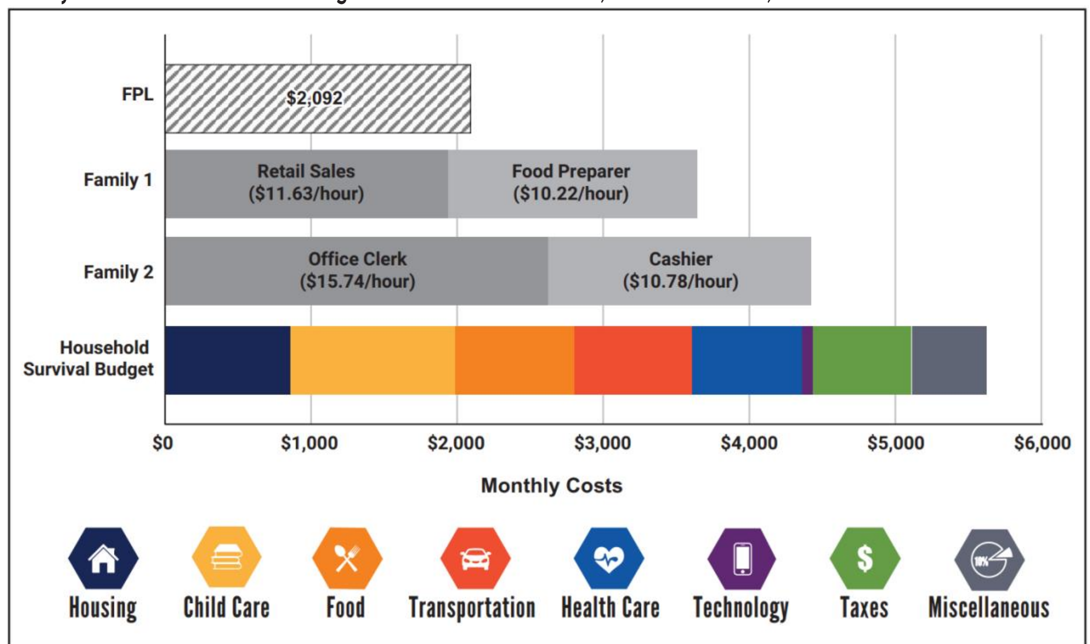
The daily challenges that ALICE families face — tough decisions and often no-win choices — are stressful and heart wrenching. ALICE workers, often unrecognized, keep our economy running, yet their struggles go uncharted by broad economic statistics.

Most ALICE households have adults who are working, primarily in low-wage jobs but also sometimes in higher-paid jobs that don't provide enough hours to support their family. Others work two or three jobs at once. Some of these households consist of families with parents looking for work or training for better jobs. Some are not able to work at all.

The core of the problem is a simple fact: The cost of household basics is higher than the wages of many of the most common occupations. The Household Survival Budget reports the cost of the essentials (housing, child care, food, transportation, health care, and a smartphone plan, plus taxes) needed to live and work in the modern economy. In 2018, the average annual budget for a family with two adults and two children in child care was $67,476 — three times the FPL ($25,100)[2] and more than the median wages of each of the four most common occupations nationwide (Figure 1). For example, a family with both parents working full time — one in retail sales earning the median hourly wage of $11.63, and the other in food preparation earning $10.22 per hour — cannot afford this budget. A family with the next two most common occupations — office clerk ($15.74 per hour) and cashier ($10.78 per hour) — also falls short.[3]

Figure 1.

Family Household Survival Budget vs. Income and FPL, United States, 2018



Sources: ALICE Household Survival Budget, 2018; Bureau of Labor Statistics—Occupational Employment Statistics, 2018

Households below the ALICE Threshold are composed of all races/ethnicities, household types, and ages, and they live in all areas of the U.S. — urban, suburban, and rural. The demographic breakdowns of these households are highlighted here, and more detail is available on our website: UnitedForALICE.org/national-overview.

In 2018, in absolute terms, the nearly 51 million households **below the ALICE Threshold** — which include both ALICE households and those in poverty — were dominated by three groups:

Largest numbers:

- **Race/ethnicity:** White households (29 million)
- **Household type:** Single or cohabiting households with no seniors or children under the age of 18 (23 million)
- **Age:** Households headed by someone 45 to 64 years old (17 million)[4]

Overall, 42% of U.S. households were below the ALICE Threshold. But because some groups faced additional barriers to higher income, they also disproportionately faced financial hardship:

Largest percentages:

- **Race/ethnicity:** 60% of Black households, 57% of American Indian/Alaska Native, and 56% of Hispanic households were below the ALICE Threshold, compared to 36% of White and Asian households.[5]
- **Household type:** Single-female-headed families (77%) were more than three times as likely to be below the ALICE Threshold as married-parent families (22%).
- **Age:** The youngest households (headed by someone under age 25) and seniors (over 65 years old) were by far the most likely to be below the ALICE Threshold, at 70% and 50%, respectively.

Additional groups that face barriers to higher incomes include recent immigrants, especially those who are undocumented or unskilled; those with low proficiency in English or little formal education; lesbian, gay, bisexual, transgender, or queer (LGBTQ+) people; formerly incarcerated people; or those with a disability. Households facing more than one of these factors — recent immigrants with special needs, for example, who may have both limited English proficiency and a disability; or LGBTQ+ people of color, who face systemic racism and discrimination — are even more likely to experience financial hardship.[6]

Figure 2 shows that the mismatch between household income and expenses holds true across the U.S., with ALICE households living in every county in every state. For each state, the gold square shows the average percentage of households below the ALICE Threshold in 2018. The blue lines show the lowest-to-highest range of the percentage of households below the ALICE Threshold by county.

The extent of financial hardship varied from 31% of households in Alaska to 51% in Louisiana. There were even larger ranges within states, though some of the most extreme were in sparsely populated rural counties. For more details, go to UnitedForALICE.org/National-Overview.

Figure 2.

Percent of Households Below the ALICE Threshold and Ranking by State, United States, 2018

State (Rank)	State Average
Louisiana (1)	51%
Mississippi (2)	50%
Georgia (3)	48%
New Mexico (4)	47%
West Virginia (4)	47%
Tennessee (4)	47%
Alabama (4)	47%
Florida (8)	46%
Arkansas (8)	46%
New York (10)	45%
California (10)	45%
District of Columbia (12)	45%
Kentucky (13)	44%
Texas (14)	44%
Oregon (14)	44%
North Carolina (14)	44%
Missouri (14)	44%
South Carolina (18)	44%
Oklahoma (19)	42%
Hawaii (19)	42%
Massachusetts (21)	42%
Maine (21)	42%
Nevada (23)	41%
Delaware (23)	41%
Vermont (25)	41%
Michigan (26)	40%
Idaho (26)	40%
Colorado (26)	40%
Virginia (29)	39%
Rhode Island (29)	39%
Pennsylvania (29)	39%
Ohio (29)	39%
Maryland (29)	39%
Arizona (29)	39%
Montana (35)	38%
Kansas (35)	38%
Connecticut (35)	38%
New Jersey (38)	37%
Indiana (38)	37%
Utah (40)	36%
South Dakota (40)	36%
Nebraska (40)	36%
New Hampshire (43)	35%
Minnesota (44)	35%
Illinois (44)	35%
Wisconsin (46)	34%
Iowa (46)	34%
Washington (48)	33%
Wyoming (49)	32%
North Dakota (49)	32%
Alaska (51)	31%

0% 5% 10% 15% 20% 25% 30% 35% 40% 45% 50% 55% 60% 65% 70% 75% 80% 85%

State Average Percent of Households Below ALICE Threshold

County Average Percent of Households Below ALICE Threshold

Sources: ALICE Threshold, 2018; American Community Survey, 2018

YEARS IN THE MAKING: WHY 2020 HIT SO HARD FOR SO MANY

The national scope and prolonged duration of the COVID-19 pandemic has exposed the longstanding weaknesses in our economy. The pandemic has amplified the financial hardship that ALICE households and those in poverty already felt so acutely, and it has made them more vulnerable than ever. At the same time, it has exacerbated longstanding inequities in our society. This section outlines the seven reasons why the COVID-19 pandemic has hit so hard for so many.

ALICE NEVER RECOVERED FROM THE GREAT RECESSION

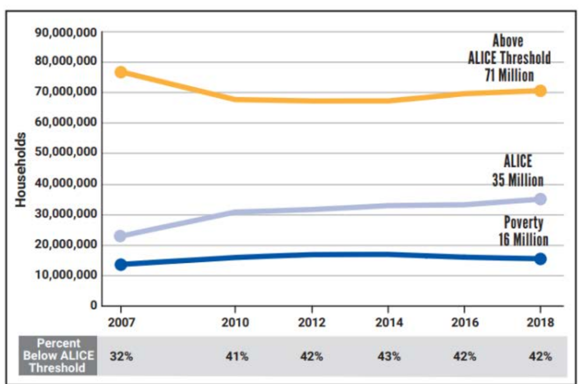
The number of ALICE and poverty-level households increased in direct response to the severe contraction of the economy during the Great Recession (Figure 3). From 2007 to 2010, the share of households in poverty increased from 12% to 14% (dark-blue line), and the share that were ALICE grew from 20% to 27% (medium-blue line).

Perhaps even more striking, the number of ALICE households continued to grow during the “recovery.” **From 2010 to 2018, the number of households in poverty actually decreased by 3%, leading many to believe the economy was improving for all. But the number of ALICE households continued to increase, growing by another 14%.** The rate of growth was even greater for some ALICE groups: 27% for Black households; 28% for American Indian/Alaska Native households; 33% for Hispanic households; 36% for Asian households; and 39% for Native Hawaiian and Other Pacific Islander households, compared to 13% for White, non-Hispanic households.[7]

Overall, from 2007 to 2018, there was a 38% increase in the number of households below the ALICE Threshold (poverty and ALICE combined — the dark-blue and medium-blue lines in Figure 3). This laid the groundwork for economic catastrophe in 2020, and two things accounted for it: the steadily rising cost of living, and the increasing dominance of low-wage jobs with less security.

Figure 3.

Households by Income, United States, 2007-2018



Sources: ALICE Threshold, 2007–2018; American Community Survey, 2007–2018

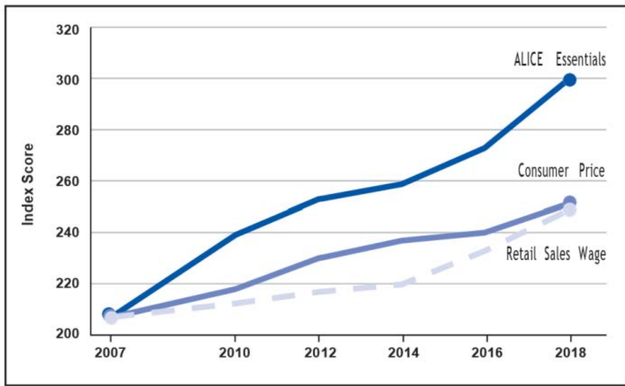
APPENDICES

2 BASIC COSTS ARE RISING

The cost of goods that ALICE households buy on a regular basis is increasing faster than the overall rate of inflation as measured by the Consumer Price Index (CPI). **The ALICE Essentials Index** is a national standardized measure of the change over time in the costs of the household essentials included in the Household Survival Budget (housing, child care, food, transportation, health care, and a smartphone plan). **From 2007 to 2018, the average annual rate of increase in the ALICE Essentials Index was 3.4% in urban areas and 3.3% in rural areas, compared with a CPI increase of 1.8% (Figure 4).**[8] This difference is primarily due to the fact that the costs of essentials — especially basic housing and health care — have increased, while the costs of other items that ALICE households are less likely to buy — notably manufactured goods, from apparel to cars — have remained relatively flat.

Figure 4.

ALICE Essentials Index vs. CPI, United States, 2007-2018



Sources: ALICE Threshold, 2007-2018; American Community Survey, 2007-2018

The cost of living is generally higher in urban areas; from 2007 to 2018, basic household goods were 18% to 22% more expensive in urban areas than in rural areas. Yet those costs increased at nearly the same rate in both areas. For more details, see the ALICE Essentials Index report at UnitedForALICE.org/Essentials-Index.

The increase in the cost of these basic goods may not be noticed by many consumers, but for ALICE households, it means that their already stretched income covers even less. ALICE's wages have not kept pace with rising costs; for example, from 2007 to 2018, ALICE workers in retail sales saw their wages increase from $9.69 to $11.63 — only 1.7%, about half the rate at which the ALICE Essentials Index grew.9 The impact is even starker for those who also depend on public assistance: Families with children reliant on the Supplemental Nutrition Program for Women with Infants and Children (WIC), or those with a disability who rely on Supplemental Security Income (SSI), are seeing the value of their benefits erode over time as costs rise.

MOST EMPLOYMENT GROWTH HAS BEEN IN LOW-WAGE JOBS

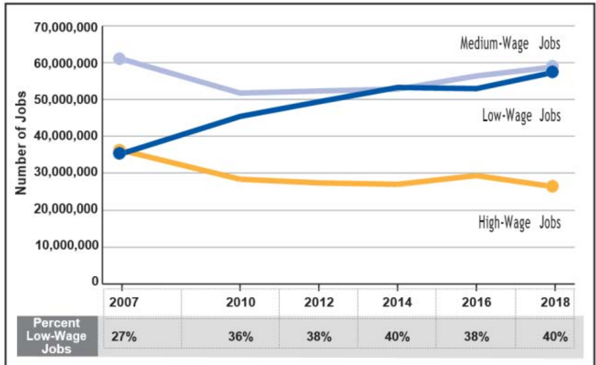
The number of low-wage jobs in the U.S. (dark-blue line in Figure 5) **increased 63% from 2007 to 2018.** These are jobs that cannot support the family Household Survival Budget (which includes costs for two adults, an infant, and a four-year-old), even with two people working full time, year-round. By 2018, they accounted for 40% of all U.S. jobs.

The number of medium-wage jobs (light-blue line), those that allow two parents working full time to afford a family Household Survival Budget, fell during the Great Recession, then rebounded after 2010, but never fully returned to pre-Recession levels. By 2018, these jobs accounted for 41% of all U.S. jobs.

During this same period, the number of high-wage jobs (gold line) — those that allow one worker to afford a family Household Survival Budget — declined overall, falling 27%.

There are also significant disparities in wages by race/ethnicity and gender. Notably, women earn 19% less than men, and Black and Hispanic workers earn 37% and 22% less, respectively, than White, non-Hispanic workers. Age and education level also play a key role, with younger workers earning less than older workers and income rising with level of education.[10] Increasingly, there are also discrepancies between those who have jobs with secure, full-time work and those who are paid by the hour or project, where schedules are not regular and income is not dependable.

Figure 5.
Number of Jobs by Wage Level, United States, 2007-2018

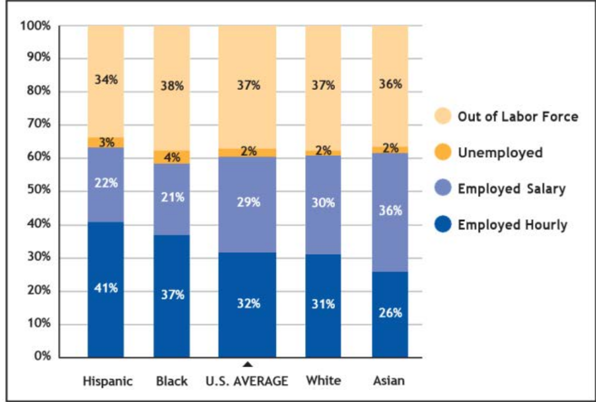


Sources: ALICE Threshold, 2007-2018; Bureau of Labor Statistics—Occupational Employment Statistics, 2018

ALICE WORKERS BEAR THE BRUNT OF ECONOMIC FLUCTUATIONS

Over the last decade, the economy has become more dependent on shifting risk to workers. Broader economic volatility — from changes in the price of materials and transportation costs, to impacts related to cyberattacks, natural and human-made disasters, and economic downturns — all directly impact workers' schedules and wages.[11] Of the 258 million working-age adults (16 years and over) in the U.S. in 2018, 32% were paid hourly (Figure 6, middle column, dark blue segment).[12] Hourly paid workers include non-traditional workers within the gig economy, but also many in traditional jobs — especially in retail, health care, food service, and construction — and, increasingly, higher-wage workers who now work by the project or contract.[13]

Figure 6.
Labor Status by Race/Ethnicity, United States, 2018



Sources: ALICE Threshold, 2007-2018; Bureau of Labor Statistics—Labor Force Statistics, 2018

In addition to fluctuations in income, hourly paid workers face a range of challenges in meeting their basic needs each month. They are more likely to have multiple sources of income as they try to cobble together a full-time schedule from part-time jobs. They are often on their own in finding affordable technical support or navigating basic worker safety. They are also less likely to receive benefits such as health insurance, paid time off, family leave, or retirement benefits, especially if they work fewer than 30 hours per week at a single job.[14]

Black and Hispanic adults disproportionately work in hourly paid jobs: In 2018, this was the case for 41% of Hispanic workers and 37% of Black workers, compared to 31% of White workers and 26% of Asian workers (Figure 6).[15] Despite the fact that the majority of adults in the U.S. were working in 2018 and most households had at least one worker, only 29% of all workers had the security of a full-time job with a salary. For Black and Hispanic workers, only 21% and 22%, respectively, worked in salaried jobs.[16]

Since ALICE is more likely to work in jobs that can't be done remotely, many on-site, essential ALICE workers are more likely to contract COVID-19 while on the job.

Adding to the challenge of supporting a family is the large number of adults not working. While only 2% of adults were actively looking for work in 2018, almost 4 in 10 adults were outside the labor force (Figure 6, middle column, light- gold segment), the largest percentage since 1979.[17]

ALICE workers are the ones who have been hardest hit by the pandemic — both in terms of wage levels and hours available for those who are working, and in terms of the increased likelihood of becoming unemployed. Since ALICE is more likely to work in jobs that can't be done remotely, many on-site, essential ALICE workers are more likely to contract COVID-19 while on the job. They are also more likely to work in the industries — food, hospitality, tourism — that have been hardest hit, so they have disproportionately suffered reduced wages and unemployment.[18] These workers are more likely to be Black, Hispanic, and/or women, the same groups who are sustaining a disproportionate number of pandemic-related job losses and reduced wages.[19]

A GROWING NUMBER OF HOUSEHOLDS LIVE ON THE EDGE

For much of the last century, incomes across the income distribution grew at nearly the same pace. Then, beginning in the 1970s, income disparities began to widen. From 1979 to 2016, the average income for the top 1% increased over five times more than that of the middle 60% and over two and a half times more than that of the bottom fifth.[20] With that divergence in income has come a divergence in perception: 70% of Americans identify as middle class,[21] yet one in three households in the middle three income quintiles do not earn enough to afford the ALICE Household Survival Budget.

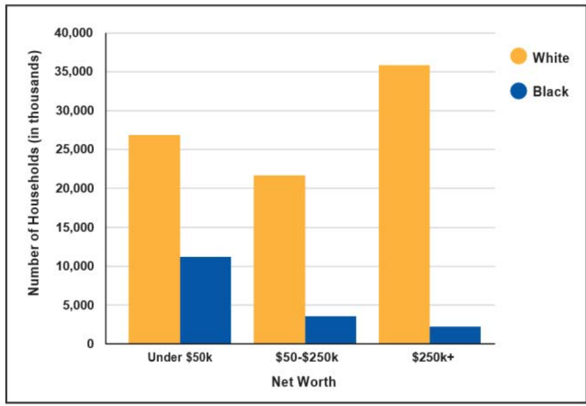
Today, more households are on the edge of the ALICE Threshold than before the Great Recession. These families are one crisis — a rent increase, car breakdown, or decrease in work hours — away from becoming ALICE. Before the Great Recession, over 6 million households were just above the ALICE Threshold; by the end of the Recession in 2010, the number of ALICE households had increased by 8 million. Faced with reduced wages or unemployment during the COVID-19 pandemic, the 9 million households (8%) that were just above the ALICE Threshold in 2018 could now become ALICE.[22] That would bring the total share of households below the ALICE Threshold to 50% — half of all U.S. households facing financial hardship.

6 ALICE EARNS TOO LITTLE TO SAVE, TOO MUCH FOR ASSISTANCE

Low wages make it impossible to save, yet they are often just high enough to keep families from receiving public assistance. As a result, many ALICE families suffer from a vicious cycle of budget shortfalls: A failure to pay bills on time leads to fees, penalties, and low credit scores, which in turn increase interest rates, insurance rates, and costs for other financial transactions (from check-cashing to credit card fees).[23] The costs of financial instability are cumulative and intensify over time.

Dreams to build for retirement or put a down payment on a house are dashed. If there is an emergency — anything from a car repair to a medical crisis — there is no savings safety net to fall back on. The lack of savings is widespread in the U.S: 42% of U.S. households had not set aside any money in 2017 that could be used for unexpected expenses or emergencies such as illness or the loss of a job.[24]

Figure 7.
Household Net Worth and Race/Ethnicity, United States, 2017



Source: U.S. Census Bureau—Wealth and Asset Ownership, 2017

Income disparities have led to even greater disparities in savings among households, especially by race/ethnicity. In 2017, two-thirds of Black households had assets valued at less than $50,000, while only one-third of White households did (Figure 7). At the other end of the spectrum, 43% of White households had assets of more than $250,000, compared to only 13% of Black households.[25]

While ALICE families are not earning enough to afford basic essentials, their earnings are often too high to qualify for assistance. Only a small fraction of struggling families receive public assistance: 29% of households below the ALICE Threshold received assistance from the Supplemental Nutrition Assistance Program (SNAP) in 2018, down from 34% in 2012. An even smaller portion received Supplemental Security Income (SSI) (13%), or Temporary Assistance to Needy Families (TANF) (5%).[26] Without access to public assistance, ALICE families are left to make difficult and often heart- wrenching choices about how to make ends meet.

The pandemic is increasing these longstanding disparities in savings and assets. Out of necessity, low-income households are spending (wages, stimulus checks, unemployment benefits, and savings), while high-income households have actually increased their savings during this time.[27]

A LICE IS MORE VULNERABLE TO NATURAL DISASTERS

From floods, hurricanes, and wildfires to pandemics, ALICE households disproportionately bear the impact of crisis and disaster. ALICE families feel the economic impact almost immediately — if they can't work, they lose pay; if there is damage to their home or car, there are immediate repair bills; and if the power goes out, they need money to replace spoiled food supplies.

ALICE households are more likely to live in housing units and communities that are more vulnerable to flooding, fire, and other hazards, primarily because those areas are more affordable. Yet ALICE families do not have the resources to withstand disasters. Often they cannot afford to make protective repairs, evacuate, or take necessary precautions during a public health crisis.[28] After a disaster, they take longer to recover, if ever: Because they are less likely to have insurance or savings to repair damage, it is harder to recover from illness, make housing repairs, and pay ongoing bills.[29]

ALICE households are more likely to live in housing units and communities that are more vulnerable to flooding, fire, and other hazards, primarily because those areas are more affordable.

The increase in natural disasters and the COVID-19 pandemic in particular have also brought to the fore the striking health disparities between different racial/ethnic groups during crises.[30] For example, Black, Hispanic, American Indian/Alaska Native, and Pacific Islander individuals have contracted and died from COVID-19 at much higher rates than Whites.[31] Nationally, as of November 12, 2020, the age-adjusted death rate of Blacks from COVID-19 was 3.0 times higher than that of Whites. Other groups that are smaller and therefore less likely to receive national media attention, including American Indians/Alaska Natives and Pacific Islanders, have mortality rates 3.2 and 2.3 times higher than Whites, respectively. In Arkansas, which has a large Marshallese community, the death rate among Pacific Islanders is a shocking 48 times higher than among Whites.[32]

At the same time that ALICE workers face these sharply increased risks, they are also essential to the pandemic recovery, as well as to rebuilding from other recent natural disasters. ALICE workers are "Maintainers," working in occupations that build and repair the infrastructure and educate and care for the past, current, and future workforce.[33] In these roles, they are the pandemic "heroes," the workers essential to caring for COVID-19 patients and to keeping the economy running by working in food service, grocery stores, and warehouse and fulfillment centers. Yet they receive low wages and little protective gear to keep them and their families safe.[34] In the aftermath of hurricanes and wildfires, ALICE workers are essential for debris removal, housing repairs, and rebuilding basic infrastructure. Yet these jobs are nearly impossible to do if workers and their families are in crisis themselves.

AN ESCALATING CRISIS IN MEETING BASIC NEEDS

Not only has the COVID-19 pandemic exposed disparities and vulnerabilities that have long existed in our communities and our society, but it is widening these gaps in profound and interconnected ways, with major impacts on the lives and well-being of households across the United States. This section outlines and highlights ways in which the pandemic has contributed to wider and more deeply entrenched disparities across the ALICE Survival Budget areas. As the impacts of the pandemic are still unfolding, these examples represent conditions at the time this Report was released (December 2020). For regularly updated content on the impact of COVID-19 on ALICE households, visit our website at UnitedForALICE.org/COVID19.

Overall, many households are now seeking public assistance for the first time, and getting assistance for all of these most basic resources can be a difficult and stigmatized process.[35] To learn more about the difficult decisions ALICE households face, see United For ALICE's 2019 Report, The Consequences of Insufficient Income, at UnitedForALICE.org/Consequences.

HOUSING

Housing is the cornerstone to stability, but it is also the most expensive item in many household budgets. Without safe, affordable housing, families cannot maintain stability in other areas of life, including school and work, and access to health care and healthy food.

Where we live matters; it impacts current and future health and economic well-being.36 Many ALICE households spend a disproportionate amount of their income on housing, limiting their ability to afford other essentials and setting the stage for vulnerability during a crisis.[37] Before the pandemic, the number of severely rent burdened households (with rent accounting for more than 50% of their income) was already rising, and that number is projected to grow by at least 11%, to 13.1 million households, by 2025.[38]

In order to get by, families have to make tough decisions, which often include renting or buying substandard housing that is more susceptible to damage from environmental impacts. By necessity, they may have to borrow at unsustainable rates; have to live in less desirable locations, including unsafe communities and neighborhoods with lower- quality schools, older infrastructure, or a dearth of health care and grocery stores; or have to choose housing that is far from work, leading to longer commutes and higher transportation costs.[39]

In addition to insufficient income, many households face other barriers to quality housing and prosperous communities, including discrimination and institutionalized racism. In 2018, there were over 31,000 reported acts of housing discrimination nationwide — up 8% from the prior year, and a record high since these statistics were first reported in 1995.[40] Significant racial disparities still exist in homeownership in particular: In 2018, the homeownership rate was 43% for Black households and 47% for Hispanic households, compared to 73% for White households.[41]

The importance of housing as a foundation for both health and financial stability has been made even clearer by COVID-19. The potential number of evictions is at a near-record high, and those living in crowded conditions with lack of space to social distance are disproportionately contracting — and dying from — the virus.[42] In addition, Black and Hispanic renters have been more likely to fall behind in rent and to face eviction, and Black and Hispanic owners have been more likely to miss or defer mortgage payments during the pandemic.[43]

CHILD CARE

Child care is essential for parents to work and children tobe prepared for school. Education is one of the best predictors offinancial well-being. Yet for families with two children in child care, it is the most expensive item in thefamily budget, and ALICE families face challenges finding quality education at every level.

With working parents making up approximately one-third of the U.S. workforce, child care has become a critical component of the economy as well as a key factor in child development.44 Yet the child care sector, the workforce behind the workforce, has been facing economic challenges for the last decade. The lack of affordable, accessible child care costs the U.S. economy an estimated $57 billion annually in lost productivity, revenue, and earnings.[45]

At the start of the pandemic, virtually all child care centers and schools closed. Even with partial re-opening and distance learning, the long-term impact on children, parents, child care providers, teachers, and the economy has already been severe:

- **Children:** Early learning opportunities are key to closing educational achievement gaps by income or race/ethnicity. Diminished access to theseprograms and to quality K-12 education will exacerbate existing educationalinequities in the long term. Childhood learning is strongly associated with lifetime earnings, with each school year linked to an average of about 10% higher income.[46]
- **Parents:** Parents are juggling work (remote and in-person) and child care in new ways, with the greatest impact on women and parents in less flexible, lower-income jobs — often to the detriment of both parents and children.[47]
- **Child care providers:** Temporary closures and reduced income are taking a lasting toll among child care workers. The Center for American Progress estimates that nationwide, almost 4.5 million child care slots could be lost permanently due to the pandemic.[48] Between February and April 2020, 370,600 child care workers — 95% of them women — lost their jobs, and by July, only 42% of those jobs had returned.[49]
- **Public school teachers and districts:** With states facing dire budget shortfalls on top of difficult and changing work conditions, there could be a more than 8% reduction in the teacher workforce.[50]
- **The economy:** Without functioning child care and K-12 education for working families, neither local economies nor the national economy can recover.

FOOD

Food is the most basic of all needs. In the short term, food is the easiest place for a family to skimp on cost, but in the long term, the consequences of a poor diet or food insecurity can include developmental delays in children, compromised performance at school or work, and chronic disease in adults.

A healthy diet is basic to good health and daily functioning, and is often taken for granted in a country with vast agricultural resources. Yet access to affordable, high-quality, healthy food continues to be a challenge for many households nationwide. No community is immune to this problem; there are individuals in almost every U.S. county who are food insecure. By 2017, estimates were that up to 18% of the U.S. population lived in a food desert, without sufficient access to a grocery store.[51]

When ALICE and poverty-level households do not have enough money for food, they often have no alternative but to buy less food or less healthy food. In 2014, almost 80% of food-insecure families in the U.S. reported purchasing inexpensive, unhealthy food; more than half ate food that was past its expiration date; and 40% watered down their food or drinks. Food insecurity affects health, which impacts school performance, work productivity, and levels of chronic stress.52 Short-term effects of food insecurity include fatigue and reduced immune response; in the longer term, there can be developmental, psychological, physical, and emotional harms.[53]

Food insecurity has increased significantly in 2020. During the first few months of the pandemic, food insecurity doubled nationwide and almost tripled for households with children, and 7% of households reported that they received free food.[54] Meals and snacks from schools or child care centers, many of which have been closed during the pandemic, typically provide up to two-thirds of children's daily nutritional needs and save families at least $30 per week per child. Senior food insecurity is also on the rise, up almost 60% from the pre-COVID rate.[55] Many ALICE households have turned to food pantries/banks, as they are one of the few social services that do not require income verification; ALICE families often earn too much to qualify for SNAP.[56]

TRANSPORTATION

Transportation is necessary to get to jobs, housing, grocerystores, child care, school, health care services, and social events. Although public transportation is cheaper, it is not available in many communities. That makes owning a car essential for many — but it is a purchase most ALICE families struggle to afford.

ALICE households depend on reliable transportation in order to reach jobs, schools and child care, health care, stores, and more. Yet access to transportation is a significant barrier for many ALICE families. Because public transportation is not available in most parts of the U.S., owning or leasing a vehicle is necessary. A car is the most common asset in the U.S., but many lower-income families must buy lower-priced, used vehicles that are usually less fuel-efficient, tend to break down, and need more frequent repairs, which increases expenses. This, in turn, can lead to tardiness or absenteeism at work; missed medical, dental, or social service appointments; limited child care and school options; and limited access to healthy food.[57] These factors further push ALICE families to the brink of financial instability and make it harder to catch up. That situation is then compounded by crises like the pandemic: In August 2020, for example, 4.3% of auto loan accounts were in hardship, up from 0.5% in April 2019.[58]

Public transportation, when available, is a vital service, especially for lower-income commuters who do not have vehicles. Yet due to COVID-19, many buses, trains, subways, and light-rail lines have had to limit service; overall ridership was down 58% from July 2019 to July 2020.[59] During the start of the pandemic, many services were cut to protect drivers and workers, with an almost 90% drop in ridership. Public transportation that was already struggling financially will have difficulty reinstating services, even after rider demand increases, as the primary sources of funding — fares, local sales taxes, parking tickets, and other fines — all took a hit during the pandemic.[60]

HEALTH CARE

Health care is often linked to financial hardship. Depending on age, illnesses, and overall health, costs vary widely between families. There are still millions without insurance and even more who cannot access health care due to cost, gaps in service, and scheduling issues.

Poor health can be both a consequence and a cause of financial instability. When basic needs are not met, ALICE and poverty-level families are more likely to face health problems. Access to care; economic factors like employment and income; and environmental factors like housing, air/water quality, and community safety are the primary determinants of health. Individual health behaviors (like diet and exercise) only account for about 30% of health outcomes.[61]

Due to lack of health insurance coverage, many families forgo preventative care and become more likely to have an ongoing chronic condition.[62] A serious health emergency can also lead to a downward financial spiral: Two-thirds of all bankruptcies in the U.S. between 2013 and 2016 were tied to medical issues — because of either high costs for care or time out of work.[63]

The health impacts of COVID-19 are the most obvious outcomes of the pandemic, not just in terms of fatalities — total U.S. deaths had passed 269,000 by November 2020 — but also in highlighting disparities in health care quality, access, affordability, and the profound effects of institutionalized racism and discrimination. Many low-wage employees have not been provided sufficient safety equipment, resulting in greater exposure. This is especially true for those working in retail, warehousing, restaurants, hotels, pharmacies, hospitals, and nursing homes, with perhaps the most egregious exposure among workers in meatpacking plants.[64] For all of these reasons, those with the lowest incomes have incurred the greatest number of serious COVID-19 infections.[65] Similarly, people of color are also at a sharply increased risk of infection, severe illness, and death from COVID-19.[66] Older adults are at an increased risk as well, and half of U.S. senior households were already unable to afford the basics, much less increased health costs.[67]

The pandemic is also widening health disparities by reducing access for those who need it most, through both hospital closures and growing reliance on telemedicine. The health care costs of the pandemic are adding more pressure on already struggling hospitals, forcing many in rural and low-income communities to close. The alternative — telemedicine — has grown exponentially. Yet for rural or low-income families, or communities without reliable internet services or digital devices, this trend further reduces access to health care.68

TECHNOLOGY

Technology is an essential need in the modern economy. Without access to basic technology like a smartphone plan, ALICE faces disadvantages in job searches and performance, school work, accessing public benefits, and health care.

Even before the pandemic, access to technology varied significantly by incomeand geography — a reality often referred to as the "digital divide." Across the U.S., 31% of households with income below the ALICE Threshold do not have an internetsubscription, compared with only 8% for households above the ALICE Threshold.

Rates of access also vary widely by location, for reasons of both availability and cost: The lowest access rates are in rural counties often not covered by high-speed internet service, and where 41% of households below the ALICE Threshold do not have an internet subscription.[69] For many, that lack of access translates directly to reduced job opportunities, educational opportunities, and access to health care and financial tools.

Because of COVID-19, the digital divide is more exposed than ever — and it is growing.The pandemic is forcing a wide range of workers to utilize new technology platforms, work remotely, and use technology to report and analyze data.[70] ALICE workers are less likely to have access to the internet and digital devices, and therefore less likely to have these skills or the opportunity to develop them, limiting the types of jobs available to them during the pandemic as well as their longer-term career possibilities.

Low-wage workers are six times less likely to be able to work from home than higher-wage workers. And increasingly, many of the permanent job losses resulting from the pandemic are in occupations at high risk of automation — particularly thoseheld by already vulnerable workers of color. ALICE workers without digital skills and resources face tougher job prospects ahead.[70]

TAXES

Taxes are an additional expense for ALICE. Because most ALICE households are not eligible for public assistance, they are net contributors and, on average, pay a higher rate of taxes than households in the highest income bracket.

While headlines often feature low-income households receiving government assistance, ALICE households are net contributors and pay about 22% of what they earn in income, property, and payroll taxes. Workers, including ALICE, bear the greatest burden of taxation, paying for the majority of government revenue through taxes on labor — individual income taxes account for 47% of governmentrevenue and payroll taxes for 33%. By contrast, taxes on wealth — property taxes, capital gains taxes, and corporate taxes — contribute less than 20% of governmentrevenue, even though wealth cushions households and can be leveraged to help them build even more wealth and access to tax shelters.[73] Overall, the federal income tax structure in the U.S. is progressive (those earning higher incomes pay a higher rate of tax). However, this is generally not the case for state, local, payroll,and sales taxes, which are regressive. **Nationwide, the lowest-income taxpayers (the 20% of households with the lowest income) pay state and local tax rates thatare over 50% higher than the top 1% of households.**[74]

The pandemic has made things more difficult for low-income taxpayers. With many free tax-preparation assistance sites closed, and potential challenges in finding internet access, many have found it harder to file their taxes and receive credits, such as EITC and the child tax credit. Not filing taxes or updating tax return information also delayed stimulus checks for many.[75]

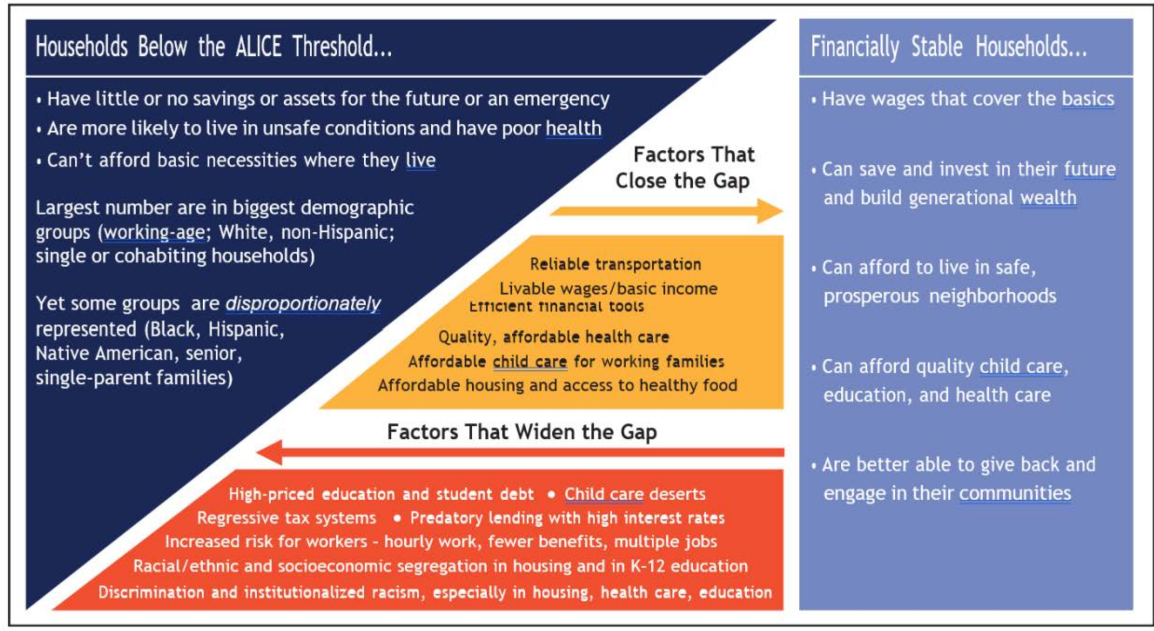
BEYOND RECOVERY: A VISION FOR FINANCIAL STABILITY

This Report shines a spotlight on a system that leaves more than two in five American households struggling to make ends meet. In 2018 — even before 2020's pandemic and natural disasters — a total of 51 million households were below the ALICE Threshold. United for ALICE research makes it clear that the status quo is not working for millions of households, and the COVID-19 pandemic has pushed our communities and economy to a tipping point. During this period of crisis, not only are families dealing with imminent risks to health and safety, but many are facing reduced wages or unemployment and are forced to deplete savings, accumulate debt, and make other sacrifices just to get by. And when eviction moratoria, renter payment plans, and mortgage forbearance end, many of these families will not be able to pay backlogged balances and will risk losing their homes. Without substantial intervention, it is likely that the 9 million households who were just above the ALICE Threshold in 2018 will become ALICE. **This means that half of all U.S. households could be in poverty or be ALICE by the end of the pandemic.**

Now is the time to reimagine this system, create new policies and institutions, and ensure that all households earn enough to meet their basic needs. This moment calls for significant action; it is a critical juncture where the decisions we make will shape the path of the future economy.[76] To make these crucial decisions, it is important to first examine both the barriers to and facilitators of financial stability. The factors that work to widen or close the gap between living below the ALICE Threshold and being financially stable are outlined in Figure 8.

Figure 8.

Closing the Gap: Moving ALICE Households Toward Financial Stability



Note: Sources for this figure are included following the Endnotes for this Report

NEXT STEPS: A VISION FOR ALICE

Intervention is needed across the board — in business, government, nonprofit, and educational institutions — not just to recover, but to set the groundwork for a more equitable future. Current policy is primarily designed to fill short-termneeds for basic survival; it is not designed to bring families to financial stability, much less to ensure a sustainablefuture.[77] As a result, the amount of public assistance households receive, even when added to wages (more than half of government spending on assistance for low-income households goes to working families), falls far short of what is actually needed. An economy where half of all households cannot buy even basic necessities cannot sustaineconomic growth.

Overcoming the magnitude of financial hardship, the extent of the structural imbalance between costs and wages, and the depth of institutional racism will require decisive action. The ALICE framework and data can provide the underpinnings necessary to guide this process in three key ways:

- **Include ALICE at the table:** ALICE needs to be included in the policymaking process at all levels. These firsthand voices provide an often ignored perspective. It is important to hear stories of ALICE's lived experience — of struggles, triumphs, and navigating the very systems that policymakers aim to improve. Putting a face to this experience is key to reaffirming the inherent worth and dignity of all, regardless of income. ALICE can also share real-time problems, which can inform priority areas — for example, identifying where there are child care or food deserts, where public transportation routes or timetables limit employment opportunities, which health centers engage in discriminatory practices, or where housing is unsafe. ALICE voices can be heard when policymakers andbusiness leaders who have themselves been ALICE share their experiences; when workers participate in workers' councils, unions, or policy convenings about "the future of work"; and when ALICE participates in their community and votes: ALICE and poverty-level voters make up more than one-third of the electorate.[78]

- **Use ALICE measures:** Inequities can only be addressed if disparities are identified and tracked over time. The ALICE measures provide the necessary tools and data to better gauge the health of the overall economy. Specifically, it is time to replace the FPL. The Household Survival Budget provides a more realistic estimate of the local cost of basicsfor every county in the country; the ALICE Threshold then provides a more accurate measure of how many householdsare struggling financially; and the ALICE Essentials Index shows how costs are growing over time. Using these measures together is critical to accurately portray the scopeof financial hardship and which demographic groups are disproportionately impacted, as well as to ensure thatpolicy reflects the growth in the cost of essential goods over time.

ALICE needs to be included in the policymaking process at all levels.

- **Make data-informed decisions:** Good data is the essential foundation for effective policy. ALICE measures can also be explored along with the location of key community resources, and analyzed alongside data on health, education, and social factors. To address pressing, immediate needs, mapping ALICE with community resourcesshows where gaps exist so that stakeholders can direct assistance to those areas. To address more ingrained, interconnected challenges, ALICE data can be compared with other indicators such as food insecurity, internet access, life expectancy, grocery-store access, rent burden, and homeownership. This analysis can help identify underlying causes of hardship and barriers to mobility, as well as highlight areas of success. In addition, the Census is a key metric for the ALICE Threshold; an accurate Census count is especially important for small groups. The marginalization of disadvantaged groups has traditionally started with undercounting them, from enslaved Africans who were counted as 3/5 of a person to American Indians/Alaska Natives who wereundercounted in the last three Censuses: by 12% in 1990, 0.7% in 2000, and 5% in 2010.[79]
  Knowing where ALICE households live can help federal, state, and local governments target preparation, response,and assistance for natural disasters and public health crises. Because ALICE households and communities do not have the same resources as their wealthier counterparts, such as insurance or savings, local responders know they will need more assistance over a longer period of time.[80] In addition, knowing which customers are ALICE can help companies plan where to develop new products; knowing

which employees are ALICE can helpemployers deploy new skills training and strengthen career paths.[81] And finally, understanding which patients are ALICE can help health care providers not only address presenting health issues, but work with community stakeholders to confront the underlying problems.[82] (To see examples of ALICE data mapped with key indicatorsvisit UnitedForALICE.org/indicators/New-Jersey.)

Our **Vision for ALICE** is a country where ALICE families not only have sufficient income to afford the basics but can alsosave and invest in their future. Having enough income for safe, affordable housing, quality child care, adequate food, reliable transportation, quality health care, and sufficient technology not only has the immediate impact of fulfilling essential needs, but it also has a ripple effect across all aspects of life for ALICE households (Figure 9). It means thathouseholds can build their credit scores and avoid late fees, predatory lending, and higher interest rates.[83] That, in turn, means that families have more resources to use to reduce risks (e.g., by purchasing insurance), stay healthy (e.g., by getting preventative health care), or save and invest in education or assets that could grow over time (e.g., by buying a home or opening a small business). Instead of a downward cycle of accumulating fees, debt, and stress, families can have an upward cycle of savings and health that makes them even better able to be engaged in their communities and, in turn, enjoy a reasonable quality of life.

When ALICE households can afford the basics, there is a significant positive impact on local communities and the wideeconomy. Financial stability leads to greater economic activity, greater tax revenue, lower levels of crime, and fewer demands on the social safety net, allowing more investment in vital infrastructure, schools, and health care (Figure 9).[84] This is a vision not only for ALICE, but for the nation as a whole.

Figure 9.

Benefits of Meeting Basic Needs

If households have sufficient income for...	Impact on ALICE Households	Impact on the Community
Safe, Affordable Housing	Improved health through safer environments and decreased stress, improved educational performance and outcomes for children, greater stability for household members, a means to build wealth for homeowners	Less traffic, lower health care costs, better maintained housing stock, lower crime rates, less spending on homelessness/social services
Quality Child Care and Education	Improved academic performance, higher lifetime earnings, higher graduation rates, improved job stability/access for parents, better health	Decreased racial/ethnic and socioeconomic performance gaps, decreased income disparities, high return on investment (especially for early childhood education)
Adequate Food	Decreased food insecurity, improved health (especially for children and seniors), decreased likelihood of developmental delays and behavioral problems in school	Lower health care costs, improved workplace productivity, less spending on emergency food services
Reliable Transportation	Improved access to job opportunities, school and child care, health care, retail markets, social services, and support systems (friends, family, faith communities)	Fewer high-emissions vehicles on the road, more diverse labor market, decreased income disparities
Quality Health Care	Better mental and physical health (including increased life expectancy), improved access to preventative care, fewer missed days of work/school, decreased need for emergency services	Decreased health care spending and need for emergency services, fewer communicable diseases, improved workplace productivity, decreased wealth-health gap
Reliable Technology	Improved access to job opportunities, expanded access to health information and telemedicine services, increased job and academic performance	Decreased “digital divide” in access to technology by income, increased opportunities for civic participation
Savings	Ability to withstand emergencies without impacting long-term financial stability and greater asset accumulation over time (e.g., interest on savings; ability to invest in education, property, or finance a secure retirement)	Greater charitable contributions, less spending on emergency health, food, and senior services

Note: Sources for this figure are included following the Endnotes for this Report

ENDNOTES

1 Note: A household consists of all the people who occupy a housing unit. In this Report, households do not include those living in group quarters such as a dorm, nursing home, or prison. American Community Survey. (2018). 1-year and 5-year estimates. U.S. Census Bureau. Retrieved from
https://data.census.gov/cedsci/ ; United for ALICE (2020). The ALICE Threshold, 2018. Research Center: National Comparison. Retrieved from www.UnitedForALICE.org/national-comparison

2 United For ALICE. (2020). ALICE research methodology overview. Retrieved from
https://www.unitedforalice.org/methodology

Bureau of Labor Statistics. (n.d.). Occupational employment statistics: May 2018 national occupational employment and wage estimates United States. U.S. Department of Labor. Retrieved from https://www.bls.gov/oes/2018/may/oes_nat.htm

U.S. Department of Health and Human Services. (2018). 2018 poverty guidelines. Office of the Assistant Secretary for Planning and Evaluation. Retrieved from https://aspe.hhs.gov/2018-poverty-guidelines

3 Bureau of Labor Statistics. (2018). Occupational employment statistics: May 2018 national occupational employment and wage estimates United States. U.S. Department of Labor. Retrieved from https://www.bls.gov/oes/2018/may/oes_nat.htm

4 Note: The groups shown in the following text overlap across categories (age, household type, race/ethnicity); households are counted in all relevant groups. Within the race/ethnicity category, all racial categories except Two or More Races are for one race alone. Race and ethnicity are overlapping categories; in this Report, the Asian, Black, Hawaiian (includes other Pacific Islanders), and Two or More Races groups may include Hispanic households. The White group includes only White, non-Hispanic households. The Hispanic group may include households of any race. Because household poverty data is not available for the American Community Survey's race/ethnicity categories, annual income below $15,000 is used as a proxy.

5 Note: "…Black or African American: A person having origins in any of the Black racial groups of Africa. It includes people who indicate their race as "Black or African American," or report entries such as African American, Kenyan, Nigerian, or Haitian.

American Indian and Alaska Native: A person having origins in any of the original peoples of North and South America (including Central America) and who maintains tribal affiliation or community attachment. This category includes people who indicate their race as "American Indian or Alaska Native" or report entries such as Navajo, Blackfeet, Inupiat, Yup'ik, Central American Indian groups, or South American Indian groups….

Native Hawaiian and Other Pacific Islander: A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands. It includes people who reported their race as 'Fijian,' 'Guamanian or Chamorro,' 'Marshallese,' 'Native Hawaiian,' 'Samoan,' 'Tongan,' and 'Other Pacific Islander' or provide other detailed Pacific Islander responses.

Two or More Races [to keep to style]: People may choose to provide two or more races either by checking two or more race response check boxes, by providing multiple responses, or by some combination of check boxes and other responses. For data product purposes, "Two or More Races" refers to combinations of two or more of the following race categories: 'White,' 'Black or African American,' 'American Indian or Alaska Native,' 'Asian,' 'Native Hawaiian or Other Pacific Islander,' or 'Some Other Race.'" (U.S. Census Bureau, Population Estimates Program (PEP). (n.d.). Race. Retrieved from
https://www.census.gov/quickfacts/fact/note/US/RHI425219)

Hispanic or Latino: "Person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race." (U.S. Census Bureau. (n.d.) About Hispanic origin. Retrieved from
https://www.census.gov/topics/population/hispanic-origin/about.html#:~:text=OMB%20defines%20%22Hispanic%20or%20 Latino,or%20origin%20regardless%20of%20race.)

6 Note: Collectively, LGBTQ+ people are more likely to live in poverty compared to straight cis-gender people. However, there are important within-group differences. For example, transgender people and bisexual cisgender women experience the highest rates of poverty, while gay cisgender men — particularly those in married couples — are less likely to have low incomes than other LGBTQ+ groups.

Badgett, M. V. L., Choi, S. K., & Wilson, B. D. M. (2019 October). LGBT poverty in the United States: A study of differences between sexual orientation and gender identity groups. University of California Los Angeles School of Law, Williams Institute. Retrieved from https://williamsinstitute.law.ucla.edu/wp-content/uploads/National-LGBT-Poverty-Oct-2019.pdf

Ballard, J., Wieling, E., Solheim, C., & Dwanyen, L. (2016). Immigrant and Refugee Families, 2nd Edition. University of Minnesota Libraries Publishing. Retrieved from https://open.lib.umn.edu/immigrantfamilies/

Goodman, N., Morris, M., & Boston, K. (2017, February 8). Financial inequality: Disability, race, and poverty in America. National Disability Institute. Retrieved from https://www.nationaldisabilityinstitute.org/wp-content/uploads/2019/02/disability-race-poverty-in-america.pdf

Pettit, B., & Sykes, B. (2017). State of the union 2017: Incarceration. The Stanford Center on Poverty and Inequality. Retrieved from https://inequality.stanford.edu/sites/default/files/Pathways_SOTU_2017_incarceration.pdf

University of Wisconsin Institute for Research on Poverty. (2020, May). Connections among poverty, incarceration, and inequality. Fast Focus Research/Policy Brief No. 48- 2020. Retrieved from https://www.irp.wisc.edu/resource/connections-among-poverty-incarceration-and-inequality/

Wolla, S. A., & Sullivan, J. (2017, January). Education, income, and wealth. Page One Economics, Federal Reserve Bank of St. Louis. Retrieved from https://research.stlouisfed.org/publications/page1-econ/2017/01/03/education-income-and-wealth/

7 Note: The groups shown in the text overlap across categories (age, household type, race/ethnicity); households are counted in all relevant groups. Within the race/ ethnicity category, all racial categories except Two or More Races are for one race alone. Race and ethnicity are overlapping categories; in this Report, the Asian, Black, Hawaiian (includes other Pacific Islanders), and Two or More Races groups may include Hispanic households. The White group includes White, non-Hispanic households. The Hispanic group may include households of any race. Because household poverty data is not available for the American Community Survey's race/ethnicity categories, annual income below $15,000 is used as a proxy.

8 Bureau of Labor Statistics. (n.d.). CPI inflation calculator. U.S. Department of Labor. Retrieved from https://www.bls.gov/data/inflation_calculator.htm

9 Bureau of Labor Statistics. (2018). Occupational employment statistics: May 2018 state occupational employment and wage estimates United States. U.S. Department of Labor. Retrieved from https://www.bls.gov/oes/2018/may/oes_nat.htm

10 Torpey, E. (2018, April). Measuring the value of education. U.S. Bureau of Labor Statistics. Retrieved from https://www.bls.gov/careeroutlook/2018/data-on-display/education-pays.htm

York, E. (2019, March 21). Average income tends to rise with age. Tax Foundation. Retrieved from https://taxfoundation.org/average-income-age/

American Community Survey. (2018). 1-year estimates [S1902: Mean income in the past 12 months ; S2002: Median earnings in the past 12 months of workers by sex and women's earnings as a percentage of men's earnings…]. U.S. Census Bureau. Retrieved from https://data.census.gov/cedsci/

11 Board of Governors of the Federal Reserve System. (2019, May). Report on the economic well-being of U.S. households in 2018. Retrieved from https://www.federalreserve.gov/publications/files/2018-report-economic-well-being-us-households-201905.pdf

Dokko, J., Mumford, M., & Schanzenbach, D. W. (2015, December). Workers and the Online Gig Economy. The Hamilton Project. Retrieved from https://www.hamiltonproject.org/assets/files/workers_and_the_online_gig_economy.pdf

Eden, P., & Gaggl, M. (2015, November). On the welfare implications of automation. World Bank Group. Retrieved from http://documents.worldbank.org/curated/en/2015/11/25380579/welfare-implications-automation

Freelancers Union & Upwork. (2017). Freelancing in America: 2017. Retrieved from https://s3.amazonaws.com/fuwt-prod-storage/content/FreelancingInAmericaReport-2017.pdf

Katz, L. F., & Krueger, A. B. (2018, November 13). The rise and nature of alternative work arrangements in the United States, 1995–2015. ILR Review, 72(2), 382–416. Retrieved from https://scholar.harvard.edu/lkatz/publications/rise-and-nature-alternative-work-arrangements-united-states-1995-2015

Manyika, J., Lund, S., Bughin, J., Robinson, K., Mischke, J., & Mahajan, D. (2016, October 10). Independent work: Choice, necessity, and the gig economy. McKinsey Global Institute. Retrieved from http://www.mckinsey.com/global-themes/employment-and-growth/independent-work-choice-necessity-and-the-gig-economy

Torpey, E., & Hogan, A. (2016, May). Working in a gig economy. Career Outlook. U.S. Bureau of Labor Statistics. Retrieved from https://www.bls.gov/careeroutlook/2016/article/what-is-the-gig-economy.htm?view_full

Tran, M., & Sokas, R. (2017, April). The gig economy and contingent work: An occupational health assessment. Journal of Occupation and Environmental Medicine, 59(4), e63–e66. Retrieved from https://journals.lww.com/joem/FullText/2017/04000/The_Gig_Economy_and_Contingent_Work An.20.aspx

U.S. Government Accountability Office. (2015, April 20). Contingent workforce: Size, characteristics, earnings, and benefits. Retrieved from https://www.gao.gov/assets/670/669766.pdf

12 Bureau of Labor Statistics. (2018). Labor Force Statistics from the Current Population Survey [Table 3.; Table 4; Table 44.]. U.S. Department of Labor. Retrieved from https://www.bls.gov/cps/cps_aa2018.htm

13 Board of Governors of the Federal Reserve System. (2019, May). Report on the economic well-being of U.S. households in 2018. Retrieved from https://www.federalreserve.gov/publications/files/2018-report-economic-well-being-us-households-201905.pdf

Goldren, L. (2016, December 5). Still falling short on hours and pay. Economic Policy Institute. Retrieved from https://www.epi.org/publication/still-falling-short-on-hours-and-pay-part-time-work-becoming-new-normal/

Gould, E. (2020, February 20). State of Working America Wages 2019. Economic Policy Institute. Retrieved from https://www.epi.org/publication/swa-wages-2019/

Kossek, E. E. & Lautsch, B. A. (2018, May 7). Hourly workers need flexibility the most, but are often the least likely to get it. Harvard Business Review. Retrieved from https://hbr.org/2018/05/hourly-workers-need-flexibility-the-most-but-are-often-the-least-likely-to-get-it

14 Eisenberg, R. (2019, February 18). How well is the gig economy working for gig workers? Forbes. Retrieved from https://www.forbes.com/sites/nextavenue/2019/02/18/how-well-is-the-gig-economy-working-for-gig-workers/#4255bb9b3f0a

Katz, L. F., & Krueger, A. B. (2018, November 13). The rise and nature of alternative work arrangements in the United States, 1995–2015. ILR Review, 72(2), 382–416. Retrieved from https://scholar.harvard.edu/lkatz/publications/rise-and-nature-alternative-work-arrangements-united-states-1995-2015

Manyika, J., Lund, S., Bughin, J., Robinson, K., Mischke, J., & Mahajan, D. (2016, October 10). Independent work: Choice, necessity, and the gig economy. McKinsey Global Institute. Retrieved from http://www.mckinsey.com/global-themes/employment-and-growth/independent-work-choice-necessity-and-the-gig-economy

U.S. Government Accountability Office. (2015, April 20). Contingent workforce: Size, characteristics, earnings, and benefits. Retrieved from https://www.gao.gov/assets/670/669766.pdf

15 Bureau of Labor Statistics. (2018). Labor Force Statistics from the Current Population Survey [Table 3.; Table 4,; Table 44.]. U.S. Department of Labor. Retrieved from https://www.bls.gov/cps/cps_aa2018.htm

16 Bureau of Labor Statistics. (2018). Labor Force Statistics from the Current Population Survey [Table 3.; Table 4,; Table 44.]. U.S. Department of Labor. Retrieved from https://www.bls.gov/cps/cps_aa2018.htm

Federal Reserve Bank of St. Louis. (2018). Employed full time: Workers paid hourly rates: Wage and salary workers: 16 years and over. Retrieved from https://fred.stlouisfed.org/series/LEU0253126800A

17 American Community Survey. (2018). 1-year estimates. U.S. Census Bureau. Retrieved from https://data.census.gov/cedsci/
Federal Reserve Bank of St. Louis. (2018). Labor Force Participation Rate. Retrieved from https://fred.stlouisfed.org/series/CIVPART

18 Gould, E., & Wilson, V. (2020, June 1). Black workers face two of the most lethal preexisting conditions for coronavirus—racism and economic inequality. Economic Policy Institute. Retrieved from https://www.epi.org/publication/black-workers-covid/

Blau, F. D., Koebe, J., & Meyerhofer, P. A. (2020, April 30). Essential and frontline workers in the COVID-19 crisis. Econofact. Retrieved from https://econofact.org/essential-and-frontline-workers-in-the-covid-19-crisis

Kinder, M., & Ross, M. (2020, June 23). Reopening America: Low-wage workers have suffered badly from COVID-19 so policymakers should focus on equity. Brookings. Retrieved from https://www.brookings.edu/research/reopening-america-low-wage-workers-have-suffered-badly-from-covid-19-so-policymakers-should-focus-on-equity/

Greene, S., & McCargo, A. (2020, May 29). New data suggest COVID-19 is widening housing disparities by race and income. Urban Wire. Urban Institute. Retrieved from https://www.urban.org/urban-wire/new-data-suggest-covid-19-widening-housing-disparities-race-and-income

Garfield, R., Rae, M., Claxton, G., & Orgera, K. (2020, April 29). Double jeopardy: Low wage workers at risk for health and financial implications of COVID-19.
Kaiser Family Foundation. Retrieved from https://www.kff.org/coronavirus-covid-19/issue-brief/double-jeopardy-low-wage-workers-at-risk-for-health-and-financial-implications-of-covid-19/

19 Ewing-Nelson, C. (2020, October), Four time more women than men dropped out of the labor force in September. Retrieved from https://nwlc-ciw49tixgw5lbab.stackpathdns.com/wp-content/uploads/2020/10/september-jobs-fs1.pdf

20 Desilver, D. (2018, August 7). For most U.S. workers, real wages have barely budged in decades. Pew Research Center. Retrieved from https://www.pewresearch.org/fact-tank/2018/08/07/for-most-us-workers-real-wages-have-barely-budged-for-decades/

Economic Policy Institute. (2020). The unequal states of America: Income inequality in the United States. Retrieved from https://www.epi.org/multimedia/unequal-states-of-america/

Stone, C., Trisi, D., Sherman, A., & Taylor, R. (2019, August 21). A guide to statistics on historical trends in income inequality. Center on Budget and Policy Priorities. Retrieved from https://www.cbpp.org/research/poverty-and-inequality/a-guide-to-statistics-on-historical-trends-in-income-inequality#_ftnref1

21 Pew Research Center. (2015, December 9). The American middle class is losing ground. Retrieved from http://www.pewsocialtrends.org/2015/12/09/the-american-middle-class-is-losing-ground/

Smith, S. (2017, October 31). Most think the 'American dream' is within reach for them. Pew Research Center. Retrieved from https://www.pewresearch.org/fact-tank/2017/10/31/most-think-the-american-dream-is-within-reach-for-them/

22 Note: Households on the cusp are defined as those with income in the Census income bracket above the ALICE Threshold. Income brackets begin with less than
$10,000/year; they increase in $5,000 intervals from $10,000 to $50,000/year; then they extend to $50,000-$60,000/year, $60,000-$75,000/year, $75,000-$100,000/year,
$100,000-$125,000/year, and $125,000-$150,000/year.

23 Federal Reserve System. (2019, May). Report on the economic well-being of U.S. households in 2018. Retrieved from https://www.federalreserve.gov/publications/files/2018-report-economic-well-being-us-households-201905.pdf

Beard, M. P. (2010). In-depth: Reaching the unbanked and underbanked. Federal Reserve Bank of St. Louis. Retrieved from https://www.stlouisfed.org/publications/central-banker/winter-2010/reaching-the-unbanked-and-underbanked

McKernan, S.-M., Ratcliffe, C., & Shanks, T. W. (2011). Is poverty incompatible with asset accumulation? Urban Institute. Retrieved from https://www.urban.org/research/publication/poverty-incompatible-asset-accumulation

24 Federal Deposit Insurance Corporation. (2018, October). Table E.2 rates of saving for unexpected expenses or emergencies by State, 2015–2017. In FDIC National Survey of Unbanked and Underbanked Households, Appendix Tables. Retrieved from https://www.fdic.gov/householdsurvey/2017/2017appendix.pdf

Karlan, D., Ratan, A. L., & Zinman, J. (2014, March). Savings by and for the poor. The Review of Income and Wealth, 60(1), 36–78. Retrieved from https://onlinelibrary.wiley.com/doi/full/10.1111/roiw.12101

The Pew Charitable Trusts. (2015, October). The role of emergency savings in family financial security: How do families cope with financial shocks? Retrieved from https://www.pewtrusts.org/~/media/assets/2015/10/emergency-savings-report-1_artfinal.pdf

25 U.S. Census Bureau. (2017). Wealth and asset ownership for households, by type of asset and selected characteristics: 2017 [Table 4]. Retrieved from https://www.census.gov/data/tables/2017/demo/wealth/wealth-asset-ownership.html

26 American Community Survey. (2010-2018). 1-year and 5-year estimates. U.S. Census Bureau. Retrieved from https://data.census.gov/cedsci/ ; United for ALICE. (2012- 2020). The ALICE Threshold [2010-2018]. Research Center: National Comparison. Retrieved from www.UnitedForALICE.org/national-comparison

27 Cox, N., Ganong., P., Noel., P., Vavra, J., Wong., A., Farrell., D., et al. (2020, July). Initial impacts of the pandemic on consumer behavior: Evidence from linked income, spending, and savings data. Brookings Papers on Economic Activity, no. 2020-82. Retrieved from https://bfi.uchicago.edu/wp-content/uploads/BFI_WP_202082.pdf

28 Boustan, L. P., Yanguas, M. L., Kahn, M., & Rhode, P. W. (2017, July 1). As the rich move away from disaster zones, the poor are left behind. Grist. Retrieved from https://grist.org/article/as-the-rich-move-away-from-disaster-zones-the-poor-are-left-behind/
California Institute of Technology. (2018). Scientific consensus: Earth's climate is warming. Retrieved from https://climate.nasa.gov/scientific-consensus/ Krause, E., & Reeves R. V. (2017, September 18). Hurricanes hit the poor the hardest. Brookings Institution.
https://www.brookings.edu/blog/social-mobility-memos/2017/09/18/hurricanes-hit-the-poor-the-hardest/

Lavizzo-Mourey, R. (2015). In it together — building a culture of health: 2015 president's message. Robert Wood Johnson Foundation. Retrieved from https://www.rwjf.org/en/library/annual-reports/presidents-message-2015.html

Mutter, J. C. (2015). The disaster profiteers: How natural disasters make the rich richer and the poor even poorer. New York, NY: St. Martin's Press.

Oxfam America. (2009). Exposed: Social vulnerability and climate change in the U.S. Southeast. Retrieved from https://www.oxfamamerica.org/explore/research-publications/exposed-social-vulnerability-and-climate-change-in-the-us-southeast/

29 Harnett, S. (2018, September 19). Low-income communities struggle to recover after a wildfire. KQED. Retrieved from https://www.npr.org/2018/09/19/647606049/low-income-communities-struggle-to-recover-after-a-wildfire

Hoopes Halpin, S. (2013). The impact of Superstorm Sandy on New Jersey towns and households. Retrieved from https://rucore.libraries.rutgers.edu/rutgers-lib/44886/

Boustan, L. P., Yanguas, M. L., Kahn, M., & Rhode, P. W. (2017, July 1). As the rich move away from disaster zones, the poor are left behind. Grist. Retrieved from https://grist.org/article/as-the-rich-move-away-from-disaster-zones-the-poor-are-left-behind/ California Institute of Technology. (2018). Scientific consensus: Earth's climate is warming. Retrieved from https://climate.nasa.gov/scientific-consensus/ Krause, E., & Reeves R. V. (2017, September 18). Hurricanes hit the poor the hardest. Brookings Institution. https://www.brookings.edu/blog/social-mobility-memos/2017/09/18/hurricanes-hit-the-poor-the-hardest/

Lavizzo-Mourey, R. (2015). In it together — building a culture of health: 2015 president's message. Robert Wood Johnson Foundation. Retrieved from https://www.rwjf.org/en/library/annual-reports/presidents-message-2015.html

Mutter, J. C. (2015). The disaster profiteers: How natural disasters make the rich richer and the poor even poorer. New York, NY: St. Martin's Press.

Oxfam America. (2009). Exposed: Social vulnerability and climate change in the U.S. Southeast. Retrieved from https://www.oxfamamerica.org/explore/research-publications/exposed-social-vulnerability-and-climate-change-in-the-us-southeast/

30 Romney, L. (2020, September 4). Poverty and racism leave people more vulnerable to wildfire smoke. Retrieved from https://www.kqed.org/news/11836398/who-is-most-vulnerable-to-wildfire-smoke-poverty-and-racism-play-a-part

Davies, I. P., Haugo, R. D., Robertson, J. C., & Levin, P. S. (2018, November 2). The unequal vulnerability of communities of color to wildfire. PLoS ONE, 13(11), e0205825. Retrieved from https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0205825

31 People's Equal Action and Community Effort, Inc. (2020, June 22). A COVID-19 community needs chronicle and assessment for Syracuse and Onondaga County, New York. Retrieved from https://www.peace-caa.org/wp-content/uploads/2020/06/PEACE_COVID_Community_Needs_Assessment.pdf

32 American Public Media. (2020, September 16). The color of Coronavirus: Covid-19 deaths by race and ethnicity in the U.S. Retrieved from https://www.apmresearchlab.org/covid/deaths-by-race

33 Russell, A. & Vinsel, L. (2016, April 7). Hail the maintainers. Aeon. Retrieved from https://aeon.co/essays/innovation-is-overvalued-maintenance-often-matters-more Vinsel, L., & Russell, A.L. (2020). The innovation delusion: How our obsession with the new has disrupted the work that matters most. Penguin Random House.

34 O'Donnell, J. (2020, September 3). Essential workers during COVID-19: At risk and lacking union representation. Brookings. Retrieved from https://www.brookings.edu/blog/up-front/2020/09/03/essential-workers-during-covid-19-at-risk-and-lacking-union-representation/

Blau, F. D., Koebe, J., & Meyerhofer, P. A. (2020, April 30). Essential and frontline workers in the COVID-19 crisis. Econofact. Retrieved from https://econofact.org/essential-and-frontline-workers-in-the-covid-19-crisis

Kinder, M., & Ross, M. (2020, June 23). Reopening America: Low-wage workers have suffered badly from COVID-19 so policymakers should focus on equity. Brookings. Retrieved from https://www.brookings.edu/research/reopening-america-low-wage-workers-have-suffered-badly-from-covid-19-so-policymakers-should-focus-on-equity/

35 Feeding America. (2020, April 22). The impact of the coronavirus on food insecurity. Retrieved from https://www.feedingamerica.org/sites/default/files/2020-04/Brief_Impact%20of%20Covid%20on%20Food%20Insecurity%204.22%20%28002%29.pdf

Schanzenbach, D., & Pitts, A. (2020, September 9). How much has food insecurity risen? Evidence from the Census Household Pulse Survey. Institute for Policy Research Rapid Research Report. Retrieved from https://www.ipr.northwestern.edu/documents/reports/ipr-rapid-research-reports-pulse-hh-data-10-june-2020.pdf

36 Robert Wood Johnson Foundation. (n.d.). Could where you live influence how long you live? Retrieved from https://www.rwjf.org/en/library/interactives/whereyouliveaffectshowlongyoulive.html

Tate, W. F. (2008). "Geography of opportunity": Poverty, Place, and Educational Outcomes. Educational Researcher, 37(7), 397–411. Retrieved from https://journals.sagepub.com/doi/abs/10.3102/0013189X08326409?journalCode=edra

Chetty, R., Hendren, N., & Katz, L. F. (2015, August). The effects of exposure to better neighborhoods on children: New evidence from the Moving to Opportunity Experiment. Retrieved from http://scholar.harvard.edu/files/hendren/files/mto_paper.pdf

37 Nationwide, households that are severely rent burdened (with rent accounting for more than 50% of their income) are projected to grow by at least 11%, to 13.1 million households, by 2025. And households with lower incomes (less than $50,000 per year) are more likely to be housing burdened than those with higher incomes (above $75,000) across all housing types.

Charette, A., Herbert, C., Jakabovics, A., Marya, E. T., & McCue, D. T. (2015). Projecting trends in severely cost-burdened renters: 2015–2025. Joint Center for Housing Studies of Harvard University. Retrieved from https://www.jchs.harvard.edu/sites/default/files/projecting_trends_in_severely_cost-burdened_renters_final.pdf

Joint Center for Housing Studies of Harvard University. (2019). The state of the nation's housing 2019. Retrieved from https://www.jchs.harvard.edu/sites/default/files/Harvard_JCHS_State_of_the_Nations_Housing_2019.pdf

Scally, C. P., & Gilbert, B. (2018, October 1). Rural communities need more affordable rental housing. Urban Wire. Urban Institute. Retrieved from https://www.urban.org/urban-wire/rural-communities-need-more-affordable-rental-housing

38 Charette, A., Herbert, C., Jakabovics, A., Marya, E. T., & McCue, D. T. (2015). Projecting trends in severely cost-burdened renters: 2015–2025. Joint Center for Housing Studies of Harvard University. Retrieved from https://www.jchs.harvard.edu/sites/default/files/projecting_trends_in_severely_cost-burdened_renters_final.pdf

Federal Reserve Bank of Philadelphia. (n.d.). Rental housing affordability data tool. Retrieved from https://www.philadelphiafed.org/community-development/housing-data-dashboard
The Pew Charitable Trusts. (2019, April). Philadelphia 2019: The state of the city. Retrieved from https://www.pewtrusts.org/-/media/assets/2019/10/sotc_2019.pdf 39 Bliss, L. (2016, June 8). How much does sprawl cost American commuters? CityLab. Retrieved from
http://www.citylab.com/design/2016/06/cost-of-sprawl-us-commuters/486170/

Boehm, T., & Schlottman, A.M. (2004, February). The dynamics of race, income, and homeownership. Journal of Urban Economics, 55(1), 113–130. Retrieved from https://www.researchgate.net/publication/4890916_The_dynamics_of_race_income_and_homeownership

Chetty, R., Hendren, N., & Katz, L. F. (2015, August). The effects of exposure to better neighborhoods on children: New evidence from the Moving to Opportunity Experiment. Retrieved from http://scholar.harvard.edu/files/hendren/files/mto_paper.pdf

Crabtree, S. (2010, August 13). Well-being lower among workers with long commutes. Gallup-Healthways Well-Being Index. Retrieved from http://www.gallup.com/poll/142142/wellbeing-lower-amongworkers-long-commutes.aspx

Galster, G. (2014, March). How neighborhoods affect health, well-being, and young people's futures. MacArthur Foundation. Retrieved from https://www.macfound.org/media/files/HHM_-_Neighborhoods_Affect_Health_Well-being_Young_Peoples_Futures.pdf

Garriga, C., Ricketts, L. R., & Schlagenhauf, D. E. (2017). The homeownership experience of minorities during the Great Recession. Federal Reserve Bank of St. Louis Review, 99(1), 139-167. Retrieved from https://research.stlouisfed.org/publications/review/2017/02/15/the-homeownership-experience-of-minorities-during-the-great-recession/

Graif, C., & Matthews, S. A. (2017, January 25). The long arm of poverty: Extended and relational geographies of child victimization and neighborhood violence exposures. Justice Quarterly, 34(6), 1096–1125. Retrieved from https://www.tandfonline.com/doi/abs/10.1080/07418825.2016.1276951?scroll=top&needAccess=true&journalCode=rjqy20

Joint Center for Housing Studies at Harvard University. (2019). The state of the nation's housing 2019. Retrieved from https://www.jchs.harvard.edu/sites/default/files/Harvard_JCHS_State_of_the_Nations_Housing_2019.pdf

Morgan, R. E., & Truman, J. L. (2018, December). Criminal victimization, 2017. U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics. Retrieved from https://www.bjs.gov/content/pub/pdf/cv17.pdf

National Low Income Housing Coalition. (2020). Out of reach: The high cost of housing. Retrieved from https://reports.nlihc.org/sites/default/files/oor/OOR_BOOK_2020.pdf

Riley, S. F., Ru, H., & Feng, Q. (2013). The user cost of low-income homeownership. The Journal of Regional Analysis & Policy, 43(2), 123–137. Retrieved from http://www.jrap-journal.org/pastvolumes/2010/v43/v43_n2_a3_riley_etal.pdf

Ross, T. (2013, August). A disaster in the making: Addressing the vulnerability of low-income communities to extreme weather. Center for American Progress. Retrieved from https://www.americanprogress.org/wp-content/uploads/2013/08/LowIncomeResilience-3.pdf

Shonkoff, J. P.; Garner, A. S.; The Committee on Psychosocial Aspects of Child and Family Health; Committee on Early Childhood, Adoption, and Dependent Care; Section on Developmental and Behavioral Pediatrics, et al. (2012, January). The lifelong effects of early childhood adversity and toxic stress. Pediatrics, 129(1). Retrieved from https://pediatrics.aappublications.org/content/129/1/e232.short

Taylor, L. (2018, June 7). Housing and health: An overview of the literature. Health Affairs Health Policy Brief. Retrieved from https://www.healthaffairs.org/do/10.1377/hpb20180313.396577/full/

van Ommeren, J.N., & Gutiérrez-i-Puigarnau, E. (2011, January). Are workers with a long commute less productive? An empirical analysis of absenteeism. Regional Science and Urban Economics, 41(1), 1–8. Retrieved from http://www.sciencedirect.com/science/article/pii/S0166046210000633

40 National Fair Housing Alliance. (2019). 2019 fair housing trends report. Retrieved from https://nationalfairhousing.org/wp-content/uploads/2019/10/2019-Trends-Report.pdf

41 Veal, S., & Spader, J. (2019, July 10). Rebounds in homeownership have not reduced the gap for Black homeowners. Joint Center for Housing Studies of Harvard University. Retrieved from https://www.jchs.harvard.edu/blog/rebounds-in-homeownership-have-not-reduced-the-gap-for-black-homeowners/

Federal Reserve Bank of St. Louis. (2018). Homeownership Rate for the United States: Hispanic or Latino. Retrieved from https://fred.stlouisfed.org/series/HOLHORUSQ156N

42 Eviction Lab. (n.d.). Eviction Tracking System. Retrieved from https://evictionlab.org/eviction-tracking/

Blau, M. (2019, January 18). Black southerners are bearing the brunt of America's eviction epidemic. Stateline. The Pew Charitable Trusts. Retrieved from https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2019/01/18/black-southerners-are-bearing-the-brunt-of-americas-eviction-epidemic

Desmond, M., & Gershenson, C. (2017, February). Who gets evicted? Assessing individual, neighborhood, and network factors. Social Science Research, 62, 362–377. Retrieved from https://www.sciencedirect.com/science/article/abs/pii/S0049089X16300977

Greene, S., & McCargo, A., (2020, May 29). New data suggest COVID-19 is widening housing disparities by race and income. Urban Wire, Urban Institute. Retrieved from https://www.urban.org/urban-wire/new-data-suggest-covid-19-widening-housing-disparities-race-and-income

Maru, D., Maru, S., Bass, E., & Masci, J. (2020, May 26). To stem the spread of COVID-19, address the challenges of crowded housing. Health Affairs Blog. Retrieved from https://www.healthaffairs.org/do/10.1377/hblog20200521.144527/full/

43 Greene, S., & McCargo, A., (2020, May 29). New data suggest COVID-19 is widening housing disparities by race and income. Urban Wire. Urban Institute. Retrieved from https://www.urban.org/urban-wire/new-data-suggest-covid-19-widening-housing-disparities-race-and-income

U.S. Census Bureau. (n.d.). Household Pulse Survey [Housing insecurity]. Retrieved from https://www.census.gov/data-tools/demo/hhp/#/?measures=HIR

44 Dingel, J. I., Patterson, C., & Vavra, J. (2020, April). Childcare obligations will constrain many workers when reopening the US economy [Working Paper NO. 2020-46]. Becker Friedman Institute for Economics at the University of Chicago. Retrieved from https://bfi.uchicago.edu/wp-content/uploads/BFI_WP_202046.pdf

45 Belfield, C. R. (2018, September). The economic impacts of insufficient child care on working families. ReadyNation. Retrieved from https://www.strongnation.org/documents/522

Bishop-Josef, S. Beakey, C., Watson, S., & Garrett, T. (2019, January). Want to grow the economy? Fix the child care crisis. ReadyNation. Retrieved from https://www.strongnation.org/documents/602

46 Aucejo, E. M., French, J. F., Ugalde Araya, M. P., & Zafar, B. (2020). The impact of COVID-19 on student experiences and expectations: Evidence from a survey. National Bureau of Economic Research (NBER) Working Papers, (27392). Retrieved from https://ideas.repec.org/p/nbr/nberwo/27392.html

Berman, J. (2020, June 12). 'Higher education essentially preserves intergenerational racial and call inequality': How coronavirus could
make it worse. MarketWatch. Retrieved from https://www.marketwatch.com/story/how-the-coronavirus-pandemic-could-create-a-ticking-time-bomb-that-worsens-racial-and- income-inequality-in-higher-education-2020-06-11

Hanushek, E. A. & Woessmann, L. (2020, September). The economic impacts of learning losses. Organisation for Economic Cooperation and Development. Retrieved from http://www.oecd.org/education/The-economic-impacts-of-coronavirus-covid-19-learning-losses.pdf

LaFave, S. (2020, May 4). How school closures for COVID-19 amplify inequality. HUB. Johns Hopkins University. Retrieved from https://hub.jhu.edu/2020/05/04/school-closures-inequality/

Malik, R., Hamm, K., Lee, W. F., Davis, E. E., & Sojourner, A. (2020, June 22). The coronavirus will make child care deserts worse and exacerbate inequality.
Center for American Progress. Retrieved from
https://www.americanprogress.org/issues/early-childhood/reports/2020/06/22/486433/coronavirus-will-make-child-care-deserts-worse-exacerbate-inequality/

U.S. Department of Education. (2015). A matter of equity: Preschool in America. Retrieved from
https://www2.ed.gov/documents/early-learning/matter-equity-preschool-america.pdf

47 Ewing-Nelson, C. (2020, August). One in five child care jobs have been lost since February, and women are paying the price [fact sheet]. National Women's Law Center. Retrieved from https://nwlc-ciw49tixgw5lbab.stackpathdns.com/wp-content/uploads/2020/08/ChildCareWorkersFS.pdf

McNicholas, C., & Poydock, M. (2020, May 19). Who are essential workers? A comprehensive look at their wages, demographics, and unionization rates.
Working Economics Blog. Economic Policy Institute. Retrieved from
https://www.epi.org/blog/who-are-essential-workers-a-comprehensive-look-at-their-wages-demographics-and-unionization-rates/

Bipartisan Policy Center. (2020, April 10). Nationwide survey: Child care in the time of coronavirus. Retrieved from
https://bipartisanpolicy.org/blog/nationwide-survey-child-care-in-the-time-of-coronavirus/

Dingel, J. I., Patterson, C., & Vavra, J. (2020, April). Childcare obligations will constrain many workers when reopening the US economy [Working Paper NO. 2020-46]. Becker Friedman Institute for Economics at the University of Chicago. Retrieved from https://bfi.uchicago.edu/wp-content/uploads/BFI_WP_202046.pdf

Modestino, A. S., Lage, J., & Lincoln, A. (2020, July 29). The importance of childcare in reopening the economy. Econofact. Retrieved from https://econofact.org/the-importance-of-childcare-in-reopening-the-economy

48 Jessen-Howard, S., & Workman, S. (2020, April 24). Coronavirus pandemic could lead to permanent loss of nearly 4.5 million child care slots.
Center for American Progress. Retrieved from
https://www.americanprogress.org/issues/early-childhood/news/2020/04/24/483817/coronavirus-pandemic-lead-permanent-loss-nearly-4-5-million-child-care-slots/

49 Ewing-Nelson, C. (2020, August). One in five child care jobs have been lost since February, and women are paying the price [fact sheet]. National Women's Law Center. Retrieved from https://nwlc-ciw49tixgw5lbab.stackpathdns.com/wp-content/uploads/2020/08/ChildCareWorkersFS.pdf

Modestino, A. S., Ladge, J., & Lincoln, A. (2020, July 29). The importance of childcare in reopening the economy. Econofact. Retrieved from https://econofact.org/the-importance-of-childcare-in-reopening-the-economy

Procare Solutions. (2020). Tracking the impact of COVID-19 on the child care industry. Retrieved from
https://info.procaresoftware.com/impact-covid19-child-care-industry-trends-report

50 Lachlan, L., Kimmel, L., Mizrav, E., & Holdheide, L. (2020, August). Advancing quality teaching for all schools: Examining the impact of COVID-19 on the teaching workforce. Center of Great Teachers & Leaders at the American Institutes for Research. Retrieved from https://gtlcenter.org/sites/default/files/Examining_Impact_COVID19_Workforce.pdf

Griffith, M. (2020, April). The impact of the COVID-19 recession on teaching positions. Learning Policy Institute. Retrieved from https://learningpolicyinstitute.org/blog/impact-covid-19-recession-teaching-positions

51 Note: In 2019,13.7 million households (10.5% of the total population) were food insecure, including 13.6% of households with children; in total, 35.2 million people lived in food-insecure households. The prevalence of food insecurity varies by region and state, ranging from 11.2% in the South to 9.6% in the Northeast, and from 6.6% in New Hampshire to 15.7% in Mississippi. Food insecurity is more common among certain groups, including households with children headed by a single women (28.7%) or man (15.4%); households with income below 185% of the FPL (27.6%); Black, non-Hispanic households (19.1%); and Hispanic households (15.6%). There is also growing food insecurity among college students. A survey of U.S. college students administered in 2019 found that 39% of respondents were food insecure in the 30 days prior to taking the survey, with higher rates for students who are female

(41%); Hispanic/Latinx [note here that Latinx not matching style—should be clear in style guide whether Latinx is preferred and in which areas of the report] (47%); gay or lesbian (47%); bisexual (50%); transgender (52%); parenting (53%); and indigenous (60%).

Economic Research Service. (2020, September 9). Food insecurity of U.S. households in 2019. U.S. Department of Agriculture. Retrieved from https://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-us/key-statistics-graphics.aspx#foodsecure

Baker-Smith, C., Coca, V., Goldrick-Rab, S., Looker, E., Richardson, B., & Williams, T. (2020, February). #RealCollege 2020: Five years of evidence on campus basic needs insecurity. The Hope Center. Retrieved from https://hope4college.com/wp-content/uploads/2020/02/2019_RealCollege_Survey_Report.pdf

Feeding America. (2020). Map the meal gap 2020: A report on county and congressional district food insecurity and county food cost in the United States in 2018. Retrieved from https://www.feedingamerica.org/sites/default/files/2020-06/Map%20the%20Meal%20Gap%202020%20Combined%20Modules.pdf

Karpyn, A.E., Riser, D., Tracy, T., Wang, R., & Shen, Y. (2019, Summer). The changing landscape of food deserts. UNSCN Nutrition, 44:46-43. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7299236/

52 Berkowitz, S. A., Basu, S., Meigs, J. B., & Seligman, H. K. (2017, June 13). Food insecurity and health care expenditures in the United States, 2011–2013. Health Services Research, 53(3), 1600–1620. Retrieved from https://onlinelibrary.wiley.com/doi/abs/10.1111/1475-6773.12730

Feeding America. (2020). Map the meal gap 2020: A report on county and congressional district food insecurity and county food cost in the United States in 2018. Retrieved from https://www.feedingamerica.org/sites/default/files/2020-06/Map%20the%20Meal%20Gap%202020%20Combined%20Modules.pdf

Westat and the Urban Institute. (2014, August). Hunger in America 2014: National report. Feeding America. Retrieved from http://help.feedingamerica.org/HungerInAmerica/hunger-in-america-2014-full-report.pdf

Lee-Kwan, S. H., Moore, L. V., Blanck, H. M., Harris, D. M., & Galuska, D. (2017, November 17). Disparities in state-specific adult fruit and vegetable consumption — United States, 2015. CDC Morbidity and Mortality Weekly Report, 66(45),1241–1247. Retrieved from https://www.cdc.gov/mmwr/volumes/66/wr/mm6645a1.htm?s_cid=mm6645a1_w

The Aspen Institute. (2016, March 1). Advancing health through food security. Retrieved from https://www.aspeninstitute.org/publications/advancing-health-through-food-security-0/

53 Dunn. C. G., Kenney, E., Fleischhacker, S. E., & Bleich, S. N. (2020, April 30). Feeding low-income children during the Covid-19 pandemic. New England Journal of Medicine, 382(18), e40(1)-e40(3). Retrieved from https://www.nejm.org/doi/full/10.1056/NEJMp2005638

54 Schanzenbach, D., & Pitts, A. (2020, September 9). How much has food insecurity risen? Evidence from the Census Household Pulse Survey. Institute for Policy Research Rapid Research Report. Retrieved from https://www.ipr.northwestern.edu/documents/reports/ipr-rapid-research-reports-pulse-hh-data-10-june-2020.pdf

55 Note: "Food Scarcity" represents the percentage of adults in households who stated there was either sometimes or often not enough to eat in the prior seven days.

Ashbrook, A. (2020, July 31). Nearly 60 percent increase in older adult food insecurity during COVID-19: Federal action on SNAP needed now. FRAC chat. Food Research & Action Center (FRAC). Retrieved from https://frac.org/blog/nearly-60-percent-increase-in-older-adult-food-insecurity-during-covid-19-federal-action-on-snap-needed-now

U.S. Census Bureau. (n.d.). Household Pulse Survey [Food Scarcity]. Retrieved from https://www.census.gov/data-tools/demo/hhp/#/?measures=FIR

Schanzenbach, D., & Pitts, A. (2020, September 9). How much has food insecurity risen? Evidence from the Census Household Pulse Survey. Institute for Policy Research Rapid Research Report. Retrieved from https://www.ipr.northwestern.edu/documents/reports/ipr-rapid-research-reports-pulse-hh-data-10-june-2020.pdf

Ashbrook, A. (2020, July 31). Nearly 60 percent increase in older adult food insecurity during COVID-19: Federal action on SNAP needed now. FRAC chat. Food Research & Action Center (FRAC). Retrieved from https://frac.org/blog/nearly-60-percent-increase-in-older-adult-food-insecurity-during-covid-19-federal-action-on-snap-needed-now

56 Feeding America. (2020, April 22). The impact of the coronavirus on food insecurity. Retrieved from https://www.feedingamerica.org/sites/default/files/2020-04/Brief_Impact%20of%20Covid%20on%20Food%20Insecurity%204.22%20%28002%29.pdf

Schanzenbach, D., & Pitts, A. (2020, September 9). How much has food insecurity risen? Evidence from the Census Household Pulse Survey. Institute for Policy Research Rapid Research Report. Retrieved from https://www.ipr.northwestern.edu/documents/reports/ipr-rapid-research-reports-pulse-hh-data-10-june-2020.pdf

57 Duranton, G., & Puga, D. (2014). The growth of cities. In Handbook of Economic Growth, 2, 781–853. Retrieved from https://www.sciencedirect.com/science/article/pii/B9780444535405000057

Jiao, J., Miró, J., & McGrath, N. (2017, November 3). Why the 'Uberization' of public transit is good for cities. Houston Chronicle. Retrieved from http://www.houstonchronicle.com/local/gray-matters/article/Why-the-Uberization-of-public-transit-is-good-12329605.php

Robert Wood Johnson Foundation. (2012, October 25). How does transportation impact health? Health Policy Snapshot Series. Retrieved from https://www.rwjf.org/en/library/research/2012/10/how-does-transportation-impact-health-.html

Stiglic, M., Agatz, N., Savelsbergh, M., & Gradisar, M. (2018, February). Enhancing urban mobility. Computers and Operations Research, 90(no. C), 12–21. Retrieved from https://dl.acm.org/citation.cfm?id=3165324.3165603

van Ommeren, J.N., & Gutiérrez-i-Puigarnau, E. (2011, January 11). Are workers with a long commute less productive? An empirical analysis of absenteeism. Regional Science and Urban Economics, 41(1), 1–8. Retrieved from http://www.sciencedirect.com/science/article/pii/S0166046210000633

58 Transunion. (2019, April). Monthly industry snapshot. Retrieved from https://content.transunion.com/v/monthly-industry-snapshot-april-final Transunion. (2020, August). Monthly industry snapshot. Retrieved from https://content.transunion.com/v/monthly-industry-snapshot-august-final

59 National Academies of Sciences, Engineering and Medicine. (2020, September 8). COVID-19 trends impacting the future of transportation planning and research. Retrieved from https://www.nationalacademies.org/trb/blog/covid-19-trends-impacting-the-future-of-transportation-planning-and-research

60 Stewart, J. (2020, July 1). The coronavirus has highlighted the transit inequalities in America. Marketplace. Minnesota Public Radio. Retrieved from https://www.marketplace.org/2020/07/01/the-coronavirus-has-highlighted-the-transit-inequalities-in-america/

61 An, J., Braveman, P., Dekker, M., Egerter, S., & Grossman-Kahn, R. (2011, May 1). Work, workplaces and health. Robert Wood Johnson Foundation. Retrieved from https://www.rwjf.org/en/library/research/2011/05/work-and-health-.html

Bachrach, D., Pfister, H., Wallis, K., & Lipson, M. (2014, May). Addressing patients' social needs: An emerging business case for provider investment. The Commonwealth Fund. Retrieved from http://www.commonwealthfund.org/~/media/files/publications/fund-report/2014/may/1749_bachrach_addressing_patients_social_needs_v2.pdf

Bell, J., Mora, G., Hagan, E., Rubin, V., & Karpyn, A. (2013). Access to healthy food and why it matters: A review of the research. PolicyLink. Retrieved from http://thefoodtrust.org/uploads/media_items/access-to-healthy-food.original.pdf

Braveman, P., Dekker, M., Egerter, S., Sadegh-Nobari, T., & Pollack, C. (2011, May 1). How does housing affect health? Robert Wood Johnson Foundation. Retrieved from https://www.rwjf.org/en/library/research/2011/05/housing-and-health.html

Lynch, J., Smith, G.D., Harper, S., & Hillemeier, M. (2004). Is income inequality a determinant of population health? Part 2. U.S. National and regional trends in income inequality and age- and cause-specific mortality. Milbank Quarterly, 82(2), 355–400. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/15225332

Robert Wood Johnson Foundation. (2011, December). Health care's blind side: The overlooked connection between social needs and good health: Summary of findings from a survey of America's physicians. Retrieved from http://www.rwjf.org/files/research/RWJFPhysiciansSurveyExecutiveSummary.pdf

U.S. Department of Housing and Urban Development (HUD). (2016, April). Breaking down barriers: Housing, neighborhoods, and schools of opportunity. Retrieved from https://www.huduser.gov/portal/sites/default/files/pdf/insight-4.pdf

62 Choi, L. (2009). Financial stress and its physical effects on individuals and communities. Community Development Investment Review. Retrieved from http://www.frbsf.org/community-development/files/choi.pdf

Zurlo, K., Yoon, W., & Kim, H. (2014, May). Unsecured consumer debt and mental health outcomes in middle-aged and older Americans. Journals of Gerontology, 69(3), 461–469. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/24637231

Centers for Disease Control and Prevention (CDC). (2011, January 14). Health disparities and inequalities report, United States, 2011. Morbidity and Mortality Weekly Report, 60, Supplement. Retrieved from http://www.cdc.gov/mmwr/pdf/other/su6001.pdf

3achrach, D., Pfister, H., Wallis, K., & Lipson, M. (2014 May). Addressing patients' social needs: An emerging business case for provider investment. The Commonwealth Fund. Retrieved from http://www.commonwealthfund.org/~/media/files/publications/fund-report/2014/may/1749_bachrach_addressing_patients_social_needs_v2.pdf

3 Himmelstein, D. U., Lawless, R. M., Thorne, D., Foohey, P., & Woolhandler, S. (2019, March 1). Medical bankruptcy: Still common despite the Affordable Care Act. American Journal of Public Health, 109(3), 431-433. Retrieved from https://ajph.aphapublications.org/doi/10.2105/AJPH.2018.304901

4 Kinder, M., & Ross, M. (2020, June 23). Reopening America: Low-wage workers have suffered badly from COVID-19 so policymakers should focus on equity. Brookings. Retrieved from https://www.brookings.edu/research/reopening-america-low-wage-workers-have-suffered-badly-from-covid-19-so-policymakers-should-focus-on-equity/

5 Koma, W., Artiga, S., Neuman, T., Claxton, G., Rae, M., Kates, et al. (2020, May 7). Low-income and communities of color at higher risk of serious illness if infected with Coronavirus. Kaiser Family Foundation. Retrieved from https://www.kff.org/coronavirus-covid-19/issue-brief/low-income-and-communities-of-color-at-higher-risk-of-serious-illness-if-infected-with-coronavirus/

6 Higgins, E. (2020, August 3). States launch initiatives to address racial inequities highlighted by COVID-19. National Academy for State Health Policy. Retrieved from https://www.nashp.org/states-launch-initiatives-to-address-racial-inequities-highlighted-by-covid-19/

Gould, E., & Wilson, V. (2020, June 1). Black workers face two of the most lethal preexisting conditions for coronavirus—racism and economic inequality. Economic Policy Institute. Retrieved from https://www.epi.org/publication/black-workers-covid/

Moore. J. T., Ricaldi, J.N., Rose, C.E., Fuld, J., Parise, M., Kang, G. J., et al. (2020, August 21). Disparities in incidence of COVID-19 among underrepresented racial/ethnic groups in counties identified as hotspots during June 5–18, 2020 — 22 States, February-June 2020. Morbidity and Mortality Weekly Report, 69(33), 1122–1126. Centers for Disease Control and Prevention. Retrieved from https://www.cdc.gov/mmwr/volumes/69/wr/mm6933e1.htm

Chowkwanyun, M., & Reed, A. L. (2020, July 16). Racial health disparities and COVID-19—Caution and context. New England Journal of Medicine, 383, 201–203. Retrieved from https://www.nejm.org/doi/full/10.1056/NEJMp2012910

Madrigal, A. (2020, April 15). Tracking race and ethnicity in the COVID-19 pandemic. The COVID Tracking Project at The Atlantic. Retrieved from https://covidtracking.com/blog/tracking-race-and-ethnicity

Centers for Disease Control and Prevention (n.d.). Health disparities: Race and Hispanic origin, Provisional death counts of Coronavirus Disease 2019 (COVID-19). Retrieved from https://www.cdc.gov/nchs/nvss/vsrr/covid19/health_disparities.htm

The New York Times. (2020) COVID in the U.S.: Latest map and case count. Retrieved from https://www.nytimes.com/interactive/2020/us/coronavirus-us-cases.html 67 United for ALICE (2020). The ALICE Threshold, 2018. Retrieved from www.UnitedForALICE.org/national-comparison
Centers for Disease Control and Prevention. (2020, August 18). COVID-19 hospitalizations and death by age. Retrieved from https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-age.html

8 Loustaunau, L., Scott, E., Petrucci, L., & Stepick, L. (2020, July 23). Low-wage service workers are facing new emotional hazards in the workplace during COVID-19. The Conversation. Retrieved from https://theconversation.com/low-wage-service-workers-are-facing-new-emotional-hazards-in-the-workplace-during-covid-19-140619

Kim, J, H., Desai, E., & Cole, M. B. (2020, June 2). How the rapid shift to telehealth leaves many community health centers behind during the COVID-19 pandemic, Health Affairs Blog, Retrieved from https://www.healthaffairs.org/do/10.1377/hblog20200529.449762/full/

9 Note: Data calculated by applying the ALICE Threshold income levels to internet data from the American Community Survey. (2018). 1-year and 5-year estimates [Table S2801: Types of computers and internet subscriptions]. U.S. Census Bureau. Retrieved from https://data.census.gov/cedsci/

Chandra, S., Chang, A., Day, L., Fazlullah, A., Liu, J., McBride, L., et al.(2020). Closing the K–12 digital divide in the age of distance learning.
San Francisco, CA: Common Sense Media. Boston, Massachusetts, Boston Consulting Group. Retrieved from https://www.commonsensemedia.org/sites/default/files/uploads/pdfs/common_sense_media_report_final_6_26_7.38am_web_updated.pdf

Ramsetty, A., & Adams, C. (2020, April 28). Impact of the digital divide in the age of COVID-19. Journal of the American Medical Informatics Association, 27(7), 1147–1148. Retrieved from https://academic.oup.com/jamia/article/27/7/1147/5826352

Vogels, E. A., Perrin, A., Rainie, L., & Anderson, M. (2020, April 30). 53% of Americans say the internet has been essential during the COVID-19 outbreak. Pew Research Center. Retrieved from https://www.pewresearch.org/internet/2020/04/30/53-of-americans-say-the-internet-has-been-essential-during-the-covid-19-outbreak/

70 Baig, A., Hall, B., Jenkins, P., Lamarre, E., & McCarthy, B. (2020, May 14). The COVID-19 recovery will be digital: A plan for the first 90 days. McKinsey Digital. Retrieved from https://www.mckinsey.com/business-functions/mckinsey-digital/our-insights/the-covid-19-recovery-will-be-digital-a-plan-for-the-first-90-days

De', R., Pandey, N., & Pal, A.. (2020, June 9). Impact of digital surge during Covid-19 pandemic: A viewpoint on research and practice. International Journal of Information Management, 102171. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7280123/

Ding, L., & Molina, J. S. (2020, September). "Forced automation" by COVID-19? Early trends from Current Population Survey data. Federal Reserve Bank of Philadelphia. Retrieved from https://philadelphiafed.org/-/media/community-development/publications/discussion-papers/discussion-paper_automation.pdf

Manyika, J., Chui, M., Miremadi, M., Bughin, J., George, K., Wilimott, P., & Dewhurst, M. (2017). A future that works: Automation, employment, and productivity. McKinsey Global Institute. Retrieved from https://www.mckinsey.com/~/media/mckinsey/featured%20insights/Digital%20Disruption/Harnessing%20automation%20for%20a%20future%20 that%20works/MGI-A-future-that-works-Executive-summary.ashx

71 Kinder, M., & Ross, M. (2020, June 23). Reopening America: Low-wage workers have suffered badly from COVID-19 so policymakers should focus on equity. Brookings. Retrieved from https://www.brookings.edu/research/reopening-america-low-wage-workers-have-suffered-badly-from-covid-19-so-policymakers-should-focus-on-equity/

72 Flahery, C. (2020, May 8). Reserved: Internet parking. Inside Higher Ed. Retrieved from https://www.insidehighered.com/news/2020/05/08/parking-lot-wi-fi-way-life-many-students

Will, M. (2020, April 29). Teachers without internet work in parking lots, empty school buildings during COVID-19. Education Week. Retrieved from https://www.edweek.org/ew/articles/2020/04/29/teachers-without-internet-work-in-parking-lots.html

73 Center on Budget and Policy Priorities. (2020, August 6). Policy basics: Where do federal tax revenues come from? Retrieved from https://www.cbpp.org/research/federal-tax/policy-basics-where-do-federal-tax-revenues-come-from

Internal Revenue Service. (2020, October 9). Topic Number 409: Capital gains and losses. Retrieved from https://www.irs.gov/taxtopics/tc409

74 Institute on Taxation and Economic Policy. (2018, October). Who pays? A distributional analysis of the tax system in all 50 states, sixth edition. Retrieved from https://itep.org/wp-content/uploads/whopays-ITEP-2018.pdf

75 Loudenback, T. (2020, June 3). 9 reasons your full stimulus payment might be delayed, and what to do about it. Business Insider. Retrieved from https://www.businessinsider.com/personal-finance/stimulus-check-delayed-what-to-do-answers-2020-4

Internal Revenue Service. (2020,August 31). IRS operations during COVID-19: Mission-critical functions continue. Retrieved from https://www.irs.gov/newsroom/irs-operations-during-covid-19-mission-critical-functions-continue

76 Hogan, J. (2006). Remoulding the Critical Junctures Approach. Canadian Journal of Political Science / Revue Canadienne De Science Politique, 39(3), 657-679. Retrieved September 28, 2020, from http://www.jstor.org/stable/25165997

Capoccia, G. (2016, May). Critical junctures. In The Oxford Handbook of Historical Institutionalism. Retrieved from https://www.oxfordhandbooks.com/view/10.1093/oxfordhb/9780199662814.001.0001/oxfordhb-9780199662814-e-5

Clemens, A., & Garvey, M. (2020, September 24). Structural racism and the coronavirus recession highlight why more and better U.S. data need to be widely disaggregated by race and ethnicity. Washington Center for Equitable Growth. Retrieved from https://equitablegrowth.org/structural-racism-and-the-coronavirus-recession-highlight-why-more-and-better-u-s-data-need-to-be-widely-disaggregated-by-race-and-ethnicity/

Boushey, H. (2020). New measurement for a new economy. In Vision 2020: Evidence for a stronger economy. Retrieved from https://equitablegrowth.org/new-measurement-for-a-new-economy/

77 See Income Assessment in ALICE Reports, Arkansas, 2019; Connecticut, 2016, Florida, 2017; Hawaii 2017; Idaho 2015; Illinios 2019; Indiana 2016; Iowa, 2016; Louisiana
2016; Maryland 2016; Michigan 2017; New Jersey 2016; New York 2016; Ohio 2017; Oregon 2015; Pennsylvania 2019; Tennessee 2019; Texas 2018; Virginia 2017; Washington, 2015; and Wisconsin 2016. Available from https://www.unitedforalice.org/all-reports

78 Greenhouse, S. (2019, October 22). Where are the workers when we talk about the future of work? The American Prospect. Retrieved from https://prospect.org/labor/where-are-the-workers-when-we-talk-about-the-future-of-work/#.X5HVqSVSm4V.twitter

79 Carlson, K. (2020, March 11). Indian Country leaders urge Native people to be counted in 2020 Census. The Conversation. Retrieved from https://theconversation.com/indian-country-leaders-urge-native-people-to-be-counted-in-2020-census-132419#:~:text=Native%20Americans%20living%20on%20
reservations,in%20the%202010%20U.S.%20Census.&text=This%20undercount%20was%20a%20significant,living%20on%20their%20traditional%20lands

Lujan, C.C. (2014). American Indians and Alaska Natives Count: The US Census Bureau's efforts to enumerate the native population. American Indian Quarterly, 38(3), 319– 341. doi:10.5250/amerindiquar.38.3.0319

National Indian Council on Aging. (2019, July 26). 2020 Census especially important for tribes. Retrieved from https://www.nicoa.org/2020-census-especially-important-for-tribes/#:~:text=The%20Census%20Bureau%20reported%20an,undercount%20in%20the%202010%20Census

Bereitter, C. (2018, September 13). A history of undercounting people of color: Why the 2020 Census may make it worse. Common Cause. Retrieved from https://www.commoncause.org/democracy-wire/a-history-of-undercounting-people-of-color-why-the-2020-census-may-make-it-worse/

80 Martin, C. (2019, October 29). Improving the Disaster Recovery of Low-Income Families. Urban Institute. Retrieved from https://www.urban.org/debates/improving-disaster-recovery-low-income-families

Substance Abuse and Mental Health Services Administration. (2017, July). Disaster Technical Assistance Center Supplemental Research Bulletin: Greater Impact: How Disasters Affect People of Low Socioeconomic Status. U.S. Department of Health & Human Services. Retrieved from https://www.samhsa.gov/sites/default/files/programs_campaigns/dtac/srb-low-ses.pdf

81 Vanhulle, L. (2015, December 15). Making it work for workers: Employers aim to retain low-income employees, improve bottom line. Crain's Detroit Business. Retrieved from https://www.crainsdetroit.com/article/20151213/NEWS/312139982/making-it-work-for-workers-employers-aim-to-retain-low-income

Stanczyk, A., Adelstein, S., Lauderback, E., & Adams, G. (2019, October). Employers, work-family supports, and low-wage workers. Urban Institute. Retrieved from https://www.urban.org/sites/default/files/publication/101145/employers_work-family_supports_and_low-wage_workers_1.pdf

Hund-Mejean, M., & Escobari, M. (2020, April 28). Our employment system has failed low-wage workers. How can we rebuild? Brookings. Retrieved from https://www.brookings.edu/blog/up-front/2020/04/28/our-employment-system-is-failing-low-wage-workers-how-do-we-make-it-more-resilient/

Harnett, C. (2018, June 28). Responding to the needs of low-wage workers. Human Resource Executive. Retrieved from https://hrexecutive.com/responding-to-the-needs-of-low-wage-workers/

82 American Hospital Association. (2019). Making the case for hospitals to invest in housing. Retrieved from https://www.aha.org/system/files/media/file/2019/05/AIHC_issue_brief_final.pdf

Solomon, L. S., & Kanter, M. H. (2018). Health care steps up to social determinants of health: Current context. The Permanente Journal, 22, 18-139. Retrieved from https://doi.org/10.7812/TPP/18-139

The EveryONE Project. (2018). Addressing social determinants of health in primary care: Team-based approach for advancing health equity. American Academy of Family Physicians. Retrieved from https://www.aafp.org/dam/AAFP/documents/patient_care/everyone_project/team-based-approach.pdf

83 Beard, M. P. (2010). In-depth: Reaching the unbanked and underbanked. Federal Reserve Bank of St. Louis. Retrieved from https://www.stlouisfed.org/publications/central-banker/winter-2010/reaching-the-unbanked-and-underbanked

Hahn, R. A., Barnett W. S., Knopf J. A., Truman B. I., Johnson R. L., Fielding J. E., et al. (2016). Early childhood education to promote health equity: A community guide systematic review. Journal of Public Health Management Practice, 22(5), E1–8. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/26672406

McKernan, S.-M., Ratcliffe, C., & Shanks, T. W. (2011). Is poverty incompatible with asset accumulation? Urban Institute. Retrieved from https://www.urban.org/research/publication/poverty-incompatible-asset-accumulation

84 Kahneman, D., & Deaton, A. (2010, September 21). High income improves evaluation of life but not emotional well-being. Proceedings of the National Academy of Sciences of America, 107(38), 16489–16493. Retrieved from https://doi.org/10.1073/pnas.1011492107

Jebb, A. T., Tay, L., Diener, E., & Shigehiro, O. (2018). Happiness, income satiation and turning points around the world. Nature Human Behavior, 2, 33–38. Retrieved from https://www.nature.com/articles/s41562-017-0277-0

American Psychological Association. (2017). Stress and health disparities: Contexts, mechanisms, and interventions among racial/ethnic minority and low-socioeconomic status populations. APA Working Group on Stress and Health Disparities. Retrieved from https://www.apa.org/pi/health-disparities/resources/stress-report.pdf

Amadeo, K. (2019, July). Consumer spending and its impact on the economy. The Balance. Retrieved from https://www.thebalance.com/consumer-spending-definition-and-determinants-3305917

Office of Policy Development and Research. (2016, Summer). Neighborhoods and violent crime. Evidence matters: Transforming knowledge into housing and community development policy. U.S. Department of Housing and Urban Development. Retrieved from https://www.huduser.gov/portal/periodicals/em/summer16/highlight2.html

McKenzie, T. L., Moody, J. S., Carlson, J. A., Lopez, N. V., & Elder, J. P. (2014). Neighborhood income matters: Disparities in community recreation facilities, amenities, and programs. Journal of Park and Recreation Administration, 31(4), 12–22. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4082954/

FIGURE 8: SOURCES

HOUSEHOLDS BELOW THE ALICE THRESHOLD

American Community Survey. (2018). 1- and 5-year estimates. U.S. Census Bureau. Retrieved from https://data.census.gov/cedsci/

Blank, R. M., & Barr, M. S. (Eds.). (2009). Insufficient funds: Savings, assets, credit, and banking among low-income households. New York: Russell Sage Foundation.

Goldren, L. (2016, December 5). Still falling short on hours and pay. Economic Policy Institute. Retrieved from https://www.epi.org/publication/still-falling-short-on-hours-and-pay-part-time-work-becoming-new-normal/

Gould, E. (2020, February 20). State of Working America Wages 2019. Economic Policy Institute. Retrieved from https://www.epi.org/publication/swa-wages-2019/

Robert Wood Johnson Foundation. (2011, December 1). Health care's blind side: The overlooked connection between social needs and good health: Summary of findings from a survey of America's physicians. Retrieved from http://www.rwjf.org/files/research/RWJFPhysiciansSurveyExecutiveSummary.pdf

United For ALICE. (2020). The ALICE Threshold: 2018. Retrieved from www.UnitedForALICE.org

FACTORS THAT CLOSE THE GAP

Alliance for Excellent Education. (2019). The graduation effect. Retrieved from http://impact.all4ed.org/

American Psychological Association. (2019). Education and socioeconomic status. Retrieved from https://www.apa.org/pi/ses/resources/publications/education

Auguste, B.G., Hancock, B., & Laboissiere, M. (2009). The economic cost of the U.S. education gap. McKinsey & Company. Retrieved from https://www.mckinsey.com/industries/social-sector/our-insights/the-economic-cost-of-the-us-education-gap

Beard, M. P. (2010). In-depth: Reaching the unbanked and underbanked. Federal Reserve Bank of St. Louis. Retrieved from https://www.stlouisfed.org/publications/central-banker/winter-2010/reaching-the-unbanked-and-underbanked

Beiler, M. O., & Mohammed, M. (2016). Exploring transportation equity: Development and application of a transportation justice framework. Transportation research part D: transport and environment, 47, 285–298. Retrieved from https://doi.org/10.1016/j.trd.2016.06.007

Cunningham, M. K. (2016, June 26). Reduce poverty by improving housing stability. Urban Institute. Retrieved from https://www.urban.org/urban-wire/reduce-poverty-improving-housing-stability

Feeding America & Oxfam America. (2014). From paycheck to pantry: Hunger in working America. Retrieved from https://www.feedingamerica.org/sites/default/files/research/hunger-in-working-america/from-paycheck-to-pantry.pdf

Gould, E. (2020, February 20). State of Working America Wages 2019. Economic Policy Institute. Retrieved from https://www.epi.org/publication/swa-wages-2019/

Office of Development and Research. (2014). How housing mobility affects education outcomes for low-income children. Evidence Matters. U.S. Department of Housing and Urban Development. Retrieved from https://www.huduser.gov/portal/periodicals/em/fall14/highlight2.html

Wright, B., Li, G., Weller, M., & Vartanian, K. (2016, February). Housing and health: Exploring the intersection between housing and health care. Enterprise Community Partners and Center for Outcomes Research and Education. Retrieved from https://www.enterprisecommunity.org/download?fid=5703&nid=4247

FACTORS THAT WIDEN THE GAP

Acs, G., Pendall, R., Treskon, M., Khare, A. (2017, March). The cost of segregation. Urban Institute. Retrieved from https://www.urban.org/sites/default/files/publication/89201/the_cost_of_segregation_final.pdf

Beard, M. P. (2010). In-depth: Reaching the unbanked and underbanked. Federal Reserve Bank of St. Louis. Retrieved from https://www.stlouisfed.org/publications/central-banker/winter-2010/reaching-the-unbanked-and-underbanked

Blank, R. M., & Barr, M. S. (Eds.). (2009). Insufficient funds: Savings, assets, credit, and banking among low-income households. New York: Russell Sage Foundation. Dickman, S. L., Himmelstein, D. U., & Woolhandler, S. (2017). Inequality and the health-care system in the USA. The Lancet, 389(10077), 1431–1441.
Dobridge, C. L. (2016). For better and for worse? Effects of access to high-cost consumer credit. Federal Reserve Board, Divisions of Research & Statistics and Monetary Affairs. Retrieved from https://www.federalreserve.gov/econresdata/feds/2016/files/2016056pap.pdf

Eisenberg, R. (2019, February 18). How well is the gig economy working for gig workers? Forbes. Retrieved from https://www.forbes.com/sites/nextavenue/2019/02/18/how-well-is-the-gig-economy-working-for-gig-workers/#4255bb9b3f0a

Garcia, E. & Weiss, E. (2017, September 27). Education inequalities at the school starting gate. Economic Policy Institute. Retrieved from https://www.epi.org/publication/education-inequalities-at-the-school-starting-gate/

Goldren, L. (2016, December 5). Still falling short on hours and pay. Economic Policy Institute. Retrieved from https://www.epi.org/publication/still-falling-short-on-hours-and-pay-part-time-work-becoming-new-normal/

Institute on Taxation and Economic Policy. (2018, October). Who pays? A distributional analysis of the tax system in all 50 states. Retrieved from https://itep.org/wp-content/uploads/whopays-ITEP-2018.pdf

Institute for Transportation and Development Policy. (2019, May 23). The high cost of transportation in the United States. Transportation Matters. Retrieved from https://www.itdp.org/2019/05/23/high-cost-transportation-united-states/

Kossek, E. E. & Lautsch, B. A. (2018, May 7). Hourly workers need flexibility the most, but are often the least likely to get it. Harvard Business Review. Retrieved from https://hbr.org/2018/05/hourly-workers-need-flexibility-the-most-but-are-often-the-least-likely-to-get-it

Manyika, J., Lund, S., Bughin, J., Robinson, K., Mischke, J., & Mahajan, D. (2016, October 10). Independent work: Choice, necessity, and the gig economy. McKinsey Global Institute. Retrieved from http://www.mckinsey.com/global-themes/employment-and-growth/independent-work-choice-necessity-and-the-gig-economy

McArdle, N., & Acevedo-Garcia, D. (2017). Consequences of segregation for children's opportunity and wellbeing. Retrieved from https://www.jchs.harvard.edu/sites/default/files/a_shared_future_consequences_of_segregation_for_children.pdf

Soloman, D., Maxwell, C., & Castro, A. (2019, August 7). Systemic inequality: Displacement, exclusion, and segregation. Center for American Progress. Retrieved from https://www.americanprogress.org/issues/race/reports/2019/08/07/472617/systemic-inequality-displacement-exclusion-segregation/

Summer & Student Debt Crisis. (2018, November 1). Buried in debt: A national survey report on the state of student loan borrowers in 2018. Retrieved from https://www.meetsummer.org/share/Summer-Student-Debt-Crisis-Buried-in-Debt-Report-Nov-2018.pdf?_t=1541171524

Williams, D. R., Lawrence, J. A., & Davis, B. A. (2019, April). Racism and health: Evidence and needed research. Annual Review of Public Health, 40, 105-125. Retrieved from https://www.annualreviews.org/doi/full/10.1146/annurev-publhealth-040218-043750

FINANCIALLY STABLE HOUSEHOLDS

Chetty, R., Hendren, N., & Katz, L. F. (2016, April). The effects of exposure to better neighborhoods on children: New evidence from the Moving to Opportunity Experiment.
American Economic Review, 106(4), 855–902. Retrieved from https://www.aeaweb.org/articles?id=10.1257/aer.20150572

McKernan, S.-M., Ratcliffe, C., & Shanks, T. W. (2011). Is poverty incompatible with asset accumulation? Urban Institute. Retrieved from https://www.urban.org/research/publication/poverty-incompatible-asset-accumulation

Office of Development and Research. (2014). How housing mobility affects education outcomes for low-income children. Evidence Matters. U.S. Department of Housing and Urban Development. Retrieved from https://www.huduser.gov/portal/periodicals/em/fall14/highlight2.html

Powell, A. (2016, February 22). The costs of inequality: Money = quality healthcare = longer life. Harvard Gazette. Retrieved from https://news.harvard.edu/gazette/story/2016/02/money-quality-health-care-longer-life/

The Economist. (2018, June 7). The stark relationship between income inequality and crime. Retrieved from https://www.economist.com/graphic-detail/2018/06/07/the-stark-relationship-between-income-inequality-and-crime

Woolf, S.H., Aron, L., Dubay, L., Simon, S.M., Zimmerman, E., & Luk. K.X. (2015, April). How are income and wealth linked to health and longevity? Urban Institute. Retrieved from https://www.urban.org/sites/default/files/publication/49116/2000178-How-are-Income-and-Wealth-Linked-to-Health-and-Longevity.pdf

FIGURE 9: SOURCES

HOUSING

Chetty, R., Hendren, N., & Katz, L. F. (2016, April). The effects of exposure to better neighborhoods on children: New evidence from the Moving to Opportunity Experiment.
American Economic Review, 106(4), 855–902. Retrieved from https://www.aeaweb.org/articles?id=10.1257/aer.20150572

Cunningham, M. K. (2016, June 26). Reduce poverty by improving housing stability. Urban Institute. Retrieved from https://www.urban.org/urban-wire/reduce-poverty-improving-housing-stability

Enterprise Community Partners, Inc. (2014). Impact of affordable housing on families and communities: A review of the evidence base. Retrieved from https://homeforallsmc.org/wp-content/uploads/2017/05/Impact-of-Affordable-Housing-on-Families-and-Communities.pdf

Goodman, L. (2018, February 21). Homeownership is still financially better than renting. Urban Institute. Retrieved from https://www.urban.org/urban-wire/homeownership-still-financially-better-renting

Joint Center for Housing Studies. (2020). The state of the nation's housing 2019. Harvard University. Retrieved from https://www.jchs.harvard.edu/sites/default/files/Harvard_JCHS_State_of_the_Nations_Housing_2019.pdf

Litman, T. (2015, March). Analysis of public policies that unintentionally encourage and subsidize sprawl. The New Climate Economy and the Victoria Transport Policy Institute. Retrieved from https://newclimateeconomy.report/workingpapers/wp-content/uploads/sites/5/2016/04/public-policies-encourage-sprawl-nce-report.pdf

Maqbool, N., Viveiros, J., & Ault, M. (2015, April). The impacts of affordable housing on health: A research summary. Center for Housing Policy. Retrieved from https://www.rupco.org/wp-content/uploads/pdfs/The-Impacts-of-Affordable-Housing-on-Health-CenterforHousingPolicy-Maqbool.etal.pdf

National Alliance to End Homelessness. (2015, June 30). Permanent supportive housing cost study map. Retrieved from https://endhomelessness.org/resource/permanent-supportive-housing-cost-study-map/

Office of Development and Research. (2014). How housing mobility affects education outcomes for low-income children. Evidence Matters. U.S. Department of Housing and Urban Development. Retrieved from https://www.huduser.gov/portal/periodicals/em/fall14/highlight2.html

Rohe, W. M., & Lindblad, M. (2013, August). Reexamining the social benefits of homeownership after the housing crisis. Joint Center for Housing Studies, Harvard University. Retrieved from https://www.jchs.harvard.edu/sites/default/files/hbtl-04.pdf

Sullivan, J. (2015, April 21). How commute issues can dramatically impact employee retention. TLNT. Retrieved from https://www.tlnt.com/how-commute-issues-can-dramatically-impact-employee-retention/

Taylor, L. (2018, June 7). Housing and health: An overview of the literature. Health Affairs Health Policy Brief. Retrieved from https://www.healthaffairs.org/do/10.1377/hpb20180313.396577/full/

The Economist. (2018, June 7). The stark relationship between income inequality and crime. Retrieved from https://www.economist.com/graphic-detail/2018/06/07/the-stark-relationship-between-income-inequality-and-crime

Wright, B., Li, G., Weller, M., & Vartanian, K. (2016, February). Housing and health: Exploring the intersection between housing and health care. Enterprise Community Partners and Center for Outcomes Research and Education. Retrieved from https://www.enterprisecommunity.org/download?fid=5703&nid=4247

United States Interagency Council on Homelessness. (2017). Ending chronic homelessness in 2017. Retrieved from https://www.usich.gov/resources/uploads/asset_library/Ending_Chronic_Homelessness_in_2017.pdf

CHILD CARE

Alliance for Excellent Education. (2019). The graduation effect. Retrieved from http://impact.all4ed.org/

American Psychological Association. (2019). Education and socioeconomic status. Retrieved from https://www.apa.org/pi/ses/resources/publications/education

Auguste, B.G., Hancock, B., & Laboissiere, M. (2009). The economic cost of the U.S. education gap. McKinsey & Company. Retrieved from https://www.mckinsey.com/industries/social-sector/our-insights/the-economic-cost-of-the-us-education-gap

Child Care Aware of America. (2019). The U.S. and the high cost of child care: An examination of a broken system. Retrieved from https://usa.childcareaware.org/advocacy-public-policy/resources/research/costofcare/

Garcia, E. & Weiss, E. (2017, September 27). Education inequalities at the school starting gate. Economic Policy Institute. Retrieved from https://www.epi.org/publication/education-inequalities-at-the-school-starting-gate/

Garcia, J. L., Heckman, J. J., Leaf, D. E., & Prados, M. J. (2016, December). The life-cycle benefits of an influential early childhood program. National Bureau of Economic Research. Retrieved from https://www.nber.org/papers/w22993

Virginia Commonwealth University, Center on Society and Health. (2015, February 13). Why education matters to health: Exploring the causes. Retrieved from https://www.aecf.org/resources/overstressed-kids/

FOOD

Berkowitz, S. A., Basu, S., Meigs, J. B., & Selgman, H. K. (2018). Food insecurity and health care expenditures in the United States, 2011–2013. Health Services Research, 53(3), 1600–1602. Retrieved from https://onlinelibrary.wiley.com/doi/full/10.1111/1475-6773.12730

Bhargava, V., & Lee, J. S. (2016). Food insecurity and health care utilization among older adults in the United States. Journal of Nutrition in Gerontology and Geriatrics, 35(3), 177–192. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/27559853

Feeding America & Oxfam America. (2014). From paycheck to pantry: Hunger in working America. Retrieved from https://www.feedingamerica.org/sites/default/files/research/hunger-in-working-america/from-paycheck-to-pantry.pdf

Food Research and Action Center. (2017). The impact of poverty, food insecurity, and poor nutrition on health and well-being. Retrieved from http://frac.org/wp-content/uploads/hunger-health-impact-poverty-food-insecurity-health-well-being.pdf

French, S.A., Tangney, C.C., Crane, M.M. et al. (2019). Nutrition quality of food purchases varies by household income: the SHoPPER study. BMC Public Health, 19(231). https://doi.org/10.1186/s12889-019-6546-2

Johnson, A. D., & Markowitz, A. J. (2017, March 21). Association between household food insecurity in early childhood and children's kindergarten skills. Child Development, 89(2). Retrieved from https://doi.org/10.1111/cdev.12764

Loopstra, R., & Lalor, D. (2017). Financial insecurity, food insecurity, and disability: The profile of people receiving emergency food assistance from The Trussell Trust Foodbank Network in Britain. The Trussell Trust. Retrieved from https://www.trusselltrust.org/wp-content/uploads/sites/2/2017/06/UO_exec_summary_final_02_04_online.pdf

McLaughlin, K. A. Green, J. G, Alegria, M., & Costello, E. J. (2012, December). Food insecurity and mental disorders in a national sample of U.S. adolescents. Journal of the American Academy of Child and Adolescent Psychiatry, 51(12), 1293–1303. Retrieved from https://www.sciencedirect.com/science/article/abs/pii/S0890856712007265

RTI International. (2014). Current and prospective scope of hunger and food security in America. Retrieved from http://www.rti.org/sites/default/files/resources/full_hunger_report_final_07-24-14.pdf

TRANSPORTATION

Beiler, M. O., & Mohammed, M. (2016). Exploring transportation equity: Development and application of a transportation justice framework. Transportation research part D: transport and environment, 47, 285–298. Retrieved from https://doi.org/10.1016/j.trd.2016.06.007

Dawkins, C., Jeon, J. S., & Pendall, R. (2015). Transportation access, rental vouchers, and neighborhood satisfaction: Evidence from the moving to opportunity experiment.
Housing Policy Debate, 25(3), 497–530. Retrieved from https://doi.org/10.1080/10511482.2014.986662

Institute for Transportation and Development Policy. (2019, May 23). The high cost of transportation in the United States. Transportation Matters. Retrieved from https://www.itdp.org/2019/05/23/high-cost-transportation-united-states/

Martens, K. (2016). Transport justice: Designing fair transportation systems. New York: Routledge.

Robert Wood Johnson Foundation. (2012, October 25). How does transportation impact health? Retrieved from https://www.rwjf.org/en/library/research/2012/10/how-does-transportation-impact-health-.html

Sullivan, J. (2015, April 21). How commute issues can dramatically impact employee retention. TLNT. Retrieved from: https://www.tlnt.com/how-commute-issues-can-dramatically-impact-employee-retention/

Young, L., Irvin, E., & Shankar, P. (2019, September). Equity and smart mobility. Institute for Sustainable Communities and the Center for Neighborhood Technology. Retrieved from https://www.cnt.org/sites/default/files/publications/Equity-and-Smart-Mobility-Report.pdf

Zhao, F., & Gustafson, T. (2013, February). Transportation needs of disadvantaged populations: Where, when, and how? FTA Report No. 0030. Federal Transit Administration. Retrieved from https://www.transit.dot.gov/sites/fta.dot.gov/files/FTA_Report_No._0030.pdf

HEALTH CARE

Centers for Disease Control and Prevention. (2016). Emergency department visits. Retrieved from https://www.cdc.gov/nchs/fastats/emergency-department.htm Claxton, G., Sawyer, B., & Cox, C. (2019, April 14). How affordability of health care varies by income among people with employer coverage.
Access & Affordability, Peterson-KFF Health System Tracker. Retrieved from https://www.healthsystemtracker.org/brief/how-affordability-of-health-care-varies-by-income-among-people-with-employer-coverage/

DeLia, D., & Lloyd, K. (2014, July). Sources of variation in avoidable hospital use and cost across low-income communities in New Jersey. Rutgers Center for State Health Policy. Retrieved from http://www.cshp.rutgers.edu/downloads/10470.pdf

Dickman, S. L., Himmelstein, D. U., & Woolhandler, S. (2017). Inequality and the health-care system in the U.S.A. The Lancet, 389(10077), 1431–1441.

Golberstein E. (2015). The effects of income on mental health: evidence from the social security notch. The Journal of Mental Health Policy and Economics, 18(1), 27–37. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4494112/

McMorrow, S., Kenney, G. M., & Goin, D. (2014). Determinants of receipt of recommended preventive services: implications for the Affordable Care Act. American Journal of Public Health, 104(12), 2392–2399. https://doi.org/10.2105/AJPH.2013.301569

Powell, A. (2016, February 22). The costs of inequality: Money = quality healthcare = longer life. Harvard Gazette. Retrieved from https://news.harvard.edu/gazette/story/2016/02/money-quality-health-care-longer-life/

Robert Wood Johnson Foundation. (2011, December 1). Health care’s blind side: The overlooked connection between social needs and good health: Summary of findings from a survey of America’s physicians. Retrieved from http://www.rwjf.org/files/research/RWJFPhysiciansSurveyExecutiveSummary.pdf

Witters, D., & Liu, D. (2013, May 7). In U.S., poor health tied to big losses for all job types. Gallup. Retrieved from http://www.gallup.com/poll/162344/poor-health-tied-big-losses-jobtypes.aspx

Woolf, S.H., Aron, L., Dubay, L., Simon, S.M., Zimmerman, E., & Luk. K.X. (2015, April). How are income and wealth linked to health and longevity? Urban Institute. Retrieved from https://www.urban.org/sites/default/files/publication/49116/2000178-How-are-Income-and-Wealth-Linked-to-Health-and-Longevity.pdf

TECHNOLOGY

Anderson, M., & Perrin, A. (2018, October 26). Nearly one-in-five teens can't always finish their homework because of the digital divide. Pew Research Center. Retrieved from https://www.pewresearch.org/fact-tank/2018/10/26/nearly-one-in-five-teens-cant-always-finish-their-homework-because-of-the-digital-divide/

Anderson, M. (2019, May 7). Digital divide persists even as lower-income Americans make gains in tech adoption. Pew Research Center. Retrieved from https://www.pewresearch.org/fact-tank/2017/03/22/digital-divide-persists-even-as-lower-income-americans-make-gains-in-tech-adoption/

Children's Hospital of Los Angeles. (2019). mHealth. Retrieved from https://www.himss.org/library/mhealth

Office of Policy Development and Research. (2016). Community development and the digital divide. U.S. Department of Housing and Urban Development. Retrieved from https://www.huduser.gov/portal/periodicals/em/fall16/highlight1.html

Pew Research Center. (2019, June 12). Mobile fact sheet. Retrieved from https://www.pewinternet.org/fact-sheet/mobile/

Rideout, V., & Katz, V. (2016, Winter). Opportunity for all? Technology and learning in lower-income families. A report of the families and media project. The Joan Ganz Cooney Center at Sesame Workshop. Retrieved from http://joanganzcooneycenter.org/wp-content/uploads/2016/01/jgcc_opportunityforall.pdf

Smith, A. (2013, April 25). Civic engagement in the digital age. Pew Research Center. Retrieved from https://www.pewinternet.org/2013/04/25/civic-engagement-in-the-digital-age/

Smith, A. (2015, April 1). Usage and attitudes toward smartphones. In U.S. smartphone use in 2015. Pew Research Center. Retrieved from https://www.pewinternet.org/2015/04/01/chapter-two-usage-and-attitudes-toward-smartphones/#job%20seeking

SAVINGS

Blank, R. M., & Barr, M. S. (Eds.). (2009). Insufficient funds: Savings, assets, credit, and banking among low-income households. New York: Russell Sage Foundation.

Collins, J. M., & Gjertson, L. (2013). Emergency savings for low-income consumers. Focus, 30(1), 12–17. Retrieved from https://www.irp.wisc.edu/publications/focus/pdfs/foc301c.pdf

Econsult Solutions, Inc. (ESI). (2018, January 18). ESI examines the impact of insufficient retirement savings on Pennsylvania. Pennsylvania Treasury. Retrieved from https://patreasury.gov/pdf/Impact-Insufficient-Retirement-Savings.pdf

Helm, S., Serido, J., Ahn, S.Y., Ligon, V., & Shim, S. (2019, November). Materialist values, financial and pro-environmental behaviors, and well-being. Emerald Insight. Retrieved from https://www.emerald.com/insight/content/doi/10.1108/YC-10-2018-0867/full/html

Krieger, J, Carter, G., Burr, M., & Collins, J.M. (2017, January). The case for reducing poverty among seniors: Encouraging savings for retirement by people in Wisconsin: Projected reductions in Wisconsin state expenditures. La Follette School of Public Affairs, the University of Wisconsin–Madison, and AARP. Retrieved from https://lafollette.wisc.edu/images/publications/otherpublications/AARP-The-Case-for-Reducing-Poverty-Among-Seniors.pdf

Levins, N. (2016, April). Why cities should care about family financial security. Urban Institute. Retrieved from https://www.urban.org/features/why-cities-should-care-about-family-financial-security

Mutchler, J., Li, Y., & Roldán, N.V. (2019). Living below the line: Economic insecurity and older Americans, insecurity in the states 2019. Center for Social and Demographic Research on Aging at the University of Massachusetts Boston. Retrieved from https://scholarworks.umb.edu/demographyofaging/40/

Poterba, J. M., & Venti, S. F. (2001). Preretirement cashouts and foregone retirement saving: Implications for 401(k) asset accumulation. In D. A. Wise (Ed.), Themes in the Economics of Aging (pp. 23-58). Chicago: University of Chicago Press. Retrieved from https://www.nber.org/chapters/c10320

Rhee, N. & Boivie, I. (2015, March). The continuing retirement savings crisis. National Institute on Retirement Savings. Retrieved from https://www.nirsonline.org/wp-content/uploads/2017/07/final_rsc_2015.pdf

Wang, L., & Graddy, E. (2008). Social capital, volunteering, and charitable giving. Voluntas: International Journal of Voluntary and Nonprofit Organizations, 19(1), 23. Retrieved from https://www.researchgate.net/publication/226255124_Social_Capital_Volunteering_and_Charitable_Giving

ALICE is a registered trademark of the United Way of Northern New Jersey.

© Copyright 2009-2020 United Way of Northern New Jersey. All rights reserved.
No further use, copying, dissemination, distribution, or publication is permitted without the express written permission of United Way of Northern New Jersey.

Appendix III:

Community Health Needs Survey

Appendix III: Community Health Needs Survey

The survey instrument was created for the 2021 Goshen Health community health needs assessment was built off the previous 2018 survey instrument. It included the following 18 questions in both English and Spanish:

1. How healthy do you think your community is overall?
    - Very healthy
    - Somewhat healthy
    - Somewhat unhealthy
    - Very unhealthy
2. COVID-19 has negatively impacted community health.
    - Strongly agree
    - Agree
    - Neutral
    - Disagree
    - Strongly disagree
3. Following our community's experience with COVID-19, I am more committed to maintain my health and the health of my family.
    - Strongly agree
    - Agree
    - Neutral
    - Disagree
    - Strongly disagree
4. What are the top three health issues that are a significant need/problem in your community?
    - Availability to health services
    - Treatment of chronic diseases
    - Health education
    - Prevention of injuries/Safety
    - Substance abuse/Addictions
    - Mental health/Depression
    - Obesity/Weight management
    - Diet and healthy eating
    - Diabetes treatment and prevention
    - Physical fitness/Exercise
    - Poverty
    - Tobacco use/Smoking
    - Violence
    - Abuse
    - Unsafe sex
    - Cardiovascular health
    - Cancer
    - Prenatal/Early childhood health
    - Insurance coverage
    - Family and social support
    - Air quality
    - Water quality
    - Safe housing
    - Other (please specify)
5. What are the top three barriers to addressing these significant needs/problems?
    - Lack of initiative
    - Nutritional habits
    - Lack of insurance
    - Lack of transportation
    - Lack of mental health providers
    - Distance for medical care
    - Ability to navigate the health system
    - Lack of healthcare providers
    - Lack of health education
    - Lack of housing
    - Income inequality

- Work environment
- Language and culture differences
- Lack of family and social support
- Stigma associated with the health issue
- Cultural health attitudes
- Lack of governmental or community health programs
- Other (please specify)

6. What are the top three resources that could be provided to overcome these barriers?
    - Locally grown foods
    - Area medical providers
    - Home remedies
    - Natural product stores
    - Church/Community crisis support
    - Mental health providers
    - Goshen Health services
    - Bike paths and walking trails
    - Non-profit organizational services
    - Government programs
    - Health information provided in schools
    - Employer benefits
    - Other (please specify)
7. Identify the top three resources that members of the community most often utilized during COVID-19.
    - Locally grown foods
    - Area medical providers
    - Home remedies
    - Natural product stores
    - Church/Community crisis support
    - Mental health providers
    - Goshen Health services
    - Bike paths and walking trails
    - Non-profit organizational services
    - Government programs
    - Health information provided in schools
    - Employer benefits
    - Other (please specify)
8. What are the top three areas of health education needed in the community?
    - Nutrition/Healthy eating
    - Importance of regular exercise/Physical fitness
    - Weight management/Obesity
    - Regular dental checkups
    - Yearly medical checkups
    - Prenatal care during pregnancy
    - Getting vaccinations
    - Tobacco use prevention
    - Parenting education
    - Elder care education
    - Caring for family members with special needs or disabilities
    - Sexually transmitted disease
    - Drug and alcohol abuse prevention
    - Mental health/Depression
    - Stress management
    - Sexual abuse

- Air quality
- Water quality
- Safe housing
- Diabetes treatment and prevention
- Other (please specify)

9. Please respond to the following statements with a score from 1 to 5, where 1 means strongly disagree and 5 means strongly agree.
    - People in my community feel a sense of strong social connection to one another.
    - I frequently socialize with my neighbors and take part in community activities.
    - I feel safe in my community.
    - Public spaces in my community are clean and welcoming.
10. Are there enough services, resources and support available in the community for the following groups? Please rate from 1 to 5, where 1 means strongly disagree and 5 means strongly agree.
    - Aging adults
    - Children with special needs
    - Children during non-school hours
    - Low-income individuals/families
    - People experiencing homelessness
    - Pregnant women
    - Women/Mothers
    - Men/Fathers
    - Refugees
    - Immigrants
    - Non-English speakers
    - People with physical disabilities
    - People with other disabilities (learning, psychological or medical)
    - People that identify with LGBTQIA+
    - People that identify as transgender, nonbinary/outside the binary of male/female
    - Veterans
11. Are there any other groups in the community who are not adequately served or supported?
    - Yes
    - No
12. If you answered yes, please list the groups in the community who are not adequately served or supported.
13. What is your current age?
    - 18 to 29 years old
    - 30 to 39 years old
    - 40 to 49 years old
    - 50 to 59 years old
    - 60 to 69 years old
    - 70+ years old
14. What is your race/ethnicity?
    - Black or African American
    - American Indian or Alaskan Native
    - Asian or Pacific Islander
    - Hispanic/Latino
    - White
    - Other (please specify)
15. What gender do you identify with?
    - Male
    - Female

- Transgender or Nonbinary
- Prefer not to say
- Other (please specify)

16. What is the highest level of school you have completed or the highest degree you have received?
    - Less than high school
    - High school
    - Some college
    - Associate degree
    - Bachelor's degree
    - Master's degree
    - More than a master's degree
17. What is your current employment status?
    - Employed full-time
    - Employed part-time
    - Unemployed, seeking employment
    - Unemployed, not seeking employment
    - Unable to work
    - Retired
    - Student
    - Homemaker/primary caregiver/stay-at-home parent
    - Other (please specify)

18. In which county do you reside?
    - Elkhart, Indiana
    - LaGrange, Indiana
    - St. Joseph, Indiana
    - Marshall, Indiana
    - Kosciusko, Indiana
    - Noble, Indiana
    - Other (please specify)

The survey was provided to four populations, described in the following table.

	General Community**	GCS Parents and Guardians	Focus Group and Interview Participants	Amish Community Leaders
Dates Open	April 26–May 26	April 19–May 26	May 10–June 7	May 14–May 28
TOTAL RESPONSES	**1293**	**696**	**24**	**5**
Completed Responses*	**792**	**395**	**21**	**4**
Latino	*36*	*95*	*1*	*0*
Non-Latino	*756*	*300*	*20*	*4*

**Reponses which included answers to at least eight questions were considered complete; most incomplete responses included only one answer.*
***This population was made up of community members who had previously been recipients of Goshen Health services.*

Appendix IV:

Community Health Needs Survey Findings

Latino Respondents

What are the top three health issues that are a significant need/problem in your community?	#	%
Mental health/Depression	14	39
Obesity/Weight management	14	39
Substance abuse/Addictions	10	28
Poverty	10	28
Diet and healthy eating	8	22
Health education	7	19
Insurance coverage	7	19
Diabetes treatment and prevention	6	17
Availability to health services	5	14
Treatment of chronic diseases	5	14
Cancer	4	11
Physical fitness/Exercise	3	8
Abuse	3	8
Prenatal/Early childhood health	3	8
Tobacco use/Smoking	2	6
Other (please specify)	2	6
Violence	1	3
Cardiovascular health	1	3
Family and social support	1	3
Water quality	1	3
Prevention of injuries/Safety	0	0
Unsafe sex	0	0
Air quality	0	0
Safe housing	0	0

Non-Latino Respondents

What are the top three health issues that are a significant need/problem in your community?	#	%
Mental health/Depression	333	44
Obesity/Weight management	316	42
Substance abuse/Addictions	203	27
Diet and healthy eating	175	23
Availability to health services	131	17
Physical fitness/Exercise	129	17
Insurance coverage	129	17
Health education	121	16
Cancer	101	13
Treatment of chronic diseases	89	12
Poverty	84	11
Cardiovascular health	65	9
Tobacco use/Smoking	63	8
Family and social support	58	8
Other (please specify)	57	8
Diabetes treatment and prevention	55	7
Violence	27	4
Safe housing	25	3
Abuse	20	3
Prenatal/Early childhood health	17	2
Air quality	14	2
Water quality	11	1
Prevention of injuries/Safety	10	1
Unsafe sex	7	1

* *The top third of health issues by percentage for each survey respondent group is highlighted red.*

Goshen Community Schools

Latino Parents/Guardians

What are the top three health issues that are a significant need/problem in your community?	#	%
Mental health/Depression	38	40
Obesity/Weight management	35	37
Health education	26	27
Availability to health services	23	24
Insurance coverage	23	24
Substance abuse/Addictions	18	19
Physical fitness/Exercise	18	19
Diet and healthy eating	17	18
Diabetes treatment and prevention	16	17
Tobacco use/Smoking	13	14
Poverty	7	7
Violence	7	7
Treatment of chronic diseases	5	5
Cancer	5	5
Family and social support	5	5
Safe housing	5	5
Water quality	4	4
Other (please specify)	2	2
Abuse	1	1
Unsafe sex	1	1
Prenatal/Early childhood health	1	1
Air quality	1	1
Prevention of injuries/Safety	0	0
Cardiovascular health	0	0

Non-Latino Parents/Guardians

What are the top three health issues that are a significant need/problem in your community?	#	%
Mental health/Depression	177	59
Obesity/Weight management	90	30
Poverty	90	30
Substance abuse/Addictions	83	28
Insurance coverage	66	22
Diet and healthy eating	60	20
Availability to health services	57	19
Family and social support	49	16
Physical fitness/Exercise	40	13
Health education	35	12
Treatment of chronic diseases	24	8
Tobacco use/Smoking	16	5
Cancer	14	5
Other (please specify)	14	5
Safe housing	13	4
Diabetes treatment and prevention	12	4
Air quality	11	4
Cardiovascular health	7	2
Prevention of injuries/Safety	5	2
Violence	5	2
Abuse	5	2
Unsafe sex	5	2
Prenatal/Early childhood health	5	2
Water quality	4	1

Focus Group and Interview Participants

What are the top three health issues that are a significant need/problem in your community?	#	%
Mental health/Depression	12	57
Obesity/Weight management	9	43
Substance abuse/Addictions	5	24
Availability to health services	4	19
Health education	4	19
Family and social support	4	19
Treatment of chronic diseases	3	14
Diet and healthy eating	3	14
Diabetes treatment and prevention	3	14
Poverty	3	14
Cardiovascular health	3	14
Physical fitness/Exercise	2	10
Tobacco use/Smoking	2	10
Cancer	2	10
Other (please specify)	2	10
Insurance coverage	1	5
Safe housing	1	5
Prevention of injuries/Safety	0	0
Violence	0	0
Abuse	0	0
Unsafe sex	0	0
Prenatal/Early childhood health	0	0
Air quality	0	0
Water quality	0	0

Amish Community Leaders

What are the top three health issues that are a significant need/problem in your community?	#	%
Diet and healthy eating	3	75
Substance abuse/Addictions	2	50
Tobacco use/Smoking	2	50
Cancer	2	50
Obesity/Weight management	1	25
Violence	1	25
Cardiovascular health	1	25
Availability to health services	0	0
Treatment of chronic diseases	0	0
Health education	0	0
Prevention of injuries/Safety	0	0
Mental health/Depression	0	0
Diabetes treatment and prevention	0	0
Physical fitness/Exercise	0	0
Poverty	0	0
Abuse	0	0
Unsafe sex	0	0
Prenatal/Early childhood health	0	0
Insurance coverage	0	0
Family and social support	0	0
Air quality	0	0
Water quality	0	0
Safe housing	0	0
Other (please specify)	0	0

Appendix V:

Community Resources

Appendix V: Community Resources

Resources Needed: Focus Group and Key Informants

Resources to address the community's health needs were identified by each primary data group. Each survey respondent group's responses were coded and correlated with the critical health factors using the Community Health Rankings Model and summarized in the table below:

Resources identified by Survey Respondent Groups

Resources to Address Significant Health Needs							
Data Set		Community Survey: Latino Respondents	Community Survey: Non-Latino Respondents	GCS Survey: Latino Parents/ Guardians	GCS Survey: Non-Latino Parents/ Guardians	Focus Group & Key Informant Survey	Amish Community Leader Survey
Health Factors	Healthy Behaviors			Locally grown foods			Locally grown foods
	Clinical Care	Mental health providers	Mental health providers	Mental health providers	Mental health providers	Mental health providers	Home remedies
		Goshen Health services	Goshen Health services	Goshen Health services		Area medical providers	Natural product stores
		Area medical providers				Goshen Health services	
	Social & economic		Employer benefits	Church/Community crisis support	Employer benefits		Church/Community crisis support
			Health information provided in schools	Health information provided in schools	Health information provided in schools	Health information provided in schools	
			Church/Community crisis support				
	Physical Environment						
Policies & programs		Non-profit organizational services	Non-profit organizational services	Non-profit organizational services	Non-profit organizational services	Non-profit organizational services	

As the focus groups and key informants identified resources for specific health needs, the resources they identified are displayed separately in the following two tables:

Resources Identified by Focus Groups

Focus Groups — Resources to Address Significant Health Needs

Mental health
- Better and earlier mental health education
- Better resources for accessing services and treatment
- Interpersonal assistance and accountability

Obesity
- Interpersonal assistance and accountability
- Employer incentives for healthy living
- Dietary programs for distinct cultures

Substance abuse: addictions, alcohol, drugs
- Better resources for accessing services and treatment
- Better and earlier substance abuse education
- Interpersonal assistance and accountability

Disinformation around health issues caused by political polarization
- Developing a broader base of respected community voices

Transportation
- Supporting local, public transportation
- Voucher programs for transit

Advocacy for seniors
- Outreach through families and health system
- Starting a senior center

Resources Identified by Key Informants

Key Informants — Resources to Address Significant Health Needs	
Diabetes and Obesity • Partnering with other programs (like Diabetes Alliance at Healing for Hope) • Obesity/nutrition education • Subsidized or greater access to healthy foods • Greater access and encouragement to exercise **Mental Health** • Continued public mental health education • Telehealth and better scheduling **Poverty** • Affordable housing • Increased wages • Employer health incentives **Social Isolation** • Better community provision of basic needs **Cancer** • Workplace screenings • Public education and outreach	**Chronic Disease Management** • Chronic disease clinics **Drug Abuse** • Referrals from primary care physicians • Embedding mental healthcare into primary healthcare **Smoking** • Programs for education, stories, peer support to address **Chronic Mental Illness** • Interpersonal social support programs **Immigrant Health** • Expand events and touchpoints for immigrant community **Lack of physicians** • Goshen's educational institutions • Community hospitality

Community Resources

Goshen Health keeps an extensive up-to-date directory of all community resources available to our patients and their families. The directory allows our care teams to quickly search and provide important resource connections in a timely and relevant manner. To request a copy of this comprehensive list, you may email us at **healthinfo@GoshenHealth.com**.

Appendix VI:

Organizations Represented by Focus Group and Individual Interview Participants

Appendix VI: Organizations Represented by Focus Group and Individual Interview Participants

Organizations represented by the focus groups and key informants are listed below.

Focus Group Organizations Represented

- Bashor Children's Home
- Cancer Resources for Elkhart County
- Child & Parent Services of Elkhart County
- Council on Aging of Lagrange County
- Council on Aging of Elkhart County
- Courtyard Healthcare
- Crossroad United Way
- Goshen Interfaith Hospitality Network
- Greencroft Communities
- Habitat for Humanity of Elkhart County
- Hubbard Hill
- Miller's Merry Manor
- Minority Health Coalition of Elkhart County
- Northern Indiana Hispanic Health Coalition
- Waterford Crossing

Key Informant Organizations Represented

- Boys & Girls Club of Elkhart County
- Center for Healing and Hope
- City of Goshen
- Goshen Community Schools
- Maple City Health Care Center
- Oaklawn
- LaGrange County Health Department

Appendix VII:

Frequency Rankings of Community Health Needs

Appendix VII: Frequency Rankings of Community Health Needs

Community health needs identified in the primary and secondary datasets were tabulated in the frequency chart below.

2021 CHNA Data: Goshen Health Service Area

2021 Community Health Needs

Number of groups that selected need	Health-related need	Primary data: Groups that identified need: Amish Community Leaders	Community Survey Latino	Community Survey Non-Latino	GCS Latino	GCS Non-Latino	Group/ Informant Survey	Focus Group Meetings	Key Informant Interviews	Secondary data
9	Obesity/Weight management	X	X	X	X	X	X	X	X	X
9	Substance abuse/Addictions	X	X	X	X	X	X	X	X	X*
8	Lack of access to health care**		X	X	X	X	X	X	X	X
	Availability of health services		*X*	*X*	*X*	*X*	*X*			
	Lack of providers								*X*	*X*
	Lack of access to affordable quality health care							*X*		
7	Mental health**		X	X	X	X	X	X	X	
	Acute care for mental health/Mobile crisis unit to respond to dysfunction							*X*		
	Chronic mental illness								*X*	
6	Health education		X	X	X		X	X	X	
6	Nutrition	X	X	X	X	X	X			
5	Insurance coverage		X	X	X	X				X
5	Treatment of chronic diseases		X	X			X	X	X	
4	Cancer	X	X	X					X	
4	Diabetes treatment and prevention		X		X		X		X	
4	Physical fitness/Exercise			X	X	X				X
4	Poverty		X			X	X		X	
3	Family and social support					X	X	X		
3	Tobacco use/Smoking	X			X				X	
2	Cardiovascular health	X					X			
1	Advocacy for seniors							X		
1	Air pollution									X
1	Child abuse								X	
1	Child mortality									X
1	Combined/Comorbid health issues							X		
1	Culture and lifestyle							X		
1	Disinformation around health issues caused by political polarization							X		
1	Formal education									X
1	Immigrant health								X	
1	Infant mortality									X
1	Social isolation								X	
1	Teen births									X
1	Transportation							X		
1	Violence	X								

**In the secondary data, arrests for the sale and possession of controlled substances is taken as an indirect metric for substance abuse*

***For the purposes of prioritization, some health issues were combined into an umbrella health issue and counted together but still individually presented. Availability of health services, lack of providers, and lack of access to affordable quality health care were combined into the broader category lack of access to health care, while chronic mental illness and acute care for mental illness were combined with mental illness.*

Appendix VIII:

CHNA Leadership Groups

Goshen Health appointed three groups to oversee, guide or participate in the CHNA process:

- Goshen Health Steering Committee
- Planning Team
- Community Advisory Council

Goshen Health Steering Committee

The Steering Committee members listed below oversaw both the community health needs assessment report process and the development of the implementation plan.

- Stacey Bowers, Community Engagement Manager, Goshen Health
- Jim Caskey, Vice President of Goshen Health Foundation and Capital Campaign Director, Goshen Health
- Susan Franger, Vice President, Cancer Services and Marketing, Goshen Health
- Shannon McNett-Silcox, Director of Marketing and Community Outreach, Goshen Health
- Rob Myers, Chief Operating Officer, Goshen Health

Planning Team

The planning team members listed below implemented the CHNA process as defined by the Steering Committee.

- Stacey Bowers, Community Engagement Manager, Goshen Health
- Shannon McNett-Silcox, Director of Marketing and Community Outreach, Goshen Health
- Curt Bechler, CEO, Venture International
- Tamra Ummel, Partner, Venture International
- Justin Weaver, Managing Partner, Venture International

Community Advisory Council

Goshen Health requested the Community Advisory Council (CAC) to:

- Serve as advocates in the community for the CHNA process and outcomes
- Provide counsel regarding the membership of focus group and individuals to be interviewed
- Assist in understanding and interpreting the data gathered during the CHNA process
- Identify and prioritize the health needs of the community

Members of CAC included:

- Stacey Bowers, Community Engagement Manager, Goshen Health
- Jim Caskey, Vice President of Goshen Health Foundation and Capital Campaign Director, Goshen Health
- Susan Franger, Vice President, Cancer Services and Marketing, Goshen Health
- Stephen Harmon, Physician, Vista Community Health Center
- Shannon McNett-Silcox, Director of Marketing and Community Outreach, Goshen Health
- Rob Myers, Chief Operating Officer, Goshen Health
- Susan Stiffney, Director of Human Resource Services, Goshen Community Schools
- Kari Tarman, Executive Director of the Oaklawn Foundation, Oaklawn
- Bethany Wait, Health Officer, Elkhart County Health Department
- Candy Yoder, Chief Program Officer, Community Foundation of Elkhart County

Appendix IX:

Strategies that Addressed 2021 Community Health Needs

Goshen Health CHNA Action Plan: 2019-2021

The mission of Goshen Health is to improve the health of our communities by providing innovative, and outstanding care and services through exceptional people doing exceptional work. To ensure our work is driving our mission, we measure the impact of our efforts to verify that we are doing our very best for those who matter most.

In 2018, once again Goshen Health completed an evaluation of its communities' healthcare needs as required by the Patient Protection and Affordable Care Act. This process continues Goshen Health's long-standing practice of regularly identifying and addressing health needs within its communities.

To identify the health needs for the 2018 Community Health Needs Assessment (CHNA), data were collected from secondary sources and from Latino and non-Latino parents and guardians of school age children, Amish, community leaders, focus groups and key informants from business, not-for-profit and service organizations, health care and mental health workers, and those from or representing vulnerable or medically underserved populations. These data were analyzed to identify and prioritize health needs in the Goshen Health communities.

Based on findings of the 2018 CHNA report, Goshen Health has developed the following action plan that focuses on improving the health of our communities. We look forward to sharing the results with you as we work alongside additional engaged community partners to make a difference in the lives of those we serve.

PRIORITY AREA	Obesity/Physical Fitness/Nutrition/Health Education
GOAL	Reduce the rate of obesity in the Goshen Health service area through both external and internal programs.

LONG TERM INDICATORS OF IMPACT

	BASELINE VALUES AND SOURCE	FREQUENCY
1. Slow or halt the rapidly accelerating rate of adult obesity within our community	2018 CHNA and 2019 indicators Elkhart County: 32.8%, 11.2% increase over 4 years	Annual
2. Reduce the percent of adults reporting physical inactivity within our community	2018 CHNA: 25.9% reporting physical inactivity in Elkhart County in 2013 2019 indicators Elkhart County: 26.4% from 2014-2018	Annual
3. Increase engagement with health education related to nutrition, physical fitness and obesity within our community, for both adults and children	Community Wellness and Education/Goshen Health engagement data for benchmarking. 2019 is a benchmark year for programming	Annual

STRATEGY #1	TYPE
Lead a community coalition focused on improving and expanding broad access obesity initiatives with outcomes measures. This group will focus on high risk populations, cultural minorities, leveraging community assets and advancing the role of social determinants of health in programming choices.	Community-partner program development and execution

PARTNERS

Elkhart County Health Department, Goshen College, Horizon Education Alliance, Goshen Community Schools, Mayor's Office, Plain Church Group Ministry, Northern Indiana Hispanic Health Coalition and others.

BACKGROUND ON STRATEGY

Evidence of Effectiveness: Social Determinants of Health (SDOH) are published to have a strong impact on both general wellness and obesity in particular within communities. General obesity related programming fails to engage true change in behavior. In order to create lasting improved health status for our community, programs must be built or revised with these SDOH at the forefront. Further, high risk and minority groups differ in how they approach both health education and behavior change. Only by engaging closely with these communities as we seek to provide support for positive change can it be realized successfully.

Bryant, P.H., Hess, A, & Bowen, P. (2015). Social determinants of health related to obesity. The Journal of Nurse Practitioners, 11 (2), 1-7.

Benedict, S., Campbell, M., Doolen, A., Rivera, I., Negussie, T., & Turner-McGrievy, G. (2007). Seeds of hope: A model for addressing social and economic determinants of health in a woman's obesity prevention project in two rural communities. Journal of Women's Health, 16 (8). Doi 10.1089/jwh.2007.CDC9

SHORT TERM INDICATORS

PROCESS INDICATORS	ANNUAL TARGETS BY DECEMBER 31 2019	 2020	 2021
1. Expansion of existing, successful program or development of new programming per year, executed with the coalition's recommendation	2	2	2
2. Number of participants in program(s)	Baseline	Baseline + 10%	Baseline + 20%
IMPACT INDICATORS			
1. Percentage of participants that report positively to established success measures for program	Baseline	Baseline + 10%	Baseline + 20%
2. Percentage of participants that report improved outcomes compared to baseline	Baseline	Baseline + 10%	Baseline + 20%
3. Percentage of participants that demonstrate long term improvement through follow-up surveillance	Baseline	Baseline + 10%	Baseline + 20%

STRATEGY #2	TYPE
Establish a consistent, evidence based pathway for obese patients within the Accountable Care Organization	Clinical Program

PARTNERS

Goshen Physicians, Medical Staff and Referring Providers

BACKGROUND ON STRATEGY

Evidence of Effectiveness: Every patient screened in the ACO medical homes with a BMI over 30 will be engaged through the use of the PAM[1] assessment. The use of a standardized, evidence-based clinical pathway will allow us to connect those patients who are ready to make changes in their lifestyle to health coaches or other specific resources. Patients will be entered into a registry to track outcomes.

SHORT TERM INDICATORS

	ANNUAL TARGETS BY DECEMBER 31		
PROCESS INDICATORS	2019	2020	2021
1. Pilot of pathway/assessment	Execute	Audit	Audit
2. Number of Colleagues with advanced education in PREPARE and lifestyle change training or as health coaches	Baseline	2x Baseline	2x Baseline
3. Number of patients referred to health coaches	Pilot	200% of Pilot	300% of Pilot
IMPACT INDICATORS			
1. Number of new patients who are referred to health coach who attend first visit	Pilot	200% of Pilot	300% of Pilot
2. Improved biometric for patients - weight	Baseline	Baseline + 5%	Baseline + 10%
3. Improved biometric for patients – fasting blood glucose	Baseline	Baseline + 5%	Baseline + 10%

[1] The PAM assessment is an evidence-based tool that addresses an individual's ability to self-manage illness or problems, engage in activities that maintain functioning and reduce health declines, involvement in treatment and diagnostic choices, collaborate with providers, select providers based on performance and quality and navigate the health care system. The survey then determines if the patient is in one of four activation levels including believing the patient role in activation is important, having the confidence and knowledge necessary to take action, proactively taking action to maintain and improve one's health and staying the course even under stress.

STRATEGY #3	TYPE
Establish an evidence-based pathway for overweight or obese pediatric patients that takes into account SDOH.	At risk or acute intervention strategy

PARTNERS

Goshen Physicians

BACKGROUND ON STRATEGY

Evidence of Effectiveness: Use of research supported, evidence-based interventions will advise the selection of process and impact indicators once programming is established. Partner with Horizon Education Alliance, Goshen Community Schools or other organizations to screen and implement evidence-based interventions to decrease the level of obesity in a targeted group of grade levels.

SHORT TERM INDICATORS

	ANNUAL TARGETS BY DECEMBER 31		
PROCESS INDICATORS	2019	2020	2021
1. Establish pilot program based on evidence-based approaches in the pediatric population	Development	Execution	Auditing
2. Number of participants	NA	Pilot	TBD
IMPACT INDICATORS			
1. Percentage of participants that complete program	NA	200% of Pilot	300% of Pilot
2. Percentage of adult caregivers who report improved understanding of care plans for patient	NA	Pilot	TBD
3. Improved biometric for patients - BMI	Baseline	TBD	TBD

PRIORITY AREA	Diabetes/Nutrition/Health Education
GOAL	Reduce the rate of uncontrolled diabetics within the ACO population

LONG TERM INDICATORS OF IMPACT

	BASELINE VALUE, DATE AND SOURCE	FREQUENCY
1. Slow or halt the accelerating rate of Adult Diabetes in our community	ACO Data Set; County Health Rankings, CDC Diabetes Interactive Atlas shows 10.4% in Elkhart County, with an increase of 11.8% over 4 years.	Annual Updates

STRATEGY #1	TYPE
Establish primary care driven intervention platform for uncontrolled diabetes.	Acute intervention, training and education

PARTNERS

Medical Staff

BACKGROUND ON STRATEGY

Evidence of Effectiveness: Use of community-developed, evidence-based MAAP It Out© education strategy that ties patients with A1Cs > 8 on the diabetes registry to ongoing diabetes education should advance disease control. Additional screening of patients with diabetes for engagement level using evidence-based PAM[1] screening system will validate use of resources toward improved outcomes.

SHORT TERM INDICATORS

	ANNUAL TARGETS BY DECEMBER 31		
PROCESS INDICATORS	2019	2020	2021
1. Number of patients on diabetes registry screened for engagement	Baseline	Baseline + 10%	Baseline + 20%
2. Number of patients referred to diabetes education	Baseline	Baseline + 10%	Baseline + 20%
IMPACT INDICATORS			
1. Percentage of patients referred who engage with diabetes education	Baseline	+ 20%	+ 25%
2. Percentage of participants that demonstrate HbgA1C<8 on the registry post education	Baseline	Baseline + 10%	Baseline + 20%

Goshen Health has developed this implementation plan to meet a prioritized need identified through a community health needs assessment process. Goshen Health may refocus resources if necessary to best address the needs of the community as they change over time.