



2019 Community Health Needs Assessment

Kaiser Foundation Hospitals: Fontana and Ontario

San Bernardino County Area

License number: 240000159

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

September 16, 2019

Kaiser Permanente Southern California Region Community Benefit CHNA Report for KFH-Fontana and Ontario

Contents

I. Introduction/background	1
A. About Kaiser Permanente (KP)	1
B. About Kaiser Permanente Community Health	1
C. Purpose of the Community Health Needs Assessment (CHNA) Report	2
D. Kaiser Permanente’s approach to Community Health Needs Assessment	2
II. Community served	3
A. Kaiser Permanente’s definition of community served	3
B. Map and description of community served	3
i. Map	3
ii. Geographic description of the community served	4
iii. Demographic profile of the community served	5
III. Who was involved in the assessment?	9
A. Identity of hospitals and other partner organizations that collaborated on the assessment	9
B. Identity and qualifications of consultants used to conduct the assessment	9
IV. Process and methods used to conduct the CHNA	9
A. Secondary data	10
i. Sources and dates of secondary data used in the assessment	10
ii. Methodology for collection, interpretation, and analysis of secondary data	10
B. Community input	14
i. Description of who was consulted	15
ii. Methodology for collection and interpretation	15
C. Written comments	16
D. Data limitations and information gaps	16
V. Identification and prioritization of the community’s health needs	16
A. Identifying community health needs	16
i. Definition of “health need”	16
ii. Criteria and analytical methods used to identify the community health needs	16
B. Process and criteria used for prioritization of health needs	17
C. Prioritized description of all the community needs identified through the CHNA	17
D. Community resources potentially available to respond to the identified health needs	19
VI. KFH-Fontana and Ontario 2016 Implementation Strategy evaluation of impact	19

A. Purpose of 2016 Implementation Strategy evaluation of impact	19
B. 2016 Implementation Strategy evaluation of impact overview	20
C. 2016 Implementation Strategy evaluation of impact by health need	22
VII. Appendices	27
Appendix A. Secondary data sources and dates	28
i. Secondary sources from the KP CHNA Data Platform	28
ii. Additional sources	29
Appendix B. Community input tracking form	30
Appendix C. Health need profiles	32
Appendix D. Community resources	50
Appendix E. Strategic Lines of Inquiry for Community Engagement	53
Overview of Question Design Process	53

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-Fontana and Ontario 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-Fontana Service Area

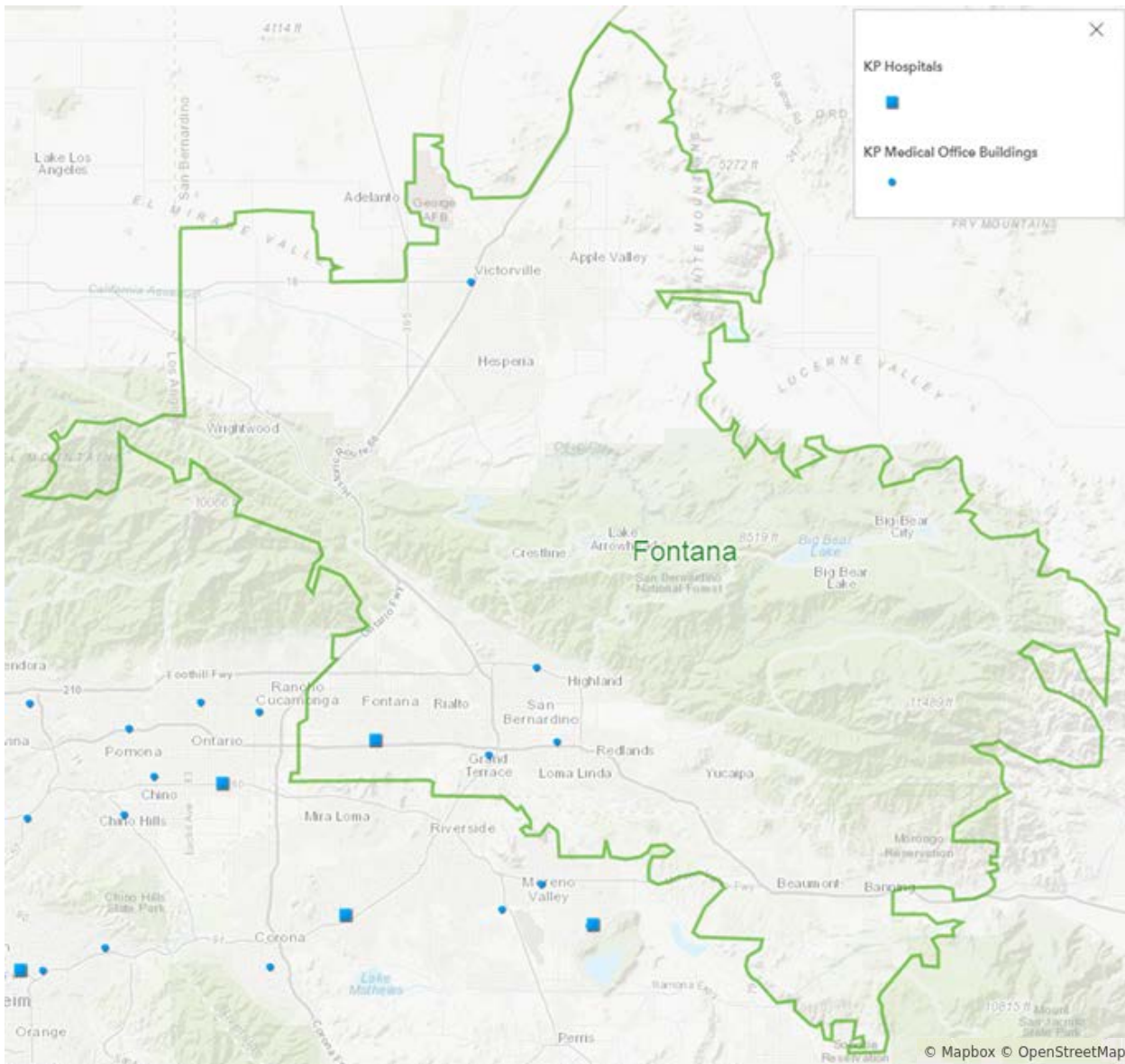
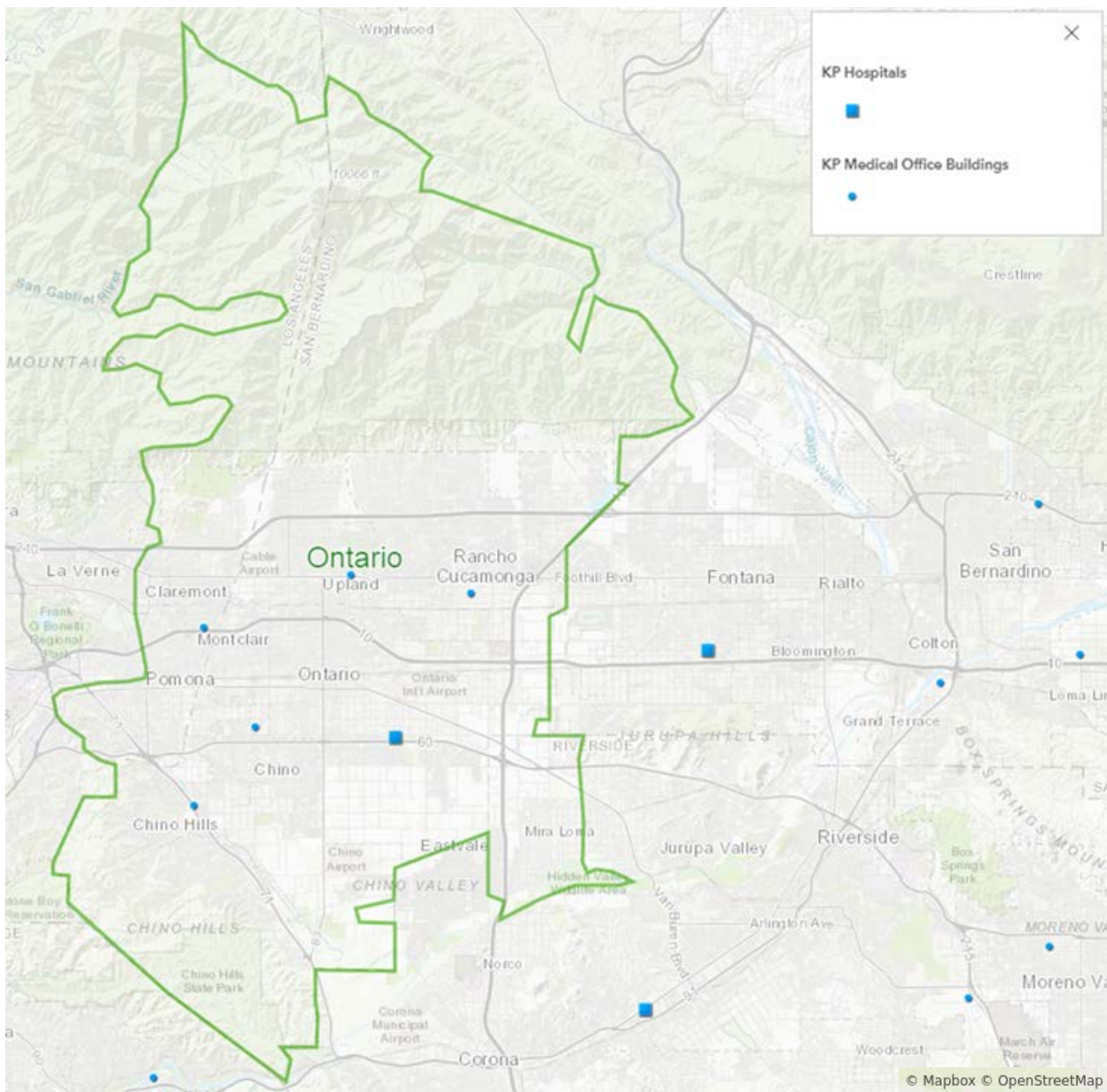


Figure B – KFH-Ontario Service Area



ii. Geographic description of the community served

The KFH-Fontana service area includes the majority of San Bernardino County, a section of eastern Los Angeles County, and the northwest portion of Riverside County. This includes the communities of Angelus Oaks, Apple Valley, Banning, Beaumont, Big Bear City, Big Bear Lake, Bloomington, Calimesa, Cedar Glen, Cedarpines Parks, Cherry Valley, Colton, Crestline, Crest Park, Diamond Bar, Fawnskin, Fontana, Forest Falls, Glen Avon, Grand Terrace, Green Valley, Hesperia, Highland, Lake Arrowhead, Loma Linda, Lytle Creek, Mentone, Mountain View Acres, Muscoy, Patton, Phelan, Pinon Hills, Redlands, Rialto, Rimforest, Rubidoux, Running Springs, San Bernardino, Skyforest, Sugarloaf, Twin Peaks, Victorville, Wrightwood, and Yucaipa. The KFH-Ontario service area includes the west end of San Bernardino County and a section of eastern Los Angeles County. The service area includes the communities of Chino, Chino Hills, Claremont, Diamond Bar, La Verne, Mira Loma, Montclair, Mt. Baldy, Ontario, Pomona, Rancho Cucamonga, San Antonio Heights, and Upland.

iii. Demographic profile of the community served

The following table includes race, ethnicity, and additional socioeconomic data for the KFH-Fontana and Ontario 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-Fontana Service Area¹

Race/Ethnicity		Socioeconomic	
Total Population	1,387,704	Living in Poverty (<100% Federal Poverty Level)	20.9%
Asian	4.5%	Children in Poverty	28.9%
Black	8.7%	Unemployment	3.9%
Hispanic/Latino	54.0%	Uninsured Population	15.1%
Native American/Alaska Native	0.4%	Adults with No High School Diploma	23.0%
Pacific Islander/Native Hawaiian	0.3%		
Some Other Race	0.2%		
Multiple Races	2.0%		
White	30.0%		

Table 2. Demographic profile, KFH-Ontario Service Area²

Race/Ethnicity		Socioeconomic	
Total Population	823,166	Living in Poverty (<100% Federal Poverty Level)	13.7%
Asian	11.8%	Children in Poverty	19.4%
Black	6.1%	Unemployment	4.0%
Hispanic/Latino	51.9%	Uninsured Population	13.3%
Native American/Alaska Native	0.3%	Adults with No High School Diploma	19.1%
Pacific Islander/Native Hawaiian	0.2%		
Some Other Race	0.2%		
Multiple Races	2.4%		
White	27.2%		

iv. Severely under-resourced communities

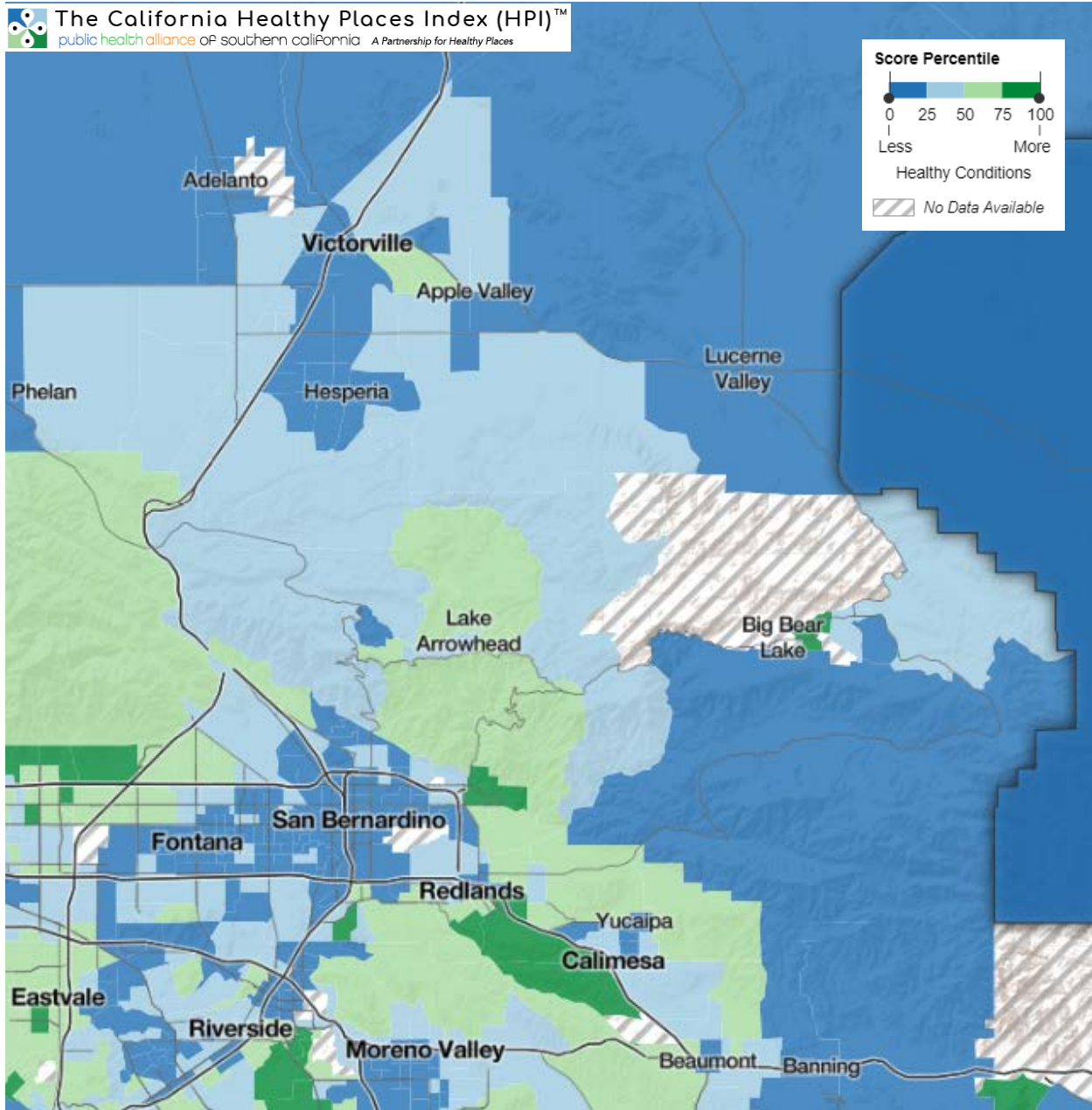
Identifying disparities in the upstream factors that predict negative health outcomes is critical to Kaiser Permanente’s social mission. The map below displays the differences in opportunity for residents in the KFH-Fontana and Ontario service area to live a long and healthy life. Areas in dark blue 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.).

Note: this map displays an area slightly larger than KFH-Fontana service area boundaries and is taken directly from the [Southern California Public Health Alliance’s Healthy Places Index](#).

¹ American Community Survey [2012-2016].

² American Community Survey [2012-2016].

Figure C – Under-resourced Communities in KFH-Fontana



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

Major under-resourced communities in the KFH-Fontana service area, ranking in the bottom 25 percent of all California communities:

- Angelus Oaks
- Banning
- Bloomington
- *Cherry Valley (part)*
- Colton
- *Fontana (part)*

- Forest Falls
- Hesperia
- *Loma Linda (part)*
- Mountain View Acres
- Muscoy
- *Pinon Hills (part)*
- Rialto
- San Bernardino
- Victorville

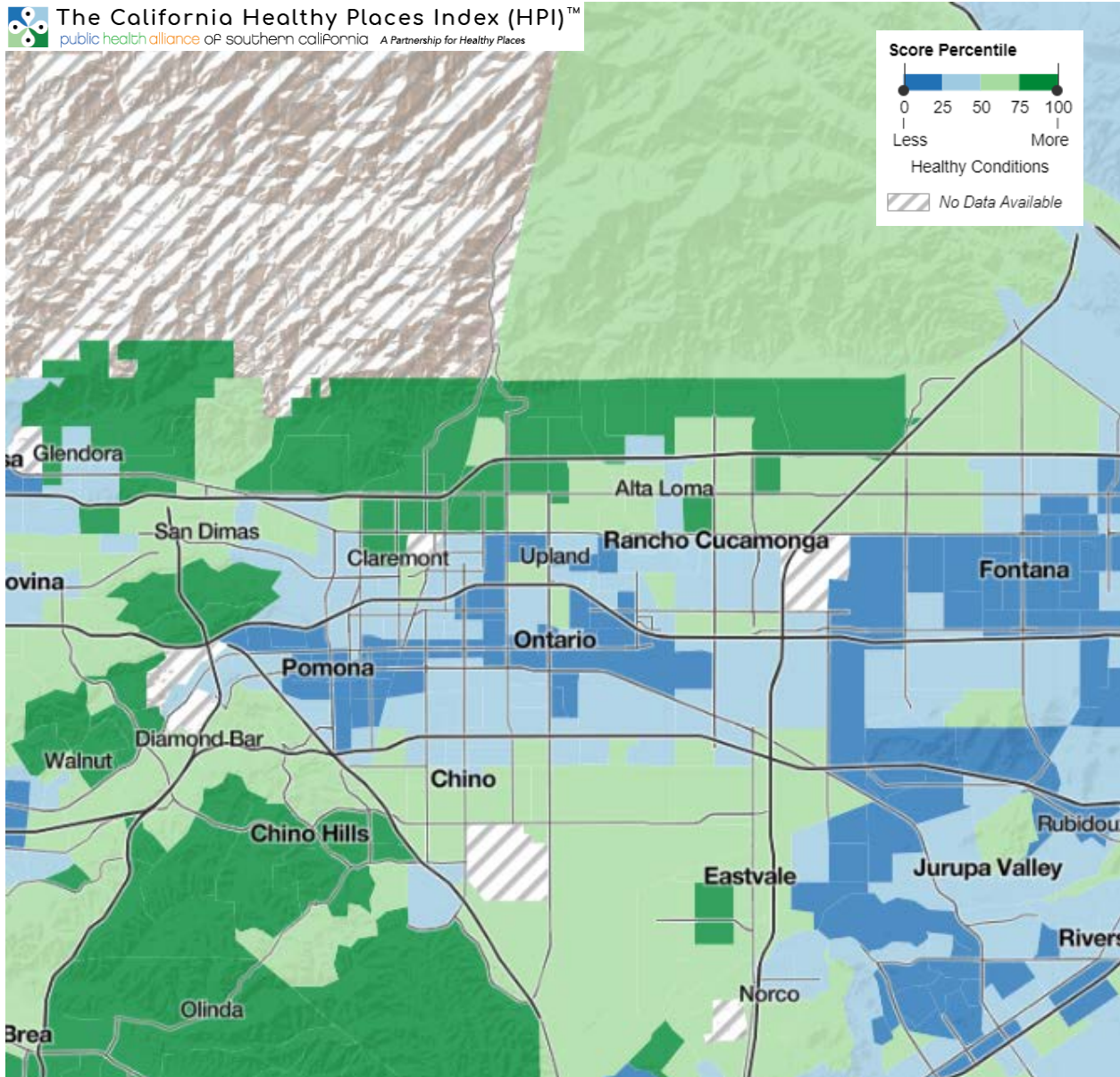
In aggregate, residents living in the KFH-Fontana service area are in the 24th percentile for health opportunity³ among all California residents with approximately 752,872 people living in severely under-resourced census tracts. In effect, this means that 7 out of 10 Californians have a greater opportunity to live a long healthy life than residents living in this service area.⁴

Note: this map displays an area slightly larger than KFH-Ontario service area boundaries and is taken directly from the [Southern California Public Health Alliance's Healthy Places Index](#).

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

⁴ Calculations are estimates based on population-weighted [HPI](#) scores using the most recent US census data.

Figure D – Under-resourced Communities in KFH-Fontana



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

Major under-resourced communities in the KFH-Ontario service area, ranking in the bottom 25 percent of all California communities:

- Montclair
- Pomona

In aggregate, residents living in the Ontario service area are in the 48th percentile for health opportunity among all California residents with approximately 178,823 people living in severely under-resourced

census tracts. In effect, this means that over half of California residents have a greater opportunity to live a long healthy life than residents living in this service area.⁵

III. Who was involved in the assessment?

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

KFH-Fontana and Ontario did not collaborate with other hospitals on the CHNA, though other hospitals and health centers were included during community engagement. KFH-Fontana and Ontario is an active participant in several countywide collaboratives and convenings whose work helped inform the CHNA, including the Oral Health Action Coalition-Inland Empire, the Hospital Association of Southern California Homeless Systems Assessment of Care, the San Bernardino County Homeless Partnership, Office of Homeless Services, the High Desert Food Collaborative, and a Kaiser Permanente San Bernardino County Area Community Mental and Behavioral Health Convening.

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

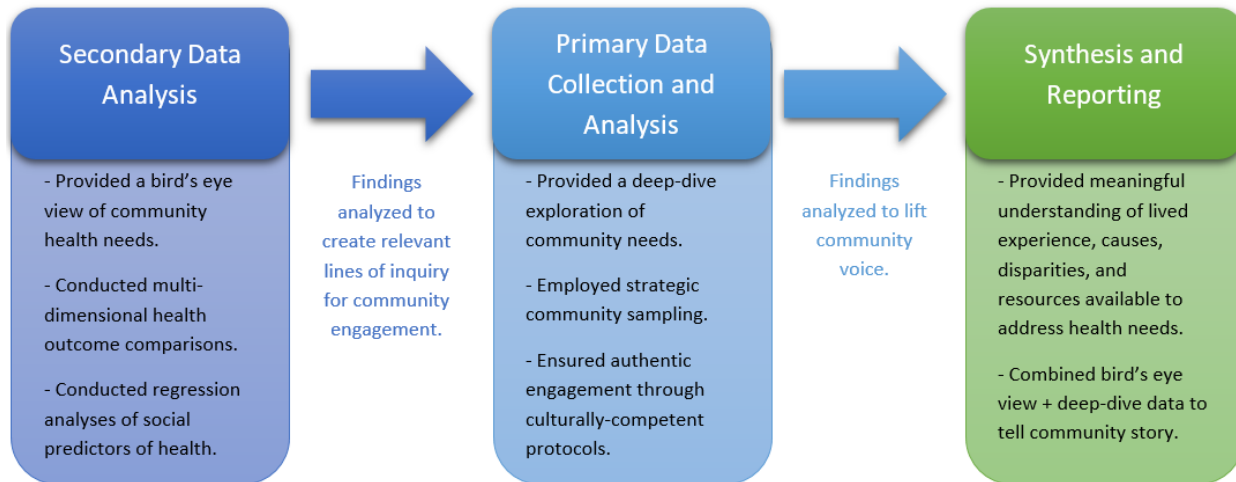
Harder+Company Community Research is a comprehensive social research and planning firm with offices in San Francisco, Sacramento, San Diego, and Los Angeles, California. Since 1986, Harder+Company has assisted public, nonprofit, and foundations nationwide to reveal new insights about the nature and impact of their work. Through high-quality, culturally-based planning, evaluation, and consulting services, the firm helps organizations translate data into action. The firm's staff offers deep experience assisting hospitals, health departments, and other health agencies on a variety of efforts – including conducting needs assessments; developing and operationalizing strategic plans; engaging and gathering meaningful input from community members; and using data for program development and implementation. Harder+Company's success rests on providing services that contribute to positive social impact in the lives of vulnerable people and communities.

IV. Process and methods used to conduct the CHNA

KFH-Fontana and Ontario 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 E below).

⁵ Calculations are estimates based on population-weighted [HPI](#) scores using the most recent US census data.

Figure E – Mixed-Method Assessment Approach to the CHNA



A. Secondary data

i. Sources and dates of secondary data used in the assessment

KFH-Fontana and Ontario 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 Figures C and D to see these maps⁶).

⁶ Maps from the California Healthy Places Index captured in this report are © 2018 Public Health Alliance of Southern California, <https://phasocal.org/>.

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 the KFH-Fontana and Ontario 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 3 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 4 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.

Kaiser Permanente Community Health staff and hospital leadership reviewed secondary data analysis findings to select health outcomes and social predictors of health for deeper exploration during the community engagement process. Health outcomes with high average scores across all dimensions (e.g. prevalence, severity, etc.) were selected as well as the social factors that were predictive of many negative health outcomes in the KFH service area. For further questions about the CHNA methodology and secondary data analyses, please contact CHNA-communications@kp.org.

Table 3. Social Factors Linked to Health Outcomes

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”).

	More Poor Mental Health Days	Heart Attack ER Visits	Higher Asthma Prevalence	Higher Obesity Prevalence	Higher Diabetes Prevalence	More Strokes	Higher Cancer Prevalence	Higher Percentage of Babies Born with Low Birth Weight	Higher Smoking Prevalence	More Pedestrian Injuries	Number of Outcomes Affected
Lower Income	X		X	X	X	X			X	X	7
More Racial Segregation	X		X	X	X	X		X			6
Fewer Bachelor's Degrees	X	X		X		X			X		5
More Crowded Housing	X		X	X					X		4
Less Health Insurance	X			X	X						3
Less Employment		X	X						X		3
More Homeownership					X	X					2
More Bachelor's Degrees							X				1
Less Homeownership									X		1
Fewer Two Parent Households			X								1
Less Supermarket Access					X						1

Table 4. Ranked Health Outcome Comparison Table

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.⁷

Health Outcome Category Name	Prevalence	Difference From State Average	Reduction in Length of Life Per Year	Worst Performing Race/Ethnicity vs. Average	Listed in Partner County Top 5 Cause of Death
Mental Health*	13.3%	1.17% (Worse than CA)	61.3% Reduction	76% Worse than Average	No
Obesity	35.7%	6.1% (Worse than CA)	37% Reduction	29% Worse than Average	No
Substance/Tobacco Use	7.1%	0.06% (Worse than CA)	69.7% Reduction	48% Worse than Average	No
Diabetes*	11.5%	3.1% (Worse than CA)	24.1% Reduction	3% Worse than Average	Yes
Maternal/Infant Health	7.1%	0.3% (Worse than CA)	17.9% Reduction	53% Worse than Average	No
Cancer*	3.7%	0.36% (Worse than CA)	51% Reduction	15% Worse than Average	Yes
HIV/AIDS/STD	0.2%	-0.16% (Better than CA)	58.2% Reduction	211% Worse than Average	No
Asthma	13.9%	-0.9% (Better than CA)	13.3% Reduction	73% Worse than Average	No
Stroke*	3.7%	0% (Same as CA)	57% Reduction	15% Worse than Average	Yes
Oral Health	11.9%	0.6% (Worse than CA)	2.8% Reduction	17% Worse than Average	No
CVD*	5.3%	-1.65% (Better than CA)	30% Reduction	17% Worse than Average	Yes
Violence/Injury	0.0%	0.01% (Worse than CA)	13.2% Reduction	23% Worse than Average	Yes

⁷Indicators 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.

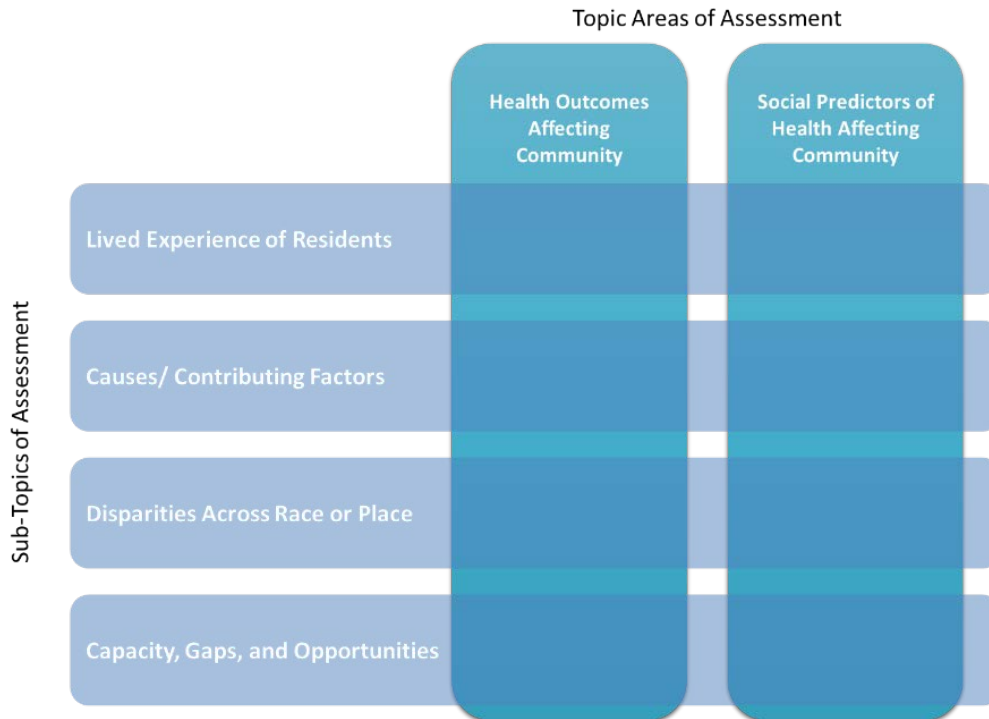
B. Community input

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 F for more details about how these questions were developed):

1. Why are suicide rates so much higher in White communities than other racial/ethnic groups?
2. How is social media being used to exclude and bully youth and teens impacting mental health and increasing the risk of suicide?
3. How can social media be used to positively impact social and emotional well-being and decrease exclusion/isolation/bullying among youth and teens?
4. What factors continue to contribute to high obesity rates, especially among Black and Hispanic/Latino communities?
5. How does level of education influence people's understanding of obesity and its health impact?
6. What more could be done to promote healthy eating and active living?
7. Which communities are experiencing the greatest challenges with opioid abuse? How is opioid abuse impacting these communities? What factors contribute to abuse?
8. What factors impact low birth weight and preterm births, especially in minority communities and in the High Desert and Mountain communities?
9. What factors continue to contribute to high diabetes rates?
10. How might lower education, lower incomes and lower homeownership rates impact diabetes rates?
11. What factors contribute to the high asthma discharge rates in African American communities?
12. What barriers do parents experience in managing their child's asthma?
13. How well equipped are early childhood education and the K-12 educational systems to support parents with asthma management in the classroom? What would make it easier to manage asthma in childcare and school settings?

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 F below).

Figure F. 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-Fontana and Ontario service area, community engagement efforts set out to target those geographies most under-resourced and where health outcomes were the poorest (see Figures C and D for a map referencing the most underserved areas of KFH-Fontana and Ontario). 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. For a complete list of individuals who provided input on this CHNA, see Appendix B.

ii. Methodology for collection and interpretation

In seeking information to help answer strategic lines of inquiry, primary data was collected through interviews and focus groups. Individuals were consulted who had knowledge, information, and expertise relevant to the health needs of the community and the lived experiences of residents. These efforts were designed to create a comprehensive portrait of the health needs through engagement at multiple levels. Engagements sought to understand the lived experience of residents and identify health outcomes and health drivers, as well as assets and barriers to accessing resources across five distinct geographic regions in the service area. A list of individuals that provided input via interview and focus group may be found in Appendix B.

Community members represented 40% of focus group individuals. The majority of experts that participated in focus groups represented public health providers and local department agencies (50%),

community-based or faith-based organizations (48%), and school educators (9%), serving primarily low income and racial and ethnic minority populations. (Note: focus groups participants could select more than one groups to represent, so percentages do not add up to 100%.) The majority of provider experts interviewed represented local and county public health agencies (57%), school educators (29%), and city officials (14%), serving primarily low income and racial and ethnic minority populations.

Each focus group and interview was recorded and transcribed as a stand-alone piece of data. When all groups and interviews had been conducted, analysts used Atlas.ti, a qualitative data analysis software tool, to analyze the information collected. 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 Community Engagement Framework to generate themes useful for answering strategic learning questions and ultimately informing an implementation strategy plan.

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.

As of the time of this CHNA report development, KFH-Fontana and Ontario received one written comment related to the previous CHNA Report. This comment inquired about the timing of the next CHNA report and were answered by Community Health Manager.

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- or city-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. Lastly, given the large and diverse geographic footprint of the service areas, findings from primary data may not be fully generalizable to the demographic or ethnic groups that the sampled community stakeholders represent.

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 or the related conditions that contribute to a defined health outcome. 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

Health needs were identified using secondary data from data reports prepared by Kaiser Permanente regional analysts and primary data from interviews and focus groups. Criteria for identifying health needs included whether at least one secondary indicator for the need fared worse than the state or

Southern California benchmark (as shown in Table 4), whether notable disparities by race/ethnicity or geographic location appeared in the secondary data indicators, and whether a health need consistently emerged during interviews and focus groups.

B. Process and criteria used for prioritization of health needs

Before beginning the prioritization process, KFH-Fontana and Ontario chose a set of criteria to use in prioritizing the list of health needs. Health needs were then prioritized in two phases. In phase one, secondary data was used to identify high priority health needs based on severity of need, scale of need, and clear disparities of inequities. Severity of need refers to how severe the health need is (such as its potential to cause death or disability) and its degree of poor performance against the relevant benchmark. Scale or magnitude of need refers to the number of people affected by the health need. Clear disparities or inequities refers to differences in health outcomes by subgroups. Subgroups may be based on geography, languages, ethnicity, culture, citizenship status, economic status, sexual orientation, age, gender, or others. Given the sheer size of the county, special attention was placed on disparity by geographic region.

In phase two, primary data was used to determine if the community prioritizes the need over other issues and to identify points of leverage for addressing the need. Community prioritization refers to evidence from primary data that the community recognizes the severity of the needs and is willing to address it. Points of leverage of addressing the need refers to existing attention and/or resources dedicated to the issue. For example, there are effective efforts in the community that can be leveraged to address the need, especially initiatives that involve collaboration among several agencies, organizations and sectors. Throughout the prioritization process, the Community Health Manager also supplied information about leverage based on her extensive knowledge of, and experience working in, the community.

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

Access to Care. Access to comprehensive, quality health care services is important for the achievement of health equity and for increasing the quality of life for everyone. Limited access to health care and compromised healthcare delivery impact people's ability to reach their full potential, negatively affecting their quality of life. Across the KFH-Fontana and Ontario service area, residents report worse values on several indicators of access to care compared to the state as a whole. Residents report more poor physical health days per month (4.40 in the KFH-Fontana service area, 4.30 in the KFH-Ontario service area, and 3.71 in California), lower rates of recent primary care visits (66.6% in the KFH-Fontana service area, 66.8% in the KFH-Ontario service area, and 72.9% in California), and higher preventable hospital events per 1,000 residents (44.1 in the KFH-Fontana service area, 43.7 in the KFH-Ontario service area, and 35.9 in California).

Asthma. Causing shortness of breath, coughing, wheezing, and chest tightness, asthma has no cure, according to the Centers for Disease Control and Prevention. While symptoms can be controlled with access to regular, proper care, asthma can severely impact sufferers' ability to participate in daily activities. According to the American Lung Association, asthma leads to more than 10 million missed school days per year among children. Higher shares of residents in the KFH-Fontana and Ontario service area suffer from asthma that in the rest of Southern California. In Southern California as a whole, 12.1% of residents live with asthma, compared to 13.9% of residents in the KFH-Fontana service area and 13.0% in the KFH-Ontario service area. Across the region, however, asthma disproportionately affects Black residents. In the KFH-Fontana service area, hospital discharge rates for

asthma and related complications are 73% higher for Blacks than the average for all residents, while the rate for Blacks in the KFH-Ontario service area is 28% higher.

Diabetes. Diabetes is a costly and deadly disease, which can place a heavier burden on certain groups, including people of color, those from a lower socioeconomic group, and the elderly. Diabetes is the seventh leading cause of death in the US, and over the last 20 years, the number of adults diagnosed with diabetes has tripled, according to the Centers for Disease Control and Prevention. In the KFH-Fontana and Ontario service area, 11.5% (KFH-Fontana) and 10.2% (KFH-Ontario) of adults have been informed by a doctor that they have diabetes, higher than the California state and southern California region prevalence. In addition, 76.5% of the diabetic Medicare patients in the KFH-Fontana service area and 77.6% in the KFH-Ontario service area have received a blood sugar test for diabetes, while Blacks in the service areas get hemoglobin A1C tests at 3 percent and 4 percent below the average rates, respectively.

Maternal and Infant Health. Equal access to high-quality health care before, during, and after pregnancy is essential to women and the next generation. There is still work needed in the U.S. to ensure that women, regardless of race, zip code, or class status have this access. At 11%, Blacks have the highest infant mortality rate, followed by 9% of American Indians/Native Americans (National Center for Health Statistics). In 2016, there were more than 23,000 infant deaths in the U.S. The five leading causes in that year were congenital disabilities, preterm birth, sudden infant death syndrome, maternal pregnancy complications, and injuries (Centers for Disease Control and Prevention). The average death rate for infants in the KFH-Fontana service area is 6.2 per 1,000, and 6.0 per 1,000 in the KFH-Ontario service area. Minority infants across the KFH-Fontana and Ontario service area die at more than 50% above-average rates.

Mental Health. Mental Health is central to everyone's well-being. If not treated, it can affect individuals' daily life, relationships, and physical health. Research shows that almost 1 in 5 or 43.8 million adults in the United States experience mental illness, according to the National Institute of Mental Health. Residents across the KFH-Fontana and Ontario service area report having nearly 4 days per month with poor mental health, which is higher than the state of California and the southern California region. Moreover, the average suicide rate for the KFH-Fontana service area is 10.3 per 100,000 and 9.8 per 100,000 in the KFH-Ontario service area. Across the KFH-Fontana and Ontario service area, Whites die of suicide at rates 76% above average, and in the KFH-Fontana service area, Native American/Alaskan Natives also die of suicides at rates 8% above average.

Obesity. Physical activity, healthy body weight, and balanced meals are essential to the holistic well-being of individuals. Together these can reduce the risks of developing many health conditions. The U.S continues to see alarming rates of obesity, with 1 out of 3 children and 2 out of 3 adults overweight or obese (National Academies Press). Obesity prevalence in the KFH-Fontana and Ontario service area is 35.7% (KFH-Fontana) and 32.1% (KFH-Ontario), both higher than the prevalence in California (29.6%) and southern California region (31.3). Blacks and Hispanics/Latinos in the KFH-Fontana and Ontario service areas are obese at above-average rates.

Substance Abuse. Substance abuse, including use or abuse of tobacco, alcohol, prescription drugs, and illegal drugs, can have profound physical and mental health consequences. For example, of the 20.3 million adults nationwide struggling with substance abuse 37.9% also had a mental illness, according to the National Institute on Drug Abuse. Rates of smoking and excessive drinking in the KFH-Fontana and Ontario service area are higher than statewide averages. Compared to 11.7% of California residents who report smoking, 14.2% of residents in the KFH-Fontana service area and

13.7% in the KFH-Ontario service area are current smokers. In addition, 37.3% of residents in the KFH-Fontana service area and 36.5% in the KFH-Ontario service areas report excessive drinking, compared to 33.4% of residents statewide. Finally, San Bernardino County as a whole experienced a 49% increase in prescription opioid death rates between 2015 and 2017. These rates are dramatically higher for certain groups, including residents in parts of the High Desert and Native Americans.

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

The service area for KFH-Fontana and Ontario 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.

VI. KFH-Fontana and Ontario 2016 Implementation Strategy evaluation of impact

A. Purpose of 2016 Implementation Strategy evaluation of impact

KFH-Fontana and Ontario'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-Fontana and Ontario'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-Fontana-and-Ontario-IS-Reports.pdf>. For reference, the list below includes the 2016 CHNA health needs that were prioritized to be addressed by KFH-Fontana and Ontario in the 2016 Implementation Strategy Report.

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

KFH-Fontana and Ontario 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-Fontana and Ontario 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. Kaiser Permanente'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-Fontana and Ontario 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-Fontana and Ontario 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, KFH-Fontana paid 100 grants amounting to a total of \$3,896,667 in service of KFH-Fontana 2016 health needs. Additionally, KFH-Fontana has funded significant contributions to California Community Foundation in the interest of funding effective long-term, strategic community benefit initiatives within the Fontana service area. During 2017-2018, a portion of money managed by this foundation was used to pay 21 grants totaling \$2,854,836 in service of 2016 health needs. From 2017-2018, KFH-Ontario paid 55 grants amounting to a total of \$2,994,167 in service of KFH-Ontario 2016 health needs. Additionally, Kaiser Permanente

has funded significant contributions to California Community Foundation in the interest of funding effective long-term, strategic community benefit initiatives within the Ontario service area. During 2017-2018, a portion of money managed by this foundation was used to award 23 grants totaling \$4,092,003 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-Fontana and Ontario leveraged significant organizational assets in service of 2016 Implementation Strategies and health needs. Supported programs included:

- Kaiser Permanente Educational Theatre Performance (Amazing Food Detective, Conflict Management, Adolescent Bullying Awareness, Literacy Promotion, STD Prevention)
- Kaiser Permanente Hospital based Farmers' Markets accept EBT, where low income customers can purchase fresh fruits and vegetables.
- Kaiser Permanente child psychiatry on school site therapy, classroom observation, and special education meeting consulting
- Kaiser Permanente Health Educators teach classes in community (IEHP Community Resource Center, San Bernardino).
- Kaiser Permanente inner city Small Business Growth Training
- Kaiser Permanente Fontana and Ontario Medical Center Hospital Food Redistribution to nonprofits
- Kaiser Permanente Workforce Pipeline and Impact Hiring
 - Hippocrates Circle Program for Middle School Students
 - Summer Youth Employment Program for High School Students
 - AB Miller High School Health Academy 5-week department rotations
- Kaiser Permanente Staff & Physicians Volunteerism (MLK Day, Hesperia Clean Up, etc.)
- Kaiser Permanente Staff & Physicians Donation Drives (Back to School, Thanksgiving Food, Holiday Giving)

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-Fontana and Ontario engaged in several partnerships and collaborations in service of 2016 Implementation Strategies and health needs, including:

- Healthy Eating Active Living Initiative, City of Ontario
- Healthy Communities, San Bernardino County Public Health Department (21 Healthy City partners)
- Healthy Schools Initiative, Fontana Unified School District
- Healthy Schools Initiative, San Bernardino City Unified School District
- San Bernardino County Homeless Partnership, Office of Homeless Services
- High Desert Food Collaborative

- Early Learning and Development, Local Planning Council, San Bernardino County Superintendent of Schools
- Funders Alliance of San Bernardino and Riverside Counties
- Community Health Association Inland Southern Region
- Local Oral Health Program Advisory, San Bernardino County Public Health Department
- Oral Health Action Coalition Inland Empire

C. 2016 Implementation Strategy evaluation of impact by health need

Need	Summary of impact	Examples of most impactful efforts
Access to Care	<p><i>During 2017 and 2018, Kaiser Permanente paid 19 grants, totaling \$1,571,667 addressing the priority health need in the KFH-Fontana service area. In addition, a portion of money managed by a donor advised fund at California Community Foundation was used to pay 7 grants, totaling \$991,667 that address this need.</i></p> <p><i>During 2017 and 2018, Kaiser Permanente paid 11 grants, totaling \$1,101,667 addressing the priority health need in the KFH-Ontario service area. In addition, a portion of money managed by a donor advised fund at California Community Foundation was used to pay 6 grants, totaling \$941,667 that address this need.</i></p>	<p><u>Providing Affordable Healthcare</u> Over two years (2017-2018), KFH-Fontana provided \$76,411,737 in medical care services to 95,342 Medi-Cal recipients (both health plan members and non-members) and \$23,718,102 in medical financial assistance (MFA) for 28,428 beneficiaries.</p> <p>Over two years (2017-2018), KFH-Ontario provided \$26,376,696 in medical care services to 36,903 Medi-Cal recipients (both health plan members and non-members) and \$2,479,204 in medical financial assistance (MFA) for 9,251 beneficiaries.</p> <hr/> <p><u>Building Primary Care Capacity:</u> 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:</p> <ul style="list-style-type: none"> • Hold statewide convenings and conferences and topic-specific peer networks to support over 1,200 California community health centers. • Provide 90 in-person and web-based trainings to over 4,400 attendees and 2,890 individual instances of technical assistance. <hr/> <p><u>Preserving and Expanding California Coverage Gains:</u> 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:</p> <ul style="list-style-type: none"> • 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. <hr/> <p><u>Expanding Medical Services to Vulnerable Populations:</u> The Well of Healing Mobile Medical Clinic (WHMMC) provides holistic care coordination for patients with chronic disease; including access to primary care, referrals to specialty services, and referrals to identified social service resources. Over two years (2017-2018), Kaiser Permanente paid \$40,000 to WHMMC to:</p> <ul style="list-style-type: none"> • Provide direct services to 632 low-income, uninsured, and homeless individuals.

		<ul style="list-style-type: none"> • Conduct over 1,400 encounters on Saturdays. • Offer services at three church sites in San Bernardino, Fontana, and Ontario. <hr/> <p>Leveraging Assets: Our core functions across Kaiser Permanente are using their assets to drive Access to Care in the KFH-Fontana and Ontario service area. For example:</p> <ul style="list-style-type: none"> • Physician Community Clinic Engagement: Over two years (2017-2018), 44 SCPMG physicians provided a total of 2,053 medical community service hours to provide primary care and specialty care services to 3,626 low-income and uninsured clients of Al Shifa Free Clinic (Muscoy), Lestonnac Free Clinic (San Bernardino), and the Well of Healing Mobile Medical Mobile on Saturdays at church sites (Ontario, Fontana, San Bernardino). • Physician Specialty Care: Over two years (2017-2018), KFH-Fontana held the once a year Community Saturday Surgery Day where 100 Kaiser Permanente surgeons, anesthesiologists, and staff volunteered a total of 200 hours to provide medical procedures (colonoscopies, hernia repairs, and cataract surgeries) to 20 low-income, uninsured individuals who do not qualify for any other public assistance program.
Economic Security	<p><i>During 2017 and 2018, Kaiser Permanente paid 33 grants, totaling \$510,000 addressing the priority health need in the KFH-Fontana service area. In addition, a portion of money managed by a donor advised fund at California Community Foundation was used to pay 1 grant, totaling \$258,947 that addresses this need.</i></p> <p><i>During 2017 and 2018, Kaiser Permanente paid 16 grants, totaling \$270,000 addressing the priority health need in the KFH-Ontario service area. In addition, a portion of money managed by a donor advised fund at California Community Foundation was used to pay 1 grant, totaling \$258,947 that addresses this need.</i></p>	<p>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-Fontana and Ontario joined this county-wide initiative to:</p> <ul style="list-style-type: none"> • Collectively enroll 299 businesses across the LA County initiative; 65% of participants are minority owned and 52% of participants are women owned. <hr/> <p>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:</p> <ul style="list-style-type: none"> • 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. <hr/> <p>Advocating for At-Risk Youth: Court Appointed Special Advocate (CASA) of San Bernardino County improves the educational outcomes of at-risk foster and juvenile justice youth. CASA identifies and develops volunteers to serve as mentors and advocates for at-risk youth. Over two years (2017-2018), Kaiser Permanente paid \$40,000 to CASA to:</p>

		<ul style="list-style-type: none"> • Screen and train a total of 151 new community volunteers to serve as advocates for 115 new foster youth and 84 reappointed youth for a total of 199 high-risk foster youth served (ages 12+). • Provide 5,700 hours of advocacy support, mentorship, and case management/guidance to improve the educational outcomes of high risk foster and juvenile justice youth. <p>Promoting Higher Education in Low-income Communities: Bright Prospect empowers low-income students from the Pomona Unified School District to gain admission to and graduate from four-year colleges and universities. They educate families about the long-term impacts of higher education and provide students with free services and a multi-level support system. Over two years (2017-2018), Kaiser Permanente paid \$25,000 to Bright Prospects to:</p> <ul style="list-style-type: none"> • Serve and mentor 1,340 high school students and 1,260 college students. • Outreach to 3,154 9th and 10th grade students to inform them of resources and service for college. • Conduct a week-long Summer Academy for 220 students. <p>Increasing Access to Housing for Homeless Individuals: Mercy House improves the living conditions of homeless clients living in and around the city of Ontario by providing crisis case management, referrals to other specialists, and necessities. This is a drop-in center that serves at-risk families with emergency housing, food vouchers, and transportation. Over two years (2017-2018), Kaiser Permanente paid \$40,000 to Mercy House to:</p> <ul style="list-style-type: none"> • Serve 1,545 homeless individuals with crisis case management, referrals, and/or direct basic needs and services. • Increase the number of vouchers distributed to 1,191 individuals that prevent homelessness and alleviate crisis. <p>Improving Internal Programs to Leverage Assets</p> <p>Our core functions across Kaiser Permanente are using their assets to drive Economic Security in the KFH-Fontana and Ontario service area. For example:</p> <ul style="list-style-type: none"> • Over two years (2017-2018), the Hippocrates Circle Program, reached a total of 124 middle school students from the Victor Valley Union High School District and the San Bernardino City Unified School District who received in-depth hands-on experience with the career of a physician over an intense 8-week program. • Over two years (2017-2018), the Summer Youth Employment Program hired 40 high school students from across the service area who completed an intense 6-week rotation in diverse Kaiser Permanente departments (physical therapy, pediatrics, family medicine, patient support services, etc.)
Mental and Behavioral Health	<p><i>During 2017 and 2018, Kaiser Permanente paid 24 grants, totaling \$995,000 addressing the priority health need in the KFH-Fontana service area. In addition, a portion of money managed by a donor advised</i></p>	<p>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:</p>

fund at California Community Foundation was used to pay 1 grants, totaling \$40,000 that address this need.

During 2017 and 2018, Kaiser Permanente paid 15 grants, totaling \$845,000 addressing the priority health need in the KFH-Ontario 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

- 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.

Addressing Adverse Childhood Experiences (ACEs)

The ACEs Task Force of San Bernardino partners with Trauma Transformed to address the need for workforce training and implementation of trauma-informed approaches through cross-sectoral education and training. In 2018, Kaiser Permanente paid \$75,000 to the ACEs Task Force to:

- Train three Master Trainers in a train-the-trainer program.
- Lead learning sessions with 12 cross-sectoral organizations including mental health care, primary health care, education, law enforcement, social services and childcare, serving children and families in the City of San Bernardino.

Addressing Sexual Abuse and Trauma: Project Sister Family Services improves the mental health of sexual violence and child abuse survivors by providing free counseling and case management in English and Spanish. Over two years (2017-2018), Kaiser Permanente paid \$45,000 to Project Sister Family Services to:

- Provide 5,269 hours of counseling and intake sessions.
- Provide 373 clients with therapy and case management.
- Decrease depressive and other unhealthy symptoms for 280 individuals utilizing the Trauma Symptom Inventory, self-reports, and therapist observations.

Improving Mental Health of Homeless Individuals: Imtasik Family Counseling Services provides mental health services, case management, and support services to homeless individuals living in places not suitable for human habitation who have a mental illness or co-occurring substance abuse disorder in Fontana and San Bernardino. Over two years (2017-2018), Kaiser Permanente paid \$50,000 to Imtasik Family Counseling Services to:

- Outreach to 400 homeless individuals.
- Provide 146 clients with case management, mental health services, and support services upon request.
- Decrease 80% of poor mental health symptoms of the 146 served.

Leveraging Assets: Our core functions across Kaiser Permanente are using their assets to drive Mental Health & Wellness in the KFH-Fontana and Ontario service area. For example:

- Convener: Over two years (2017-2018), organized two Mental Health Convenings that engaged 30 cross-sector stakeholders (community clinics, non-profit mental health providers, K-12 school districts, county, colleges and universities, shelters, community groups, Hospitals, Health Plans) to identify top organizational and countywide capacity building needs (coordination, collaboration, network building, education, and training).
- Education/Awareness: Educational Theatre reached nearly 4,000 3rd – 5th Grade Students, at 8 schools, through their Conflict Management performance.

		<ul style="list-style-type: none"> • Education/Awareness: Educational Theatre reached nearly 7,000 6th – 8th Grade Students grades 6-8th, at 18 schools, through their Adolescent Bullying Awareness performance.
<p>Obesity/ HEAL/ Diabetes</p>	<p><i>During 2017 and 2018, Kaiser Permanente paid 24 grants, totaling \$820,000 addressing the priority health need in the KFH-Fontana service area. In addition, a portion of money managed by a donor advised fund at California Community Foundation was used to pay 12 grants, totaling \$1,564,222 that address this need.</i></p>	<p><u>Improving Access to Nutritious Foods:</u> 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, Kaiser Permanente paid \$212,500 to CFPA to:</p> <ul style="list-style-type: none"> • Lead the implementation workgroup for the Cal-Fresh Fruit and Vegetable EBT pilot project for Southern California retailers.
	<p><i>During 2017 and 2018, Kaiser Permanente paid 13 grants, totaling \$777,500 addressing the priority health need in the KFH-Ontario service area. In addition, a portion of money managed by a donor advised fund at California Community Foundation was used to pay 15 grants, totaling \$2,851,389 that address this need</i></p>	<p><u>Advocating for Maternal, Infant, and Child Health:</u> 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:</p> <ul style="list-style-type: none"> • Pilot two video conferencing projects increasing awareness and consideration within the CA WIC community. • 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. • Participate in Capitol WIC Education Day in Sacramento with 50 attendees from 30 WIC agencies from all over the state.
		<p><u>Fighting Food Insecurity:</u> 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:</p> <ul style="list-style-type: none"> • 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. <p><u>Supporting Healthy Eating and Active Living through Systems Change:</u> The City of Ontario's HEAL Zone makes policy, system, and environmental changes to increase healthy eating and physical activity opportunities in the City of Ontario. In 2018, Kaiser Permanente paid \$333,333 to the City of Ontario to:</p> <ul style="list-style-type: none"> • Conduct 23 physical activity classes per week. • Hold monthly community forums to foster community cohesion.

		<ul style="list-style-type: none"> • Revamp park facilities, including renovating restrooms, building pickle ball courts, and installing lights, benches, hydration stations, and two community-designed garden boxes. • Include two Head Start locations as access points for services including Prescription for Health resources, Zum Up physical activity classes, and 6-week health education workshop for parents.
		<p><u>Promoting Food Recovery and Redistribution</u></p> <p>Kaiser Permanente envisions foodservices 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 Mary's Kitchen and Salvation Army to:</p> <ul style="list-style-type: none"> • Recover 16,215 lbs. of food and distribute to organizations serving individuals in the KFH-Fontana and Ontario 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. Additional Secondary Data
- F. 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	2016-2017
2. California Healthy Places Index	2018
3. California HIV Surveillance Report	2015
4. Office of Environmental Health Hazard Assessment	2011-2013
5. American Community Survey	2017
6. Health Management Associates Homeless Systems Assessment of Care	2018
7. Kaiser Permanente San Bernardino County Area Community Mental and Behavioral Health Convening: Summary Brief and Recommendations	2017
8. American Lung Association Report Card: California	2014-2016
9. Centers for Disease Control and Prevention	2017
10. San Bernardino County Community Indicators Report	2018

Appendix B. Community input tracking form

Organizations						
	Data collection method	Title/name	Number	Target group(s) represented	Role in target group	Date input was gathered
1	Key Informant Interview	Greater Los Angeles Area, Santa Clarita Valley Representative, American Diabetes Association	1	minority, medically underserved, low income	Leader	11/28/2018
2	Key Informant Interview	Assistant Superintendent of Alternative Instruction, Chaffey Joint Union High School District	1	minority, medically underserved, low income	Leader	12/4/2018
3	Key Informant Interview	County Supervisor, Fourth District	1	minority, medically underserved, low income	Leader	11/29/2018
4	Key Informant Interview	Chief Psychiatric Officer, Department of Behavioral Health	1	minority, medically underserved, low income	Leader	12/14/2018
5	Key Informant Interview	Student Health Center, California State University, San Bernardino	1	minority, medically underserved, low income	Leader	12/5/2018
6	Key Informant Interview	Chief Executive Officer, Chief Operations Officer and Addiction Counselor, Cedar House Life Change Center	2	minority, medically underserved, low income	Leader	12/13/2018
7	Key Informant Interview	Health Education Specialist II, San Bernardino County Department of Public Health	1	health department representative, minority, medically underserved, low income	Leader	12/4/2018
8	Key Informant Interview	Board of Trustees, San Bernardino County Community College	1	minority, medically underserved, low income	Leader	12/11/2018
9	Key Informant Interview	Coordinator of Comprehensive Health & Clinical Programs, Fontana Unified School District	1	minority, medically underserved, low income	Leader	11/29/2018
10	Key Informant Interview	Chief Intergovernmental Relations Officer, San Bernardino County	1	minority, medically underserved, low income	Leader	12/12/2018
11	Key Informant Interview	Public Health Program Manager, Department of Public Health	1	health department representative, minority, medically underserved, low income	Leader	12/11/2018
12	Key Informant Interview	Director, Department of Public Health	1	minority, medically underserved, low income	Leader	11/26/2018
13	Key Informant Interview	Executive Director, Board President, Fontana Chamber of Commerce	2	minority, medically underserved, low income	Leader	2/4/2019
14	Key Informant Interview	Director, Grassroots & Patient Engagement, American Lung Association of California	1	minority, medically underserved, low income	Leader	2/11/2019

Community residents

	Data collection method	Title/name	Number	Target group(s) represented	Role in target group	Date input was gathered
15	Focus group	Central Region Focus Group	6	minority, medically underserved, low income	Leader, representative member	10/22/2018
16	Focus group	Mountain Region Focus Group	4	health department representative, minority, medically underserved, low income	Leader, representative member	10/23/2018
17	Focus group	West End Region Focus Group	19	minority, medically underserved, low income	Leader, representative member	10/24/2018
18	Focus group	High Desert Focus Group	14	health department representative, minority, medically underserved, low income	Leader	10/25/2018
19	Focus group	East End Focus Group	9	minority, medically underserved, low income	Leader, representative member	10/26/2018
20	Focus group	West End Youth Focus Group	5	minority, medically underserved, low income	Representative member	2/9/2019

Removing Barriers to Access to Care

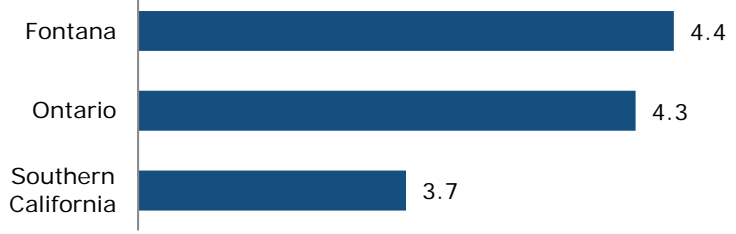
2019 Community Health Needs Assessment • San Bernardino County Service Area

Access to high-quality, affordable health care services is crucial for achieving and maintaining good physical and mental health. Across the KFH-Fontana and Ontario service area, residents report worse values on several indicators of access to care compared to the state as a whole, including more poor physical health days per month, lower rates of recent primary care visits, and higher preventable hospital events. Among others, residents and service providers identify high costs of care, geographic and transportation limitations, and lack of culturally and linguistically accessible care as barriers to seeking and receiving the health services they need.

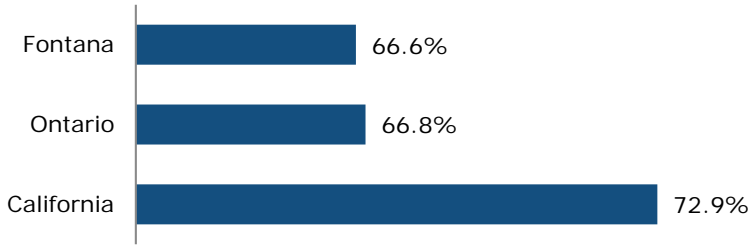
Key Data

Indicators

Average Poor Physical Health Days per Month¹



Percentage of Adults Visiting a Primary Care Physician within the Past Year²



Barriers and Challenges



- High cost of care and medication
- Limited transportation options to reach services
- Lack of linguistically and culturally competent providers
- Lack of health education
- Stigma, fear, or discomfort with seeking out services

Causes and Conditions

San Bernardino County residents and providers experience conditions and causes related to access to care in their community:

- Administrative barriers make it difficult for vulnerable populations to access resources
- Lack of needed care leads to worsening physical and mental health
- While coverage does not yet reach all populations, recent state and national expansions of health insurance coverage created more people eligible for care, but resources have not scaled up to meet increasing need.

“When they rolled [the expansion of] Medi-Cal, that created thousands of people that needed access to healthcare and I think a lot of the clinics are just overwhelmed with appointments.”

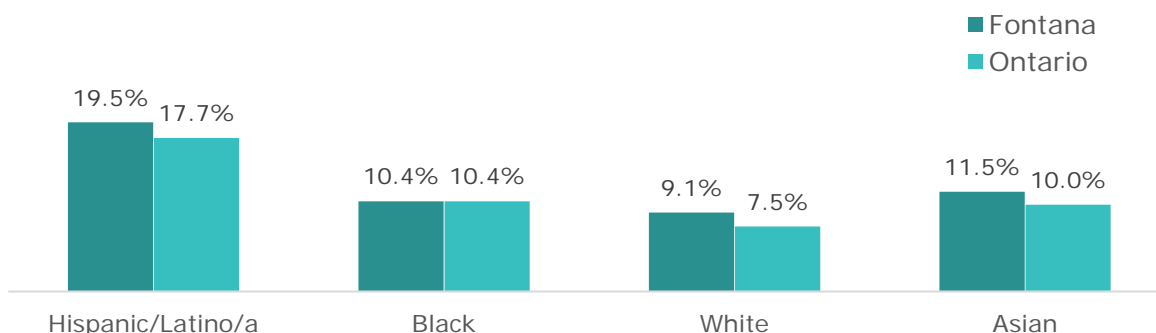
- Service Provider

While racial disparities in health insurance coverage persist, the overall share of San Bernardino County residents without health insurance has fallen from 20.6% in 2012 to 7.6% in 2017.³

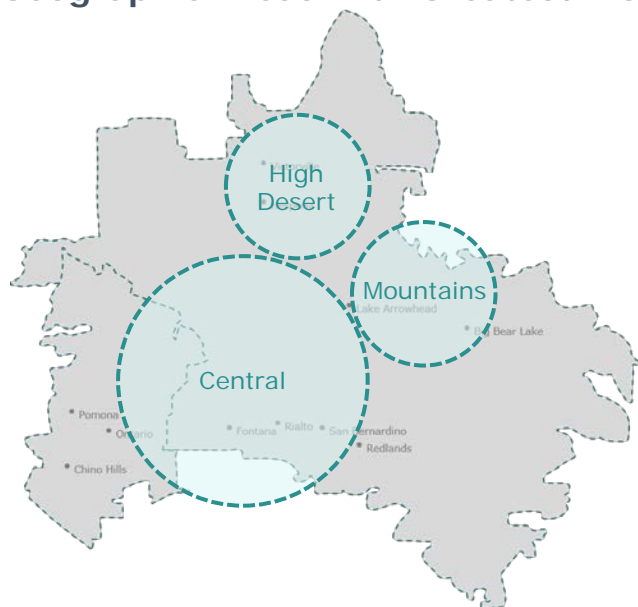
Populations Disproportionately Affected

Populations with Greatest Risk by Race and Ethnicity

Percentage of Population without Health Insurance⁴



Geographic Areas with Greatest Risk



Patterns of access to care in the San Bernardino County service area varied by geographic communities:

Percentage of adults without health insurance⁵ is highest in the Mountains and Central regions, including the cities of Big Bear City, San Bernardino, and Fontana.

Automobile access,⁶ which enables residents to access services, is lower in the High Desert and Central regions, including the cities of Victorville and San Bernardino.

Selected Social Predictors of Health

In San Bernardino County and nationwide, the following social predictors are linked to access to care:⁷

- **Less racial integration:** low racial integration can limit the ability of certain groups to access equal opportunities and resources needed to achieve good health.
- **Lower income:** low economic opportunity and poverty limit the ability of residents to afford the goods and services needed to achieve good health.
- **Less employment:** unemployment, underemployment, and unstable employment limit the ability of residents to afford the goods and services needed to achieve good health.
- **Less homeownership:** homeownership is often closely linked with economic and residential stability, and lack of stability can limit the ability of residents to afford the services needed to achieve good health.

“A lot of the folks that are most highly impacted don't seem to have the time to go to...health education programs. They are very focused on providing for their family and things like that so they don't have as much as time for themselves, and keeping themselves healthy.
- Service Provider

”



Examples of Existing Community Assets

San Bernardino County has many strengths. The following are assets identified by residents and providers.

- *Promotoras* and community health workers
- School/health system partnerships and community health education workers
- Cross-county and cross-sector partnerships to address upstream barriers to health
- Peer-to-peer health navigation programs



Community Innovations

San Bernardino County residents and providers shared their ideas for how best to meet the needs in the community.

- Support and expand health education programs so people better understand their risks and treatment options
- Expand health navigation services to help people find and use existing resources
- Co-locate more health services in schools and other trusted community-based organizations
- Invest in service providers in under-resourced and geographically isolated areas to improve health equity

Key Opportunities for Impact

Based on what was learned from the community, access to care could be meaningfully expanded by leveraging existing programs and adapting successful models.

- In pockets within well-resourced parts of the service area, access to care is limited by residents' knowledge of and ability to navigate the health system. Investing in programs and organizations providing health education and navigation – especially those with deep community ties including *promotoras*, community health workers, or peer supports – would increase their capacity and reach to connect more residents to existing services.
- Across the county and especially in under-resourced areas, expanding and advancing innovative models of service delivery would increase access to care. Partnership with other organizations within the health system and across sectors to address complex barriers to accessing care – including economic pressures, limited transportation options, and severe shortages of primary and specialty care providers – is needed to make progress. Removing these types of barriers requires coordinated action and investment across government departments and levels, non-profit and for-profit sectors, and communities.



References

- ¹ Kaiser Permanente CHNA Data Platform. Retrieved from: <https://kp-chna.ip3app.org/>.
- ² Ibid.
- ³ San Bernardino County Community Indicators Report. (2018). Retrieved from: http://www.sbcounty.gov/uploads/cao/feature/content/sb_2018_report_-2.pdf.
- ⁴ Kaiser Permanente CHNA Data Platform. Retrieved from: <https://kp-chna.ip3app.org/>.
- ⁵ California Healthy Places Index. (2019). Retrieved from: <https://healthyplacesindex.org/>.
- ⁶ Ibid.
- ⁷ Ibid.

Scaling Up Strategies to Address Asthma

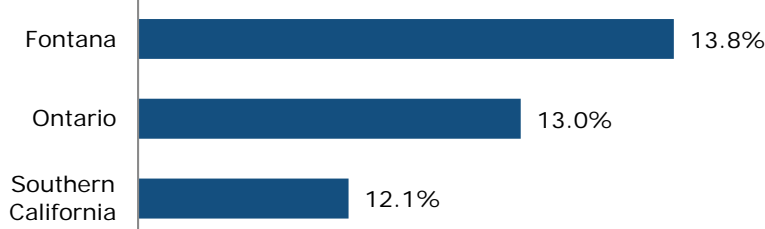
2019 Community Health Needs Assessment • San Bernardino County Service Area

While Asthma symptoms can be controlled with access to proper care, the condition can severely impact sufferers' ability to participate in daily activities. Asthma can be particularly disruptive for young children; according to the American Lung Association, asthma leads to more than 10 million missed school days each year. Residents of the KFH-Fontana and Ontario service area are more likely to suffer from asthma compared to residents of the Southern California region as a whole, although they experience a lower asthma rate than people statewide. Blacks experience much higher discharge rates for asthma and related conditions than White, Hispanic/Latino or Asian residents.

Key Data

Indicators

Asthma Prevalence¹



Percentage of Days per Year with Unhealthy Ozone Levels²



Barriers and Challenges



- Limited parent awareness of signs and symptoms
- Complexity of the diagnosis process
- High cost of preventive medications

Conditions and Contributors

San Bernardino County residents and providers experience conditions and causes of asthma in their community:

- Poor air quality, exacerbated by expansion of the logistics industry
- Lower income children and families live in communities adjacent to the 10 and 60 freeways
- Lack of ongoing support to help parents manage their child's asthma
- Lack of coordination between home and school

“Asthma is the... leading chronic health condition among kids in school. It's going to school with Asthma. Yes, it's big...that's every district throughout our county.

- *School-based Health Professional*

Medicine for asthma is really expensive and a lot of families do not have money for it.

- *Focus Group participant*”

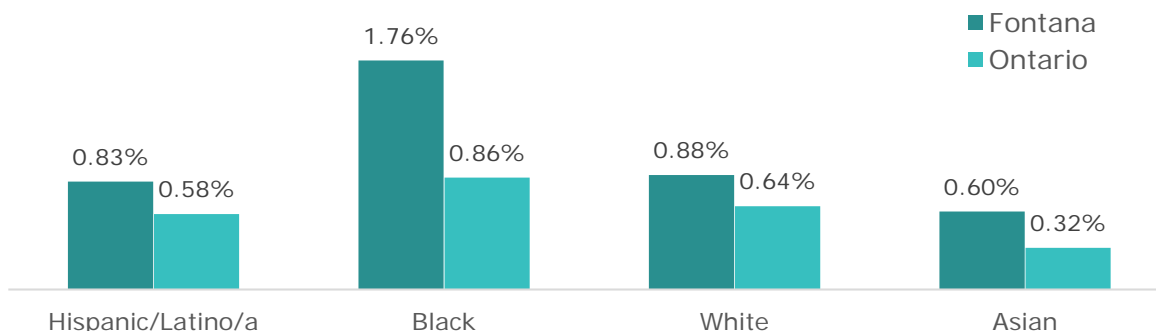
Over a three year period, San Bernardino experienced poor air quality 1 out of every 3 days. This included 144 days with ozone levels in the unhealthy or very unhealthy range.⁷



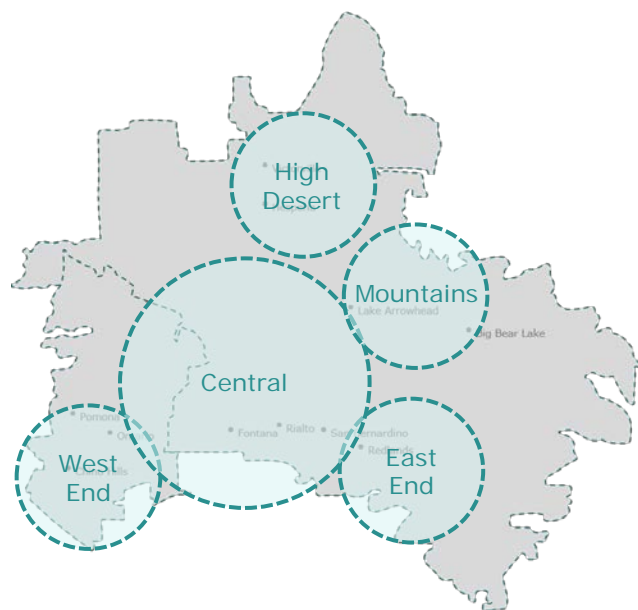
Populations Disproportionately Affected

Populations with Greatest Risk by Race and Ethnicity

Average Discharge Rate (per 10,000)³



Geographic Areas with Greatest Risk



Patterns of asthma prevalence in the San Bernardino County service area closely overlap with environmental triggers, which vary by geographic communities.

Asthma prevalence⁴ is highest in the High Desert and Central regions of the service area, including in the cities of Victorville, Hesperia, and San Bernardino.

Air quality as measured by **ozone levels⁵** is poor across the service area, but especially poor in the Mountains, Central, and East End regions.

Air quality as measured by **fine particulate matter concentration⁶** is poorest in the West End and Central Regions.

Selected Social Predictors of Health

In San Bernardino County, the following social determinants are linked to higher Asthma prevalence:^{8,9}

- **Less racial integration:** low racial integration can limit the ability of certain groups to access equal opportunities and resources needed to achieve good health.
- **Lower income:** low economic opportunity and poverty limit the ability of residents to afford the goods and services needed to achieve good health.
- **More crowded housing:** crowded housing, with more than one person per room, negatively impacts both physical and mental health.
- **Less employment:** unemployment, underemployment, and unstable employment limit the ability of residents to afford the goods and services needed to achieve good health.
- **Fewer two parent households:** households with fewer caregivers can face economic challenges that limit their ability to afford the goods and services needed to achieve good health.



I think we will continue to struggle around air quality issues simply because we are battling this balance of logistics for economics over logistics for air quality.

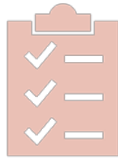
- *Public Health Leader*



Examples of Existing Community Assets

San Bernardino County has many strengths. The following are assets identified by residents and providers.

- School/hospital partnerships
- Community health workers
- Home visitation programs
- Mobile diagnosis and treatment
- Asthma action plans



Community Innovations

San Bernardino County residents and providers shared their ideas for how best to meet the needs in the community.

- Expand existing mobile diagnosis and treatment services to the Mountains and High Desert
- Train community health workers who already have trusted relationships with parents
- Expand home visitation services to identify and mitigate asthma triggers in the home
- Expand school-hospital partnerships to train teachers and staff to recognize and support asthma management in schools

Key Opportunities for Impact

Based on what was learned from the community, Asthma-related hospitalizations and missed days of school could be meaningfully impacted by expanding the scale of what is already working well.

- The Breathmobile, which effectively helps identify new cases of asthma, provides parent education and access to free/low cost medications for families who need the support should be expanded to the Mountains and other geographies where access to services is limited.
- Schools (including early care settings), teachers and parents would benefit from additional support to manage Asthma in the classroom. Some districts (such as Fontana) have well-developed systems that include robust teacher training provided by the American Lung Association and Asthma action-plans for each student.



References

- ¹ 2019 CHNA Secondary Data Launchpad. (2018).
- ² Kaiser Permanente CHNA Data Platform. Retrieved from: <https://kp-chna.ip3app.org/>.
- ³ 2019 CHNA Secondary Data Launchpad. (2018).
- ⁴ California Healthy Places Index. (2019). Retrieved from: <https://healthyplacesindex.org/>.
- ⁵ Ibid.
- ⁶ Ibid.
- ⁷ Report Card: California – High Ozone Days. (2014-2016). Retrieved from: <https://www.lung.org/our-initiatives/healthy-air/sota/city-rankings/states/california/>.
- ⁸ 2019 CHNA Secondary Data Launchpad. (2018).
- ⁹ California Healthy Places Index. (2019). Retrieved from: <https://healthyplacesindex.org/>.

Overcoming Challenges to Reach a Healthy Weight

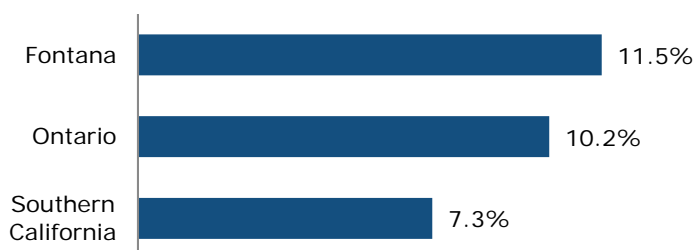
2019 Community Health Needs Assessment • San Bernardino County Service Area

Healthy body weight, balanced eating, and engaging in physical activity are essential for holistic well-being.¹ Together, these can reduce the risks of developing many health conditions including diabetes and obesity, which are on the rise nationwide. In the KFH-Fontana and Ontario service area, a higher percent of adults have been informed by a doctor that they have diabetes, higher than in the state of California as a whole and the southern California region. Diabetes is a costly and deadly disease, which can place a heavier burden on certain groups, including people of color, those from a lower socioeconomic group, and the elderly.^{3,4} Community members identified lack of safe spaces for physical activity, lack of affordable healthy food, and limited access to care to support chronic disease management as barriers to maintaining a healthy weight and disease management.

Key Data

Indicators

Diabetes Prevalence³



Obesity Prevalence⁴



Barriers and Challenges



- Limited spaces for physical activity
- Limited access to affordable healthy food
- Limited access to primary health care
- Lack of culturally sensitive providers and education

Conditions and Contributors

San Bernardino County residents and providers experience conditions and causes of diabetes and obesity in their community:

- Physical inactivity
- Eating patterns that are not balanced
- Late diagnoses driven by limited health care access and uninsured status
- Lack of ongoing support to help residents manage their chronic conditions

“

...[With insulin] we're talking about a drug that literally is as important to them as air...[Because of economic circumstances] being able to access their medication and insulin, that's going to be an even bigger burden for some folks.

- State agency representative

”

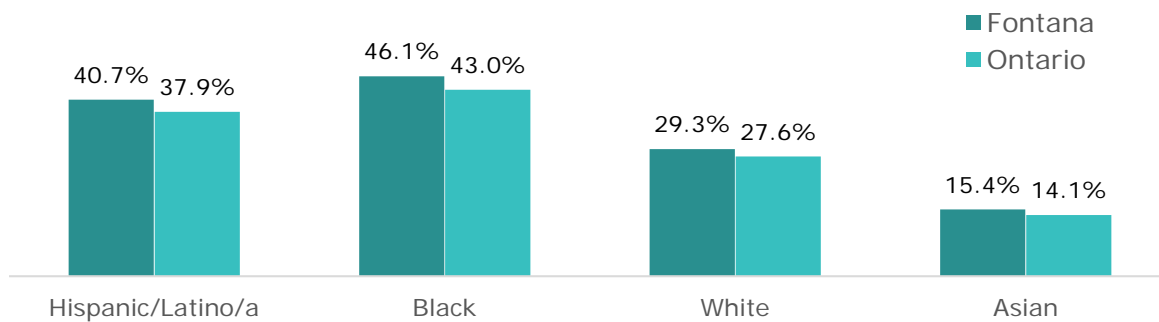
As of 2016, San Bernardino County had the third highest rate of deaths due to diabetes among all California counties.⁵



Populations Disproportionately Affected

Populations with Greatest Risk by Race and Ethnicity

Obesity Prevalence⁶



Geographic Areas with Greatest Risk



Disease prevalence of conditions closely related to physical activity, healthy body weight, and balanced meals varied by geographic community:

Diabetes prevalence⁷ is highest in the High Desert and Mountains regions of the service area, including in the cities of Victorville, Hesperia, Lake Arrowhead, and Big Bear Lake.

Percent of the population **with low proximity to supermarkets**, an indicator for low access to healthy food, is especially high for residents in the High Desert (28%) and Mountains (20-28%) regions when compared to other communities (1-13%) in San Bernardino County.⁸

Selected Social Predictors of Health

In San Bernardino County, the following social predictors are linked to higher diabetes and obesity prevalence:^{9,10}

- **Lower socioeconomic status:** lower economic opportunity – including lower education, income, and employment levels – can impact the ability to access healthy food and chronic disease prevention and management services.
- **Less racial integration:** low racial integration can limit the ability of certain groups to access equal opportunities and resources needed to achieve good health.
- **More crowded housing:** crowded housing, with more than one person per room, negatively impacts physical health.
- **Less park access:** limited access to parks impacts the walkability, bike ability, and overall ability to be physically active.
- **Less supermarket access:** high food prices, limited access and proximity to supermarkets, high number of fast food restaurants, low nutrition assistance program participation, and limited availability of local food impact the ability to eat healthy foods and chronic disease prevention and management.

“...for our seniors, they receive social security. It's very, very little money. So somebody who's a diabetic that needs to eat healthy, they can't afford it. They do have to go to the dollar store or buy canned goods, things that are processed.”
-Public Health Leader



Examples of Existing Community Assets

San Bernardino County has many strengths. The following are assets identified by residents and providers.

- Community health workers
- Fitness and healthy eating classes
- Health initiatives and awareness campaigns
- Community advocacy for policy change



Community Innovations

San Bernardino County residents and providers shared their ideas for how best to meet the needs in the community.

- Expand healthy eating and fitness classes that are culturally appropriate
- Support holistic disease treatment that incorporates mental health wellness
- Leverage schools and CBO partnerships to address disease prevention and management
- Empower community members to engage in policy advocacy to determine land use
- Automate lists to identify patients with uncontrolled chronic conditions to target for management services

Key Opportunities for Impact

Based on what was learned from the community, preventable disease related to healthy eating and exercise can be meaningfully impacted by expanding the scale of what is working well to underserved geographic areas.

- Diabetes prevention and management services should be strengthened and expanded for communities disproportionately affected by diabetes, such as residents with lower socioeconomic status, older adults, and African-American and Hispanic/Latino communities.
- Investments should be made to increase access to translation services, as well as cultural competence of health care service providers.
- Successful models of culturally appropriate education to underserved regions in the Mountains and High Desert should be expanded.
- Partnerships with cross-sector community-based organizations should be leveraged to increase reach.



References

- ¹ Centers for Disease Control and Prevention. (2017). Retrieved from <https://www.cdc.gov/diabetes/basics/diabetes>.
- ² Behavioral Risk Factor Surveillance System. (2006-2012). Retrieved from <https://www.cdc.gov/brfss/>.
- ³ 2019 CHNA Secondary Data Launchpad. (2018).
- ⁴ Ibid.
- ⁵ San Bernardino County Community Indicators Report. (2018). Retrieved from: http://www.sbcounty.gov/uploads/cao/feature/content/sb_2018_report_-2.pdf.
- ⁶ 2019 CHNA Secondary Data Launchpad. (2018).
- ⁷ Ibid.
- ⁸ Kaiser Permanente CHNA Data Platform. Retrieved from: <https://kp-chna.ip3app.org/>.
- ⁹ 2019 CHNA Secondary Data Launchpad. (2018).
- ¹⁰ California Healthy Places Index. (2019). Retrieved from: <https://healthyplacesindex.org>

Addressing Inequity in Maternal and Infant Health

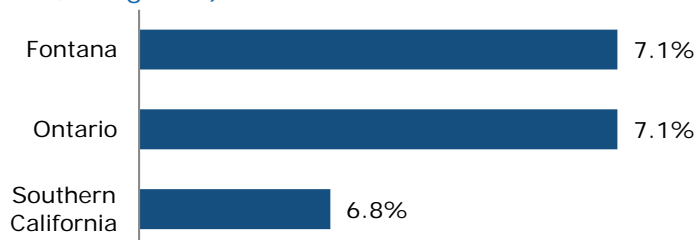
2019 Community Health Needs Assessment • San Bernardino County Service Area

Equal access to high-quality health care before, during, and after pregnancy is essential to women and the next generation. There is still work needed in the U.S. to ensure that women, regardless of race, zip code, or class status have this access. Nationwide, Black infants have the highest mortality rate, followed by American Indian/Native American infants. The five leading causes of infant death include congenital disabilities, preterm birth, sudden infant death syndrome, maternal pregnancy complications, and injuries.

Key Data

Indicators

Percentage of Total Births that are Low Birthweight (under 2,500 grams)^{1,2}



Infant Death Rate (per 1,000 births)^{1,2}



Barriers and Challenges



- Lack of access to quality care
- Lack of trust with providers
- Limited knowledge of systems of care
- Lack of support systems
- Financial stressors

Conditions and Contributors

San Bernardino County residents and providers experience conditions and causes of poor maternal and infant health in their community:

- Need for consistent care for new mothers to prevent post-partum depression
- High infant mortality and preterm births for African American babies
- Lack of transportation (i.e., car or license) to get to doctor's appointment
- Availability of education around child development

“ I think that the medical providers that they're seeing need to recognize that these women are at higher risk of different things and I do believe that needs to be discussed with them.

- Health Education Specialist

There is no support for women once they bring their baby home. Once they come home that is it – there is no support.

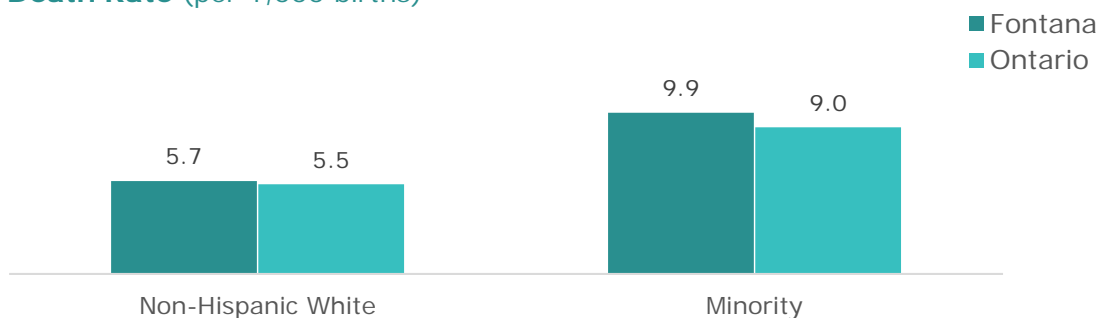
- Focus Group participant ”

According to San Bernardino County, many of the County's infant deaths – primarily due to congenital defects, maternal pregnancy complications, and prematurity or low birthweight – are preventable through preconception and prenatal health care.³

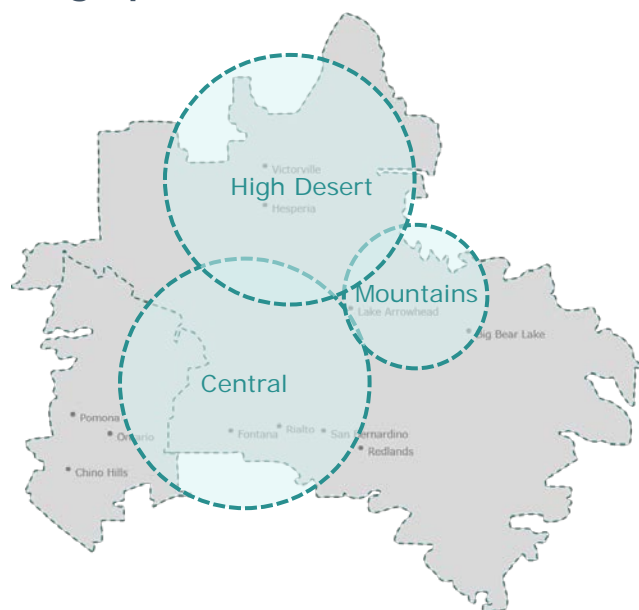


Populations with Greatest Risk by Race and Ethnicity

Infant Death Rate (per 1,000 births)⁴



Geographic Areas with Greatest Risk



Residents and providers identified several common barriers to maternal health, which varied by geographic communities.

Low birthweight infants⁵ are most common in the High Desert, Mountains, and Central regions of the service area, including the cities of Hesperia, Victorville, Big Bear Lake, San Bernardino, and Fontana.

Infant mortality⁶ among African-Americans is highest in the High Desert and Central regions, including the cities of Hesperia and Rialto.

Selected Social Predictors of Health

In San Bernardino County, the following social predictors are linked to a higher percentage of babies with low birth weight prevalence:^{7,8}

- **Less racial integration:** low racial integration limit the ability of certain groups to access equal opportunities and resources needed to achieve good health.
- **Less homeownership:** homeownership is often closely linked with economic and residential stability, and lack of stability can limit the ability of residents to afford the goods and services needed to achieve good health.
- **Worse air quality:** safe, clean air is essential to achieve and maintain good overall health, while poor air quality is tied to many negative health effects including poor birth outcomes.

“ [There are many] different things [driving poor birth outcomes]. I don't think anyone can say that it's one thing. Because if there was just one thing, then it's easy to fix if everybody, if people knew exactly what it is. But the thing is, we don't, and researchers don't know. But I know they take into consideration different things, which include the knowledge aspect, empowerment, and being able to speak up.

- Health Education Specialist ”

Examples of Existing Community Assets

San Bernardino County has many strengths. The following are assets identified by residents and providers.

- Community organizations providing resources and linkages to pre- and post-natal care
- Home visitation programs



Community Innovations

San Bernardino County residents and providers shared their ideas for how best to meet the needs in the community.

- Expand home visitation programs to help new mothers care for themselves and their babies, connect to additional resources and services, and maintain follow-up care plans
- Provide mobile resources for hard-to-reach and under-resourced areas
- Provide classes on maternal and infant care
- Provide education and resources to support and encourage women – especially African-American women – to advocate for their maternal health needs

Key Opportunities for Impact

Based on what was learned from the community, maternal and infant health could be addressed in an efficient way targeting underserved and hard-to-reach populations, including African-American women and communities in the Mountains.

- To better serve African-American women and infants at highest risk for poor birth outcomes, investments can be made to expand initiatives all working well at limited scale. For example, with additional partnerships and resources, the Black Infant Health program can expand the reach of its maternal health education programs.
- Without a labor and delivery facility for women in the Mountains, existing services such as the Mobile Resource Center and home visitors can be supported to expand outreach and provide support for pre- and post-natal care and connection to resources.



References

- ¹ 2019 CHNA Secondary Data Launchpad. (2018).
- ² Kaiser Permanente CHNA Data Platform. Retrieved from: <https://kp-chna.ip3app.org/>.
- ³ San Bernardino County Community Indicators Report. (2018). Retrieved from: http://www.sbcounty.gov/uploads/cao/feature/content/sb_2018_report_-2.pdf.
- ⁴ 2019 CHNA Secondary Data Launchpad. (2018).
- ⁵ California Healthy Places Index. (2019). Retrieved from: <https://healthyplacesindex.org>
- ⁶ African American (Non-Hispanic Black) Infant Mortality Rate by City (per 1,000 Live Births) (2014-2016): California Center for Health Statistics, Birth and Death Statistical Master files, 2014-2016
- ⁷ 2019 CHNA Secondary Data Launchpad. (2018).
- ⁸ California Healthy Places Index. (2019). Retrieved from: <https://healthyplacesindex.org/>.

Expanding Access to Mental Health Care

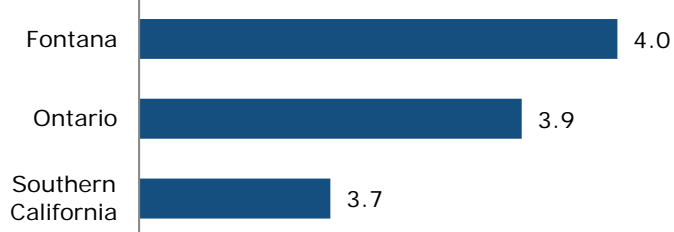
2019 Community Health Needs Assessment

Mental health is central to overall well being, affecting individuals' daily life, relationships, and physical health. Residents across the KFH-Fontana and Ontario service area report more days per month with poor mental health than residents in the state of California and the southern California region. Moreover, the suicide rate for the KFH-Fontana and Ontario service area is higher than in Southern California overall. Across the service area, residents and providers identify lack of adequate resources and services, stigma around seeking help, and language and cultural barriers as impediments to achieving better mental health.

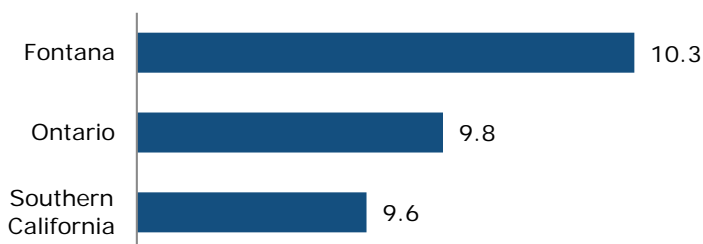
Key Data

Indicators

Poor Mental Health Days Per Month¹



Suicide Death Rate (per 100,000)²



Barriers and Challenges



- Lack of resources, services, and trust
- Long wait times for services
- Limited knowledge of systems of care
- Stigma associated with mental health
- Financial stressors
- Language barriers

Conditions and Contributors

San Bernardino County residents and providers experience conditions and causes related to mental health in their community:

- Increase in youth suicides
- Lack of bilingual providers, leading to lack of trust and cultural competency
- Increase in people experiencing homelessness
- Overstretched and under-resourced mental health clinics and professionals countywide, leading to reliance on emergency and crisis services



We're talking about kids that are already cutting themselves and there's really nowhere to send them other than saying, "Well, here's the crisis helpline." If it gets so bad, call them, they'll send somebody out to you"
- *Service Provider*



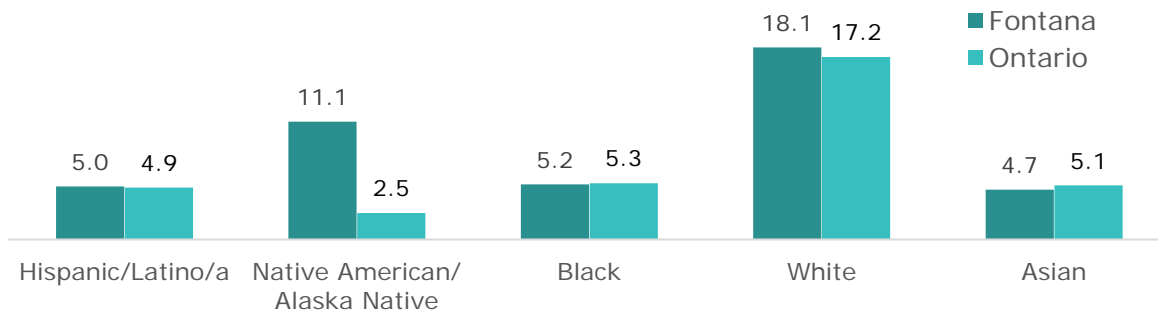
According to San Bernardino County, approximately 21,000 low-income residents needed mental health services in 2016/17 but did not receive services.³



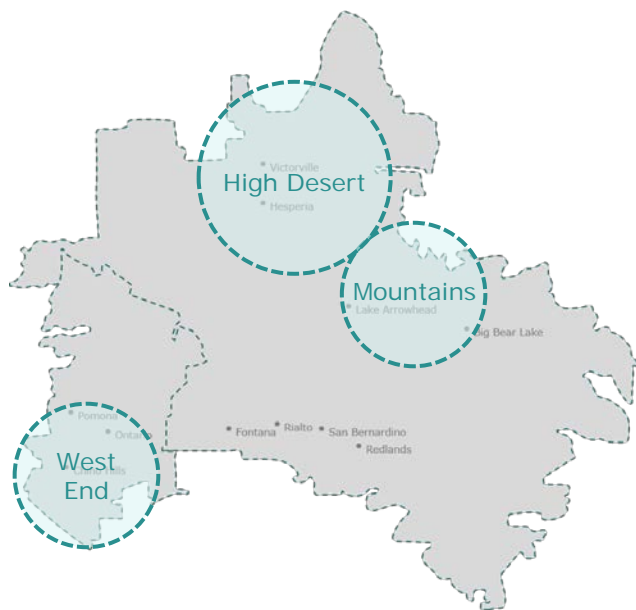
Populations Disproportionately Affected

Populations with Greatest Risk by Race and Ethnicity

Suicide Death Rate (per 100,000)⁴



Geographic Areas with Greatest Risk



Residents and providers identified several common barriers to mental and behavioral health, which varied by geographic communities

The number of **mental health providers**⁵ is low across the service area, but lowest in the High Desert and Mountains regions, including the cities of Victorville, Hesperia, Lake Arrowhead, and Big Bear Lake.

The number **poor mental health days**⁶ is highest in the High Desert and West End of the service area, including the cities of Victorville, Ontario, and Pomona.

Selected Social Predictors of Health

In San Bernardino County, the following social predictors are linked to more poor mental health days:^{7,8}

- **Less racial integration:** low racial integration limit the ability of certain groups to access equal opportunities and resources needed to achieve good health.
- **Lower socioeconomic status:** lower economic opportunity – including lower education, income, and employment levels – can impact the ability to access healthy food and chronic disease prevention and management services.
- **More crowded housing:** crowded housing, with more than one person per room, negatively impacts both physical and mental health.
- **Less homeownership:** homeownership is often closely linked with economic and residential stability, and lack of can limit the ability of residents to afford the goods and services needed to achieve good health.
- **Less health insurance:** lack of health insurance can prevent people from accessing the high-quality, regular care needed to achieve good health.

“I’ve worked for this school district since 2001 as an administrator at the sites and now at the district office, I’ve never seen this kind of demand for mental health services spike the way that I’ve seen it in the last three years or so...
- School Administrator”



Examples of Existing Community Assets

San Bernardino County has many strengths. The following are assets identified by residents and providers.

- *Promotoras* and community health workers provide mental health education
- Crisis hotline available around the clock
- Free counseling and case management
- Wellness centers and mental health forums at schools
- Mental Health Taskforce connects school districts and communities
- Therapeutic spaces such as community gardens



Community Innovations

San Bernardino County residents and providers shared their ideas for how best to meet the needs in the community.

- Support peer-to-peer programs
- Provide technical assistance for linguistically and culturally competent services
- Provide training to organizations around trauma-informed practices
- Provide routine mental health assessments
- Strengthen referral networks and coordination between traditional systems of care and mental health
- Fund mental health professionals to work in community-based settings instead of health clinics
- Support more community green spaces

Key Opportunities for Impact

Based on what was learned from the community, poor mental health and high suicide rates could be meaningfully impacted by focusing on increasing access to mental health services and investing in provider capacity.

- With a large and diverse service area, access to mental health can be expanded by supporting mobile mental health professionals, co-location of mental health providers within trusted community settings such as schools and local organizations, and technical assistance for providers and staff to increase linguistic and cultural competency, as well as representation.
- Existing community resources can be leveraged to reach more communities, including the Mental Health Taskforce and Youth Health Ambassadors. Such groups can provide or support cultural competency training, basic mental health education, and community support to alleviate stigma around seeking care.



References

- ¹ 2019 CHNA Secondary Data Launchpad. (2018).
- ² Ibid.
- ³ San Bernardino County Community Indicators Report. (2018). Retrieved from: http://www.sbcounty.gov/uploads/cao/feature/content/sb_2018_report_-2.pdf.
- ⁴ Kaiser Permanente CHNA Data Platform. Retrieved from: <https://kp-chna.ip3app.org/>.
- ⁵ Ibid.
- ⁶ Ibid.
- ⁷ 2019 CHNA Secondary Data Launchpad. (2018).
- ⁸ California Healthy Places Index. (2019). Retrieved from: <https://healthyplacesindex.org/>.

Confronting Substance Use to Support Health

2019 Community Health Needs Assessment • San Bernardino County Service Area

Substance abuse, including use or abuse of tobacco, alcohol, prescription drugs, and illegal drugs, can have profound physical and mental health consequences. Rates of smoking and excessive drinking in the KFH-Fontana and Ontario service area are higher than statewide averages, while San Bernardino County as a whole (like many areas of the country) has experienced a surging prescription opioid death rates between in recent years. These rates are dramatically higher for certain groups, including residents in the High Desert and Native Americans.

Key Data

Indicators

Opioid Prescription Claim Rate¹



Percentage of Current Smokers²



Barriers and Challenges



- Easy access to heavy drugs
- Lack of medication withdrawal plans
- Increase in cannabis stores
- Lack of knowledge of available resources
- Lack of recreational activities

Conditions and Contributors

San Bernardino County residents and providers experience conditions and causes of substance abuse in their community:

- Majority of people seeking care at treatment centers have co-occurring physical or mental health issues, many of them serious
- Opioid use is especially common among young people
- Increase in number of people experiencing homelessness

“A lot of [clients] that come through here have been hurt at work and then put on medication...They just stop the medication and of course they don't want to go into that physical withdrawal so they look to see where else they can get the medication so that they don't get sick”

- Service Provider

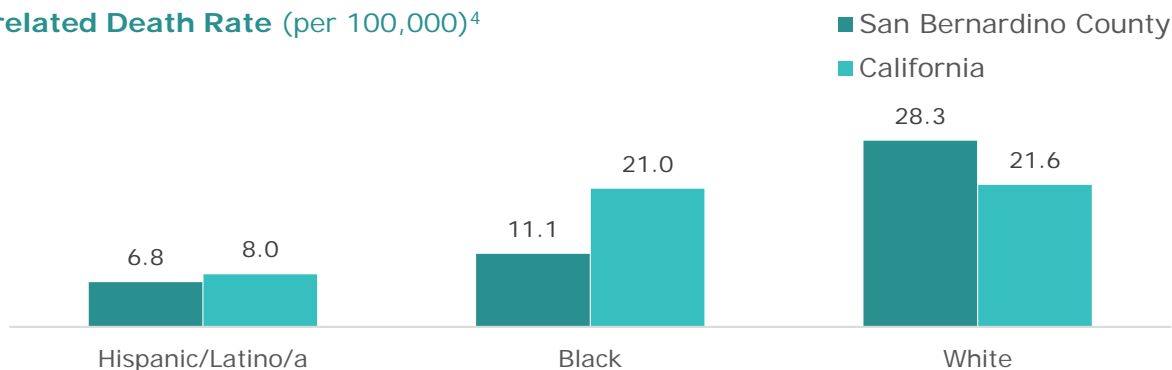
Between 2012/13 and 2016/17 the number of San Bernardino County residents admitted to county-funded treatment services for opioid-related use disorders has doubled.³



Populations Disproportionately Affected

Populations with Greatest Risk by Race and Ethnicity

Drug-related Death Rate (per 100,000)⁴



Geographic Areas with Greatest Risk



Residents and providers identified several common barriers to prevention and treatment of substance abuse, which varied by geographic communities.

A lack of **substance abuse treatment centers** in the Mountains and High Desert regions, including the cities of Lake Arrowhead, Big Bear Lake, Hesperia, and Victorville.

A lack of **response teams** accessible to youth in the Mountains region.

Selected Social Predictors of Health

In San Bernardino County, the following social predictors are linked to higher smoking prevalence:^{5,6}

- **Lower socioeconomic status:** lower economic opportunity – including lower education, income, and employment levels – can impact the ability to access healthy food and chronic disease prevention and management services.
- **More crowded housing:** crowded housing, with more than one person per room, negatively impacts both physical and mental health.
- **Less homeownership:** homeownership is often closely linked with economic and residential stability, and lack of can limit the ability of residents to afford the goods and services needed to achieve good health.

“

A lot of our population, they're homeless. They're living at the park, under the bridge, river bottom, that kind of thing. They're just not accessing those services

- Service provider

”



Examples of Existing Community Assets

San Bernardino County has many strengths. The following are assets identified by residents and providers.

- Peer-to-peer supports and navigation programs
- Crisis walk-in clinic
- Alternative medicine options
- Holistic supportive services for the re-entry population



Community Innovations

San Bernardino County residents and providers shared their ideas for how best to meet the needs in the community.

- Create and expand accessible tolerance reduction programs in community settings
- Support education on withdrawal protocols for providers and patients
- Create trauma-informed response teams

Key Opportunities for Impact

Based on all data collected across San Bernardino County, Kaiser Permanente has key opportunities to impact substance use prevention and treatment:

- By providing capacity building to organizations offering substance abuse services, Kaiser can help elevate and disseminate best practices used at tolerance reduction programs, as well as make such programs more accessible to a broader clientele.
- More education is needed for both providers and patients on proper withdrawal protocols for opioids. As many substance abuse problems begin with legitimate pain prescriptions, additional support is needed as patients transition off of their medications.
- Investing in existing peer-to-peer supportive programs would expand a valuable resource for residents struggling with substance abuse, connect programs with additional resources for financial and technical support, and build the capacity of peer navigators working through their own recovery and rebuilding processes.



References

- ¹ 2019 CHNA Secondary Data Launchpad. (2018).
- ² Ibid.
- ³ San Bernardino County Community Indicators Report. (2018). Retrieved from: http://www.sbcounty.gov/uploads/cao/feature/content/sb_2018_report_-2.pdf.
- ⁴ Centers for Disease Control and Prevention. (2019). Retrieved from: <https://wonder.cdc.gov/mcd.html/>.
- ⁵ 2019 CHNA Secondary Data Launchpad. (2018).
- ⁶ California Healthy Places Index. (2019). Retrieved from: <https://healthyplacesindex.org/>.

Appendix D. Community resources

Identified need	Resource provider name	Summary description
Asthma	The Breathmobile®	Arrowhead Regional Medical Center and the County of San Bernardino in association with the Asthma and Allergy Foundation of America have support the Breathmobile® to provide coordinated case identification, structured mobile office visits, diagnostic testing, physical exam, pharmacological therapy and patient/family education in asthma management. All services are provided at no cost to the patients.
	American Lung Association	The American Lung Association develops and provides resources to inform asthma policy and systems change based on evidence-based guidelines and practices. Resources for schools include: <ul style="list-style-type: none"> • Asthma Educator Institute • Breathe Well, Live Well: The Guide to Managing Asthma at Home and Work • Open Airways for Schools
Healthy Eating & Active Living	San Bernardino County Department of Public Health – Healthy Communities	In 2006, the Healthy Communities program was created as a central point of contact for health-related issues throughout the County. The Department of Public Health provides technical assistance to communities, giving specific recommendations for policy and environmental strategies to improve residents' health, and partnering with schools, community and faith-based organizations, public and private agencies, and city governments.
	High Desert Food Collaborative	The goals of the collaborative are to create synergy, enhance communication, and address food transportation, pick-up, and storage challenges and barriers faced by food providers unique to the High Desert, given the county Food Bank is located in the central part of the County far from High Desert communities
Maternal and Infant Health	San Bernardino County Preschool Services – LIFT Home Visitation Program	San Bernardino County Preschool Services works to improve the health, well-being and self-sufficiency of first-time, low-income mothers and their children. LIFT services are delivered in the participant's home, where nurses provide education to promote effective physical and emotional care of children. Nurses also link family members with health, mental health, and human services.
	San Bernardino County Department of Public Health	The Department of Public Health's Black Infant Health (BIH) Program uses a group approach paired with individual case management to help women develop life skills, learn strategies for reducing stress, and build social support. Program components are designed to help participants access their own strengths and set health-promoting goals for themselves and their babies.
Mental Health	San Bernardino County Department of Behavioral Health – Mental Health Services Act	Through funding from Proposition 63 – the Mental Health Services Act – San Bernardino County supports six locally developed program components: <ul style="list-style-type: none"> • Prevention and Early Intervention • Community Services and Support • Housing Development Projects • Innovation • Workforce Education and Training • Capital Facilities (buildings and housing) and Technology Needs

		Since its inception in 2005, MHSA funded programs have provided enhancements to the public behavioral health system of care that promote wellness, recovery, and resilience and include the values of cultural competency, community-based collaboration, and meaningful inclusion of clients and family members in all aspects of behavioral health planning and services.
	National Alliance for Mental Illness (NAMI) Inland Valley	NAMI's mission is to improve the quality of life for individuals with severe mental illnesses and their families. NAMI is dedicated to providing education, support and advocacy for individuals with mental illnesses, their families and the wider community.
	Mental Health Regional Collaborative	Over two years (2017-2018), 30 cross-sector stakeholders (community clinics, non-profit mental health providers, K-12 school districts, county, colleges and universities, shelters, community groups, hospitals, and health plans) convened with the following goals: <ul style="list-style-type: none"> • develop strategies to deliver integrated mental/behavioral health care • develop and implement strategies to reduce mental health stigma in the region • develop strategies to increase the mental health provider workforce and educational needs.
Access to Care	Community Health Association Inland Southern Region (CHAISR)	CHAISR provides services to community-based health centers and clinics in Riverside and San Bernardino Counties, including advocacy, public policy promotion, and education in order to support access to quality care in safety net communities.
	Visión y Compromiso	Visión y Compromiso is a network of <i>promotoras</i> across five states and Mexico. The network provides leadership, training, and advocacy for <i>promotoras</i> and community health workers. In the Inland Empire, Bilingual Community Health Workers work in partnership with safety net clinic partners to connect low-income uninsured to a medical home.
Substance Abuse	Cedar House Life Change Center	Cedar House supports individuals suffering from chemical dependency by providing evidence-based, high quality therapeutic clinical treatment services, while educating and engaging the community through open communication and outreach activities. Founded in 1973 as a 12-bed alcohol treatment facility, Cedar House Life Change Center is now a 142-bed facility serving men and women working to overcome chemical dependence.
	San Bernardino County Department of Behavioral Health – Friday Night Live and Club Live	The Friday Night Live (FNL) program is designed to offer high school aged youth opportunities to connect to their school and community through fun, skill-building activities, and caring relationships in environments free of alcohol, drugs, tobacco and violence. The Club Live (CL) program is an extension of the Friday Night Live program and is for middle school age youth.
	San Bernardino County Department of Behavioral Health – Environmental Prevention	Through Environmental Prevention, the Department of Behavioral Health offers technical assistance countywide to community coalitions, schools, law enforcement, and others in the community to address alcohol and other drugs availability and accessibility through evidence-based research and practices.
Social Predictors of Health	2-1-1 San Bernardino	211 San Bernardino is the County's Community Resource Hub connecting individuals to health and social services. Specialty areas and focus populations include the Homeless, Veterans, Re-entry, Early Childhood,

	Children & Families, Healthcare (Heart Disease & Lactation Support), and Transportation.
Connect IE	Connect-IE is a one-stop, interactive website linking individuals to community resources in the Inland Empire, including reduced cost services providing medical care, food, job training, and more.
San Bernardino County Department of Public Health – Community Vital Signs	Community Vital Signs is a collaboratively-developed community health improvement framework. It builds upon the Countywide Vision by setting evidence-based goals and priorities for action that encompass policy, education, environment, and systems change in addition to quality, affordable and accessible health care and prevention services. Community Vital Signs works to improve the county's health rankings by supporting solutions in health care and across all sectors.
San Bernardino County Homeless Partnership, Office of Homeless Services	The San Bernardino County Homeless Partnership works to provide a system of care for all who are homeless or at-risk of becoming homeless. The Partnership provides comprehensive services and resources for individuals experiencing homelessness, and works to increase permanent supportive housing opportunities for very low-income and long-term homeless persons.
Alliance for Education	The Alliance for Education is the backbone organization for the San Bernardino County Superintendent of Schools, and works to foster partnerships among business, labor, government, community, and education. These partnerships provide programs, activities, and events to engage students in Science, Technology, Engineering and Mathematics (STEM) related and locally available high-skill, high-wage careers.

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 and the resulting list of strategic questions that guided community engagement for this report.

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.