2019 Community Health Needs Assessment

Kaiser Foundation Hospital: South Bay Medical Center

License number: 930000079

Approved by Kaiser Foundation Hospitals Board of Director's Community Health Committee

September 16, 2019

KAISER PERMANENTE®

Kaiser Permanente Southern California Region Community Benefit

CHNA Report for KFH-South Bay

Contents

I. Introduction/background

A. About Kaiser Permanente (KP)

Founded in 1942 to serve employees of Kaiser Industries and opened to the public in 1945, Kaiser Permanente is recognized as one of America's leading health care providers and nonprofit health plans. We were created to meet the challenge of providing American workers with medical care during the Great Depression and World War II, when most people could not afford to go to a doctor. Since our beginnings, we have been committed to helping shape the future of health care. Among the innovations Kaiser Permanente has brought to U.S. health care are:

- Prepaid health plans, which spread the cost to make it more affordable
- A focus on preventing illness and disease as much as on caring for the sick
- An organized, coordinated system that puts as many services as possible under one roof—all connected by an electronic medical record

Kaiser Permanente is an integrated health care delivery system comprised of Kaiser Foundation Hospitals (KFH), Kaiser Foundation Health Plan (KFHP), and physicians in the Permanente Medical Groups. Today we serve more than 12 million members in nine states and the District of Columbia. Our mission is to provide high-quality, affordable health care services and to improve the health of our members and the communities we serve.

Care for members and patients is focused on their Total Health and guided by their personal physicians, specialists, and team of caregivers. Our expert and caring medical teams are empowered and supported by industry-leading technology advances and tools for health promotion, disease prevention, state-of-the-art care delivery, and world-class chronic disease management. Kaiser Permanente is dedicated to care innovations, clinical research, health education, and the support of community health.

B. About Kaiser Permanente Community Health

For more than 70 years, Kaiser Permanente has been dedicated to providing high-quality, affordable health care services and to improving the health of our members and the communities we serve. We believe good health is a fundamental right shared by all and we recognize that good health extends beyond the doctor's office and the hospital. It begins with healthy environments: fresh fruits and vegetables in neighborhood stores, successful schools, clean air, accessible parks, and safe playgrounds. Good health for the entire community requires equity and social and economic well-being. These are the vital signs of healthy communities.

Better health outcomes begin where health starts, in our communities. Like our approach to medicine, our work in the community takes a prevention-focused, evidence-based approach. We go beyond traditional corporate philanthropy or grantmaking to pair financial resources with medical research, physician expertise, and clinical practices. Our community health strategy focuses on three areas:

- Ensuring health access by providing individuals served at KP or by our safety net partners with integrated clinical and social services;

- Improving conditions for health and equity by engaging members, communities, and Kaiser Permanente's workforce and assets; and
- Advancing the future of community health by innovating with technology and social solutions.

For many years, we've worked side-by-side with other organizations to address serious public health issues such as obesity, access to care, and violence. And we've conducted Community Health Needs Assessments to better understand each community's unique needs and resources. The CHNA process informs our community investments and helps us develop strategies aimed at making long-term, sustainable change—and it allows us to deepen the strong relationships we have with other organizations that are working to improve community health.

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

The Patient Protection and Affordable Care Act (ACA), enacted on March 23, 2010, included new requirements for nonprofit hospitals in order to maintain their tax-exempt status. The provision was the subject of final regulations providing guidance on the requirements of section 501(r) of the Internal Revenue Code. Included in the new regulations is a requirement that all nonprofit hospitals must conduct a community health needs assessment (CHNA) and develop an implementation strategy (IS) every three years (http://www.gpo.gov/fdsys/pkg/FR-2014-12-31/pdf/2014-30525.pdf). The required written IS plan is set forth in a separate written document. Both the CHNA Report and the IS for each Kaiser Foundation Hospital facility are available publicly at https://www.kp.org/chna.

D. Kaiser Permanente's approach to Community Health Needs Assessment

Kaiser Permanente has conducted CHNAs for many years, often as part of long-standing community collaboratives. The new federal CHNA requirements have provided an opportunity to revisit our needs assessment and strategic planning processes with an eye toward enhanced compliance and transparency and leveraging emerging technologies. Our intention is to develop and implement a transparent, rigorous, and whenever possible, collaborative approach to understanding the needs and assets in our communities. From data collection and analysis to the identification of prioritized needs and the development of an implementation strategy, the intent was to develop a rigorous process that would yield meaningful results.

Kaiser Permanente's innovative approach to CHNAs includes the development of a free, web-based CHNA data platform that is available to the public. The data platform provides access to a core set of approximately 120 publicly available indicators to understand health through a framework that includes social and economic factors, health behaviors, physical environment, clinical care, and health outcomes. In addition, hospitals operating in the Southern California Region utilized the Southern California Public Health Alliance's Healthy Places Index Platform, which includes approximately 80 publicly available community health indicators with resolution at the census tract level.

In addition to reviewing and analyzing secondary data, each KFH facility, individually or with a collaborative, collected primary data through key informant interviews, focus groups, and surveys. Primary data collection consisted of reaching out to local public health experts, community leaders, and residents to identify issues that most impacted the health of the community. The CHNA process also included an identification of existing community assets and resources to address the health needs.

Each hospital/collaborative developed a set of criteria to determine what constitutes a health need in their community. Once all the community health needs were identified, they were prioritized, based on identified criteria. This process resulted in a complete list of prioritized community health needs. The process and the outcome of the CHNA are described in this report.

In conjunction with this report, KFH-South Bay will develop an implementation strategy for the priority health needs the hospital will address. These strategies will build on Kaiser Permanente's assets and resources, as well as evidence-based strategies, wherever possible. The Implementation Strategy will be filed with the Internal Revenue Service using Form 990 Schedule H. Both the CHNA and the Implementation Strategy, once they are finalized, will be posted publicly on our website, https://www.kp.org/chna

II. Community served

A. Kaiser Permanente's definition of community served
Kaiser Permanente defines the community served by a hospital as those individuals residing within its hospital service area. A hospital service area includes all residents in a defined geographic area surrounding the hospital and does not exclude low-income or underserved populations.

B. Map and description of community served

i. Map

Figure A – KFH-South Bay Service Area
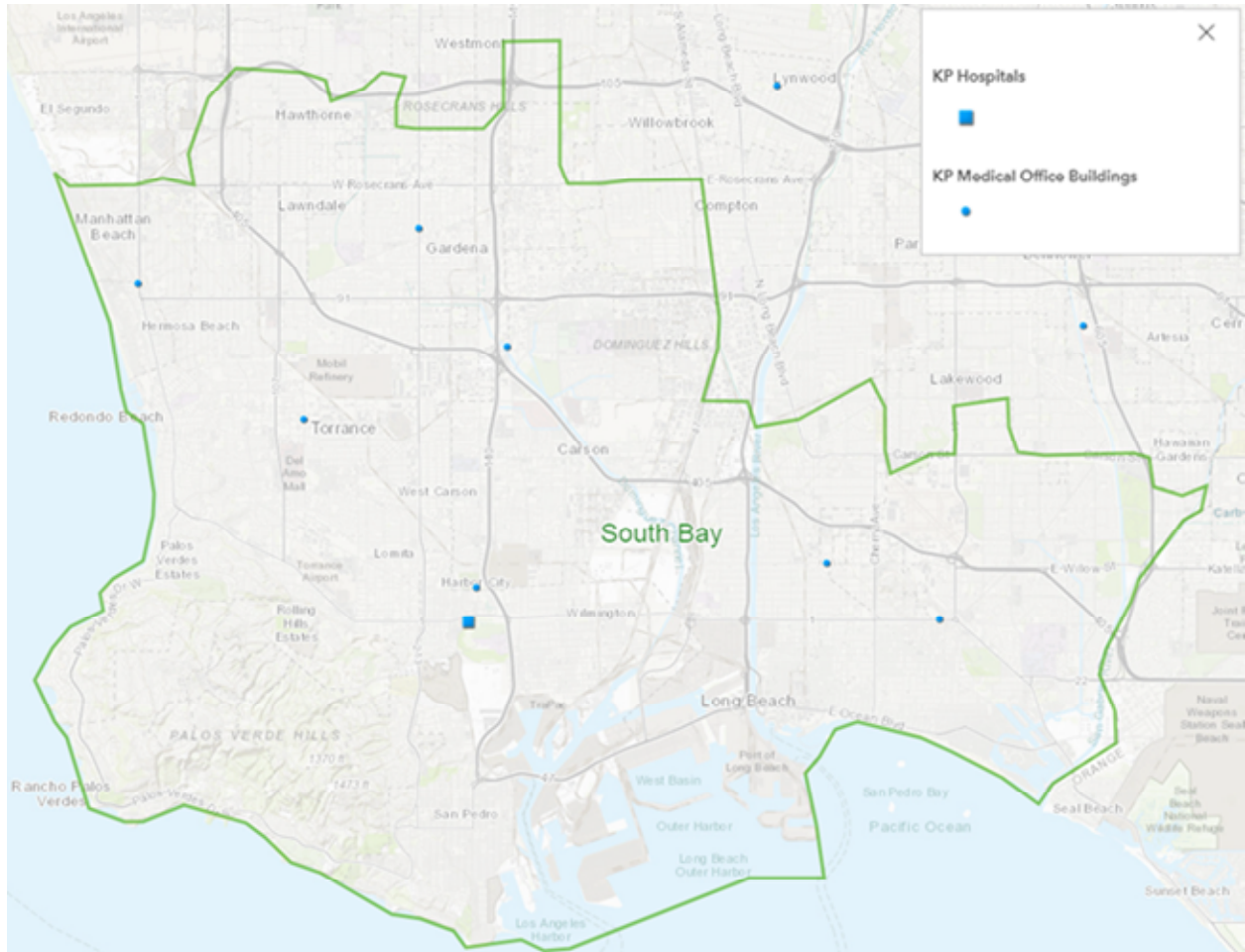
ii. Geographic description of the community served

The KFH-South Bay (formerly KFH-Harbor City) service area includes: Carson, Catalina Island, Compton, El Segundo, Gardena, Harbor City/Harbor Gateway, Hawthorne, Hermosa Beach, Lawndale, Lomita, Long Beach, Manhattan Beach, Palos Verdes Peninsula, Rancho Palos Verdes, Redondo Beach, San Pedro, Signal Hill, Torrance, Willowbrook, and Wilmington.

iii. Demographic profile of the community served

The following table includes race, ethnicity, and additional socioeconomic data for the KFH-South Bay service area. Please note that 'race' categories indicate 'non-Hispanic' population percentage for Asian, Black, Native American/Alaska Native, Pacific Islander/Native Hawaiian, Some Other Race, Multiple Races, and White. 'Hispanic/Latino' indicates total population percentage reporting as Hispanic/Latino.

Table 1. Demographic profile: KFH-South Bay[1]

Race/Ethnicity		Socioeconomic	
Total Population	1,339,944	Living in Poverty (<100% Federal Poverty Level)	15.32%
Asian	15.75%	Children in Poverty	22.53%
Black	11.39%	Unemployment	4.10%
Hispanic/Latino	38.80%	Uninsured Population	13.06%
Native American/Alaska Native	0.23%	Adults with No High School Diploma	17.20%
Pacific Islander/Native Hawaiian	0.71%		
Some Other Race	0.29%		
Multiple Races	3.48%		
White	29.35%		

The opportunity to live a long and healthy life is powerfully influenced by a wide range of social factors including economics, education, transportation, built environment, and access to care.[2] In aggregate, residents living in the **KFH-South Bay service area** are in the **51st percentile** for health opportunity[3] among all California residents, with approximately **339,478** people living in severely under-resourced census tracts. In effect, this means that on average, five out of ten Californians have a greater opportunity to live a long, healthy life compared to residents living in this service area.

iv. Severely under-resourced communities

Identifying disparities in the upstream factors that predict negative health outcomes is critical to Kaiser Permanente's community health mission. The map below displays the differences in opportunity for residents in the KFH-South Bay service area to live a long and healthy life[4]. Areas in dark blue represent census tracts in the lowest quartile of health opportunity across California. These areas are severely under-resourced across multiple domains of the social predictors of health (e.g. economics, education, transportation, built environment etc.).

---

[1] American Community Survey (2012-2016).

[2] Please read more about the strong scientific evidence for these relationships here.

[3] As described by the California Healthy Places Index.

[4] As defined by the California Healthy Places Index (HPI). HPI scores combine 25 metrics of the social predictors of health (each weighted to life expectancy) to produce a single health opportunity score for each census tract in CA. For more detailed maps and additional information about HPI methodology, please visit http://healthyplacesindex.org.

Figure B – Under-Resourced Communities in KFH-South Bay
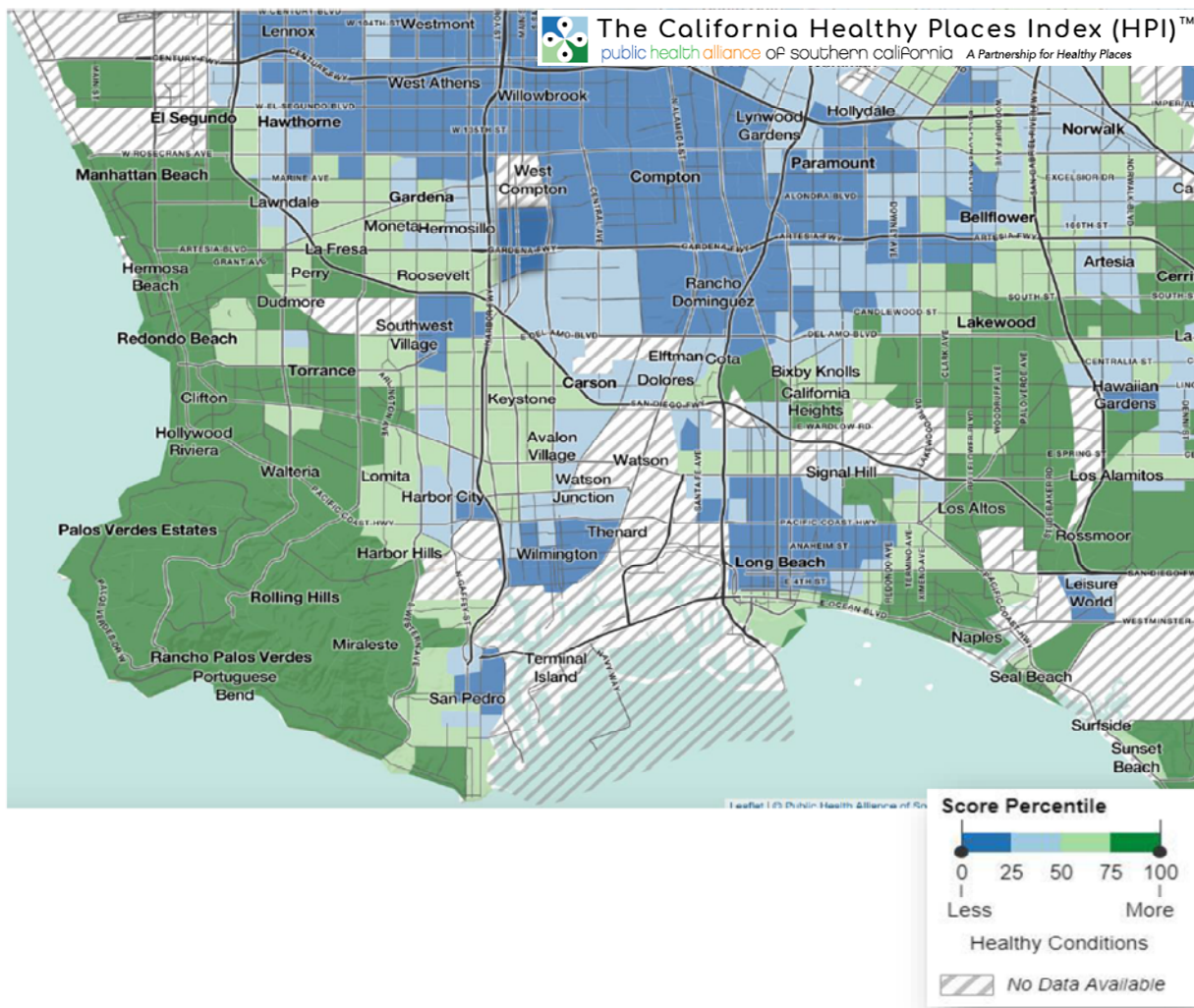
Source: The California Healthy Places Index, © 2018 Public Health Alliance of Southern California, http://healthyplacesindex.org/

Major under-resourced communities in the KFH-South Bay service area:

- Compton
- Hawthorne
- Lawndale
- Long Beach (parts of)
- Rancho Dominguez
- San Pedro (parts of)
- Watts
- Willowbrook
- Wilmington

III. Who was involved in the assessment?

A. Identity of hospitals and other partner organizations that collaborated on the assessment

KFH-South Bay community benefit manager and other internal hospital staff helped to coordinate and observe community engagement activities. KFH-South Bay collaborated with Providence Little Company of Mary Medical Center and Torrance Memorial Medical Center to plan and implement two focus groups: housing and homelessness and food insecurity. Additionally, other community partners contributed time and resources to assist with primary data collection by hosting focus groups and recruiting participants:

- Boys and Girls Clubs - LA Harbor
- Boys and Girls Clubs of Metro Los Angeles
- Boys and Girls Clubs of the South Bay
- Compton Youthbuild
- Kaiser Permanente Watts Counseling and Learning Center
- Positive Results Corporation
- Save Black Boys
- ShareFest Community Development Inc.
- South Bay Coalition to End Homelessness

KFH-South Bay also participates in The Long Beach Community Health Needs Assessment Collaborative, a group of nonprofit hospitals and organizations working together for the 2019 CHNA process and report. The Collaborative includes Memorial Care Long Beach Medical Center, Miller Children's and Women's Hospital Long Beach, Dignity Health St. Mary's Medical Center, The Children's Clinic, Kaiser Permanente South Bay, and the Long Beach Department of Health and Human Services.

B. Identity and qualifications of consultants used to conduct the assessment

A-Cubed Consulting, Inc (A3) was contracted to conduct the CHNA for KFH-South Bay. A3 believes in taking a participatory and use-focused approach to evaluation. Those doing the work should be involved in telling the story. A3 also believes the components of organizational development, research, and evaluation each play a pivotal role in the evaluation process. Ama Atiedu, CEO and Project Manager, has over 15 years of experience designing and conducting small and large-scale research and evaluation projects with focuses on public health, nutrition, health care systems, and early childhood education. Other team members supporting KFH-South Bay's CHNA include:

- Laura Keene (Keene Insights), Evaluation Consultant
- Michelle Molina (Connecting Evidence), Evaluation Consultant
- Maddy Frey (Madeleine Frey Consulting, LLC), Evaluation Consultant
- Monica Ray, Project Coordinator & Community Benefit Consultant
- Fiona Asigbee, Statistician

IV. Process and methods used to conduct the CHNA

KFH-South Bay conducted the CHNA in a mixed-methods sequential explanatory assessment intended to produce the most accurate, vivid, and meaningful story of community health possible. Secondary data was analyzed to provide a bird's eye view of the most pressing health issues across the service area and raise strategic lines of inquiry for community engagement. Findings from both the secondary and primary data collection processes were then combined to produce a robust story of community health needs (see Figure C below).

Figure C – Mixed-Method Assessment Approach to the CHNA
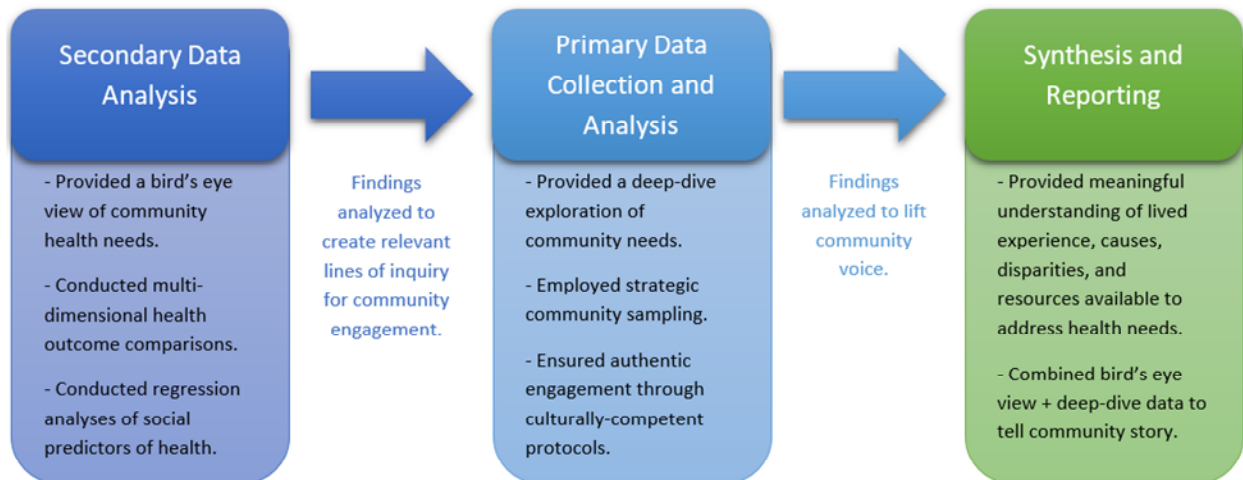
A. Secondary data

i. Sources and dates of secondary data used in the assessment
KFH-South Bay used the Kaiser Permanente CHNA Data Platform and the Southern California Public Health Alliance Healthy Places Index to review approximately 200 indicators from publicly available data sources. For details on specific sources and dates of the data used, including any data in addition to sources mentioned above, please see Appendix A.

ii. Methodology for collection, interpretation, and analysis of secondary data
Findings from secondary data analysis provided a bird's-eye view of the community health needs and created relevant lines of inquiry for community engagement. The driving purposes behind these analyses were to:

1. Determine the geographic footprint of the most under-resourced communities in the KFH service area.
2. Identify the top social predictors of health (upstream factors) linked to community health outcomes in the KFH service area.
3. Provide an initial ranked list of health needs that could inform community engagement planning and the health need prioritization process for the KFH service area.

4. Provide descriptive information about the demographic profile of the KFH service area and support understanding of key CHNA findings.

First, the most under-resourced geographic communities were identified utilizing the Public Health Alliance of Southern California's Healthy Places Index (HPI) mapping function. The social predictors of health in this index include 25 indicators related to economic security, education, access to care, clean environment, housing, safety, transportation, and social support. (Please refer to Figure B to see this map[5]).

Second, social predictor of health indicators were used in multiple linear regression analyses to produce models identifying the social factors most predictive of negative health outcomes in KFH-South Bay service area census tracts. The results of these analyses found multiple social factors with statistically significant ($p<.05$) predictive relationships with important population health outcomes. (Please refer to Table 2 to see results).

Third, health outcome indicators were analyzed across multiple dimensions including: absolute prevalence, relative service area prevalence to the state average, reduction of life expectancy (calculated through empirical literature on disability-adjusted life years), impact disparities across racial and ethnic groups, and alignment with county rankings of top causes of mortality. (Please refer to Table 3 to see results).

Fourth, additional descriptive data were used to understand the demographics of the service area and provide context to findings from secondary and primary data analysis.

In sum, the use of secondary data in this CHNA process went beyond reporting publicly available descriptive data and generated new understandings of community health in the KFH service area. Secondary data analyses and visualization tools (a) synthesized a wide variety of available health outcome data to provide a bird's-eye view of the KFH service area needs and (b) provided a closer look at the impact of social factors that influence the opportunity of community residents in the service area to live long and healthy lives. For further questions about the CHNA methodology and secondary data analyses, please contact CHNA-communications@kp.org.

---

[5] Maps from the California Healthy Places Index captured in this report are © 2018 Public Health Alliance of Southern California, https://phasocal.org/.

Multiple linear regression models used nearly one dozen social indicators to predict each of the negative health outcomes below. An "X" indicates a statistically significant ($p<.05$) predictive relationship across all census tracts in the service area between a given social factor and a health outcome (e.g. "*service area census tracts reporting less health insurance also tended to report more heart attack ER visits, even when holding many other social factors constant*").

Table 2 – Social Factors Linked to Health Outcomes

	More Poor Mental Health Days	More Heart Attack ER Visits	Higher Asthma Prevalence	Higher Obesity Prevalence	Higher Diabetes Prevalence	Higher Stroke Prevalence	Higher Cancer Prevalence	Higher Percentage of Babies Born with Low Birth Weight	Higher Smoking Prevalence	More Pedestrian Injury	Number of Outcomes Affected
More Racial Segregation	X	X	X	X	X	X		X			7
Fewer Bachelor's Degrees	X	X	X	X	X	X			X		7
Lower Income	X			X	X	X		X			5
Less Employment		X	X			X			X		4
More Crowded Housing	X			X	X						3
More Homeownership					X	X	X				3
Less Homeownership		X							X		2
Fewer Two Parent Households			X							X	2
Less Health Insurance	X										1
Worse Air Quality		X									1
More Bachelor's Degrees							X				1
Less Crowded Housing							X				1
More Health Insurance							X				1

How do service area health needs compare based on Kaiser Permanente Community Health values?

The following table ranks health needs based on several principle values: The prevalence of the health outcome compared to the California state average, the impact of the health outcome on length and quality of life, the disparity of disease prevalence across racial/ethnic groups, and the alignment with county rankings of top causes of mortality.[6]

Table 3 – Ranked Health Outcome Comparison Table

Health Outcome Category Name	Prevalence in Service Area	Difference From State Average	Reduction in Life Expectancy	Worst Performing Race/Ethnicity vs. Average	Listed in Partner County Top 5 Cause of Death
Mental Health*	12.3%	0.17% (Worse than CA)	61.3% Reduction	68% Worse than Average	No
Stroke*	4.0%	0.3% (Worse than CA)	57% Reduction	42% Worse than Average	Yes
Cancer*	4.0%	0.68% (Worse than CA)	51% Reduction	32% Worse than Average	Yes
HIV/AIDS/STD	0.6%	0.18% (Worse than CA)	58.2% Reduction	211% Worse than Average	No
Obesity	26.4%	-3.2% (Better than CA)	37% Reduction	55% Worse than Average	No
Substance/Tobacco Use	4.7%	-2.26% (Better than CA)	69.7% Reduction	48% Worse than Average	No
Diabetes*	11.0%	2.6% (Worse than CA)	24.1% Reduction	8% Worse than Average	No
Maternal/Infant Health	7.1%	0.3% (Worse than CA)	17.9% Reduction	32% Worse than Average	No
CVD*	5.3%	-1.65% (Better than CA)	30% Reduction	30% Worse than Average	Yes
Oral Health	11.6%	0.3% (Worse than CA)	2.8% Reduction	17% Worse than Average	No
Asthma	10.0%	-4.81% (Better than CA)	13.3% Reduction	82% Worse than Average	No
Violence/Injury	0.0%	-0.01% (Better than CA)	13.2% Reduction	30% Worse than Average	No

---

[6]Indicators for prevalence and racial disparities are publicly available. Technical documentation and data dictionary for this table available upon request. Health need category names provided by Kaiser Permanente Program Office. Reduction in life expectancy estimated based on disability-adjusted life years research. "Mental Health" indicators refer to "poor mental health". "Violence/Injury" prevalence is rounded down but not technically zero. "Yes" indicates health outcome is listed in the top five causes of death for the county covering the majority of this service area. If asthma is listed as "Yes", then chronic lower respiratory disease was listed in the county rankings. Asterisks are outcomes measured by Kaiser Permanente's Program Office.

B. Community input

Secondary data analyses produced high-level findings about community health needs. These findings were used to create targeted lines of inquiry intended to learn more about the story of community health by exploring the lived experience of community members, the causes of health needs, the racial or geographic disparities in health needs, and the community resources available to address health needs. These lines of inquiry were guided by the following strategic learning questions (see Appendix E for more details about how these questions were developed):

1. How has race/racial segregation led to worse health outcomes in South Bay communities?
2. What culturally competent programs/ interventions/ solutions are most effective in addressing South Bay community needs around health outcomes and social predictors? Why?
3. How does mistrust of the health care system impact health outcomes?
4. How does housing status affect health outcomes?
5. How does lack of access to health care (e.g., under-insured, not insured, other access barriers) impact health outcomes?
6. What is preventing people from graduating high school? What is preventing people from attaining a bachelor's degree?
7. Which drivers could we address that would have the most impact on health outcomes?
8. What can organizations/institutions do to get people prepared for employment opportunities?
9. How does food insecurity impact health outcomes?
10. How can we partner with organizations addressing unmet social needs?
11. When thinking about mental health, what is the most pressing concern (access, specific mental health issues, stigma, etc.)?
    a. What factors contribute to these issues?
    b. What barriers exist to accessing mental health care/services?

The community engagement plan and the community's answers to these questions (primary data) were organized and analyzed using the CHNA Community Engagement Framework (see Figure D below).

Figure D – Community Engagement Framework
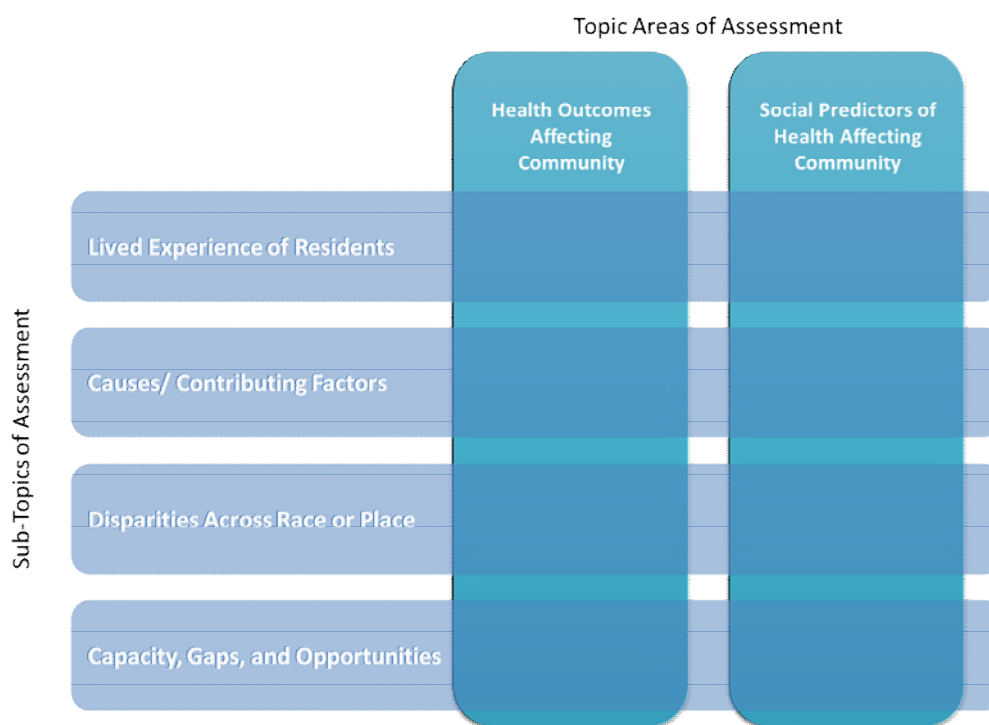
i. Description of who was consulted

Residents, community leaders, and government and public health department representatives were selected for the CHNA sample. Selection criteria across these groups included (a) those best able to respond in rich detail to the strategic learning questions, (b) those who had expertise in local health needs, (c) those who resided and/or provided services in an under-resourced or medically underserved community, and (d) those able to represent the health needs of a given racial or ethnic minority group. Given the large size of the KFH-South Bay service area, community engagement efforts set out to target those geographies most under-resourced and where health outcomes were the poorest (see Figure B for a map referencing the most underserved areas of KFH-South Bay). Once selected for engagement, participants were provided the opportunity to share their perspective on targeted health needs and raise any additional health needs outside the strategic lines of inquiry.

The majority of individuals (83%) represented the community service providers. 17% represented community residents (adult and youth). Additionally, engagements were conducted in five cities within the KFH-South Bay service area community (geography).

For a complete list of individuals who provided input on this CHNA, see Appendix B.

ii. Methodology for collection and interpretation

The purpose of the community engagement sessions was to identify health outcomes and health drivers, as well as assets and barriers to accessing resources, for health issues across the region. These engagements were designed to ensure a comprehensive portrait of the health needs at multiple levels. Individuals with the knowledge, information, and expertise relevant to the health needs of the community were consulted.

In seeking community input to help answer strategic lines of inquiry, primary data was collected through key informant interviews, focus groups, and online surveys. All primary data collection activities were confidential and voluntary. Key informant interviews consisted of one-hour telephone calls with select community leaders possessing expertise in a specific health need or social predictor of health. Focus groups were facilitated group discussions with service providers or community residents centered on a particular health topic. Groups lasted one to two hours. When feasible, preexisting meetings or gatherings of community stakeholders, like coalition meetings, were capitalized on. Select KFH-South Bay hospital staff observed some focus groups and interviews. Online surveys were sent to a diverse group of stakeholders to obtain information on the most pressing health concerns facing the community, contributing factors, and availability of resources to address health concerns.

Each group and interview was recorded and summarized as a stand-alone piece of data. When all groups had been conducted, the team used Dedoose, an online qualitative research software tool, to analyze the information and tabulated all health needs that were mentioned, along with health drivers discussed. Qualitative data analysis was designed to identify emergent themes in answer to strategic lines of questioning about specific community health needs as well as open-ended questions about health needs more broadly. Data from community engagement was coded and organized within the SCAL CHNA Learning Framework to generate themes useful for answering strategic learning questions, ultimately informing an implementation strategy plan (see Figure D).

The list of individuals that provided input via community engagement may be found in Appendix B.

C. Written comments
KP provided the public an opportunity to submit written comments on the facility's previous CHNA Report through CHNA-communications@kp.org. This email will continue to allow for written community input on the facility's most recently conducted CHNA Report.

At the time of this CHNA report development, KFH-South Bay had not received written comments about previous CHNA Reports. Kaiser Permanente will continue to track any submitted written comments and ensure that relevant submissions will be considered and addressed by the appropriate Facility staff.

D. Data limitations and information gaps

As with any community needs assessment process, the data available for use is limited. In the KP CHNA data platform, for example, some data were only available at a county level, making an accurate translation to neighborhood-level health needs challenging. In the Healthy Places Index platform, census tracts with very low populations were represented as missing data (to reduce unreliability of measurement). This caused under-sampling of rural areas. In both platforms, disaggregated data around age, ethnicity, race, and gender were not available for many indicators which limited the ability to examine disparities of health within the community. Additionally, data in both platforms were not often collected on a yearly basis and therefore may not represent 2018 values.

V. Identification and prioritization of the community's health needs

A. Identifying community health needs

i. Definition of "health need"

For the purposes of the CHNA, Kaiser Permanente defines a "health need" as a health outcome and/or the related conditions that contribute to a defined health need. Health needs are identified by the comprehensive identification, interpretation, and analysis of a robust set of primary and secondary data.

ii. Criteria and analytical methods used to identify the community health needs

To identify health needs an analysis of existing secondary data (data collected and published by public health agencies and others) related to health outcomes and the social predictors of health was conducted. These high-level analyses explored the severity, prevalence, and disparities of health outcomes and measured the strength of relationships between health outcomes and social factors.

Community knowledge and clinical expertise of Kaiser Permanente administrators and clinicians were leveraged to help contextualize the findings of these analyses and develop relevant lines of questioning for community engagement.

These strategic lines of questioning helped guide primary data collection, where input was gathered from persons serving or residing in the KFH-South Bay service area. Broad questions about pressing health concerns were also included in these community engagement sessions. Emergent themes from the analysis of primary data collection helped to describe the lived experience for residents in the service area, corroborate or challenge secondary data findings, and identify any overlooked health needs.

B. Process and criteria used for prioritization of health needs

The full list of health outcomes and social indicators identified in the secondary data analysis, along with any additional needs identified by internal and external stakeholders, was prioritized in the following process. First, a multi-dimensional analysis of secondary data ranked health outcomes using five comparison criteria: absolute prevalence rates in the service area, prevalence rate comparison to state average, severity (measured by reduction of life

expectancy), racial/ethnic disparities, and whether the health need was listed as a top five cause of death by the Los Angeles County Department of Public Health. Rankings across each of the criterion were summed with equal weighting, resulting in a total ranking score. Those health outcomes falling to the lower half of the list were removed from priority consideration. Social predictors of health were ranked by the number of connections to negative health outcomes (please see Tables 2 and 3 for details of these analyses). Those social predictors of health falling to the lower half of the list were removed from priority consideration.

Next, the list of health outcomes and social predictors of health were rated on the extent to which KFH-South Bay and its community partners were positioned to meaningfully act on the need and could align resources to make feasible impact. Those health needs that were rated as having sufficient organizational and community readiness for response were advanced through the prioritization process.

In the final step of prioritization, the list of remaining health needs was matched against the major themes from the community engagement data. Major themes were developed from quotations shared from community stakeholders. Health needs and related issues that were raised frequently and powerfully by residents and community stakeholders were selected to make the final list of priority health needs.

The finalized list of health needs derived through this prioritization process are listed below:

- Access to Care
- Education/Employment
- Food Insecurity
- Housing/Homelessness
- Mental Health
- Structural Racism and Marginalization

C. Prioritized description of all the community needs identified through the CHNA

Access to Care. Access to health care greatly impacts one's physical, mental, and social health and overall quality of life. This issue of access is comprised of many factors, including but not limited to affordability, treatment by health care professionals, ability to navigate the system, and availability of services. Indicators such as rates of uninsured and utilization of various types of care help to gauge accessibility of health care within communities. In the KFH-South Bay service area, low-income and Hispanic/Latino residents are more likely to be uninsured[7]. Community input sessions shed light on challenges people from marginalized groups face when accessing health care in the KFH-South Bay service area including experiencing judgement and

---

[7] LA Health – Recent Trends in Health Insurance Coverage published by County of Los Angeles Public Health. (2017). Retrieved from: publichealth.lacounty.gov/docs/LaHealth_RecentTrendsInHealthInsuranceCoverage_yr2017.pdf

discrimination in health care settings and being fearful of sharing information given the current political climate around immigration.

Education/Employment. Education and employment are interrelated and together impact one's socioeconomic status. A growing body of evidence demonstrates the advantages afforded those with more education and better employment, such as more resources to support healthy habits, reduced stress, stronger social and psychological skills, and larger social networks[8]. Conversely, individuals with less education and employment are more likely to have less access to food, health care, and other community resources. They also have fewer choices when it comes to their environment, often not being able to choose safer neighborhoods or neighborhoods with less exposure to environmental toxins. Using high school graduation rates as an indicator, Hispanic/Latino and Native American/Alaska Native residents in KFH-South Bay disproportionately experience higher rates of no high school diploma, as compared to White residents (38% and 42% vs. 4%, respectively)[9]. These findings were underscored by themes from community input sessions, which highlighted racial bias in the academic environment.

Food Insecurity. Food is an integral part of one's health. Low income communities struggle with having enough to eat as well as accessing healthy food options. Research has shown that individuals experiencing food insecurity have increased risk for obesity and higher rates of chronic disease. In the KFH-South Bay service area, people living in poverty, African Americans, Hispanics/Latinos, and seniors experience higher rates of food insecurity[10]. During community input sessions, participants highlighted barriers to accessing nutritious food. For example, benefits programs (e.g., CalFresh and WIC) are a big help, but can be challenging to navigate and are not available to everyone. In addition, social stigma and shame prevent people from accessing benefits and services.

Housing/Homelessness. The cost of housing continues to be a large financial burden particularly for low income families. In Los Angeles County, it has been estimated that renters need to earn $46.15/hour to afford the median monthly rent. This is more than 4 times local minimum wage. Low income renters can spend up to 71% of their income on rent, leaving little left for health care bills, food, and transportation[11]. The current demand for affordable housing exceeds existing inventory, with a gap of 500,000 homes[12]. The KFH-South Bay service area has more than 4,000 homeless individuals, 80% of which are unsheltered. African Americans are disproportionately impacted by homelessness. They make up 34% of the homeless population in South Bay and only 10% of the overall population[13]. During community engagement sessions with local service providers, they talked about factors that play a role in

---

[8] Why Education Matters to Health - Exploring the Causes published by Virginia Commonwealth University's Center on Society and Health. (2014).

[9] American Community Survey. (2012-2016).

[10] The California Health Interview Survey. (2013-2017). Retrieved from: askchis.ucla.edu

[11] Los Angeles County Health Survey. (2015). Retrieved from: publichealth.lacounty.gov/ha/LACHSDataTopics2015.htm

[12] Los Angeles County's Housing Emergency and Proposed Solutions published by California Housing Partnership Corporation. (2018).

[13] American Community Survey. (2012-2016).

homelessness including low wages and increased cost of living, lack of treatment and support for people with mental illness, and resident opposition to housing development in many communities.

Mental Health. Poor mental health is a leading cause of disability in many developed countries, and greatly impact one's physical health. A growing body of evidence demonstrates a strong association between poor mental health and chronic conditions, such as cardiovascular disease, diabetes, asthma, and some cancers[14]. Within the KFH-South Bay service area, residents experience four poor mental health days per month on average. Under-resourced communities within the KFH-South Bay service area experience higher rates of poor mental health[15]. Community input session participants shared stories about the ways in which the stresses that come with poverty, especially violence at home, impact mental health. They also discussed difficulties faced when trying to access mental health services including a severe lack of providers and reluctance to address mental health issues because of the associated stigma.

Structural Racism and Marginalization. Historic and present-day public and institutional policies and practices impact the places we live, learn, and work. However, such policies and practices have not provided everyone the necessary financial resources, investments, and opportunities to live a long healthy life, and have pushed many groups to the edge of society by not allowing them an active voice and place in it. This has resulted in significant health and economic disparities based on categorization of race, ethnicity, gender, sexual identity, or mental capacity. In South Bay, there are many indicators of health disparities. African Americans, for example, experience higher rates of diabetes, high blood pressure, stroke, and infant deaths as compared to other racial/ethnic groups[16]. Participants in community input sessions provided insights into how residents from marginalized groups experience these inequities including struggling to access care and being disproportionately impacted by upstream factors that affect health such as lack of employment, poor education, and violence in the community.

D. Community resources potentially available to respond to the identified health needs

The service area for KFH-South Bay contains community-based organizations, government departments and agencies, hospital and clinic partners, and other community members and organizations engaged in addressing many of the health needs identified by this assessment.

Key resources available to respond to the identified health needs of the community are listed in Appendix D Community Resources.

---

[14] Social Determinants of Mental Health published by World Health Organization. (2014).
[15] Behavioral Risk Factor Surveillance System. (2015).
[16] The California Health Interview Survey. (2013-2017). Retrieved from: askchis.ucla.edu

VI. KFH-South Bay 2016 Implementation Strategy evaluation of impact

A. Purpose of 2016 Implementation Strategy evaluation of impact

KFH-South Bay's 2016 Implementation Strategy Report was developed to identify activities to address health needs identified in the 2016 CHNA. This section of the CHNA Report describes and assesses the impact of these activities. For more information on KFH-South Bay's Implementation Strategy Report, including the health needs identified in the facility's 2016 service area, the health needs the facility chose to address, and the process and criteria used for developing Implementation Strategies, please visit https://about.kaiserpermanente.org/content/dam/internet/kp/comms/import/uploads/2013/10/KFH-South-Bay-IS-Report.pdf. For reference, the list below includes the 2016 CHNA health needs that were prioritized to be addressed by KFH-South Bay in the 2016 Implementation Strategy Report.

1. Access to Care
2. Economic Security
3. Injury and Violence Prevention
4. Mental and Behavioral Health
5. Obesity/HEAL/Diabetes

KFH-South Bay is monitoring and evaluating progress to date on its 2016 Implementation Strategies for the purpose of tracking the implementation and documenting the impact of those strategies in addressing selected CHNA health needs. Tracking metrics for each prioritized health need include the number of grants made, the number of dollars spent, the number of people reached/served, collaborations and partnerships, and KFH in-kind resources. In addition, KFH-South Bay tracks outcomes, including behavior and health outcomes, as appropriate and where available.

The impacts detailed below are part of a comprehensive measurement strategy for Community Health. KP's measurement framework provides a way to 1) represent our collective work, 2) monitor the health status of our communities and track the impact of our work, and 3) facilitate shared accountability. We seek to empirically understand two questions 1) how healthy are Kaiser Permanente communities, and 2) how does Kaiser Permanente contribute to community health? The Community Health Needs Assessment can help inform our comprehensive community health strategy and can help highlight areas where a particular focus is needed and support discussions about strategies aimed at addressing those health needs.

As of the documentation of this CHNA Report in March 2019, KFH-South Bay had evaluation of impact information on activities from 2017 and 2018. These data help us monitor progress toward improving the health of the communities we serve. While not reflected in this report, KFH-South Bay will continue to monitor impact for strategies implemented in 2019.

B. 2016 Implementation Strategy evaluation of impact overview

In the 2016 IS process, all KFH hospital facilities planned for and drew on a broad array of resources and strategies to improve the health of our communities and vulnerable populations, such as grantmaking, in-kind resources, collaborations and partnerships, as well as several internal KFH programs including, charitable health coverage programs, future health professional training programs, and research. Based on years 2017 and 2018, an overall summary of these strategies is below, followed by tables highlighting a subset of activities used to address each prioritized health need.

KFH programs: From 2017-2018, KFH supported several health care and coverage, workforce training, and research programs to increase access to appropriate and effective health care services and address a wide range of specific community health needs, particularly impacting vulnerable populations. These programs included:

- Medicaid: Medicaid is a federal and state health coverage program for families and individuals with low incomes and limited financial resources. KFH provided services for Medicaid beneficiaries, both members and non-members.

- Medical Financial Assistance: The Medical Financial Assistance (MFA) program provides financial assistance for emergency and medically necessary services, medications, and supplies to patients with a demonstrated financial need. Eligibility is based on prescribed levels of income and expenses.

- Charitable Health Coverage: Charitable Health Coverage (CHC) programs provide health care coverage to low-income individuals and families who have no access to public or private health coverage programs.

- Workforce Training: Supporting a well-trained, culturally competent, and diverse health care workforce helps ensure access to high-quality care. This activity is also essential to making progress in the reduction of health care disparities that persist in most of our communities.

- Research: Deploying a wide range of research methods contributes to building general knowledge for improving health and health care services, including clinical research, health care services research, and epidemiological and translational studies on health care that are generalizable and broadly shared. Conducting high-quality health research and disseminating its findings increases awareness of the changing health needs of diverse communities, addresses health disparities, and improves effective health care delivery and health outcomes.

Grantmaking: For 70 years, Kaiser Permanente has shown its commitment to improving community health through a variety of grants for charitable and community-based organizations. Successful grant applicants fit within funding priorities with work that examines social predictors of health and/or addresses the elimination of health disparities and inequities. From 2017-2018, Kaiser Permanente paid 135 number of grants amounting to a total of $5,455,903 in service of

KFH-South Bay 2016 health needs. Additionally, KFH-South Bay has funded significant contributions to California Community Foundation in the interest of funding effective long-term, strategic community benefit initiatives within KFH-South Bay. During 2017-2018, a portion of money managed by this foundation was used to award 32 grants totaling $5,479,722 in service of 2016 health needs.

In-kind resources: In addition to our significant community health investments, Kaiser Permanente is aware of the significant impact that our organization has on the economic vitality of our communities as a consequence of our business practices including hiring, purchasing, building or improving facilities and environmental stewardship. We will continue to explore opportunities to align our hiring practices, our purchasing, our building design and services and our environmental stewardship efforts with the goal of improving the conditions that contribute to health in our communities. From 2017-2018, KFH-South Bay leveraged significant organizational assets in service of 2016 Implementation Strategies and health needs. See table below for illustrative examples.

Collaborations and partnerships: Kaiser Permanente has a long legacy of sharing its most valuable resources: its knowledge and talented professionals. By working together with partners (including nonprofit organizations, government entities, and academic institutions), these collaborations and partnerships can make a difference in promoting thriving communities that produce healthier, happier, more productive people. From 2017-2018, KFH-South Bay engaged in several partnerships and collaborations in service of 2016 Implementation Strategies and health needs. See table below for illustrative examples.

C. 2016 Implementation Strategy evaluation of impact by health need

KFH-South Bay Priority Health Needs

Need	Summary of impact	Examples of most impactful efforts
Access to Care	*During 2017 and 2018, Kaiser Permanente paid 25 grants, totaling $1,109,167 addressing the priority health need in the KFH-South Bay service area. In addition, a portion of money managed by a donor advised fund at California Community Foundation was used to pay 8 grants, totaling $1,356,667 that address this need.*	**Providing Affordable Healthcare** Over two years (2017-2018), KFH-South Bay provided $37,710,531 in medical care services to 41,636 Medi-Cal recipients (both health plan members and non-members) and $8,277,212 in medical financial assistance (MFA) for 12,601 beneficiaries. **Building Primary Care Capacity** The California Primary Care Association (CPCA) provides education, training, and advocacy to their member community health centers to best serve their low-income, underserved, and diverse patients. In 2018, Kaiser Permanente paid $126,666 to CPCA to: Hold statewide convenings and conferences and topic-specific peer networks to support over 1,200 California community health centers.

Need	Summary of impact	Examples of most impactful efforts
		• ·Provide 90 in-person and web-based trainings to over 4,400 attendees and 2,890 individual instances of technical assistance.

Preserving and Expanding California Coverage Gains
Insure the Uninsured Project (ITUP) works to preserve and expand access to health care and coverage in California and to reduce access barriers for uninsured and underinsured populations. Over two years (2017-2018), Kaiser Permanente paid $150,000 to ITUP to:
- Conduct and disseminate health policy research.
- Convene 13 regional statewide work groups.
- Provide technical assistance to safety net providers and other stakeholders navigating health reform challenges.
- Serve as a bridge between health policy and the health care sector to reach 19 million Californians.

Expanding Primary and Prevention Care
Harbor Community Clinic (HCC) is a Federally Qualified Health Center works to increase access to care, and intensive services for patients with chronic and multiple conditions. Over two years (2017-2018), Kaiser Permanente paid $20,000 to HCC to:
- Provide primary and preventive care to over 7,000 low-income Harbor area residents annually.
- Reduce emergency room visits and increase and facilitate linkages to other services and available benefits by providing case management to 100 patients per week.
- Develop 15 to 20 referrals a month to social service and health resources; including application assistance for applicable programs and follow-up.

Alleviating Burdens for Stroke Survivors
City of Carson Stroke Center serves the needs of people living with the effects of stroke and offers support to their caregivers. The Center offers a variety of services including speech and occupational therapy, individual and group exercise, caregiver support groups, and social activities. Over two years (2017-2018), Kaiser Permanente paid $15,000 to City of Carson to:
- Serve over 300 people annually including stroke survivors and their families.
- Support 45 interns that staff the occupational therapy program, thereby expanding services provided to 200 stroke survivors.
- Develop and implement an important database that monitors a patient's progress and provides quantitative metrics to demonstrate successes.

Need	Summary of impact	Examples of most impactful efforts
Economic Security	*During 2017 and 2018, Kaiser Permanente paid 22 grants, totaling $514,000 addressing the priority health need in the KFH-South Bay service area. In addition, a portion of money managed by a donor advised fund at California Community Foundation was used to pay 5 grants, totaling $1,116,667 that address this need.*	**Building the Capacity of Small Businesses** Kaiser Permanente promotes local economic development and enhances economic opportunity by helping to strengthen small business capacity. The Inner-City Capital Connections (ICCC) Program is an initiative that builds the capacity of local business located in economically underserved areas to access capital (financing) and grow their business. Over two years (2017-2018), KFH-South Bay joined this county-wide initiative to: • Collectively enroll 299 businesses across the LA County initiative; 65% of participants are minority owned and 52% of participants are women owned. **Building Safety Net Provider Capacity** The Charles Drew University of Medicine & Science's program works to alleviate the financial burden of undergraduate and graduate education that can prevent low socioeconomic students from completing their education. Recipients of these scholarships are required to work in the safety net for a period of 2 years following graduation. Over two years (2017-2018), Kaiser Permanente paid $666,667 to the university to: • Award eight students a total of $215,833 in scholarships. • Award 12 additional scholarships ranging from $3,750 to $14,833 to students in the programs of nursing, family nurse practitioner, physician assistant, or school of medicine. **Developing Workforce Pipeline for the Safety Net** The Community Clinic Association of Los Angeles County (CCALAC) aims to increase and develop the safety net health care workforce through a pipeline initiative. In 2018, Kaiser Permanente paid $250,000 to CCALAC to: • Implement at least two student exposure programs, training rotations and experiential learning opportunities within member clinics annually for up to 40 students. • Pilot a Nurse Practitioner Residency program that will provide 10 new graduates with a residency placement in five member clinics annually. • Develop an allied health training program to provide resources, trainings, and toolkits to strengthen clinic recruitment, onboarding, and retention efforts. **Training Leaders in Service of Community Health** The Los Angeles Albert Schweitzer Fellowship (ASF) program aims to reduce disparities in health and healthcare by developing "leaders in service" who are dedicated to helping underserved communities. ASF selects Fellows from diverse universities and disciplines (i.e. medicine, dentistry, pharmacy, occupational therapy, psychology, public health, law, social work, etc.) annually to participate in the yearlong service project and awards each

Need	Summary of impact	Examples of most impactful efforts
		Fellow with a stipend of $2,500. For the 2017 to 2018 fellowship class, Kaiser Permanente paid $90,000 to ASF to: • Recruit and train nine Fellows for the 2017-2018 fellowship class. • Support the 2017-2018 fellowship class to develop a plan of action and implement a community project to address local unmet health needs. • Review and prepare for the 2018-2019 fellowship class by selecting eight Fellows for year two.
		Increasing Latino Medical School Applicants in California The Latino Physicians of California (LPOC)/MiMentor Partnership supports current and future Latino physicians through education, advocacy, and health policy. This is a culturally responsive mentoring program to increase underrepresented in medicine (UIM) applicants in California. LPOC will expand the Medical School Ready Program to increase the medical school readiness of UIM students through a year-long mentorship workshop series, supporting applicants through the entire medical school application process. In 2018, Kaiser Permanente paid $25,000 to LPOC to: • Enroll 45 UIM undergraduate and post-graduate students from Southern California into the Medical School Ready Series. • Enroll and train 45 physician mentors/coaches/advisors to mentor UIM medical school applicants.
		Raising Awareness of the California Earned Income Tax Credit Golden State Opportunity (GSO) leads and supports efforts related to economic security such as job creation, community development, and distribution of benefits. In 2018, Kaiser Permanente paid $75,000 to GSO to: • Support GSO's efforts to expand its innovative California Earned Income Tax Credit (Cal EITC) outreach and education. • Inform 250,000 low-income workers on Cal EITC eligibility and benefits through digital advertising, peer-to-peer text messaging, and grassroots outreach. • Train 25 community partners on smart digital targeting, community messaging, and peer-to-peer text messaging to outreach and engage in the Cal EITC campaign.
Violence/ Injury Prevention	*During 2017 and 2018, Kaiser Permanente paid 15 grants, totaling $140,000 addressing the priority health need in the KFH-South Bay service area. In addition, a portion of money managed by a donor advised*	**Providing Safe Environments for At-Risk Youth** The GRYD Foundation holds Summer Night Lights (SNL) programming to provide extended recreational, athletic, artistic, and health and wellness programming and linkages to community resources throughout the City of Los Angeles. Over two years (2017-2018), Kaiser Permanente paid $90,000 to SNL to: • Support case management services to 86 at risk-youth.

27

Need	Summary of impact	Examples of most impactful efforts
	fund at California Community Foundation was used to pay 1 grant, totaling $45,000 that addresses this need.	• Serve 434,644 total meals across 32 sites with a variety of healthy choices. • Provide Zumba, Play Rugby, Go Stadia Go, Dance, and Yoga for 9,385 community members. • Engage 695,430 community members across all SNL sites.
		Providing Mentorship Opportunities for Students California State University Dominguez Hills' Male Success Alliance (MSA) is a high school and middle school program that supports curriculum development, training, and community discussions focused on violence prevention and healthy communities. I Over two years (2017-2018), Kaiser Permanente paid $20,000 to MSA to: • Support the training of 75 high school and middle school students on violence prevention and peer mediation. • Provide mock interviews and serve as guest speakers at mentorship events in partnership with KFH-South Bay staff.
		Practicing Meditation in Schools to Reduce Violence Centinela Youth Services' (CYS) reduces violence in low-income communities and schools by providing peer mediation and conflict resolution interventions. This approach disrupts the school-to-prison pipeline by improving the school environment and reducing truancy and suspension. Over two years (2017-2018), Kaiser Permanente paid $20,000 to CYS to: • Expand their program to 11 middle and high schools in the Hawthorne, Inglewood, Lennox, and Centinela Valley school districts. • Train 15 students across the 11 participating schools. • Provide peer meditations for 748 student participants. • Resolve 470 conflicts through mediation. • Refer 278 students to other CYS programs for additional support, such as family mediation.
Mental and Behavioral Health	*During 2017 and 2018, Kaiser Permanente paid 23 grants, totaling $914,495 addressing the priority health need in the KFH-South Bay service area. In addition, a portion of money managed by a donor advised fund at California Community Foundation was used to pay 1 grants, totaling $40,000 that address this need.*	**Strengthening Mental Health Policies and Practices in Schools** Children Now educates policymakers, school district leaders, and other key stakeholders about best practices and policy solutions to address suspension and expulsion policies that disproportionately impact students of color, improve school climate, and increase students' access to mental health services. Over two years (2017-2018), Kaiser Permanente paid $150,000 to Children Now to: • Inform over 200 key legislators and stakeholders. • Support the California Department of Education in the development of the Whole Child Resource Map. • Lead committees for both the State School Attendance Review Board and the Superintendent's Mental Health Policy Workgroup. **Improving Services for Human Trafficking Survivors**

Need	Summary of impact	Examples of most impactful efforts
		The Coalition to Abolish Slavery and Trafficking (CAST) expands services to improve health outcomes for trafficking victims in Los Angeles County. CAST coordinates a continuum of care for trafficking victims by combining social, medical, and legal services with leadership and advocacy. In 2018, Kaiser Permanente paid $75,000 to CAST to: • Coordinate Whole Person Care services, including housing, food, medical, mental health, legal, education, and employment for 100 human trafficking survivors. • Educate and advocate with policymakers, county officials, and community leaders on how to expand or improve access to emergency and permanent housing for victims.
		Building the Mental Health Workforce Mental Health America of Los Angeles (MHALA) builds the emerging workforce through a 13-week, full time fellowship program that trains and places individuals interested in working in the field of mental health into internships with employers in LA County with its Jump Start Fellowship Training Project. In 2018, Kaiser Permanente paid $40,000 to MHALA to: • Provide eight additional individuals, above the current program capacity of 54, with 180 hours of culturally competent education, including resume and interview support during the fellowship and post-graduation. • Provide eight additional individuals with 240 hours of mental health internship experience.
		Disseminating Knowledge and Best Practices to Surrounding Providers The Gay and Lesbian Center of Long Beach (GLCLB) strives to increase the size and capacity of the mental health workforce in Long Beach. The Center is working to expand its existing internal and external training programs to become a Continuing Education Units (CEU) certified provider training site. Over two years (2017-2018), Kaiser Permanente paid $13,000 to GLCLB to: • Serve as an expert training site for MFT and MSW interns and trainees working towards state licensure. Through the provision of on-site counseling services, coupled with individual and group supervision, interns and trainees of The Center gain tremendous expertise in serving LGBTQ populations. • Offer several half-day trainings facilitated by licensed therapists at a nominal fee to surrounding service providers.
		Addressing Trauma in Transitional Aged Youth The Positive Results Corporation (PRC) specializes in programs supporting children, transitional aged youth (ages 16 to 24), and adults. The programs address the negative effects of trauma and provide youth with the skills necessary to cope with triggers of

29

Need	Summary of impact	Examples of most impactful efforts
		trauma. Over two years (2017-2018), Kaiser Permanente paid $15,000 to PRC to: • Provide capacity training for community, non-profit, and educational organizations addressing stigma, trauma, violence, abuse and mental and behavioral health. • Train 325 educators, case managers and service providers who work with transitional aged youth on a wide range of topics including: the homeless and foster youth experience; levels and types of trauma (sexual, physical, emotional); ways to address emotional, social and financial support; and how to interact with transitional aged youth in a culturally responsive manner.
Obesity/ HEAL/ Diabetes	*During 2017 and 2018, Kaiser Permanente paid 50 grants, totaling $2,778,241 addressing the priority health need in the KFH-South Bay service area. In addition, a portion of money managed by a donor advised fund at California Community Foundation was used to pay 17 grants, totaling $2,921,389 that address this need.*	**Improving Access to Nutritious Foods** California Food Policy Advocates (CFPA) is a statewide policy and advocacy organization that aims to improve the health and well-being of low-income Californians by increasing their access to nutritious, affordable food and reducing food insecurity. In 2018, KP paid $212,500 to CFPA to: • Lead the implementation workgroup for the Supplemental Drinking Water EBT benefit for approximately 40,000 Cal-Fresh households in Kern County. • Lead the implementation workgroup for the Cal-Fresh Fruit and Vegetable EBT pilot project for Southern California retailers.
		Advocating for Maternal, Infant, and Child Health The California WIC Association (CWA) supports efforts to increase local WIC agencies' capacity, increase state and federal decision makers' understanding of WIC services, and increase the capacity of community health centers to build a breastfeeding continuum of care in low-income communities. Over two years (2017-2018), Kaiser Permanente paid $100,000 to CWA to: • Pilot two video conferencing projects increasing awareness and consideration within the CA WIC community. • Collaborate with health centers to share WIC staff for nutrition and breastfeeding counseling (Watts Health Care and clinics in San Diego). • Work to strengthen ties with CPCA and present at CPCA's annual conference. • Visit all CA legislators with 44 appointments and drop-in visits. • Provide extensive information to legislators on nutrition and breastfeeding counseling, food benefits, local economic impacts to grocers, health outcomes, access to Farmers markets, and updates on immigration threats.

Need	Summary of impact	Examples of most impactful efforts
		• Participate in Capitol WIC Education Day in Sacramento with 50 attendees from 30 WIC agencies from all over the state.

Fighting Food Insecurity

California Association of Food Banks' (CAFB) Farm to Family program's goal is to improve health food access by providing fresh produce to food banks, CalFresh outreach and enrollment, advocacy to support anti-hunger policies, and technical assistance to members. In 2018, Kaiser Permanente paid $95,000 to CAFB to:

- Distribute 250,000 pounds of subsidized fresh fruits and vegetables to 11 member food banks.
- Maintain the State Emergency Food Assistance Program to provide food and funding of emergency food to food banks.

Supporting Healthy Eating and Active Living through Systems Change

The City of Long Beach Department of Health and Human Services' HEAL Zone site focuses on school and community strategies that address healthy eating and physical activity opportunities in North Long Beach through policy, environmental, and system changes. In 2018, Kaiser Permanente paid $333,333 to the City of Long Beach Department of Health and Human Services' to:

- Support the passing of City tax incentives for community gardens or urban farms.
- Exchange approximately 1,800 lbs of produce at resident and farmer crop swaps with 305 farmers and 200 participating residents.
- Successfully train12 Resident Leadership Academy participants and 17 Healthy LB Teen Leadership Program participants.
- Advocate for a safer intersection on Artesia and Muriel near Starr King Elementary with the Mayor's office.
- Implement the enhanced Healthy Lifestyle Prescription Program at The Children's Clinic (TCC).

Addressing Food Insecurity through Nonprofit Organizations

The Foodbank of Southern California conducts the Healthy Choices Program (HCP) that promotes accessibility to fresh produce and other nutritional food items. HCP donates products to nonprofit partner agency emergency and non-emergency feeding programs and distributes over 22.9 million pounds of fresh produce annually. Over two years (2017-2018), Kaiser Permanente paid $22,500 to Foodbank of Southern California to:

- Support the purchase and transport of fresh produce, as well as, distribution packaging and supplies.

Need	Summary of impact	Examples of most impactful efforts
		• Help 188 Nonprofit Partner Agencies and 12 Brown Bag for Seniors Distribution Sites to obtain health foods at no cost. • Provide information, resources, and nutritious foods to 450,000 individuals a month.
		Practicing Food Recovering and Redistribution Kaiser Permanente envisions food services not only as the source of nutritious meals for their patients, staff and guests, but as a resource for local communities. Over two years (2017-2018), Kaiser Permanente partnered with Food Finders to: • Recover 11,194.5 lbs of food and distribute to organizations serving individuals in the KFH-South Bay region who face food insecurity.

VII. Appendices
A. Secondary data sources and dates
     i. KP CHNA Data Platform secondary data sources
    ii. "Other" data platform secondary data sources
B. Community Input Tracking Form
C. Health Need Profiles
D. Community Resources
E. Strategic Lines of Inquiry for Community Engagement

Appendix A. Secondary data sources and dates

i. Secondary sources from the KP CHNA Data Platform

Source	Dates
1. American Community Survey	2012-2016
2. American Housing Survey	2011-2013
3. Area Health Resource File	2006-2016
4. Behavioral Risk Factor Surveillance System	2006-2015
5. Bureau of Labor Statistics	2016
6. California Department of Education	2014-2017
7. California EpiCenter	2013-2014
8. California Health Interview Survey	2014-2016
9. Center for Applied Research and Environmental Systems	2012-2015
10. Centers for Medicare and Medicaid Services	2015
11. Climate Impact Lab	2016
12. County Business Patterns	2015
13. County Health Rankings	2012-2014
14. Dartmouth Atlas of Health Care	2012-2014
15. Decennial Census	2010
16. EPA National Air Toxics Assessment	2011
17. EPA Smart Location Database	2011-2013
18. Fatality Analysis Reporting System	2011-2015
19. FBI Uniform Crime Reports	2012-14
20. FCC Fixed Broadband Deployment Data	2016
21. Feeding America	2014
22. FITNESSGRAM® Physical Fitness Testing	2016-2017
23. Food Environment Atlas (USDA) & Map the Meal Gap (Feeding America)	2014
24. Health Resources and Services Administration	2016
25. Institute for Health Metrics and Evaluation	2014
26. Interactive Atlas of Heart Disease and Stroke	2012-2014
27. Mapping Medicare Disparities Tool	2015
28. National Center for Chronic Disease Prevention and Health Promotion	2013
29. National Center for Education Statistics-Common Core of Data	2015-2016
30. National Center for Education Statistics-EDFacts	2014-2015
31. National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention	2013-2014
32. National Environmental Public Health Tracking Network	2014
33. National Flood Hazard Layer	2011
34. National Land Cover Database 2011	2011
35. National Survey of Children's Health	2016
36. National Vital Statistics System	2004-2015
37. Nielsen Demographic Data (PopFacts)	2014
38. North America Land Data Assimilation System	2006-2013
39. Opportunity Nation	2017
40. Safe Drinking Water Information System	2015

41.	State Cancer Profiles	2010-2014
42.	US Drought Monitor	2012-2014
43.	USDA - Food Access Research Atlas	2014

ii. Additional sources

	Source	**Dates**
1.	California Department of Public Health	2016
2.	California Healthy Places Index	2018
3.	California HIV Surveillance Report	2015
4.	Office of Environmental Health Hazard Assessment	2011-2013
5.	Los Angeles County Department of Public Health	2015
6.	Los Angeles Homeless Services Authority	2018

Appendix B. Community input tracking form

	Data collection method	Title/name	Number	Target group(s) represented	Role in target group	Date input was gathered
Organizations						
1	Online Survey	Multiple stakeholders, Core Learning Question Survey	18	Health department Minority Medically underserved Low income	Leader	10/1/18 - 1/31/19
2	Key Informant Interview	Health Educator, Los Angeles County Department of Public Health	1	Health department	Leader	10/19/18
3	Key Informant Interview	Assistant Director and Assistant Professor, Charles Drew University	1	Minority Medically underserved	Leader	10/19/18
4	Focus Group	Staff from local organizations focused on education and employment, Cultivate Career Pathways Focus Group	12	Low income	Leaders	10/22/18
5	Focus Group	Staff from local organizations focused on food insecurity, HEAL Focus Group	11	Minority Medically underserved Low income	Leaders	11/13/18
6	Key Informant Interview	Executive Director and Chief Food Enthusiast, Feast	1	Low income	Leader	11/19/18
7	Online Forum	Local clinics and nonprofits focused on health care access and mental health, Mental Health Online Forum	4	Minority Medically underserved Low income	Leaders	12/3/18-12/7/18
8	Focus Group	Staff, Watts Counseling and Learning Center	7	Minority Medically underserved Low income	Leaders	12/5/18
9	Key Informant Interview	Pathway Connections Specialist, Centinela Valley Union High School District	1	Minority Medically underserved Low income	Leader	12/13/18
10	Key Informant Interview	Parent Nutrition Education Facilitator, Hawthorne School District	1	Minority Medically underserved Low income	Leader	12/17/18

	Data collection method	Title/name	Number	Target group(s) represented	Role in target group	Date input was gathered
11	Key Informant Interview	Community Wellness Coordinator, The Children's Clinic	1	Medically underserved	Leader	1/4/19
12	Key Informant Interview	Community Engagement Coordinator, Neighborhood Housing Services of Los Angeles County	1	Minority Medically underserved Low income	Leader	1/8/19
13	Key Informant Interview	Registered Associate Marriage and Family Therapist, Richstone Family Center	1	Medically underserved Low income	Leader	1/17/19
14	Key Informant Interview	Chief Executive Officer, Harbor Community Clinic	1	Minority Medically underserved Low income	Leader	1/24/19
15	Key Informant Interview	Regional Program Director, Torrance-South Bay YMCA	1	Minority Medically underserved Low income	Leader	1/28/19
16	Focus Group	Staff from local organizations focused on health equity, Health Equity Focus Group	9	Minority Medically underserved Low income	Representatives	1/29/19
17	Focus Group	Associate State Director, AARP	1	Minority Medically underserved Low income	Leader	1/30/19
18	Focus Group	Staff from local organizations focused on homelessness, Homelessness Focus Group	20	Health department Minority Medically underserved Low income	Representatives	1/31/19
19	Key Informant Interview	Division of Student Health and Human Services, Los Angeles Unified School District	1	Minority Medically underserved Low income	Leader	1/31/19
20	Key Informant Interview	Prevention Coordinator, Behavioral Health Services, Inc.	1	Minority Medically underserved Low income	Leader	2/4/19

Community residents

	Data collection method	Title/name	Number	Target group(s) represented	Role in target group	Date input was gathered
21	Focus Group	High school youth, South Bay Youth Focus Group	7	Minority Low income	Representatives	10/20/18

	Data collection method	Title/name	Number	Target group(s) represented	Role in target group	Date input was gathered
22	*Focus Group*	*Middle school youth, South Bay Youth Focus Group*	*6*	*Minority* *Low income*	*Representatives*	*10/20/18*
23	*Focus Group*	*Youth, Compton YouthBuild*	*12*	*Minority* *Low income*	*Representatives*	*11/28/18*
24	*Focus Group*	*Clients, Watts Counseling and Learning Center*	*6*	*Minority* *Low income*	*Representatives*	*12/5/18*

Appendix C. Health Need Profiles

ACCESS TO CARE

Access to health care is critical to preventing disease, managing illnesses, reducing unnecessary disability, and minimizing premature death. When people experience delays or are not able to access services it can also have consequences beyond poor physical health including increased emotional stress, missed work/school, and financial burdens.[1]

Community Voice

During community engagement sessions with local service providers, they talked about some of the challenges **people from marginalized groups** face when accessing health care in South Bay including:

Patients experience judgement, bias, and discrimination, which reduces their trust in and comfort with providers.

> *"There's sort of clinician bias. There's social experience between the trust of the residents and them encountering continuous stigmas that people relate to them, whether it's because they're the angry black person, or they're the monolingual Spanish-speaking illiterate person. These assumptions that they can constantly encounter doesn't make it a space that they want to continuously be around."*

Patients fear the ramifications of sharing personal information with health care institutions

> *"Basically a lot of families are mixed so the children are on Medicaid but the parents are not. The children are maybe documented, the parents are not. They're even fearful, even though the children using Medicaid will not affect their ability to get citizenship, people are still afraid."*

Indicators

24%

of adults in South Bay experience delays or are not able to get needed medical services or prescription drugs[2]

Percentage of adults who have to delay/forgo medical care or meds

South Bay	24%
LA County	21%
California	21%
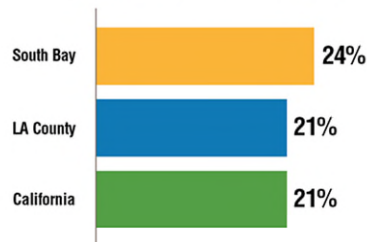
Contributors

Research shows that people are unable to access care when: [3]

They can't enter the health system (e.g., don't have insurance)

They don't have access to a location where services are provided

They don't have a provider they trust and can communicate with

ACCESS TO CARE

Community Voice

Local service providers shared additional challenges that South Bay residents face when accessing care including:

Not being able to **afford care**, especially those who are insured through Covered California, which can have high co-pays

Not being able to get **appointments quickly** or at a time that works for them because clinics are at max capacity

Having difficulties **navigating** the health care system and/or knowing about available services

Dealing with more pressing issues like figuring out how to get **food and shelter**, which keeps people from accessing care until it's an emergency

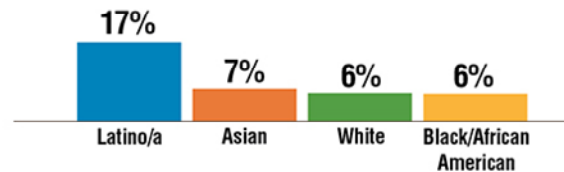Not having **transportation** to get to clinics, hospitals, and other service providers

Disparities
Low-income and Latino/a communities are more affected.

≥30% of adults (18-64) are **uninsured** in under-resourced communities like Compton, Hawthorne, and Lawndale[4]

Percentage of uninsured adults (18-64) in LA County[5]

Latino/a	Asian	White	Black/African American
17%	7%	6%	6%

Local service providers also reported health care access disparities for the following populations: **LGBTQ, homeless, people of color, immigrants, those suffering from mental illness**.

For more information on disparities, please see the Structural Racism and Marginalization profile in the 2019 Community Health Needs Assessment report.

KP Partnerships

Kaiser Permanente South Bay Medical Center (KPSB) has traditionally awarded grants to safety net partners to provide health care services for low-income, uninsured individuals and families. Increasingly, there is greater demand for these partners to connect patients to resources and services that address unmet social needs.

> In 2018, KPSB awarded a partnership grant to a Federally Qualified Health Center (FQHC) to train nonprofit organizations on food stamp enrollment programs in the Long Beach Cambodian community.

As a certified stroke center designated by The Joint Commission, KPSB's Quality Improvement Department partnered with the City of Carson Stroke Center to streamline the process for their patient data collection and designed a database that would allow them to produce reports and increase their capacity to secure additional grants. A $7,500 grant supported the purchase of IT software.

KAISER PERMANENTE.
South Bay Medical Center

ACCESS TO CARE

What's being done?

- Enrolling people in health insurance (e.g., Covered California)

- Going out to the community to provide services

- Educating patients on how to navigate the health care systems

- Advocating for policy change

What else can be done?

- Get community input on and involvement in what services are provided and how

- Provide funding and support for smaller community-based organizations

- Increase the health care workforce

- Streamline healthcare systems

People want to see **more** of this!

- Providing more holistic, coordinated patient care via partnerships and collaborations
- Providing free and low-cost screenings and services
- Providing transportation for patients
- Hiring a diverse workforce
- Delivering programs and services in the language people speak
- Providing cultural competency/implicit bias training for providers

_____

[1] Access to Health Services published by Office of Disease Prevention and Health Promotion. Retrieved from: healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services

[2] The California Health Interview Survey. (2014). Retrieved from: askchisne.ucla.edu

[3] Access to Health Services published by Office of Disease Prevention and Health Promotion.

[4] Health Profile Reports published by County of Los Angeles Public Health. (2018). Retrieved from: publichealth.lacounty.gov/ohae/cchp/healthProfilePDF.htm

[5] LA Health – Recent Trends in Health Insurance Coverage published by County of Los Angeles Public Health. (2017). Retrieved from: publichealth.lacounty.gov/docs/LaHealth_RecentTrendsInHealthInsuranceCoverage_yr2017.pdf

Note: Data for American Indian/Alaska Native and Native Hawaiian/Other Pacific Islander are not included due to confidentiality

KAISER PERMANENTE
South Bay Medical Center

EDUCATION & EMPLOYMENT

Community Voice

During community engagement sessions with local youth, service providers, and school districts, they talked about the issues limiting academic success.

Poverty creates numerous barriers that make focusing on education difficult

"All these programs are fantastic and it's great for career exploration and all of that but if there is no food to eat or there's no electricity, or no water, or no roof over your head you can have all the career exploration you want that's not going to be your biggest problem for the day."

–Service provider

"They can't afford college so they don't feel like getting the rest of their education in high school is that important."

–Student

People of color are impacted by racial biases that are built into the academic environment

"But we do have a lot of work to be done because it definitely shows that there's still ethnic, and racial biases that they are still suspending, or not graduating, or expelling youth of color."

–Service Provider

Evidence shows that people with more education and better employment are more likely to live healthier lives. Higher levels of educational attainment and stable, well-paying jobs create opportunities for better health in myriad ways including higher earnings, more resources to support healthy habits, reduced stress, stronger social and psychological skills, and larger social networks.[1]
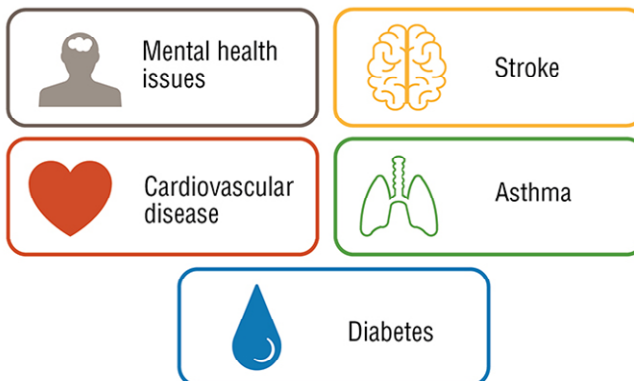
Indicators
In **South Bay**:

17%
of adults do not have a **high school diploma**, similar to the region (20%) and state (18%)[2]

4%
of adults are **unemployed**, the same as the region and state[3]

Less education and less employment are linked to:[4]

Mental health issues

Stroke

Cardiovascular disease

Asthma

Diabetes

KAISER PERMANENTE®
South Bay Medical Center

EDUCATION & EMPLOYMENT

Community members also identified several factors that are critical to supporting students' academic and career success.

Youth need caring adults who can support them in all aspects of their life including academics

> *"[Students] need caring, loving adults who are going to support in their goals of moving forward."*
> –Service provider

The link between education and work should be clear and continually supported

> *"It's a training program right now…it's six week training program for your [security] guard card"*
> –Student

Youth need multiple pathways to success including trade schools, technical training, community college, and four-year college

> *"I think we have to really start to look at this through a very different lens…there are multiple pathways to get to wherever it is that you want to go."*
> –Service provider

Contributors

Research shows that many factors contribute to academic achievement gaps including:[5]

Community context

Student characteristics

School environment

Family support

Education funding
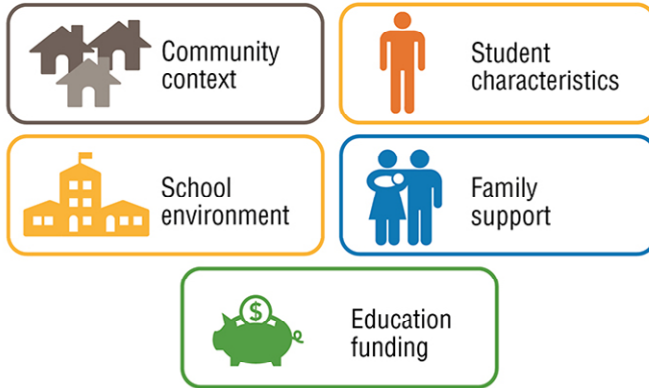
Disparities

People living in poverty and people of color are more affected. In **South Bay**:

In under-resourced communities like **Compton, Hawthorne, Lawndale, parts of Long Beach, Watts, and Wilmington**, fewer adults have a bachelor's degree or higher.[6]

There are large differences in graduation rates across race/ethnicity:[7]
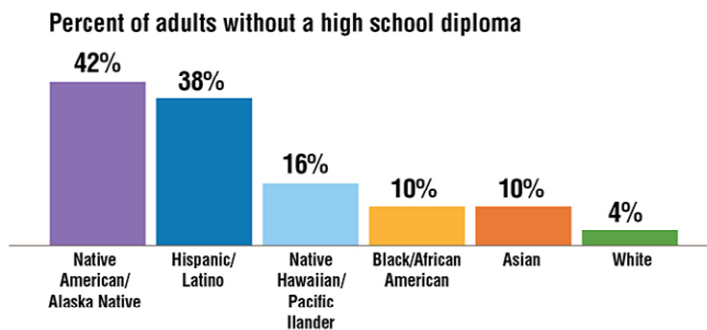
Percent of adults without a high school diploma

Native American/Alaska Native	Hispanic/Latino	Native Hawaiian/Pacific Ilander	Black/African American	Asian	White
42%	38%	16%	10%	10%	4%

For more information on disparities, please see the Structural Racism and Marginalization profile in the 2019 Community Health Needs Assessment report.

KAISER PERMANENTE
South Bay Medical Center

EDUCATION & EMPLOYMENT

KP Partnerships

Kaiser Permanente's South Bay Medical Center provides youth mentorship and employment opportunities through two signature programs and in-service trainings at local high schools.

- **Hippocrates Circle Program** matches middle school youth attending Los Angeles Unified School District (LAUSD) schools to physician mentors to expose them to a medical career.

- **Summer Youth Employment Program** is an 8-week job and soft skills training program for 20+ students each year. In 2018, we partnered with **Long Beach CALL** to hire youth from Jordan High School to work in our Long Beach and Signal Hill Medical Offices.

- Additionally, departments host in-service trainings at local high school campuses.

   Reception and Member Services designed and conducted a customer service training for students in hospitality programs at **Leuzinger High School in Lawndale**.

   Staff Education organized career and skill-building presentations on various health care topics for students at **Rancho Dominguez High School in Carson**.

What's being done?

- Partnerships with law enforcement; diversion programs
- Early childhood education programs
- Alternative schools
- College preparation programs; dual enrollment
- Youth development programs
- Training and support for youth on how to get and keep a job
- Partnerships between local organizations and schools

What else can be done?

- More partnerships between local organizations
- Structural changes among employers (e.g., re-defining professionalism, rethinking job requirements, reducing biases in the application process)
- Structural changes to education system

People want to see **more** of this!

- Collaborations between educational institutions and employers.
- Trade schools, vocational colleges, career training programs
- Programs that introduce youth to myriad career possibilities
- Programs that train educators on how to understand and respond to underlying issues that students face

1   Why Education Matters to Health - Exploring the Causes published by Virginia Commonwealth University's Center on Society and Health. (2014). Retrieved from: www.rwjf.org/en/library/research/2014/04/why-education-matters-to-health.html
2   American Community Survey. (2012-2016).
3   Bureau of Labor Statistics. (2017).
4   Behavioral Risk Factor Surveillance System. (2016). / American Community Survey. (2011-2015). / CalEnviroScreen 3.0. (2011-2013).
5   Identifying Factors that Contribute to Achievement Gaps published by National Education Association. Retrieved from: www.nea.org/home/17413.htm
6   American Community Survey. (2011-2015).
7   American Community Survey. (2012-2016).

KAISER PERMANENTE
South Bay Medical Center

FOOD INSECURITY

Community Voice

During community engagement sessions with local service providers, they talked about challenges unique to South Bay. In addition to issues around affordability and availability of nutritious food, participants talked about:

Seniors and people with disabilities are especially vulnerable

"Well I would say even seniors and people with disabilities, even those who are above the income threshold for SSI or anything like that, have more difficulty because of…obvious reasons, mobility issues, and things like that."

Education and culture change are needed in addition to more food access.

"You can increase food access, but if you don't have an engaged community that's going to take advantage of that food access, or they don't know it's there, or they don't know how to actually utilize it if it's there, then it just doesn't go anywhere, so that grassroots sort of element, that community-based element, being galvanized I think is really key as well."

In the U.S., 12% of households are food insecure, which means they face challenges getting enough nutritious, good quality food to eat. These families and individuals often have poor diets because they have to buy less expensive foods that are high in calories but lack nutritional value. The resulting hunger and malnutrition have been linked to:

- Higher rates of obesity, diabetes, high blood pressure, heart disease, stroke, and many types of cancer

- Depression and stress, especially among women and adolescents

- Impaired growth and development among children[1]

Indicators

In **South Bay**:

38%
of adults whose household income is less than 200% of the Federal Poverty Level are **food insecure**, similar to the county (40%) and state (41%)[2]

23%
of adults whose household income is less than 200% of the Federal Poverty Level receive **food stamps**, similar to the county (21%) and state (23%)[3]

55%
of children (6) whose household income is less than 200% of the Federal Poverty Level are on **WIC**, lower than the county (60%) and higher than the state (51%)[4]

FOOD INSECURITY

Community Voice

Benefit programs (e.g., CalFresh, WIC) are a big help, but present their own challenges including immigrants not being able to or being afraid to enroll.

"People were really fearful, even four years ago, signing up for the different benefits. They were concerned that it might affect their citizenship status…people really didn't want their names...into the system."

Social stigma and shame prevent people from accessing benefits and services

"And you add to that the social stigma of: "I don't want my kid to be known as someone that is on free program or free lunch"…that it's okay to be in college and visit the food bank…You're not going to go in the middle of your class with your friends. You want to go at night."

Contributors

Problems exist in multiple parts of the food system.

Availability
There are too few places that sell good quality food in many parts of South Bay.[5]

Affordability
When good quality food is available, residents can't afford it.[6]

Disparities

In **South Bay**, African Americans, Latinos, and under-resourced communities are more affected.

Percent of adults who are **food insecure** (and household income is <200% of the Federal Poverty Level[7])

Black/African American	Latino/a	White	Asian
52%	49%	37%	28%
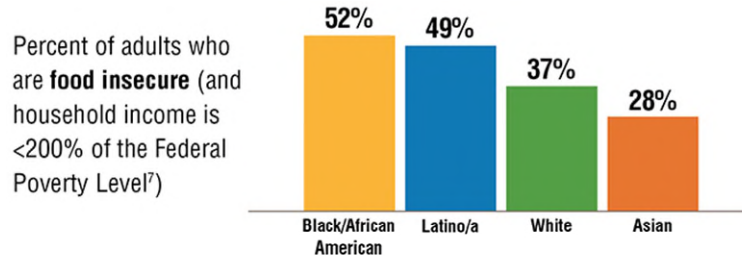
As shown in the map below, under-resourced communities like **San Pedro, Willowbrook, and Wilmington** have more areas that are classified as food deserts (orange).[8]
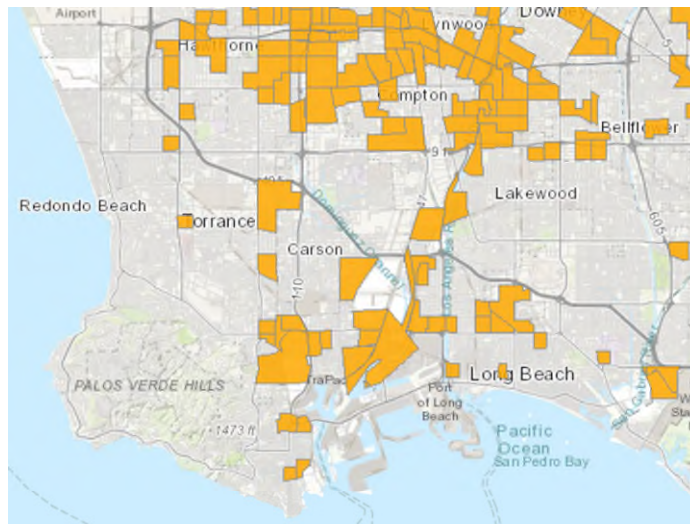
For more information on disparities, please see the Structural Racism and Marginalization profile in the 2019 Community Health Needs Assessment report.

FOOD INSECURITY

KP Partnerships

Kaiser Permanente's South Bay Medical Center partners with nonprofit organizations to reduce food insecurity by awarding grants and supporting food subsidy programs.

- Awarded a $15,000 grant and donated conference room space for culturally competent cooking classes at our Carson and Gardena Medical Offices.

- Hosted weekly farmer's markets and participated in the Summer Market Match program that provides a dollar for dollar match for participants enrolled in food subsidy programs such as CalFresh and WIC (Women Infants and Children) to purchase fresh produce.

What's being done?

- Policy change initiatives (e.g., LA Food Policy Council efforts)
- Provision of vouchers and gift cards for local stores
- Helping local small markets stock more produce and provide education
- Healthcare providers conducting food insecurity screenings and referrals

What else can be done?

- Encourage schools to provide free breakfast regardless of income
- Pick and exchange produce that grows in the area
- Create community kitchens
- Establish community gardens
- Invest in food businesses in under resourced neighborhoods

People want to see **more** of this!

- Multi-sector partnerships (e.g., government and local nonprofits, businesses and local nonprofits)

- Resident organizing and advocacy (e.g., residents pushed stores to put healthy options in check-out aisles, lobbied to change street vendor rules)

- Promotion, education, and enrollment for food assistance programs (e.g., CalFresh, WIC)

- Farmer's markets structured for low-income communities (e.g., accept CalFresh and WIC, have Market Match programs)

- Food pantries, food (re-)distribution programs

- Discounted, home-delivery services (e.g., Imperfect Produce, Farm Fresh to You)

- Culturally appropriate, hands-on nutrition education

1   LA Health - Food Insecurity in Los Angeles published by County of Los Angeles Public Health. (2017). Retrieved from: www.lafoodbank.org/wp-content/uploads/FINAL_LA-Health_FoodInsecurity_Sept-2017.pdf
2   The California Health Interview Survey. (2017). Retrieved from: askchis.ucla.edu
3   The California Health Interview Survey. (2015-2016). Retrieved from: askchis.ucla.edu
4   The California Health Interview Survey. (2014-2016). Retrieved from: askchis.ucla.edu
5   USDA Economic Research Services, ESRI. (2015). Retrieved from: www.ers.usda.gov/data-products/food-access-research-atlas/documentation. Note: Orange indicates low-income census tracts where a significant number (at least 500 people) or share (at least 33 percent) of the population is greater than ½ mile from the nearest supermarket, supercenter, or large grocery store for an urban area or greater than 10 miles for a rural area.
6   Improving Food Access in California published by the California Department of Food & Agriculture. (2012). Retrieved from: www.cdfa.ca.gov/exec/public_affairs/pdf/ImprovingFoodAccessInCalifornia.pdf
7   The California Health Interview Survey. (2013-2017). Retrieved from: askchis.ucla.edu
    Note: Some groups are excluded because there was not enough data to produce statistically stable estimates.
8   USDA Economic Research Services, ESRI. (2015).

KAISER PERMANENTE.
South Bay Medical Center

HOUSING & HOMELESSNESS

The physical and psychological impact of homelessness is immense. It's tied to mental illness, more hospitalizations, and poorer physical health including higher rates of tuberculosis, hypertension, asthma, diabetes, and HIV/AIDS.[1]

Community Voice

During community engagement sessions with local service providers, they talked about factors that play a role in homelessness, in addition to lack of affordable housing:

Many families are struggling financially – Wages aren't keeping up with the cost of living, and even a minor financial setback can leave people homeless especially those who are living paycheck to paycheck

"You have a lot of folks who [are] housed and they're barely making it. Then their car gets towed and that sets off a whole cycle of they have to reprioritize their funds to get their car back. Then, there are weeks on end where they're not going to work."

Lack of treatment and support for people with mental illness, including substance use, makes it very difficult for them to stay well and stay housed

"The highest population is mental illness and there's not enough resources too, because if you look up the street and you just kind of look around you can see most of our homeless population are suffering from mental illness…to a level of they can't take care of themselves."

Indicators
In **South Bay**:

4,000+ people are homeless[2]

6% of adults have been homeless or have not had their own place to live or sleep in the past **five** years, similar to the county (5%)[4]

Among those who are homeless:[3]

80% are unsheltered

62% are male

61% are between the ages of 25 and 54[5]

For more information on homelessness in South Bay, visit **South Bay Coalition to End Homelessness**

KAISER PERMANENTE.
South Bay Medical Center

HOUSING & HOMELESSNESS

Community Voice

Concerns and fears from local communities about the ramifications of having shelters and affordable housing in their neighborhoods hinders development

"I think people are willing to vote for the money to solve the problem with things like measure H and HHH and prop one and two…but when it comes to trying to actually locate a shelter or a permanent location for housing they don't want it in their own neighborhood because there's a lot of fear."

Not having friends and family to rely on puts people at increased risk of becoming homeless

"Yeah…any population that doesn't have any kind of support system, because that's, bottom line, we really find they just don't have family, friends, anybody left they can lean on either from a financial or emotional standpoint. I think it catches everybody."
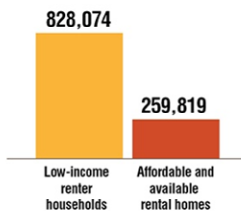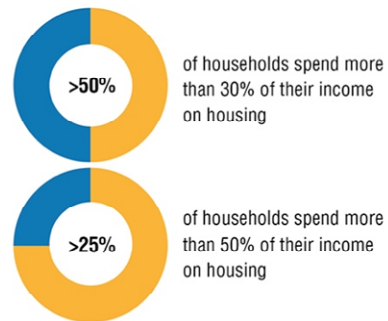
Contributors

One of the biggest issues is lack of affordable housing. In **Los Angeles County**:

$2,400
Median asking rent per month

=

$96,000
Renters need to make per year[6]

Affordable housing shortfall[7]

- 828,074 — Low-income renter households
- 259,819 — Affordable and available rental homes

In under-resourced communities like Gardena, Hawthorne, and Lawndale:[8]

>50% of households spend more than 30% of their income on housing

>25% of households spend more than 50% of their income on housing

Disparities

Many vulnerable groups are impacted by homelessness. In **South Bay**, among those who are homeless:[9]

- **24%** are experiencing **chronic** homelessness
- **22%** have a serious **mental illness**
- **12%** have a **substance use** disorder
- **19%** have experienced **domestic violence**
- **14%** have a **physical disability**
- **9%** are veterans

African Americans make up 34% of the homeless population and only 10% of the overall population.

Percent of homeless population

Black/African American	34%
White	32%
Hispanic/Latino	31%

Percent of overall population[10]

Black/African American	10%
White	25.1%
Hispanic/Latino	33.2%

KAISER PERMANENTE®
South Bay Medical Center
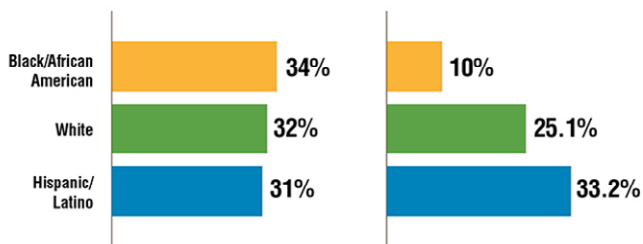
HOUSING & HOMELESSNESS

KP Partnerships

Kaiser Permanente's South Bay Medical Center has been committed to being part of the solution to address homelessness. In partnership with nonprofit organizations, hospitals, coalitions, and government, we have:

- Served as a deployment site for the Los Angeles County-wide homeless count by providing in-kind facility use, support, and employee/physician volunteers.

- Established a partnership with the SPA 8 Coordinated Entry System (CES) to provide navigator services for individuals who present to our emergency department.

- Became a founding member of the Hospital Committee for the South Bay Coalition to End Homelessness. In 2018, area nonprofit hospitals invested $60,000 to sustain a hospital liaison position. The liaison leads and organizes committee meetings and identifies and houses individuals who frequently utilize emergency rooms across hospital systems.

What's being done?
- Programs that educate community agencies (e.g., libraries, police) on the role they can play in assisting homeless people

- Rehabilitation programs

- Health fairs where people can get no-cost screenings and services

What else can be done?
- Build more housing (Measure HHH)

- Enforce state policies around zoning to allow for more housing

- Provide more flexibility in how funding can be used

- Have large hospitals do advocacy around housing and homelessness

- Have hospitals provide real estate for development

People want to see **more** of this!

- Building affordable housing, with supportive services
- Communication and coordination of services across organizations
- Outreach teams that connect homeless people to a variety of services
- Homeless prevention programs (e.g., rental assistance, food subsidies, workforce development)
- Programs that educate elected officials and other key players about housing and homelessness to combat "not in my backyard" attitudes

[1] Health & Homelessness published by American Psychological Association. Retrieved from: apa.org/pi/ses/resources/publications/homelessness-health
[2] Greater Los Angeles Homeless County SPA8. (2018). Retrieved from: sbceh.org/homeless-count-2018.html
[3] Greater Los Angeles Homeless County SPA8. (2018). Retrieved from: sbceh.org/homeless-count-2018.html
[4] Los Angeles County Health Survey. (2015). Retrieved from: publichealth.lacounty.gov/ha/LACHSDataTopics2015.htm
[5] Greater Los Angeles Homeless County SPA8. (2018).
[6] Los Angeles County's Housing Emergency and Proposed Solutions published by California Housing Partnership Corporation. (2018). Retrieved from: 1p08d91kd0c03rlxhmhtydpr-wpengine.netdna-ssl.com/wp-content/uploads/2018/05/Los-Angeles-2018-HNR.pdf
[7] Los Angeles County Annual Affordable Housing Outcomes Report published by California Housing Partnership Corporation. (2018). Retrieved from: 1p08d91kd0c03rlxhmhtydpr-wpengine.netdna-ssl.com/wp-content/uploads/2017/05/FinalOutcomesReport.pdf
[8] Health Profile Reports published by County of Los Angeles Public Health. (2018). Retrieved from: publichealth.lacounty.gov/ohae/cchp/healthProfilePDF.htm
[9] Greater Los Angeles Homeless Count SPA8. (2018).
[10] American Community Survey. (2012-2016).

KAISER PERMANENTE.
South Bay Medical Center

MENTAL HEALTH

Community Voice

During community engagement sessions, local service providers shared what mental health looks like in the communities they serve:

Most common diagnoses:

- Trauma/PTSD
- Depression/anxiety
- Substance use

The stresses that come with poverty are major contributors to poor mental health (e.g., housing insecurity, food insecurity, finding work), **especially violence at home and in the community**

"I'll find in talking to folks who have extreme level of stress especially…with extreme levels of stress, because they're worrying about the amount of income that they're receiving and if they can pay all their bills, or if they're going to make rent and so forth."

"I think understanding and addressing trauma is a major pressing mental health issue. PTSD is typically considered in relation to a single event, however many of the people we serve have experienced a range of traumatic events in their life from childhood abuse, to homelessness, to experiences with violence, health challenges, etc."

The importance of mental health is being increasingly recognized. When people are emotionally, physically, and socially secure, it has a big impact on their overall health. With one in five adults in America experiencing mental illness in a given year, it has become a key concern and a priority for Kaiser Permanente.[1,2]

Indicators
In **South Bay**:

Residents report having poor mental health almost[3]

4 days/month

9% of residents had serious psychological distress in the last year[4]

These rates are similar to Los Angeles County and California as a whole.

KAISER PERMANENTE®
South Bay Medical Center

MENTAL HEALTH

Community Voice

Access to mental health services is a major issue that presents in many ways including:

As a result of shortages in providers, space, and funding, there is a **severe lack of mental health services** including low/no-cost services and the wide variety of services needed to address all levels of care (e.g., counselors, psychiatrists, case managers)

> *"that wait list alone is...I'm gonna be honest with you, it could be six to eight months before they get it."*

Providers don't speak the patient's **language** or understand the patient's **culture**

Stigma prevents people from accessing care, especially among men and the African American community

> *"And for the African American family, there's just the stigma that, you know, what goes on in our house stays in our house."*

Providers **aren't local**, requiring patients to find transportation

> *"So there's a deep need for their transportation, which may cause them to miss a session or two because they just didn't have the proper transportation."*
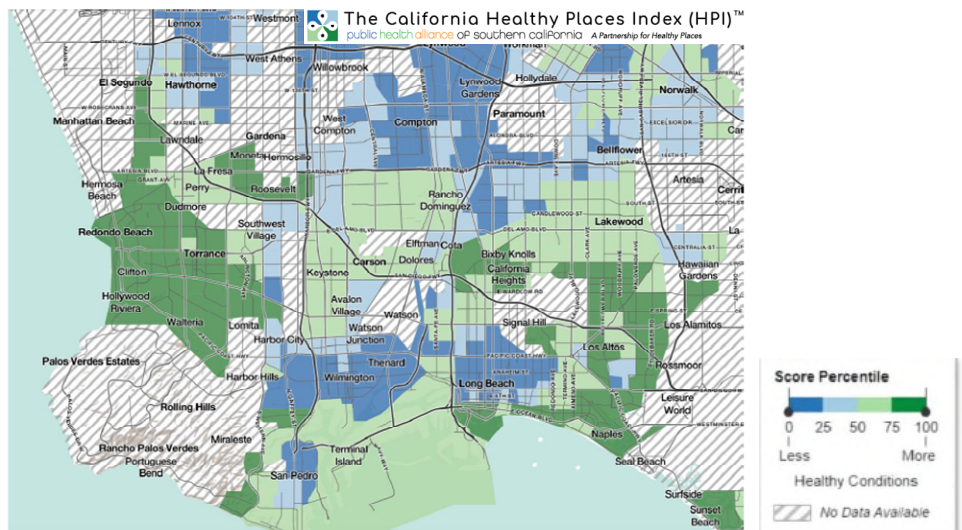
Contributors

Numerous upstream factors contribute to poor mental health, many of which are also indicators of **poverty and discrimination**.[5] In **South Bay**, the following factors are linked to poor mental health:[6]

- Racial segregation
- Level of education
- Income
- Housing status
- Access to care
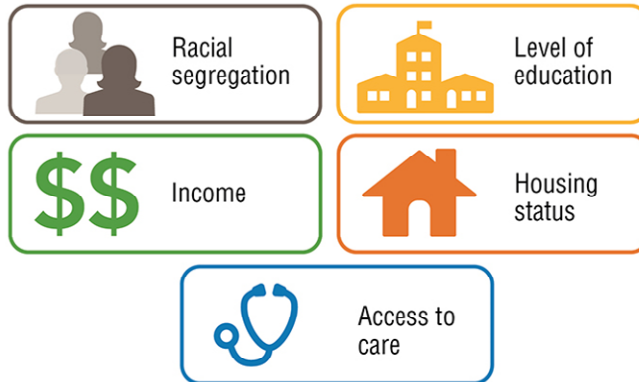
Disparities

Local service providers reported mental health disparities among: **LGBTQ, veterans, women, seniors, people of color, people with chronic illnesses and disabilities, homeless, and youth**.

As shown on the map below, because of the link between mental health and poverty, **more poor mental health days** (dark-blue) are more common in under-resourced communities in South Bay.[7]

Source: The California Healthy Places Index, © 2018 Public Health Alliance of Southern California, http://healthyplacesindex.org/

For more information on disparities, please see the Structural Racism and Marginalization profile in the 2019 Community Health Needs Assessment report.

KAISER PERMANENTE.
South Bay Medical Center

MENTAL HEALTH

KP Partnerships

In 2017, Kaiser Permanente convened community stakeholders to develop the Mental Health and Wellness Initiative. The initiative aims to improve community mental health and wellness by:

- Increasing access to high quality mental health services

- Expanding the workforce to better serve our area and its diverse population

- Reducing mental health stigma

For more information about our Mental Health and Wellness framework and grantmaking investments, check out our digital report: Tackling Mental Health: A Priority for Kaiser Permanente.

People want to see more of this!

- Providing mental health services (all types)

- Integrating physical and mental health care (e.g., co-locating services, training medical providers to conduct mental health screenings)

- Investing in cultural and linguistic capacity though staffing and training

- Promoting available mental health services

- Providing early intervention opportunities (e.g., building coping skills among children, providing self-care opportunities for adults, connecting people to reduce isolation)

- Coordinating care across providers including organizations that address underlying causes

- Providing services out in the community

- Conducting promotional campaigns and education to combat stigma

- Providing care for mental health services staff and family members of people who are mentally ill

- Providing professional development for staff so they can keep up with developments in the field

What else can be done?
- Implement programs that equip a broader range of people (e.g., employers, educators, family members) to recognize mental health issues and connect people to services

_____

[1] Mental Health Facts in America published by National Alliance on Mental Health. (2015). Retrieved from: www.nami.org/NAMI/media/NAMI-Media/Infographics/GeneralMHFacts.pdf

[2] Tackling Mental Health: A Priority for Kaiser Permanente. (2018).

[3] Behavioral Risk Factor Surveillance System. (2015).

[4] The California Health Interview Survey. (2016-2017). Retrieved from: askchis.ucla.edu

[5] Social Determinants of Mental Health published by World Health Organization. (2014).

[6] Behavioral Risk Factor Surveillance System. (2016). / American Community Survey. (2011-2015). / Decennial Census. (2010).

[7] Behavioral Risk Factor Surveillance System. (2015).

KAISER PERMANENTE.
South Bay Medical Center

STRUCTURAL RACISM AND MARGINALIZATION

Community Voice

During community engagement sessions with local service providers, they shared what structural racism and marginalization looks like in the communities they serve:

Marginalized groups struggle to access care. The most notable issue is that the health system isn't built for these groups. Service providers don't understand their unique needs, culture, and language. They experience judgement and bias. They are fearful of and don't trust providers. They avoid care. And, they experience worse health outcomes.

"There is still ongoing bias and issues of racism and marginalization, and not seeing you as an individual and the lack of cultural care and the barriers that exist in our home lives that keep us from walking to the door of the healthcare system. And then once we get there, the barriers smack us right back out the door and make us swear that we will never go back there again."

"Transgender individuals have shared multiple stories that they are going to their doctor, they become the educators for these doctors where they have to educate them on what medication to take, what hormones to take, how to do a certain procedure or how to address clients."

Historic and present-day public and institutional policies and practices impact the places we live, learn, and work. However, such policies and practices have not provided everyone the necessary financial resources, investments, and opportunities to live a long healthy life, and have pushed many groups to the edge of society by not allowing them an active voice and place in it. This has resulted in significant health and economic disparities. These disparities are shaped by systems that disadvantage one group for the benefit and advantage of another, and limit the chances for specific groups of people to be healthy based on categorization of race, ethnicity, gender, sexual identity, or mental capacity.

Decades of research and public health data, and strong themes across the community leaders and residents engaged in the Community Health Needs Assessment, all support Structural Racism and Marginalization as a major health need.[1]

Using the social ecological model of racial constructs, recommended steps toward positive change include: naming the issue, educating individuals who have influence and agency to address the issue, and starting a dialogue in partnership with community to take actionable steps that help institutions and policy makers make different choices to achieve equity and inclusion.

Figure 1: Social Ecological Model with examples of racism constructs
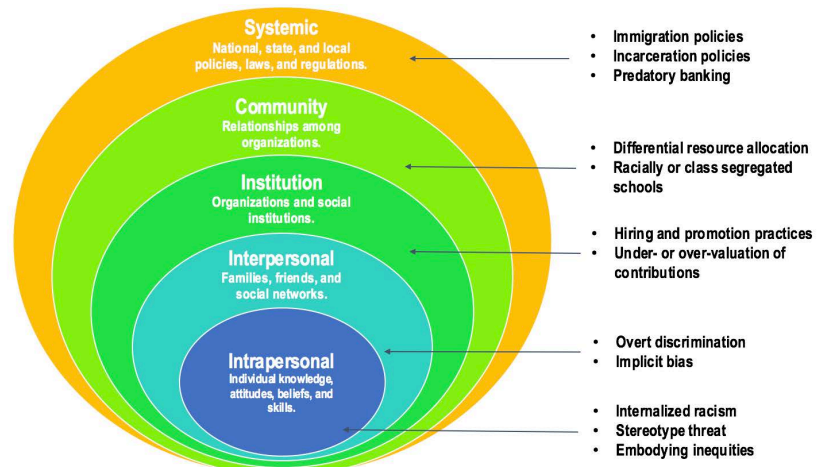
Source: National Academies of Sciences, Engineering, Medicine. Communities in Action Pathways to Health Equity, 2017

KAISER PERMANENTE®
South Bay Medical Center

STRUCTURAL RACISM AND MARGINALIZATION

Community Voice

Continued power imbalances create and sustain inequities

"Historically itself, inner city neighborhoods were not an organic development… They're the history that precedes us that have created the urban ghettos we see across the United States. Red lining policies, racial covenants, Jim Crow, housing policies that didn't allow Black folks in particular and Latinos to purchase property in certain areas of a city."

"I see it on another level too in terms of representation, like ordinary decision making people like our council members, when we look at the key managers of our city and our school district, do they represent our communities? And a lot of times they don't."

Marginalized groups are disproportionately impacted by upstream factors that affect health (e.g., employment, education, community safety)

"Minorities like African-Americans, Hispanics, they have to live in certain communities because that's all they can afford, and then in those communities, they maybe don't feel safe walking, or there's no access to parks, access to healthy food."
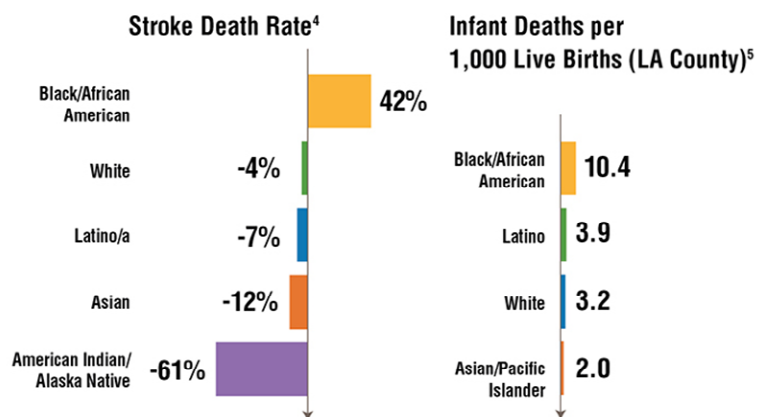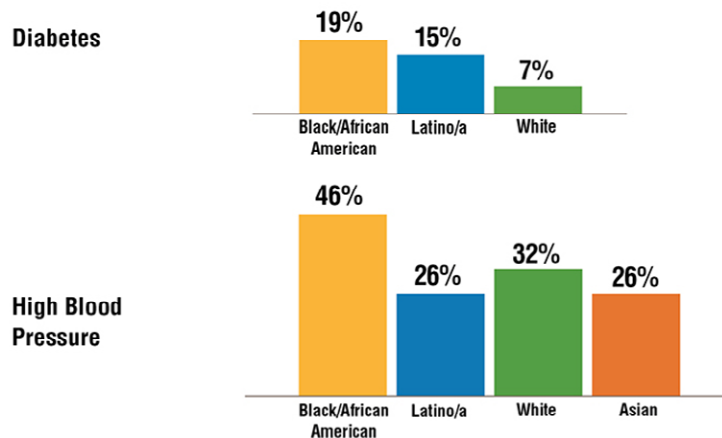
Health Disparities

Research shows that even when we account for economic and social backgrounds, race still plays a pivotal role in healthcare quality and outcomes of patients.[2] We see the impact of those disparities across many indicators in South Bay, as illustrated in the charts below.

For more examples of the impact of structural racism and marginalization, please see the other profiles in the 2019 Community Health Needs Assessment Report (Access to Care, Education & Employment, Food Insecurity, Housing & Homelessness, and Mental Health).

Percent of adults who have ever been diagnosed with: [3]

Diabetes

Black/African American	Latino/a	White
19%	15%	7%

High Blood Pressure

Black/African American	Latino/a	White	Asian
46%	26%	32%	26%

Stroke Death Rate[4]

Black/African American	42%
White	-4%
Latino/a	-7%
Asian	-12%
American Indian/ Alaska Native	-61%

Infant Deaths per 1,000 Live Births (LA County)[5]

Black/African American	10.4
Latino	3.9
White	3.2
Asian/Pacific Islander	2.0

KAISER PERMANENTE®
South Bay Medical Center

STRUCTURAL RACISM AND MARGINALIZATION

KP Partnerships

Kaiser Permanente's South Bay Medical Center (KPSB) partners with a number of nonprofit organizations that support communities and populations with the greatest health care and social needs. This includes providing grant opportunities for and developing capacity of local, grassroots organizations. Many of these programs offer culturally competent programming that is not part of the traditionally evidence-based practices, but have demonstrated outcomes to address issues impacting African Americans, LatinX, Asian and Pacific Islanders, LGBTQ/I, veterans, women, youth, and aging populations.

All of our grantmaking investments focus on under-resourced communities and about a third support nonprofit organizations providing culturally competent and population specific programs. Additionally, KPSB's Equity, Inclusion and Diversity incorporates community health into its body of work through mentorship programs, youth employment, and community partnerships

What's being done?

The county developed a Health Equity Action Plan, which aims to reduce and eliminate inequities and has five focus areas: infant mortality, sexually transmitted infections, environmental justice, health neighborhoods, and cultural and linguistic inclusion and responsiveness

What else can be done?

- Advocate for more funding at higher levels of government

Large hospitals can:
- Provide more and more consistent funding for local organizations
- Partner with local organizations
- Share/advertise their successes and data

People want to see more of this!

- Peer-led support and education (including community health workers and promotores)
- Programs and initiatives that are attuned to the unique needs, assets, cultures, and languages of the community
- Programs and initiatives that help people navigate health care systems
- Programs that bring community members together to reduce isolation
- Going out into the community to reach people where they are
- Educating health care providers on how to serve communities better
- Approaches that target families and communities, not just individuals
- Partnerships and collaboration between organizations
- Having community members design programs and initiatives

1   Race, Racism, and Health published by the Robert Wood Johnson Foundation. Retrieved from https://www.rwjf.org/en/library/collections/racism-and-health.html

2   Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care by Smedley, Stith, and Nelson published in the Journal of the National Medical Association. (2002).

3   The California Health Interview Survey. (2013-2017). Retrieved from: askchis.ucla.edu Note: Some groups are excluded because there was not enough data to produce statistically stable estimates.

4   National Vital Statistics System. (2011-2015).

5   A Pathway to Equity: A Framework to Close the Black-White Gap in Infant Mortality published by the Center for Health Equity. Retrieved from http://publichealth.lacounty.gov/CenterForHealthEquity/ PDF/AAIM-ActionPlan.pdf. (2018).

KAISER PERMANENTE.
South Bay Medical Center

Appendix D. Community resources

Identified need	Resource provider name	Summary description
Access to Care	Harbor Community Clinic	HCC is a Federally Qualified Health Center (FQHC) with two sites in San Pedro - a general care facility and pediatrics. The clinic is dedicated to providing low-cost and no-cost health services to residents with low incomes and those whose employers do not provide health insurance coverage. Services include routine, school and sports physicals, immunizations, ob/gyn care, and health screenings, as well as treatment of both acute and chronic illnesses and diseases. https://www.harborcommunityclinic.com/
	The Children's Clinic, Serving Children and Their Families (TCC)	TCC was founded in 1939 by a group of physicians and community leaders who recognized the importance of access to healthcare for all children, particularly those who are from low income families and who are at risk for health problems. Today, TCC is an FQHC providing daily, full service health care with primary care services for children, adolescents and adults. TCC is known as a unique leader in the greater Long Beach community, addressing disparities in health by providing quality care for the under-served of all ages, offering them a true "medical home". https://www.thechildrensclinic.org/
Education/Employment	California State University Dominguez Hills Male Success Alliance (MSA)	Established on the campus of CSU Dominguez Hills, the Male Success Alliance's (MSAs) mission is to improve access, retention and graduation rates of young men of color through academic support, professional development and mentoring. MSA achieves this by: 1) hiring college students to work at local middle schools and high schools to provide additional support for men of color during the instructional day. Some 250 local middle schools and high schools benefit from this program each year; and 2) providing college preparation, targeted to some of the most challenging and underserved neighborhoods of Los Angeles County including Compton, Carson, South Los Angeles, and Long Beach. https://www.csudh.edu/msa/
	Compton YouthBuild	Provides rigorous educational and occupational opportunities for opportunity youth ages 16+ who are invested in creating a sustainable future for themselves, their families and communities. https://www.entrenousyouth.org/
	South Bay One Stop and Career Cents (One Stop)	One Stop sites are cooperative partnership of business, employment development, education, training, local government, public as well as non-profit organizations, committed to developing job skills, abilities and attitudes essential for participation in today's workplace. In South Bay, there are four one-stop sites and two teen centers serving communities Carson, Gardena, Hawthorne, Inglewood, Lawndale, and Lomita. https://www.southbay1stop.org/
Housing/Homelessness	Coordinated Entry System (CES)	CES is a collaborative connecting youth, adults, and families experiencing homelessness to available resources. Using a standard survey tool helps providers quickly assess the needs and reduce the length of time a family is homeless and gets them into permanent housing. In the South Bay, there are four regional hubs represented by: Harbor Interfaith Services; St. Margaret's Center; United States Veterans Initiative; and People Assisting the Homeless (PATH); and Hathaway-Sycamores Child & Family Services. http://www.harborinterfaith.org/wp-content/uploads/2018/01/SPA-8-All-CES-Systems-brochure-1-8-18-FINAL.pdf
	South Bay Coalition to End Homelessness (SBCEH)	Founded in 2014, SBCEH is a multi-sector collaborative of nonprofit service providers, faith-based institutions, and safety-net providers with a mission is to transform and end homelessness in the South Bay. To date, SBCEH has been successful in supporting the Coordinated Entry System (CES), organizing the annual county-wide homeless count, and developing pocket-guide resources for those experiencing homelessness and for "first

Identified need	Resource provider name	Summary description
		contact" community stakeholders such as law enforcement, schools and libraries, to name a few. https://www.sbceh.org/
Food Insecurity	Black Women for Wellness (BWW)	BWW is community-based organization dedicated to improving the health and well-being of Black women and girls through health education, empowerment and advocacy. BWW services include Sisters in Motion and Kitchen Divas programs focusing on decreasing heart disease, high blood pressure, diabetes and obesity through nutrition education, lifestyle changes, prevention and physical activity. https://www.bwwla.org/
	Foodbank of Southern California (SoCal Foodbank)	SoCal Foodbank is based in Long Beach is one of the largest distributors of fresh produce in the state, distributing over 22.9 million pounds of fresh produce each year, to to over 700 community-based agencies in Los Angeles County who feed those in need through both emergency and non-emergency food programs. https://www.foodbankofsocal.org/
	Los Angeles County, Department of Public Social Services (DPSS)	DPSS enrolls low-income eligible residents in food assistance and other social services programs. The agency administers the CalFresh program, federally known as the Supplemental Nutrition Assistance Program (SNAP), to improve the nutrition of people in low-income households (less than 200% of the Federal Poverty Level). Monthly electronic benefits are issued for eligible participants to purchase most foods at many markets and food stores. A number of community clinics, nonprofit organizations and social service agencies in the South Bay are trained to provide outreach and application assistance to help families enroll. https://www.yourbenefits.laclrs.org/ybn/Index.html
Mental Health	Los Angeles County Department of Mental Health (DMH) – Health Neighborhoods	DMH provides mental health services to individuals experiencing mental health conditions. The Health Neighborhoods initiative brings clinical and service providers together to increase their capacity to prevent and manage mental health conditions in specific communities. https://dmh.lacounty.gov/about/health-neighborhoods/
	Mental Health America Los Angeles (MHALA)	MHALA is an integrated mental health care model serving adults ad transition age youth with mental health needs. With 10 sites and a staff of 400, MHALA provides direct services in north LA County, Long Beach, and south LA County.Through a county-wide training programs, MHALA is a training site for the mental health workforce of tomorrow. http://www.mhala.org/
Structural Racism and Marginalization	California Black Women's Health Project (CABWHP)	CABWHP is the only statewide, non-profit organization that is solely committed to improving the health of California's 1.2 million Black women and girls through advocacy, education, outreach and policy. Emerging Healthcare Leaders & Advocacy Training Program (EHL-ATP) focuses on training young Black women ages 16-30 who are interested in pursuing, or are currently pursuing, training and education in the health professions. https://www.cabwhp.org/
	The LGBTQ Center Long Beach (The Center)	Serving over 25,000 people each year, The Center provides support groups, workshops and seminars, youth services, free HIV & STI testing, legal assistance, domestic violence services, employment referrals, mental health counseling, cultural and social activities, educational forums, and a thriving volunteer program with an active database of over 300 volunteers. The Center also provides meeting space for more than 20 community groups each month. https://www.centerlb.org/
	United Cambodian Community (UCC)	Founded in 1977, United Cambodian Community is a nonprofit multi-cultural social services agency. UCC was originally established to assist in the resettlement of highly traumatized refugees and their families.Today, Long Beach has the largest Cambodian population outside Cambodia and

Identified need	Resource provider name	Summary description
		UCC is located in the center of Cambodia Town, allowing convenient access to the services that are needed. http://www.ucclb.org/

Appendix E. Strategic Lines of Inquiry for Community Engagement

Southern California Kaiser Permanente's approach to the 2019 CHNA employed a mixed-methods sequential explanatory assessment design intended to produce the most accurate, vivid, and meaningful story of community health possible. This appendix reports an overview of the assessment design.

Overview of Question Design Process

- Secondary data from over 200 relevant indicators were analyzed by Kaiser Permanente Regional analysts to provide a bird's eye view of the most pressing health issues across the service area.
- These analyses were reviewed and discussed by Kaiser Permanente clinicians, experts, and hospital leaders who had knowledge of the local community. These discussions helped provide additional context to findings and identify targeted strategic lines of inquiry that provided the foundation of a relevant community engagement plan. For example, Kaiser Permanente social workers might review the data during this phase and provide their perspective that immigration policies could be influencing Hispanic/Latino resident willingness to access care.
- Across these internal sensemaking sessions, strategic lines of inquiry were synthesized by consultants and re-framed to work as a driving force behind community engagement planning. These strategic questions were also designed to be answerable by human beings (not more secondary data). Strategic questions targeted the root causes of health needs, racial/ethnic disparities in impact, community lived experience, or the resources available to address a health need (e.g. *to what extent are current immigration policies inhibiting resident willingness to access healthcare and other community resources and how can these obstacles be overcome?*).
- Strategic questions were not asked *directly* of engagement participants but were instead used to build a sampling frame and culturally competent in-person engagement protocols. For example, a question asking about the impact of immigration policies on resident willingness to access health care would lead to: a) recruitment of community residents and experts who could provide rich answers to the question and b) tailored interview and focus group protocols for engagement participants that would conversationally surface the answer in a manner consistent with best practices in qualitative data collection.
- By using a series of strategic questions in this way, primary data collection allowed for authentic community engagements with residents and stakeholders that could "dive deep" on issues relevant to the community (and ground truth their relevance).
- Regardless of the strategic focus of the engagements, however, they also provided the opportunity for the community to raise any other health needs not targeted through the strategic lines of inquiry and these data were also included primary data analysis.