



2019 Community Health Needs Assessment

Kaiser Foundation Hospital: West Los Angeles

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

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Kaiser Permanente Southern California Region Community Benefit CHNA Report for KFH- West Los Angeles

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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 healthcare. 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 personal physicians, specialists, and a 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 communities 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.

- 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. We've also conducted Community Health Needs Assessments (CHNA) 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, as well as 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, 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 is to develop a rigorous process that yields 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, collects primary data through key informant interviews, focus groups, and surveys. Primary data collection involves reaching out to local public health experts, community leaders, and residents to identify issues that most impact the health of their community. The CHNA process also includes identification of existing community assets and resources to address health needs.

Each hospital or collaborative develops a set of criteria to determine what constitutes a health need in their community. All community health needs identified through primary and secondary data collection are then prioritized based on these criteria. This process results in a complete list of prioritized community health needs. A more detailed description of this process and CHNA outcomes are included in this report.

In conjunction with this report, KFH West Los Angeles 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. The CHNA and the Implementation Strategy will be posted publicly on our website once they are finalized (<https://www.kp.org/chna>).

II. Community served

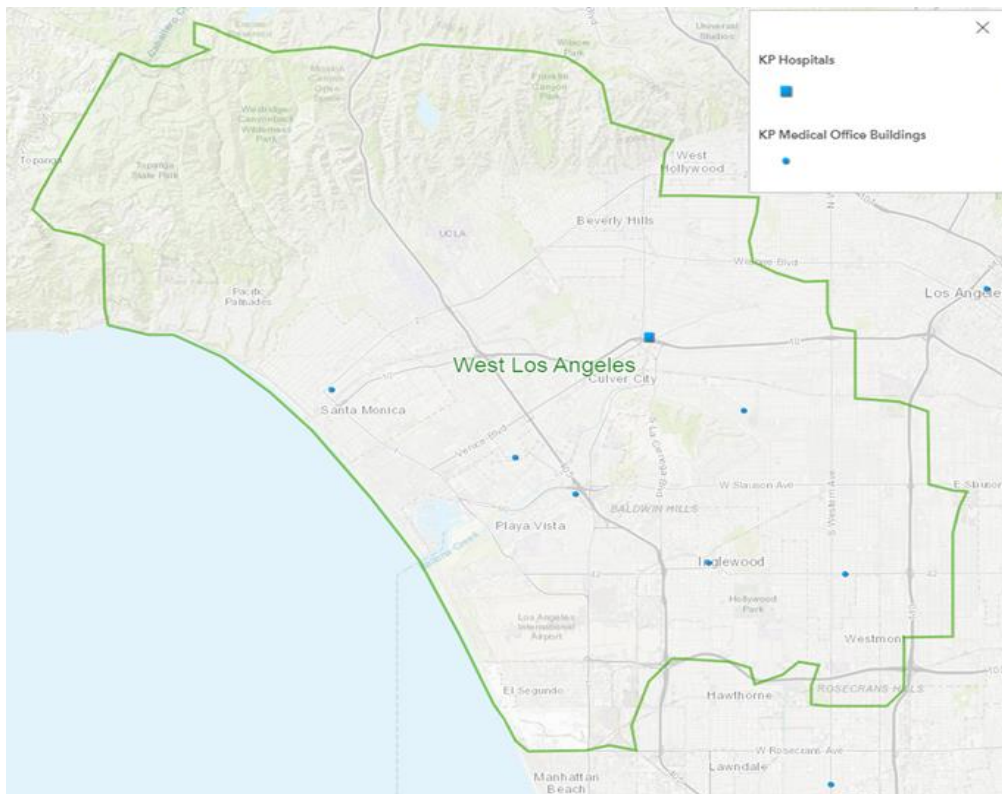
A. Kaiser Permanente's definition of community served

Kaiser Permanente defines the community served by a hospital as those individuals residing within its hospital service area. A hospital service area comprises all residents in a defined geographic area surrounding the hospital, including low-income or underserved populations.

B. Map and description of community served

i. Map

Figure A. KFH-West Los Angeles Service Area



ii. Geographic description of the community served

The KFH-West Los Angeles service area includes the cities of Beverly Hills, Culver City, El Segundo, Inglewood, Malibu, Santa Monica, West Hollywood, and part of Los Angeles, which includes the communities of Baldwin Hills, Cheviot Hills, Crenshaw, Hyde Park, Jefferson Park, La Tijera, Leimert Park, Mar Vista, Mid City, Miracle Mile, Ocean Park, Pacific Palisades, Palms, Playa Del Rey, Rancho Park, Rimpau, University Park, Venice, Vermont Knolls, West Adams, Westchester, Westwood, Wilshire, and unincorporated areas such as Ladera Heights, Lennox, Marina del Rey, View Park, Westmont, Windsor Hills and others.

iii. Demographic profile of the community served

The following table includes race, ethnicity, and additional socioeconomic data for the KFH- West Los Angeles 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 A. Demographic profile: KFH- West Los Angeles¹

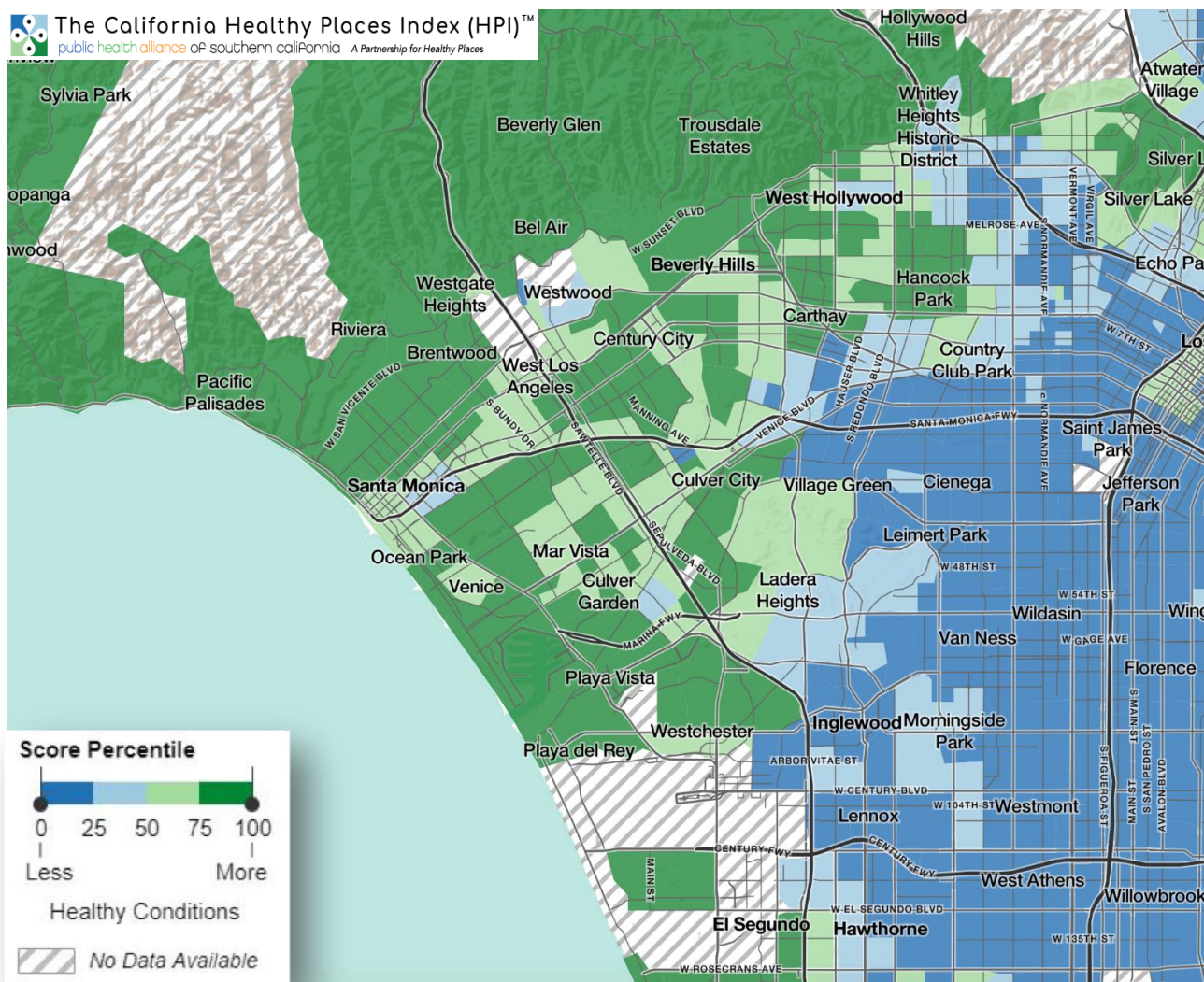
Race/Ethnicity		Socioeconomic	
<i>Total Population</i>	1,428,288	<i>Living in Poverty (<100% Federal Poverty Level)</i>	19.29%
<i>Asian</i>	8.39%	<i>Children in Poverty</i>	27.40%
<i>Black</i>	19.71%	<i>Unemployment</i>	4.1%
<i>Hispanic/Latino</i>	34.95%	<i>Uninsured Population</i>	14.82%
<i>Native American/Alaska Native</i>	0.10%	<i>Adults with No High School Diploma</i>	17.40%
<i>Pacific Islander/Native Hawaiian</i>	0.12%		
<i>Some Other Race</i>	0.48%		
<i>Multiple Races</i>	2.90%		
<i>White</i>	33.35%		

iv. Severely under-resourced areas of the community served

Identifying disparities in the upstream factors that predict negative health outcomes is critical to Kaiser Permanente’s community health mission. The map below displays the differences in opportunity for residents across the KFH-West Los Angeles 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).

¹ American Community Survey (2012-2016)

Figure B. Geographic Underserved Areas of KFH-West Los Angeles



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

The opportunity to live a long and healthy life is powerfully influenced by a wide range of social factors including economics, education, transportation, built environment, and access to care.² In aggregate, residents living in the KFH-West LA service area are in the 41st percentile for health opportunity³ among all California residents, with approximately 583,931 people living in severely under-resourced census tracts. In effect, this means that on average, six out of ten Californians have a greater opportunity to live a long, healthy life in comparison to residents living in this service area.

Under-Resourced Communities in KFH West LA include:

- Inglewood
- Lennox
- South Los Angeles

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

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

III. Who was involved in the assessment?

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

The 2019 KFH-West Los Angeles CHNA was primarily conducted independently by the medical center. However, a collaborative was formed with Cedars-Sinai (Cedars-Sinai Medical Center and Marina del Rey Hospital), Providence Saint John's Health Center, and UCLA Health. This was done in an effort to avoid duplication of phone interview data collection, given the medical centers share a common service area.

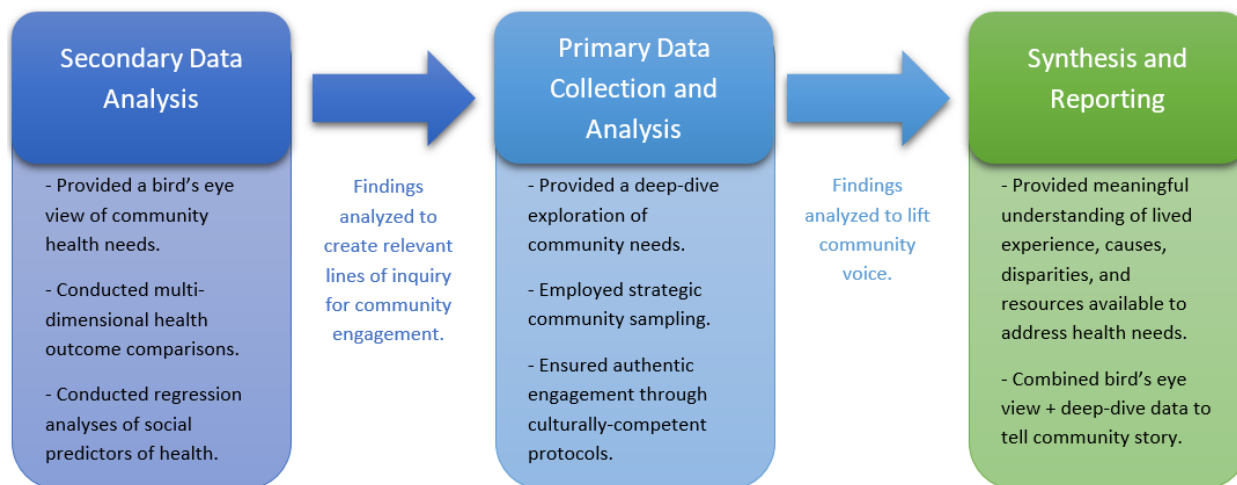
B. Identity and qualifications of consultants used to conduct the assessment

Community Health Councils, Inc. (CHC) is a non-profit, community based health advocacy, policy and research organization dedicated to promoting social justice and achieving equity in community and environmental resources for underserved communities. CHC engages, supports, and gives voice to marginalized, low income and under-served populations through advocacy, capacity building, coalition building and community mobilization, with a particular focus on South Los Angeles. CHC was established in 1992 in response to the growing health and healthcare crisis to support planning, resource development and policy education for the South Los Angeles area as well as other underserved and marginalized communities throughout LA County. CHC has since evolved to have a larger issue based, state and national health policy analysis and advocacy focus, in addition to community based research and capacity building. Today, CHC is on the cutting edge of developing public health policy, working to strengthen communities and promote collective action. These functions are integrated within the foundation of CHC's Model for Social Change, a systematic process for community engagement in the policy making process. This model is predicated on the beliefs that: (1) population health status is irrevocably linked to the structural and institutional policies which impact where people live, work, age, play, function, and grow; and (2) that transformative community change requires an iterative, interactive, engaging, and continuous dialogue with stakeholders, particularly community members and residents.

IV. Process and methods used to conduct the CHNA

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

Figure C – Mixed-Method Assessment Approach to the CHNA



A. Secondary data

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

KFH- West Los Angeles 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:

- Determine the geographic footprint of the most under-resourced communities in the KFH - West Los Angeles service area.
- Identify the top social predictors of health (upstream factors) linked to community health outcomes in the KFH - West Los Angeles service area.
- Provide an initial ranked list of health needs that could inform community engagement planning and the health need prioritization process for the KFH - West Los Angeles service area.
- Provide descriptive information about the demographic profile of the KFH - West Los Angeles service area and support understanding of key CHNA findings.

First, the most under-resourced geographic communities were identified utilizing the Public Health Alliance of Southern California's Healthy Places Index (HPI) [mapping function](#). The social predictors of health in this index include 25 indicators related to economic security, education,

access to care, clean environment, housing, safety, transportation, and social support (please refer to Figure B⁴ above).

Second, social predictors of health indicators were used in multiple linear regression analyses to produce models identifying the social factors most predictive of negative health outcomes in KFH-West Los Angeles 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 B below for detailed 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 C for detailed 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 synthesized a wide variety of available health outcome data to provide a bird's-eye view of the KFH service area needs, as well as 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) were selected as well as the social factors that were predictive of many negative health outcomes in the KFH - West Los Angeles service area. For further questions about the CHNA methodology and secondary data analyses, please contact CHNA-communications@kp.org.

⁴ Maps from the California Healthy Places Index captured in this report are © 2018 Public Health Alliance of Southern California, <https://phasocal.org/>.

Table B - Social Factors Linked to KFH-West Los Angeles 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	More Heart Attack ER Visits	Higher Asthma Prevalence	Higher Obesity Prevalence	Higher Diabetes Prevalence	Higher Stroke Prevalence	Higher Cancer Prevalence	Higher Percentage of Babies Born with Low Birth Weight	Higher Smoking Prevalence	More Pedestrian Injuries	Number of Outcomes Affected
Lower Income	X	X	X	X	X	X		X	X	X	9
Fewer Bachelor's Degrees	X	X	X	X	X	X			X		7
More Crowded Housing	X	X	X	X		X			X		6
More Racial Segregation	X		X	X	X			X	X		6
Less Employment	X					X	X				3
Worse Air Quality		X						X			2
Less Health Insurance		X	X								2
More Homeownership					X		X				2
More Bachelor's Degrees							X				1
Less Crowded Housing							X				1
Less Homeownership									X		1

Table C - 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.⁵

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*	12.3%	0.17% (Worse than CA)	61.3% Reduction	68% Worse than Average	No
Cancer*	4.6%	1.25% (Worse than CA)	51% Reduction	32% Worse than Average	Yes
Stroke*	4.0%	0.3% (Worse than CA)	57% Reduction	42% Worse than Average	Yes
HIV/AIDS/STD	0.6%	0.18% (Worse than CA)	58.2% Reduction	211% Worse than Average	No
Obesity	25.9%	-3.7% (Better than CA)	37% Reduction	55% Worse than Average	No
Substance/Tobacco Use	4.0%	-2.99% (Better than CA)	69.7% Reduction	48% Worse than Average	No
Maternal/Infant Health	7.1%	0.3% (Worse than CA)	17.9% Reduction	32% Worse than Average	No
Oral Health	11.6%	0.3% (Worse than CA)	2.8% Reduction	17% Worse than Average	No
CVD*	5.2%	-1.76% (Better than CA)	30% Reduction	30% Worse than Average	Yes
Diabetes*	8.6%	0.2% (Worse than CA)	24.1% Reduction	8% Worse than Average	No
Asthma	11.3%	-3.5% (Better than CA)	13.3% Reduction	46% Worse than Average	No
Violence/Injury	0.0%	-0.01% (Better than CA)	13.2% Reduction	30% Worse than Average	No

⁵Indicators for prevalence and racial disparities are publicly available. Technical documentation and data dictionary for this table available upon request. Health need category names provided by Kaiser Permanente Program Office. Reduction in life expectancy estimated based on disability-adjusted life years research. "Mental Health" indicators refer to "poor mental health". "Violence/Injury" prevalence is rounded down but not technically zero. "Yes" indicates health outcome is listed in the top five causes of death for the county covering the majority of this service area. If asthma is listed as "Yes", then chronic lower respiratory disease was listed in the county rankings. Asterisks are outcomes measured by Kaiser Permanente's Program Office.

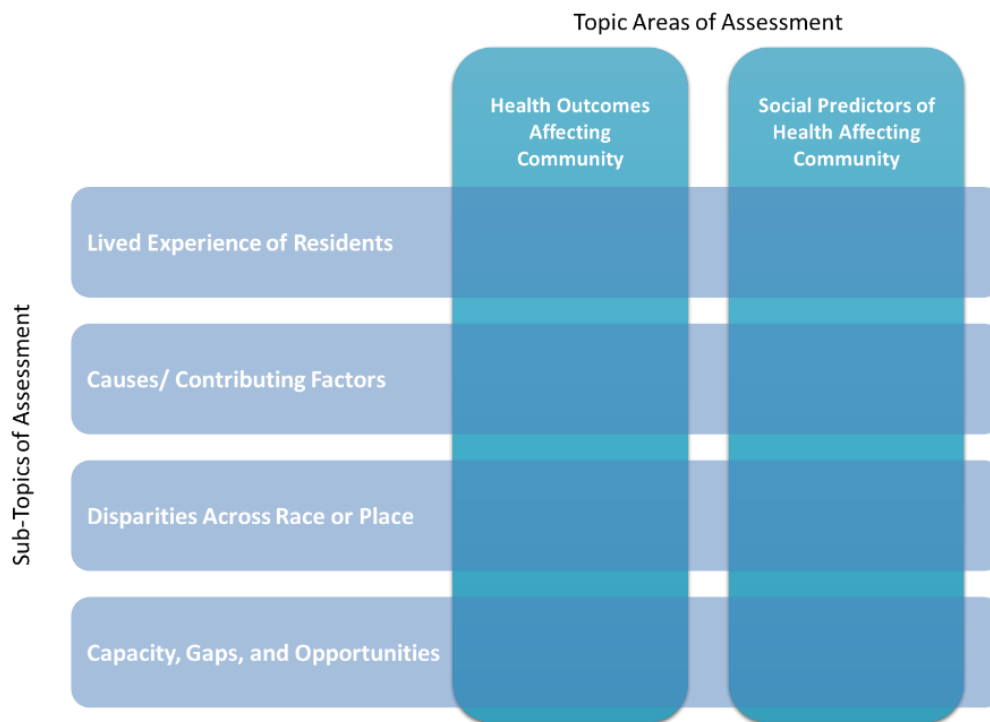
B. Community input

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

1. What are the three main drivers of lower income in under-resourced communities? What are the existing resources addressing these drivers? (Social Predictor of Health)
2. What are the challenges and barriers to improving income in our under-resourced communities? (Social Predictor of Health)
3. How are under-resourced communities benefiting from a thriving economy? Is there anything that prevents residents from benefitting from a strong economy? (Lived Experience)
4. Besides having an access issue, how does mental stress about survival and securing food, housing, etc. play a role in negative health outcomes? (Disparity/Capacity)
5. What are the barriers to higher educational attainment in under-resourced communities? Are different youth groups experiencing these barriers differently, such as foster youth, 0-5, homeless youth, immigrant vs. native born, African American vs. Latino vs. White, etc.? (Social Predictor of Health)
6. What educational resources are needed early on in the educational pipeline for bachelor's degrees to increase? (Social Predictor of Health)
7. What drives racial segregation in your community? (Institutional Practices, Financial, Social Predictor of Health)
8. How does racial segregation and racial inequities impact the health of residents in under resourced communities? (Institutional Practices/Social Predictor of Health)
9. What community strengths (or current models/initiatives/activities) can you identify that can lead to better income opportunities in communities? What kind of supports do you need for those to flourish?

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

Figure D. Community Engagement Framework



i. Description of who was consulted

Residents, community leaders, and government and public health department representatives were selected for the CHNA sample. Selection criteria across these groups included (a) those best able to respond in rich detail to the strategic learning questions, (b) those who had expertise in local health needs, (c) those who resided and/or provided services in an under-resourced or medically underserved community, and (d) those able to represent the health needs of a given racial or ethnic minority group. Given the large size of the KFH – West Los Angeles service area, community engagement efforts set out to target those geographies most under-resourced and where health outcomes were the poorest (see Figure B for a map referencing the most underserved areas of KFH-West Los Angeles). 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 the following methods:

1. *Key Informant Interviews* were conducted with 11 stakeholders, all of whom received questions about economic hardship, educational attainment, and racial segregation as well as questions specifically related to the top health needs, drivers, impacted populations, assets and gaps.
2. *Focus groups* were conducted as follows:

- a. Adult residents – four sessions were conducted with participants from an early education program in South Los Angeles (Girls Club of Los Angeles). Two sessions were held in English and two in Spanish, comprising a total of 45 residents of South Los Angeles, Inglewood and surrounding areas. These sessions focused on issues related to economic hardship and racial segregation as well as health needs more broadly.
 - b. Transitional Age Youth (TAY) - three sessions in English with a total of 25 youth, 18 to 24 years of age from South Los Angeles and participants from Sanctuary of Hope, The RightWay Foundation, and Home at Last.
3. A *photovoice project* with the participants of the TAY focus groups was conducted to visually document the health disparities and the factors that lead to those disparities. These pictures, taken by the youth, formed the basis of a case study to bring awareness to community members and stakeholders about the critical issues specific to TAY.
 4. *Surveys* were collected from 189 adult residents, which focused primarily on the resident health needs but also asked questions specific to economic hardship. CHC's healthcare enrollment staff collected 125 surveys from residents visiting their enrollment outstations (specifically WIC centers and community-based organizations across the service area) prior to or after they had received healthcare coverage assistance. An additional 64 surveys were collected from focus group participants (42 Adult residents & 23 from TAY).

CHC performed qualitative coding of all data and prepared a summary analysis synthesizing the overarching themes and representing the range of perspectives articulated. All qualitative data (meeting notes, key participant interviews, and focus groups) was analyzed using NVivo or manual coding. Qualitative data was coded using a codebook developed a priori in order to identify emergent themes related 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 CHNA Community Engagement Framework to generate themes useful for answering strategic learning questions and ultimately informing an implementation strategy plan (see Figure D).

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 - West Los Angeles received three written comments. These comments drew attention to the transportation issues in the West Los Angeles area. All commenting individuals and agencies were contacted to further discuss their comments.

D. Data limitations and information gaps

As with any community needs assessment process, the data available for use is limited. In the KP CHNA data platform, for example, some data were only available at a county level, making an accurate translation to neighborhood-level health needs challenging. In the Healthy Places Index platform, census tracts with very low populations were represented as missing data (to reduce

unreliability of measurement). This caused under-sampling of rural areas. In both platforms, disaggregated data around age, ethnicity, race, and gender were not available for many indicators which limited the ability to examine disparities of health within the community. Additionally, data in both platforms were not often collected on a yearly basis and therefore may not represent 2018 values. The sheer size and diversity of the KHF-West Los Angeles service area (and the under-resourced communities within and nearby) made collecting a representative sample infeasible. Furthermore, while all key informants represent stakeholders that serve geographies relevant to this report, they do not comprise an exhaustive list of all stakeholders who could respond to the strategic lines of inquiry.

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

A. Identifying community health needs

i. Definition of "health need"

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

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

To identify community health needs, CHC and Kaiser Permanente Community Health staff reviewed secondary data reports prepared by Kaiser Permanente Regional analysts. These reports drew from over 200 indicators and presented analyses specific to the census tracts and zip codes within the service area. These reports acted as a starting point for identification by revealing a bird's eye view of the many health needs in the service area. Kaiser Permanente and CHC used this information to build a targeted community engagement process which provided community stakeholders and residents the opportunity to speak in more depth about specific community issues and to surface additional health needs.

B. Process and criteria used for prioritization of health needs

As noted above, secondary data specific to the KFH- West Los Angeles service area was the starting point for the prioritization process. Per the data, the social predictors of health prioritized were those that impacted the most health outcomes. Additionally, health outcomes were prioritized that ranked high in severity of need and that demonstrated strong inequities through disparate impact across racial/ethnic groups⁶.

The extent to which community prioritized or highlighted these health needs was then used as final lens for prioritization. The top drivers and health outcomes across the various community input methods were chosen for final priority status.

⁶ Low ranking health outcomes in the comparison table are not indicative of low urgency in the community. On the contrary, low ranking health outcomes in this comparison are still extremely relevant to communities of West and South Los Angeles. Mounting evidence suggests strong racial disparities in reporting that impact measurement of the magnitude of health outcomes especially in under-resourced communities when rates rely on self-reports. Self-reported data can be skewed for many reasons, including a lack of screenings and adequate health care access. See: Burgarda, S. & Chenb P. Challenges of Health Measurement in Studies of Health Disparities. *Social Science & Medicine* 2014 Apr; 106: 143–150. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4077714/>.

Table D below indicates how drivers and health outcomes were ranked as high, medium, and low based on how strongly they surfaced across all data sources⁷. Several issues were later grouped to form one overarching health need based on how they presented in the community and the corresponding opportunities for successful solutions and interventions (e.g. Employment & Education and Obesity & Diabetes).

Among those health issues grouped into an overarching health need was Racial Equity. Secondary data and community input consistently identified policies and situations that fell into categories of racial segregation and institutional racism. Racial disparities in maternal/infant health and violence/injury were also consistently identified. As such, these issues were described as a unique health need identified as Racial Equity.

Table D - Process Criteria and Weights for Priority Health Needs

	Secondary Data			Community Input			
	<i>Severity of need</i>	<i>Magnitude/ scale of the need</i>	<i>Clear disparities or inequities</i>	<i>Key Informants</i>	<i>Surveys</i>	<i>Focus Groups</i>	<i>TAY Focus Groups</i>
Racial Equity	High	High	High	Medium		Medium	Medium
<i>Driver- Low Income</i>	High	High	High				
Access to Healthcare				High	High	High	High
Food Insecurity				High	High	High	High
Housing Insecurity & Homelessness				Medium	Medium	Medium	
Employment*				High	Medium	Medium	
<i>Driver- Fewer Bachelor's Degrees</i>	High	High	High				
Education*				High	Low		Low
<i>Health Outcomes</i>	High	High	High				
Obesity*	High	High	High	Low	High	High	
Mental Health	High	High	High	High	Medium	High	High
Diabetes*	High	High	High		High	High	
Substance/Tobacco Use	High	High	High	Medium	Low	High	Low

*These were combined to form Education/Employment and Obesity/Diabetes

⁷ As with the secondary data comparisons, a low ranking for any issue should not be seen as having low urgency, but rather, that issues rising to the top achieve priority through mention in several methods of data collection.

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

- **Access to healthcare:** Challenges to accessing healthcare was the most prominent issue in the primary data collection. Across all data collection methods, residents made clear that they have to make difficult choices between feeding their children, paying rent, or paying for healthcare. This choice, more often than not, places healthcare off the table when considering needs. With healthcare, a laundry list of barriers were highlighted, such as cost, long waits to see a doctor, lack of providers in the community, and fears about immigration status that can lead to potentially catastrophic and more costly health events. Residents indicated that access to care also has a direct impact on parents' ability to work or a student's ability to learn. In addition, this issue was a key concern for survey respondents to explain why cancer is seen as a critical issue. Specifically, residents felt that not being able to afford to see a doctor in time to get treatment, the cost of treatment and lack of adequate information in the community about cancer were serious concerns for the community.
- **Employment and Education:** Employment and education were highly intertwined issues that came up as major drivers of low income and poverty status as well as factors related to a range of other issues such as health care access. Adult community members noted that a lack of high paying quality jobs resulted in: 1) parents spending less time with their kids because they work multiple jobs or travel far to their jobs, and 2) lack of funding to support programs and resources from local income and sales taxes. Transitional Age Youth cited the inability to get jobs due to limited education and lack of skills-building resources. More broadly, the community stated that better jobs and education would help increase their family income. Some community members also discussed the importance of strengthening the healthcare workforce to reduce the provider shortage and provide access to quality jobs.
- **Food Insecurity:** Community residents unanimously highlighted the impact that the lack of affordable healthy food has on the community's ability live a healthy lifestyle. Specifically, community members cited: 1) abundance of liquor stores and fast food establishments, 2) lack of grocery stores, or grocery stores with rotting produce, 3) high cost of healthy food, and 4) long distance to healthy food retailers (restaurants, grocery stores). The impact of these barriers was cited as affecting many other health issues, including obesity and diabetes, oral health, mental health, and cardiovascular disease.
- **Housing Insecurity & Homelessness:** Housing insecurity was often discussed in the context of other issues such as low income, which forces residents to choose between paying for housing, healthcare, or healthy food. More broadly, housing insecurity was also discussed in relationship to historical policies in West and South LA communities that dictated where people could purchase housing. Residents also cited the current challenges presented by gentrification where new developments are driving many residents out of their communities. Additionally, community members frequently pointed out that the places where African American and Latino families could afford housing were often places significantly lacking health-promoting resources. While most of the conversations focused on access to affordable housing, people experiencing homelessness were identified as one of the groups at higher risk of experiencing poverty and poor health outcomes than other groups.
- **Mental Health:** Mental health was cited more than any other priority health issue during the data collection and was discussed as both a cause and an outcome of living with low income. Both interviewees and focus group participants discussed the mental strain of 1)

having to make critical choices due to limited income such as paying rent, food, or healthcare, 2) dealing with untreated health conditions, and 3) living in communities with high rates of poor health outcomes, limited resources, violence and over-policing. The cyclical nature of mental health issues compounds the impacts on communities, necessitating highly tailored interventions and preventative measures. Transitional Age Youth also highlighted that this stress can lead to making unhealthy and sometimes criminal choices to make ends meet or simply because they have given up and have nothing to lose.

- **Obesity and Diabetes:** Obesity and diabetes were most often discussed in tandem, and almost always in the context of residents not being able to eat a healthy diet or be physically active. Most residents blamed the lack of affordable healthy food and safe places to exercise as major contributing factors to these health issues. However, others blamed unhealthy cultural norms and behaviors as the root cause. These issues were also brought up in the context of other related illnesses such as cardiovascular disease and stroke, suggesting strong linkages between managing weight and diabetes with these other health needs.
- **Racial Equity:** Themes related to institutionalized racism were pervasive across community engagements and overlay other issues described in this report. The issue of racial equity was largely discussed in the form of housing discrimination, over-policing, lack of access to resources, gentrification, and the prevalence of liquor stores and fast food establishments with a lack of healthy food options. Community members highlighting this systematic neglect and disenfranchisement noted the downstream impacts of these discriminatory policies, including negative health outcomes and increased racial segregation. While many residents felt that racial segregation was culturally created (i.e., people wanting to live among people like themselves), there was also an acknowledgment of the barriers to resource access resulting from segregation, and a desire to strengthen bonds within their communities.
- **Substance Abuse:** During all methods of engagement, this issue was ranked as a top health issue both as a cause and as effect of living in a low-income community. Research on this issue suggests that on the individual level substance abuse is a coping mechanism to escape reality, while at the community level it acts as a pollutant and a highly destructive force. For example, several stakeholders referenced the crack epidemic as a potential contributing factor to the downfall of South LA communities.

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

The service area for KFH - West Los Angeles 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.

Some examples of key resources available to respond to the identified health needs of the community are listed in Appendix D - Community Resources.

VI. KFH West Los Angeles 2016 Implementation Strategy evaluation of impact

A. Purpose of 2016 Implementation Strategy evaluation of impact

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

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

KFH-West Los Angeles 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-West Los Angeles tracks outcomes, including behavior and health outcomes, as appropriate and where available.

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

As of the documentation of this CHNA Report in March 2019, KFH-West Los Angeles had evaluation of impact on activities from 2017 and 2018. This data help us monitor progress toward improving the health of the communities we serve. While not reflected in this report, KFH-West Los Angeles 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. An overall summary of these strategies, based on years 2017 and 2018, is included 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 healthcare workforce helps ensure access to high-quality care. This activity is also essential to making progress in the reduction of healthcare disparities that persist in most of our communities.
- **Research:** Deploying a wide range of research methods contributes to building general knowledge for improving health and health care services, including clinical research, health care services research, and epidemiological and translational studies on health care that are generalizable and broadly shared. Conducting high-quality health research and disseminating its findings increases awareness of the changing health needs of diverse communities, addresses health disparities, and improves effective health care delivery and health outcomes.

Grantmaking: For 70 years, Kaiser Permanente has shown its commitment to improving community health through a variety of grants for charitable and community-based organizations. Successful grant applicants fit within funding priorities with work that examines social predictors of health and/or addresses the elimination of health disparities and inequities. From 2017-2018, Kaiser Permanente paid 117 grants amounting to a total of \$5,341,908 in service of KFH-West Los Angeles 2016 health needs. Additionally, KFH-West Los Angeles has funded significant contributions to California Community Foundation (CCF) in the interest of funding effective long-term, strategic community benefit initiatives within the KFH-West Los Angeles service area. During 2017-2018, a portion of money managed by CCF was used to award 25 grants totaling \$3,850,555 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, purchasing, building design and services and environmental stewardship

efforts with the goal of improving the conditions that contribute to health in our communities. From 2017-2018, KFH-West Los Angeles leveraged significant organizational assets in service of 2016 Implementation Strategies and health needs. Please see table below for illustrative examples.

Collaborations and partnerships: Kaiser Permanente has a long legacy of sharing its most valuable resources – industry knowledge and talented professionals. By working together with partners, such as nonprofit organizations, government entities, and academic institutions, we can make a difference in promoting thriving communities that produce healthier, happier, more productive people. From 2017-2018, KFH-West Los Angeles engaged in several partnerships and collaborations in service of 2016 Implementation Strategies and health needs. Please see table below for illustrative examples.

C. 2016 Implementation Strategy evaluation of impact by health need

KFH West Los Angeles Priority Health Needs

Need	Summary of impact	Examples of most impactful efforts
<p>Access to Care</p>	<p><i>Over two years (2017-2018), Kaiser Permanente paid 25 grants, totaling \$1,191,667 addressing the priority health need in the KFH-West Los Angeles service area. In addition, a portion of money managed by a donor advised fund at California Community Foundation was used to pay eight grants, totaling \$1,356,667 that address this need.</i></p>	<p><u>Providing Affordable Healthcare</u> In 2017 and 2018, KFH-West Los Angeles provided \$51,567,138 in medical care services to 55,689 Medi-Cal recipients (both members and non-members) and \$14,818,801 in medical financial assistance (MFA) for 18,621 beneficiaries.</p> <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. <p><u>Providing Free Medical Procedures to the Uninsured</u> Venice Family Clinic (VFC) provides affordable health care for low-income, uninsured, and homeless families and individuals. From 2017 to 2018, 54 KFH-West Los Angeles staff members and physicians collaborated with VFC to:</p> <ul style="list-style-type: none"> • Offer free medical procedures and surgeries for 51 uninsured patients, including gallbladder removal, hernia repair, eye surgery, and diagnostic colonoscopies. • Serve 228 specialty care patients to date. <p><u>Increasing Access to Mental Health Care</u> The Alcott Center (AC) coordinates with the Pico Robertson Health Neighborhood (PRHN) to conduct a Department of Mental Health placed-based initiative that brings agencies together to prevent or reduce the incidence of mental illness and increase access to care. From 2017 to 2018, KFH-West Los Angeles paid AC \$15,000 in grant funds to AC to:</p> <ul style="list-style-type: none"> • Work with service providers to meet monthly to cross refer and coordinate care for clients experiencing mental health conditions. Partners include health care and mental health service providers, homeless services providers, and faith-based organizations. • Process more than 400 referrals and engage approximately 25% of those individuals in services.

Need	Summary of impact	Examples of most impactful efforts
		<ul style="list-style-type: none"> Host two educational seminars: "Suicide Awareness Month," and "Tech Games and Social Media."
<p>Economic Security</p>	<p>Over two years (2017-2018), Kaiser Permanente paid 20 grants, totaling \$518,000 addressing the priority health need in the KFH-West Los Angeles service area. In addition, a portion of money managed by a donor advised fund at California Community Foundation was used to pay five grants, totaling \$1,116,667 that address this need.</p>	<p><u>Building the Capacity of Small Businesses</u> 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. In 2017 and 2018, KFH-West Los Angeles joined this county-wide initiative to:</p> <ul style="list-style-type: none"> Collectively enroll 299 businesses across the LA County initiative, with 65% minorit- owned businesses and 52% women-owned businesses. <p><u>Contracting Social Enterprises</u> Social enterprises are competitive, revenue-generating businesses with a clear social mission to hire and provide training to people who are striving to overcome employment barriers including homelessness, incarceration, substance abuse, mental illness, and limited education. Social enterprises provide a real paying job and often provide wraparound services that help employees build skills and stabilize their lives. Kaiser Permanente supports these businesses by identifying and creating contractual relationships. In 2017 and 2018, KFH-West Los Angeles contracted with the following social enterprise(s):</p> <ul style="list-style-type: none"> Njoga Coffee, a small coffee cart, that distributes coffee to KP facilities. <p><u>Building Safety Net Provider Capacity</u> The Charles Drew University of Medicine & Science's program works to alleviate the financial burden of undergraduate and graduate education that can prevent low socioeconomic students from completing their education. Recipients of these scholarships are required to work in the safety net for a period of 2 years following graduation. In 2017 and 2018, Kaiser Permanente paid \$666,667 to the university to:</p> <ul style="list-style-type: none"> Award eight students a total of \$215,833 in scholarships. Award 12 additional scholarships ranging from \$3,750 to \$14,833 to students in the programs of nursing, family nurse practitioner, physician assistant, or school of medicine. <p><u>Developing Workforce Pipeline for the Safety Net</u> The Community Clinic Association of Los Angeles County (CCALAC) aims to increase and develop the safety net healthcare workforce through a pipeline initiative. In 2018, Kaiser Permanente paid \$250,000 to CCALAC to:</p> <ul style="list-style-type: none"> Implement at least two student exposure programs, training rotations and experiential learning opportunities within member clinics for up to 40 students annually. Pilot a Nurse Practitioner Residency program that will provide 10 new graduates with a residency placement in five member clinics annually. Develop an allied health training program to provide resources, trainings, and toolkits to strengthen clinic recruitment, onboarding, and retention efforts. <p><u>Training Leaders in Service of Community Health</u> The Los Angeles Albert Schweitzer Fellowship (ASF) program aims to reduce disparities in health and healthcare by developing "leaders in service" who are dedicated to helping underserved communities. ASF selects Fellows from diverse universities and disciplines (i.e., medicine, dentistry, pharmacy,</p>

Need	Summary of impact	Examples of most impactful efforts
		<p>occupational therapy, psychology, public health, law, social work, etc.) annually to participate in the year-long service project. Each Fellow receives a stipend of \$2,500. For the 2017 to 2018 fellowship class, Kaiser Permanente paid \$90,000 to ASF to:</p> <ul style="list-style-type: none"> • Recruit and train nine Fellows for the 2017-2018 fellowship class. • Support the 2017-2018 fellowship class to develop a plan of action and implement a community project to address local unmet health needs. • Review and prepare for the 2018-2019 fellowship class by selecting eight Fellows for year two. <p><u>Increasing Trainings and Employment for Low-Income Communities</u> The Asian American Drug Abuse Program (AADAP) partnered with the West Adams Work Source Center to improve employment among low-income communities. This project provides training programs that prepare individuals for entry-level positions in the medical field, opening doors for further career advancements. In 2017 and 2018, Kaiser Permanente paid \$20,000 to AADAP to:</p> <ul style="list-style-type: none"> • Screen over 200 individuals for their field-of-interest in healthcare. • Enroll approximately 65 students into the following training programs: Medical Assistant, Medical Record Insurance Biller, Nurse Assistant/Long Term Care and Home Health Aide, and Phlebotomy Technician. <p><u>Addressing Homelessness in Emergency Rooms</u> Special Service for Groups (SSG) conducts a homeless outreach program at Kaiser’s West Los Angeles Medical Center to reduce the number of inappropriate and frequent emergency room visits by homeless individuals. The program is designed to stabilize individuals experiencing homelessness by providing case management, crisis housing, benefits enrollment and linkages to mental health and substance abuse services. In 2017 and 2018, Kaiser Permanente paid \$108,000 to Special Service for Groups to:</p> <ul style="list-style-type: none"> • Innovate a Homeless Navigator that reviews and processes all referrals made by KP social workers. In the past 2 years, SCG has successfully responded and addressed more than 200 referrals. • Place 37 individuals in permanent supportive housing.
<p>Mental and Behavioral Health</p>	<p><i>Over two years (2017-2018), Kaiser Permanente paid 24 grants, totaling \$851,500 addressing the priority health need in the KFH-West Los Angeles 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 \$40,000 that addresses this need.</i></p>	<p><u>Strengthening Mental Health Policies and Practices in Schools</u> 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. In 2017 and 2018, Kaiser Permanente paid \$150,000 to Children Now to:</p> <ul style="list-style-type: none"> • 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. <p><u>Improving Services for Human Trafficking Survivors-</u> The Coalition to Abolish Slavery and Trafficking (CAST) expands services to improve health outcomes for trafficking victims in Los Angeles County. CAST coordinates a continuum of care for trafficking victims by combining social, medical, and legal services with leadership and advocacy. In 2018, Kaiser</p>

Need	Summary of impact	Examples of most impactful efforts
		<p>Permanente paid \$75,000 to CAST to:</p> <ul style="list-style-type: none"> • Coordinate Whole Person Care services, including housing, food, medical, mental health, legal, education, and employment services for 100 human trafficking survivors. • Educate and advocate with policymakers, county officials, and community leaders on how to expand or improve access to emergency and permanent housing for victims. <p><u>Integrating Mental Health and Primary Care Practices*</u> The Achievable Foundation Whole Person Care Project improves access and connection to mental health care in a clinical setting. In 2018, Kaiser Permanente paid the foundation \$40,000 to:</p> <ul style="list-style-type: none"> • Develop and implement policies and systems for integrating mental health contracting, billing, shared care plans, and quality improvement measures into the primary care delivery model. • Screen up to 1,900 primary care patients for mental health and substance abuse. • Provide care coordination and referral care services to screened patients. <p><u>Empowering Families in South Los Angeles</u> The EduCare Foundation is a youth empowerment and character-building program for at-risk students and families in South Los Angeles. It offers an intense three-day retreat to improve social and emotional intelligence, self-awareness, time management, relationships and decision making. In 2017 and 2018, Kaiser Permanente paid \$20,000 to EduCare to:</p> <ul style="list-style-type: none"> • Facilitate 20 student workshops for more than 1,500 students. • Host 13 professional development workshops for 160 teachers and staff. • Conduct 11 parent workshops for 400 parents. <p><u>Integrating Mental Health Services and Youth Development</u> Social Justice Learning Institute (SJLI) Urban Scholars facilitates a social justice youth development curriculum that focuses on community building, healing and identity, college access and critical consciousness. Students receive academic development support, research training, and skills building in organization and policy advocacy. In 2018, Kaiser Permanente paid \$10,000 to SJLI to:</p> <ul style="list-style-type: none"> • Serve 89 at-risk youth in Compton, Inglewood, and South Los Angeles. • Increase staff capacity to strengthen mental health outreach efforts to low-income student of color. • Reduce stigma associated with addressing mental health.
<p>Obesity / HEAL/ Diabetes</p>	<p><i>Over two years (2017-2018), Kaiser Permanente paid 48 grants, totaling \$2,780,742 addressing the priority health need in the KFH-West Los Angeles service area. In addition, a portion of money managed by a donor advised fund at California Community Foundation was used to pay</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, KP paid \$212,500 to CFPA to:</p> <ul style="list-style-type: none"> • Lead the implementation workgroup for the Supplemental Drinking Water EBT benefit for approximately 40,000 Cal-Fresh households in Kern County. • Lead the implementation workgroup for the Cal-Fresh Fruit and Vegetable EBT pilot project for Southern California retailers.

Need	Summary of impact	Examples of most impactful efforts
	<p>11 grants, totaling \$1,337,222 that address this need.</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. In 2017 and 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. • Collaborate with health centers to share WIC staff for nutrition and breastfeeding counseling (Watts Health Care and clinics in San Diego). • Work to strengthen ties with CPCA and present at CPCA's annual conference. • Visit all CA legislators with 44 appointments and drop-in visits. • Provide extensive information to legislators on nutrition and breastfeeding counseling, food benefits, local economic impacts to grocers, health outcomes, access to Farmers markets, and updates on immigration threats. • 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>Addressing Chronic Conditions in the Community</u> Wise & Healthy Aging improves the health of low-income communities by educating and empowering community members to address chronic disease. This includes implementing evidence-based health promotion and disease prevention workshops facilitated by community members. In 2017 and 2018, Kaiser Permanente paid \$45,000 to Wise & Healthy Aging to:</p> <ul style="list-style-type: none"> • Train volunteers to conduct evidence-based programs at 16 organizations. • Offer 10 to 12 six-week workshops serving about 100 individuals annually. • Educate 100 elders how to manage and prevent chronic conditions. <p><u>Providing Healthy Options for the Community</u> In 2017 and 2018, Kaiser Permanente provided various activities to engage community residents and promote Healthy Eating and Active Living, including:</p> <ul style="list-style-type: none"> • Two weekly public Farmers Markets at their Medical Center and Baldwin Hills Crenshaw Medical Office facilities. Each market provides access to local, fresh produce and healthy prepared food options to thousands of individuals annually. • Full range of no-cost physical activity classes are offered at facilities as well. These include Soul Line Dancing, Zumba and traditional fitness classes. Every week, approximately 300 individuals benefit from these activities.

VII. Appendices

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

Appendix A. Secondary data sources and dates

i. Secondary sources from the KP CHNA Data Platform

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

ii. Additional sources

Source	Dates
1. California Department of Public Health	2016
2. California Healthy Places Index	2018
3. California HIV Surveillance Report	2015
4. Greater Los Angeles Homeless Count	2018
5. Los Angeles County Health Survey	2015
6. Los Angeles County Department of Public Health - Alcohol Outlet Density and Alcohol-Related Consequences	2013
7. Los Angeles County Department of Public Health - Key Indicators of Health	2017
8. Los Angeles County Department of Public Health - Community Health Assessment	2015
9. Los Angeles County Department of Public Health - Health Indicators for Women	2017
10. Los Angeles County Department of Public Health - Housing & Health in LA County	2015
11. Los Angeles County Department of Public Health - Mommy and Baby Project	2016
12. Office of Environmental Health Hazard Assessment	2011-2013
13. Policy Link & USC Program for Environmental and Regional Equity (PERE) - An Equity Profile of the Los Angeles Region	2017
14. Social Science & Medicine (April Issue) - Challenges of Health Measurement in Studies of Health Disparities.	2014
15. UCLA Labor Study - Hour Crisis: Unstable Schedules in the Los Angeles Retail Sector	2018
16. United States Census	2010
17. USC Neighborhood Data for Social Change - Rising Rent Burden in Los Angeles	2018

Appendix B. Community input tracking form

	Data collection method	Title/name	Number	Target group(s) represented	Role in target group	Date input was gathered
Organizations						
1	Key Informant Interview	Sr. City Planner, Los Angeles Department of City Planning	1	Minority, medically underserved, low-income	Leader	11/30/18
2	Key Informant Interview	Senior Deputy for Health Services and Advocacy, Office of Supervisor Mark Ridley-Thomas	1	Minority, medically underserved, low-income	Leader	12/5/18
3	Key Informant Interview	President, Los Angeles Trade Tech Community College	1	Minority, medically underserved, low-income	Leader	12/13/18
4	Key Informant Interview	President and Chief Executive Officer, Green Dot Charter Schools	1	Minority, medically underserved, low-income	Leader	12/17/18
5	Key Informant Interview	Program Officer Education Pipeline, CA Community Foundation	1	Minority, medically underserved, low-income	Leader	12/18/18
6	Key Informant Interview	Executive Director, Southside Coalition of Community Health Councils	1	Minority, medically underserved, low-income	Leader	12/18/18
7	Key Informant Interview	Chief Executive Officer, LA Urban League	1	Minority, medically underserved, low-income	Leader	12/18/18
8	Key Informant Interview	President, Crenshaw Chamber of Commerce	1	Minority	Leader	1/9/19
9	Key Informant Interview	Director, LA County Department of Public Health	1	Health Department Representative, Minority, medically underserved, low-income	Leader	1/11/19
10	Key Informant Interview	Sr. Director of Strategic Planning, LA CARE Health Plan	1	Minority, medically underserved, low-income	Leader	1/11/19
11	Key Informant Interview	Executive Director, Social Justice Learning Institute	1	Minority, medically underserved, low-income	Leader	1/25/19
Community residents						
12	Focus group	Adult Residents (Spanish)	7	Minority, medically underserved, low-income	Representative Member	12/5/18
13	Focus group	Adult Residents (English)	13	Minority, medically underserved, low-income	Representative Member	12/5/18
14	Focus group	Adult Residents(Spanish)	16	Minority, medically underserved, low-income	Representative Member	12/6/18
15	Focus group	Adult Residents (English)	7	Minority, medically underserved, low-income	Representative Member	12/6/18
16	Focus group	Transitional Age Youth	2	Minority, medically underserved, low-income	Representative Member	1/24/18
17	Focus group	Transitional Age Youth	8	Minority, medically underserved, low-income	Representative Member	2/5/18
18	Focus group	Transitional Age Youth	16	Minority, medically underserved, low-income	Representative Member	2/7/18
19	Surveys	Adult Residents & Transitional Age Youth (English & Spanish)	189	Minority, medically underserved, low-income	Representative Member	11/1/18 – 2/7/18

Appendix C. Health Need Profiles

- Access to Healthcare: Navigation is Needed
- Employment and Education: Barriers for Families
- Food Insecurity: A Product of Poverty
- Housing Insecurity & Homelessness: An Escalating Crisis
- Mental Health: A Pervasive Issue
- Obesity and Diabetes: A Scarcity Issue
- Racial Equity: A Systemic Issue
- Substance Abuse: Coping with Trauma

Access to Healthcare

Navigation is Needed



Jorge, 56, is an undocumented immigrant who has lived in the area for over 20 years. He lives with his wife, Beatrice, 52 (also undocumented) and two young adult daughters, ages 19 and 22, who are citizens. Unable to work legally in the U.S., Jorge has made a life for his family; working as an auto mechanic, renting a small house in a decent area, and paying the cost of tuition at a community college for each of his daughters. The girls pay for other expenses through financial aid and part-time jobs. Though the couple does not have benefits that other workers have, like health insurance, he and his wife have been relatively healthy, and have only had to visit the local community clinic a few times in the past 10 years, paying cash for services. He does not go to the County free clinic because the wait times are longer, the workers are not nice, and he experienced at least one doctor talking down to him.

Jorge began feeling slight chest pains. At first he dismissed it as just cramps from constant bending over car hoods all day. One day it felt worse than normal. His wife suggested they go to the clinic to get it checked out, worried it might be serious. Jorge declined, knowing that they would spend all day there, only to be seen briefly before being handed a few pills, and sent home with a large bill. Additionally, Jorge no longer trusts the hospital. He is not sure what they do with the information they type into their computers and he does not want to draw attention to himself.

Late one night, Jorge again experienced chest pain, but it was unbearable and was forced to seek medical attention at the nearest emergency room eight miles away. The physician examining Jorge thought he might have had a heart attack and ordered a series of tests. Jorge refused the tests, insisting that he felt fine and it was probably just bad heartburn. He left with a prescription and instruction to follow-up with his primary care doctor. He did not fill the prescription because it was a name brand medicine and would have cost him \$130. He anticipated receiving a high medical bill and knew he would have to work on twice as many cars over the next year to pay the bill, and that he'll have less money to help his daughters pay for school. He feels like the next time his chest begins to hurt, he will wait it out.

In Los Angeles County Service Planning Area 6, while 97% of children 0-17 and 82% of adults 18+ have insurance, just 76% of population reports having a usual source of care.

Source: LA County Department of Public Health Key Indicators of Health 2017

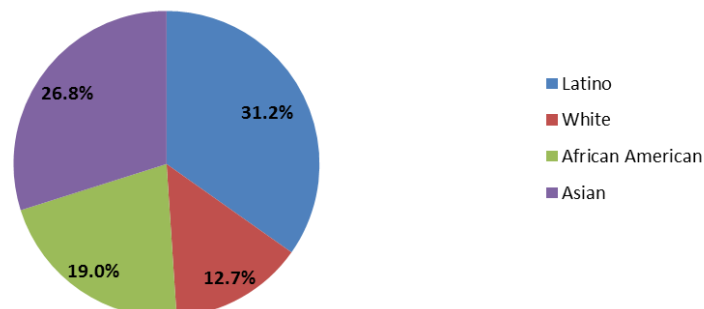
In Los Angeles County Service Planning Area 6, 57% of children 3-17 did not obtain dental care in 2014 because they could not afford it.

Source: 2015 Los Angeles County Health Survey

A survey of retail industry workers in the City of Los Angeles found that 37% did not take sick-leave when needed.

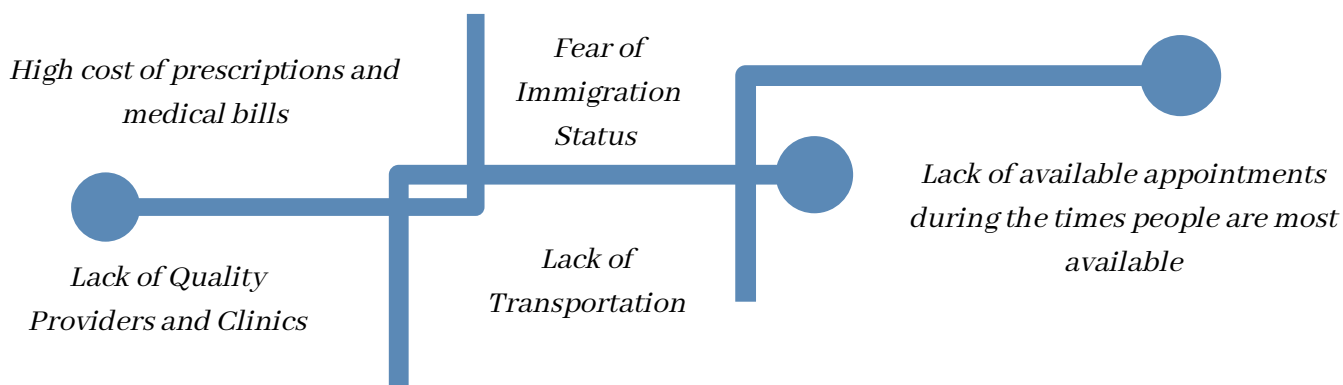
Source: UCLA Labor Study, 2018 "Hour Crisis: Unstable Schedules in the Los Angeles Retail Sector"

Percent of LA County Adults over 18 Who Reported That Obtaining Medical Care When Needed is Somewhat or Very Difficult



Source: 2015 Los Angeles County Health Survey

Key Drivers of Healthcare Access Issues



How the Community Experiences Access to Healthcare Issues

The high cost of healthcare forces residents to delay seeking treatment until the last possible moment, and, in some cases, self-diagnose or self-medicate, finding it easier and cheaper than to go to a doctor.

"Right now, just with the rent, it's really expensive. I don't know if there are people that really earn enough to pay their rent, live well, or have insurance for their family, or a health insurance. I think the majority of us try to get federal services, like Medi-Cal because paying insurance is really expensive... It's really hard. It's really hard to be able to do that." - Adult Resident Focus Group Participant

"I recently got sick and in not going to the hospital, aside from the 3-4 hours that you to sit and wait to be seen, people self-prescribe and then later people have to really go, and the consequences are worse."
- Adult Resident Focus Group Participant

However, most residents acknowledged that often times this results in a worsening condition that ultimately requires medical attention anyway.

Community Recommendations for Addressing Access to Healthcare



- Increased focus on prevention and preventative strategies to overcome challenges such as limited access to providers, expensive medications, and stigma associated with doctor's visits.
- Built environment changes to support healthy living would be well-received in participating communities.
- Increased attention on patterns of care within individual institutions.
- Community education campaigns to teach people how to better manage their conditions.

Employment & Education

Barriers for Families



Cory, a 20 year old African-American male, just moved back to Los Angeles from Lancaster, CA, where he lived in a group home. Though he grew up in the area, there are no family members left locally that he can count on for support.

Cory was able to secure a bed in a local youth shelter that provides wrap around services for youth as they transition into adulthood. For Cory, the first step was to get a job. He has been looking for a full-time job that can fit the shelter's 9:00 p.m. curfew until he is able to move. Though he has previous work experience as a part-time stock clerk at an auto supply warehouse, he has only received one callback of the 43 applications he has submitted for various entry-level jobs. Cory did not get that job as a receiving clerk for an international delivery company due to his limited experience, not having completed one year of college and only having a GED. He was also turned down for a position with a production assistant training program for youth 18-24 because he did not meet two of the minimum requirements: he does not have a driver's license or personal car, nor can he be on-call after 9:00 p.m. Two days ago he tried to apply for a cashier position at a neighborhood store, but was told they were all out of applications. Cory knows that is what people say when they do not want you working there. He has faced discrimination before in job searches, but prefers to just keep moving forward, rather than complain.

Cory has begun to lose hope that he will find a job, and is spending less and less time job hunting. He was recently written up at the shelter for staying out past curfew, and a few minor infractions. During a meeting with the shelter's Director about his recent behavior, Cory broke down in tears about his struggles to find a job. In six months, Cory will turn 21 and no longer be eligible to remain at the shelter. His only hope of not winding up on the street is to find a job as soon as possible. The Director suggests that Cory considers enrolling at the local community college, but he has already ruled this out as an option, given that it will not change his immediate need to secure housing before the shelter's age deadline arrives. He also does not think he will do well in college, since he really struggled to get his GED. He has decided that, if all else fails, he can always do "internet money plots" (slang for for quick cash), save up enough to get a car, and drive for Uber or Lyft.

In Los Angeles County Service Planning Area 6, 34% of the population have household incomes less than 100% of the Federal Poverty Level.

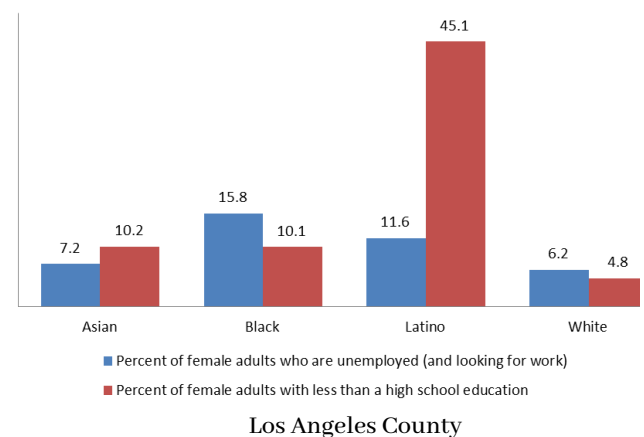
Source: LA County Department of Public Health Key Indicators of Health 2017

In South Los Angeles, the median household income is \$33,412, despite the fact that a living wage in Los Angeles is \$65,963.

Source: U.S. Census Bureau, 2012-2016 American Community Survey 5-Year Estimates

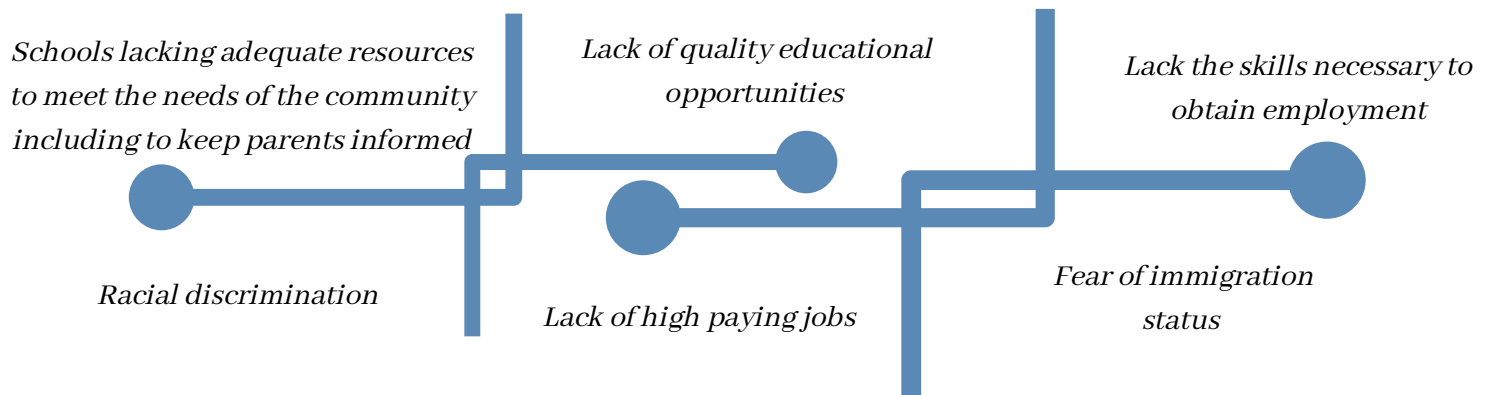
In South Los Angeles, 33% of area residents are unemployed, compared to 9% in the City of Los Angeles.

Source: 2010 Census



Source: LA County Department of Public Health Health Indicators for Women 2017

Key Drivers of Employment & Education Issues



How the Community Experiences Employment & Education Issues

Financial insecurity is taking a toll on their physical and mental health. In conversations with area residents, over half said they and their families feel stressed about making ends meet.

“If you are a young man and not able to provide for your family that could create depression, anxiety about you know, what can I do to make more money.”
- Key Informant Interviewee

“Let’s say a job pays \$13 an hour, minimum wage, so you work 4 hours, you make this, and in one hour I can make what you made in 4 hours, I will take that over this. It’s like best options.” - Transitional Age Youth Focus Group Participant

Conversations with younger adults revealed a certain level of acceptance of criminal activity as a means to generate income when they are unable to find gainful employment.

Community Recommendations for Addressing Employment and Education Issues



- Reviewing and revising operational and contracting policies of major institutions (i.e., health systems, college systems, etc.) that include things like: offering living-wages, effective job training programs, local hire provisions (including for entry-level positions), and upward career pathways for all employee levels.
- Increased access to better quality education opportunities.

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Food Insecurity

A Product of Poverty

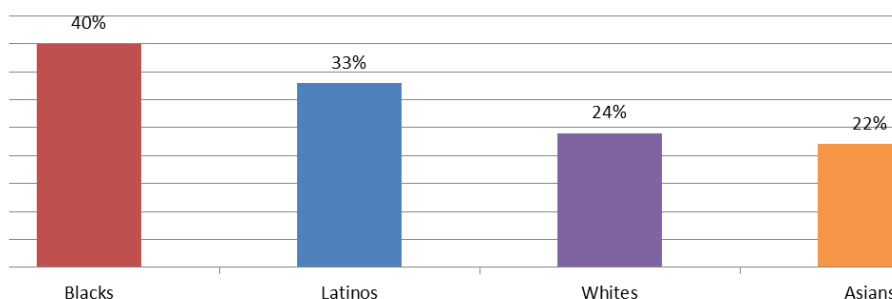


Patrick, who is 19 years old, lives at home with his mom and three younger siblings. He attends a local community college part-time, and has a part-time job as a retail clerk in a mall clothing store. He is putting himself through school, since his mother, who works two part-time jobs, cannot afford to help him. His mother is already struggling to afford the family's bills and put food on the table. His mother is an undocumented immigrant and does not want to apply for any kind of assistance, as she fears that filling out any of the paperwork will alert immigration authorities. They do not have cable television, internet access, expensive cell phone plans, or any thing that may be considered a luxury. He is grateful that, as a student, he can get access to computers and internet at school for his studies.

Patrick pitches in to help his mother with bills and basic necessities as much as he can; he pays the utility bills, and helps buy food for the house. The hardest times are when a new school semester is beginning because he has to pay his fees, buy books and supplies, which takes away from how much he has left over to help.

The family relies a lot on a few local programs that help supplement what they are able to spend on food. First, their local church has a weekly food giveaway that Patrick volunteers for. In exchange for his volunteer time, he is able to take home an extra bag of food. It is not the healthiest food, as a lot of it comes from donations, but they are grateful for it. His siblings are also able to eat free breakfast and lunch at school. Patrick's mother recently signed the children up to participate in the after school program because they can also have snacks there. As a result, the children are not as hungry in the evening, so his mother can make a little bit less food, which helps to stretch their budget.

Percent of LA County Adults in Households <300% FPL That Are Considered Food Insecure



Source: 2015 Community Health Assessment, the LA County Department of Public Health

In Los Angeles County, Service Planning Area 6:

- 19.5% of households are considered as having low food security.
- 12.9% of households are considered to have very low food security.
- 34% of households <185% FPL receive SNAP benefits (25% in LA County); this number increases to 38% for households with children.

Source: LA County Department of Public Health Key Indicators of Health 2017

Patrick has been considering postponing school in order to work full-time, so that he can help out more. His mother does not think that is a good idea. She is worried that if he quits, he will never go back. In the meantime, he recently completed an interview for a full-time job at a grocery store close to his school.

He knows that working full-time and going to school will be hard, but the increased money will help his family out. Right now, that is what is important.

Key Drivers of Food Insecurity

Lack of quality jobs that pay a living wage

Limited access to affordable healthy food

Need to prioritize other basic necessities

Limited access to resources to help with food costs



How the Community Experiences Food Insecurity

“...if it wasn't for food stamps, even though now they're being cut off, like I've already spent my February to put stuff in my house so I can be sustained throughout February. If I do run out of food before February, how am I going to get more food? ...food stamps are being cut off and I already barely make my rent, barely make my phone bill, I cut my wifi off because I couldn't make all the payments. So on top of it buy food as well, at this point is really really difficult.” - Transitional Age Youth Focus Group Participant

Residents describe various programs, services, or ways they supplement their families food budgets including: going to food banks, or free food giveaways at churches, ensuring their children eat meals offered at school, or, even selling valuables when necessary.

“It's available, but you can come like once every couple of months, like you can get so many groceries, every couple of months. You get enough but it's probably enough to last you for a month. And for a family it's not even enough. It's probably enough for a single person, or a couple, a brother; it's just not enough for like a family it's for one or two people.”

- Transitional Age Youth Focus Group Participant

However, in every instance, participants highlight that, no matter what they do, it is not enough.

Community Recommendations for Addressing Food Insecurity



- Invest in local food banks and programs that provide healthy fruits and vegetables.
- Create more Farmers Markets and community gardens.
- Public/Community Nutritionists, who are from the community, know how their peers live, and can show them how to eat healthier using what is around them.
- Nutrition education, including classes on how to eat healthy on a budget.
- More healthy grocery stores that are affordable (i.e., Sprouts, Trader Joe's).



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Housing Insecurity & Homelessness

An Escalating Crisis



Trina, 34, is a single-mother of two boys, ages four and seven, and lives in South Los Angeles. She moved into her current apartment two and a half years ago, after moving here from Ontario, CA. Trina works two jobs: full-time as a receptionist at a dental clinic and part-time as a Lyft driver. She makes \$38,000 per year. Roughly 41% of Trina's monthly income goes towards paying her monthly rent of \$1,295. Though her apartment is under rent control, she still has to pay the annual rent increase of 5% (\$64.75). Tenants in her building pay for their own utilities, adding \$73 per month to the cost of her family's housing. This brings her total housing cost to \$1,368. She has examined every part of her monthly finances, and realizes she has no room left to absorb another rent increase, which she fears is coming soon.

Trina is in constant stress over her family's financial situation. Her youngest will soon turn five, and enter school. The local public school is not that great. She would love to send them to private school, but there is no way to afford that. She cannot afford to live in a better area, as rent in these areas are typically double what she is currently paying. She has thought about moving back in with her mother, but two of her younger siblings already live there, one of which has a newborn. She doesn't see any way other than to move, which probably means moving more than 50 miles away to Riverside or Moreno Valley and finding new employment. Trina does not want to leave Los Angeles but, it is her only option if she wants her children to have a chance at a decent education and ease her stress level. She will have a better support system, since many of Trina's former neighbors and friends have already moved into this area after having been displaced.

In Los Angeles County Service Planning Area 6 has the 2nd highest homeless population (8,343) of which:

- 70% are unsheltered
- 64% are African American
- 12% are under 18 years old

Source: 2018 Greater Los Angeles Homeless Count

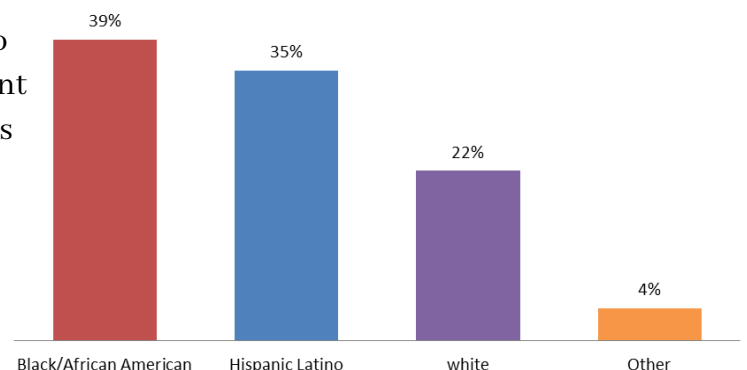
In Los Angeles County Service Planning Area 6, 63% of households spend 30% or more of their income on housing.

Source: 2015 Los Angeles County Health Survey

The average monthly rent in many areas of South Los Angeles is \$1,034.17.

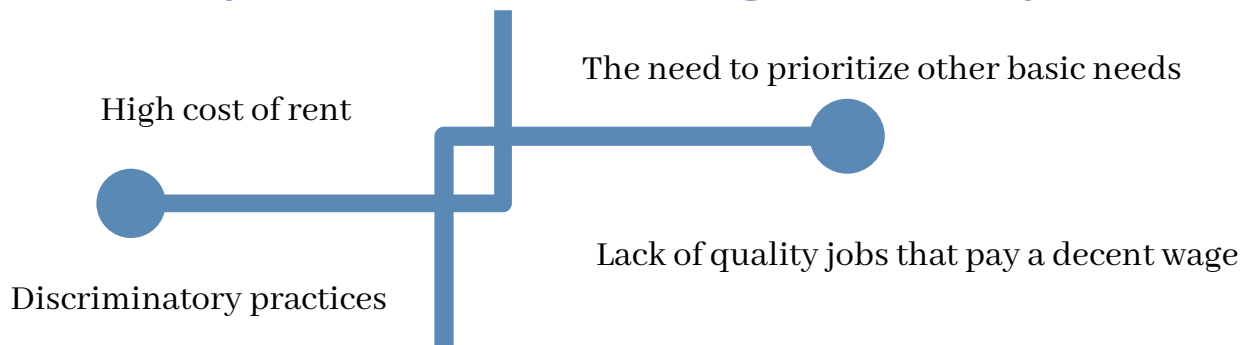
Source: USC Neighborhood Data for Social Change - Rising Rent Burden in Los Angeles

% of homeless population in Los Angeles



Source: 2015 Community Health Assessment, the LA County Department of Public Health

Key Drivers of Housing Insecurity



How the Community Experiences Housing Insecurity

“...either have to pay your rent and after you pay your rent you have to figure out what you going to do with the rest of your money like...you really have to try to budget and it’s kind of hard to budget when you don’t have very much money.”

- Adult Resident Focus Group Participant

With no wiggle room in their monthly budgets, people are put in the position of having to choose between take care of basic needs (e.g., forgoing quality childcare to leave children with neighbors or relatives; canceling car insurance because they cannot afford the monthly premiums, buying unhealthy food and cheap fast food because it is cheaper and faster, etc.) or paying rent, and developing stress and anxiety due to the overwhelming financial burden.

The high cost of housing is negatively impacting the lives of area residents. More families are crowding together in small spaces, and oftentimes in substandard conditions, to more easily afford the cost of rent and utilities. Many are working two or more jobs to stay afloat; severely limiting the time they have to attend to the needs of the families and themselves.

“I was in the Crenshaw area. I am now not in the Crenshaw area because I couldn’t find a place to live over here when it came time to move because I didn’t have an income, because basically the rent was too high. I wanted to live here and keep my kids in that school.” - Adult Resident Focus Group Participant

Community Recommendations for Addressing Housing Insecurity



- Reviewing and revising operational and contracting policies of major institutions (i.e., health systems, college systems, etc.) that include things like: offering living-wages; effective job training programs, local hire provisions (including for entry-level positions); and upward career pathways for all level of employees.
- Increased access to quality education opportunities to help increase household income.
- More affordable housing options.



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Mental Health

A Pervasive Issue



Martha, 37, is a single-mother of three school age children (ages 7, 14 & 17) who lives with them and her 69 year older mother in a small two bedroom apartment in South LA. Martha lives in a rent-controlled apartment and spends 60% of her salary on rent and utilities. She is the sole earner in her family. Though she had a full-time job, she was forced to take on a part-time job just to make ends meet.

For the past 14 months, Martha has been working close to 65 hours per week. She works everyday, leaving home before 8:00 a.m. each morning, and returning after 10:00 p.m. most nights. Her full-time job is over 12 miles from her home. Martha rides two buses during her 1 hour 13 minute commute, each way.

She naps on the bus, to make up for the sleep she loses between her two jobs, taking care of household chores, and caring for her mother, whose health is worsening. If lucky, she typically gets about 5 hours and 30 minutes of sleep each night. The long work days and long commute are beginning to take a toll on her body. Lately, she has less and less patience when dealing with her children.

Martha's oldest children are struggling academically, and her middle schooler has been suspended from school three times this year for fighting. If it happens again, she will have to find him a new school.

Martha received a referral to a family support group to help her son deal with anger issues. The group meets twice per week in the early evening, and is 3 miles away from their home and 15 miles away from her job. Martha feels as if her life is spiraling out of control and worries about the effects on her children. She has no idea where to turn for help. Her circle of friends has dwindled and she doesn't mention what she is going through to them because she feels like they would not understand.

In LA County Service Planning Area 6:

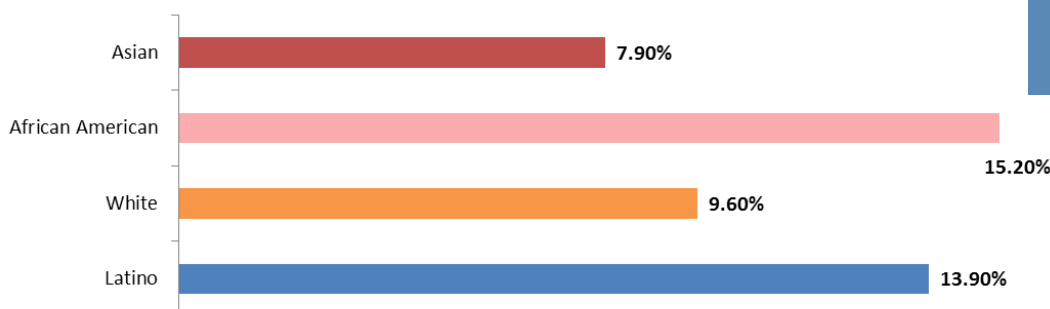
- Residents report having an average of 6 unhealthy days (over a 30 day period) as a result of poor mental and/or physical health.
- Only 56% of residents report being able to receive the social emotional support they need, compared with 64% of adults in LA County.
- Only 8% of adults report ever being diagnosed or treated for depression.

Source: La County Department of Public Health Key Indicators of Health 2017

In LA County Service Planning Area 6, 17% of adults experiencing homelessness have a serious mental illness.

Source: 2018 Greater Los Angeles Homeless Count

Percent of LA County Adults (18+ years old) At Risk for Major Depression



Source: 2015 LA County Health Survey

Key Drivers of Mental Health Issues

Financial insecurity (worried about “making ends meet”) and the strains of everyday life (limited time to take care of personal and family needs)

A general lack of awareness about mental health

The stigma associated with getting professional help to deal with mental health issues

Few if any known local resources to support people outside of those targeted towards people with serious, diagnosed mental illness



How the Community Experiences Mental Health Issues

“A lot of people are stressed because rent is too high, food is expensive, minimum wage is low, so that’s really a high stress factor; a lot of people get mental breakdowns or have strokes, can get a lot of health issues from that.” -Transitional Age Youth Focus Group Participant

This lack of education & awareness perpetuates a stigma that leads individuals and families to remain silent while struggling to deal with the impacts of stress and mental illness on their own.

Constant stress from a dwindling ability to afford the most basic needs; food, shelter, clothing, transportation, quality education and healthcare. This begins with their inability to make a living wage, despite ever increasing costs of living.

Feeling ill-equipped to address mental health issues due to a lack of and inadequate community education and awareness or inability to navigate resources.

“...there’s still a lot of stigma in regards to mental health, and coming out, and admitting that they have a mental health issue, and it’s becoming a big issue when it has to be treated.” - Transitional Age Youth Focus Group Participant

Community Recommendations for Addressing Mental Health



- Broad public awareness campaigns and opportunities for individuals to learn more about mental health and wellness in the local community.
- Family therapy services in the local community.
- Increase access to information about how and where to access local resources, including digital directories.

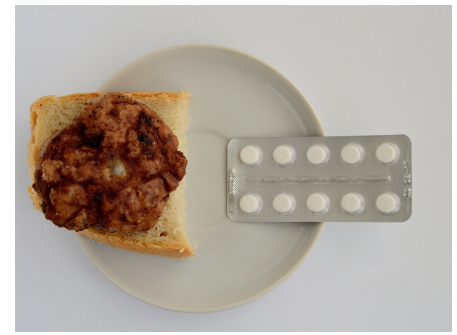
Obesity & Diabetes

A Scarcity Issue

The Jordan Family; Sylvia, 31, D'Aaron, 33, and their two children, ages 6 and 9, live in South Los Angeles. Though both parents work full-time, they still struggle to keep up with basic monthly expenses. With both parents working, both kids in school, and only one car, Sylvia and D'Aaron have very little time for cooking. Most meals are a mixture of prepackaged food that can be made quickly while the family is tending to other chores. Everyone in the family is overweight. Sylvia is considered obese.

Last year, Sylvia was diagnosed with type II diabetes. In the months following her diagnosis, Sylvia tried very hard to change her family's eating habits, to help manage her own condition, and to keep anyone else from developing diabetes. Her doctor had given her a few pamphlets to help educate her about managing diabetes, as well as a cookbook with healthy recipes. She tried four of the recipes before giving up on the book. Her family did not like the food, the recipes required too many ingredients, and too much time to make. A few changes stuck. They now drink low fat milk, do not buy as many sugary snacks, and try to have at least one vegetable with dinner.

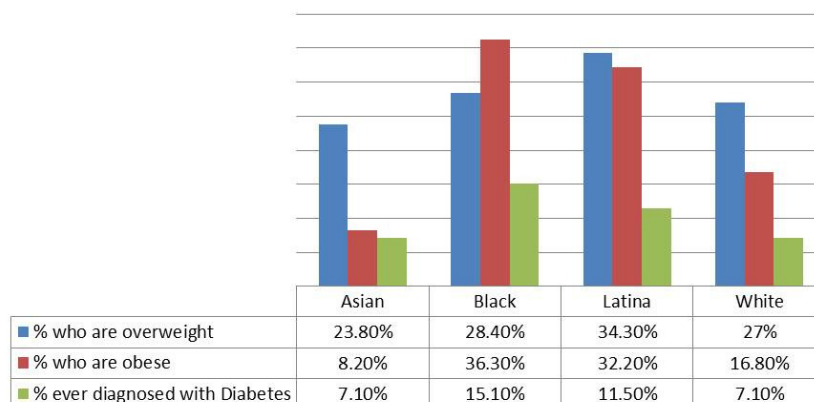
However, Sylvia's weight has not gone down much since her diagnosis and her A1C level was still elevated at her last doctor's visit. Her doctor said she should exercise. Sylvia left the office frustrated because she knows that she needs to exercise, but at this point, she is barely managing to keep up with daily life activities. However, Sylvia is determined not to give up, as she wants to be healthier for her kids. She asked around on Facebook, and found out that there is a walking group at a high school not far from her home that meets three times per week. She is going to speak with her husband to figure out how to arrange their schedule so that they can go walking with the group as a family. She knows it is a small step, but at least it is a step in the right direction.



In LA County Service Planning Area 6:

- 33% of adults are considered overweight and 34% are obese.
- Highest rates of deaths because of diabetes at 37.6 per 100,000 population.
- Only 10% of adults report consuming five or more servings of fruits and vegetables per day.
- 41% of adults and 52% of children drink at least one soda or sweetened drink per day.
- Only 64% of adults and 28% of children 6-17 get the recommended minutes of exercise per week.

Obesity & Diabetes Rates by Ethnicity for Women in LA County



Source: LA County DPH Key Indicators of Health 2017

Key Drivers of Obesity & Diabetes

Limited time due to competing priorities such as work

Lack of safe places to be physically active

Lack of access to healthy food

Lack of education/awareness about how to prevent diet-related disease



How the Community Experiences Obesity & Diabetes

“To actually sit down and make a meal....So fast food is really convenient. I know it’s really unhealthy, but when you work 8 hours and you get up at 5 in the morning, you’re tired, you have to go somewhere. It’s bad for you, but it’s convenient. It’s weird.”
- Transitional Age Youth Focus Group Participant

Residents report a great deal of difficulty finding places to purchase healthy food in the service area. However, there is a high concentration of fast food available, and residents find that 1) unhealthy food is cheaper than healthy food, and 2) given their busy lives and limited time, the convenience of fast food makes it a better choice.

Neighborhoods are plagued by high levels of violence/crime, have poorly maintained streetscapes, and other issues that create disincentives to being physically active.

“...what makes it hard for the community is that the parks it’s not even safe to be in the park. If you want exercise, anything like that, there’s a lot of homeless people, there’s a lot of shooting, how can you go out of your community, it’s dangerous.”

- Transitional Age Youth Focus Group Participant

“Some of the young parents, they don’t even know how to, like get their food together... They don’t know what to really feed their kids. They’ll go out and they’ll get sodas and all this stuff....education has a lot to do with these kids.”- Adult Resident Focus Group Participant

Residents also highlighted the lack of awareness and opportunities to learn how to cook and eat more healthy food, lack of affordable healthy food options, and an overall lack of support received in managing diabetes.

Community Recommendations for Addressing Obesity & Diabetes



- Create more farmers’ markets and community gardens.
- Public/Community Nutritionists, who are from the community, know how their peers, and can show them how to eat healthier using what is around them.
- Nutrition education, including classes on how to eat healthy on a budget.
- More healthy grocery stores that are affordable (i.e., Sprouts, Trader Joe’s).
- Marketing and advertising health supporting community resources (so that people know where to go for help), including on social media.
- More group activities for physical activity, including: sports leagues for seniors, walking paths, roller skating rinks, swimming pools, etc.
- Better use of social media for outreach and education.



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Racial Equity

A Systemic Issue



It was sunny on the day that Valerie buried her second born son, Charles. He was six months old when he died of sudden infant death syndrome. As an African American woman, Valerie was unaware of the prevalence of infant mortality among women of her demographic. She did not know that regardless of her socio-economic status, educational background or excellent prenatal care, her son had a higher likelihood than any other child to suffer an untimely death before his first birthday. Valerie grew up in West Los Angeles. She was raised by two educated parents who owned their own home and sent Valerie to the best schools.

Growing up in West Los Angeles and attending the best schools had its challenges for a young African American girl. There were not many girls of color in the schools she attended and Valerie was often teased and treated differently by students and faculty. Dating in high school was stressful, as interracial relationships were not widely accepted and Valerie's options for dating often found her with young men from white families. While in a local prominent University, Valerie joined a sorority and found support from other women of color. She sought out African American faculty as mentors, looking for encouragement to face the structural racism that she would encounter from the institution, faculty and other students. She struggled to get accepted into internships as an engineering student, trying to find her place in a sector largely dominated by white men. Valerie succeeded despite these obstacles, graduating with honors, and securing a position at an established company in Los Angeles.

Years later, Valerie started her own company after she and her husband decided to start a family. The company was wildly successful but Valerie still was not free from discrimination or the microaggressions that come with being a person of color in the United States. When Valerie bought her second brand new car, she paid for it in full. When she wrote the check at the dealership, they demanded that she get a certified check from the bank. When she returned to the dealership with her check, they asked her where the money came from and if it belonged to her.

When baby Charles died, she visited her doctors to discuss what might have happened. She was questioned about whether or not she was using drugs, smoking in the house or simply neglecting her child. Valerie fell into a deep depression, one she has continued to struggle with for many years. Her first-born child, Angela, often wishes she could figure out how to make her mother happy and even at her young age, begins to experience the devastating effects of life as an African American girl in a society lacking in effective behaviors, policies and practices that drive diversity, equity and inclusion.

37% of African American and 30% Latino adults in LA County were unable to afford or delayed paying their mortgage or rent in the past two years compared to 15% White adults.

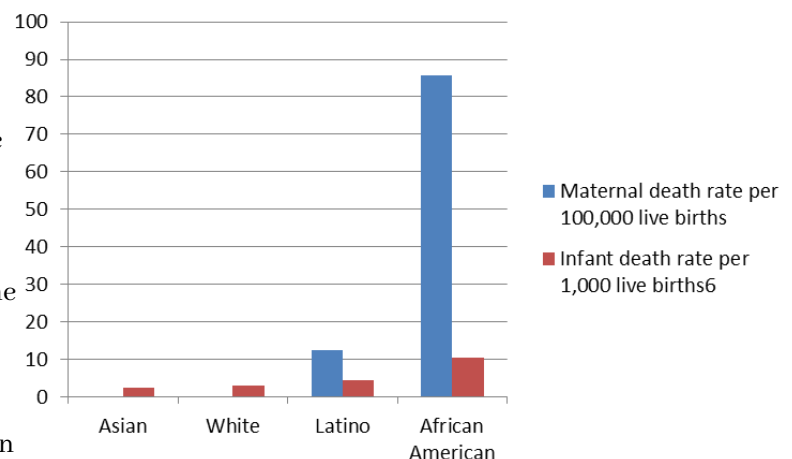
Source: LA County DPH "Housing & Health in LA County" 2015

53.7% of African American mothers in LA County reported ever experiencing discrimination compared to 34.2% White mothers.

Source: LA County DPH Los Angeles Mommy and Baby Project, 2016

Only 36% of African American and 33% Latino adults have access to high opportunity jobs compared to 58% White adults.

Source: Policy Link & PERE "An Equity Profile of the Los Angeles Region" 2017



LA County Department of Public Health Key Indicators of Health 2017

Barriers to Racial Equity

Discriminatory policies such as redlining and over-policing that have systematically neglected and disenfranchised communities of color, especially in South Los Angeles

Language barriers creating isolation

Underrepresentation of community residents in programs and efforts that are meant to support the community

Differences in access to services and/or treatment when using services between races



How the Community Experiences Barriers to Racial Equity

“I have work history, to where I can be an assistant manager, but a white man comes for his first job, probably works like three weeks, and got that manager position.” - Transitional Age Youth Focus Group Participant

“I have a friend who moved back to her mom’s house and when she was getting back on her feet. And she was calling around the vacancies in Leimert Park and they will not return her call! So she said, I don’t know, can they hear something in my voice. She asked a white coworker to call back and they called the white coworker back.” - Adult Resident Focus Group Participant

As with most low-income and communities of color, service area residents regularly deal with issues directly related to race, immigration status, and income. When seeking support from resource agencies, residents spoke of being ignored, mistreated, or not receiving the same levels of information as their peers of other races.

*“That’s crazy profiling and unfortunately it’s so prevalent here and especially around...they harass black people like it’s crazy.”
- Adult Resident Focus Group Participant*

Others outlined attitudes/perceptions and/or behaviors towards people of different races in their own communities that are barriers to building community cohesion.

*“Someone doesn’t speak English well, and then they don’t speak Spanish. There’s not a lot of communication. We don’t speak to each other.”
- Adult Resident Focus Group Participant*



Community Recommendations for Improving Racial Equity

- Investing in communities of color to ensure they have the same access to resources such as healthcare, education, healthy food, quality housing, transportation, etc. as wealthier, predominantly White communities.
- Support programs and entities that bring residents and other stakeholders together to discuss challenges faced in the community.

Substance Abuse

Coping with Trauma



Thomas, a 44 young African American man, is a resident of a local sober living facility. He has a drinking problem and uses marijuana occasionally. Thomas' issues with substance abuse began after losing his house when his mortgage nearly doubled during the midst of the economic downturn. He rented an apartment in Inglewood, but lost his job 10 months later. His unemployment benefits were barely enough to cover his monthly expenses and he kept getting hit with rent increases that strained his budget. Under constant stress, Thomas started having a drink or two in the evenings, to calm his nerves from stressful days spent looking for work, and worrying about how he was going to make it from one month to the next. He also began smoking marijuana in the mornings to help calm his nerves during the day. His drinking and smoking slowly increased to the point where he was inebriated all day, every day. The last rent increase was the breaking point, as there was no way Thomas would be able to afford it, so he moved out and began living in his car.

Soon after, Thomas received his first DUI conviction. His driver's license was suspended, he was sentenced to 6 months probation and ordered to attend Alcoholic Anonymous (AA) meetings. The AA meetings were not local and without the ability to drive to them, Thomas missed more than half of the sessions. Not only did he not benefit from the program, he violated the terms of his probation and was sent to jail for two months. After he was released he had difficulty finding a job and his drinking problems increased. The next few years were an endless cycle of arrests, attendance at short-term outpatient treatment programs, and homelessness. During his last time in court, the judge ordered Thomas to a 60-day inpatient treatment program. However, Thomas' public benefits did not cover the full cost of the program. Thomas compromised with the Judge to allow him to find a local sober living home and remain there for 90-days. Though the initial weeks were bad, Thomas has thrown himself into the program, and has now been sober for 23 days.

In the LA County Southwest Health District:

- 15% of 18 and older population reported binge drinking in the past month .
- 49.2% of the adult population had at least one alcoholic drink in the last month.
- 18.1 % of the adult population reported using some form of marijuana in the last year.
- 7.2 % of adults reported misusing any form of prescription drugs in the past year.

Source: LA County Health Survey 2015

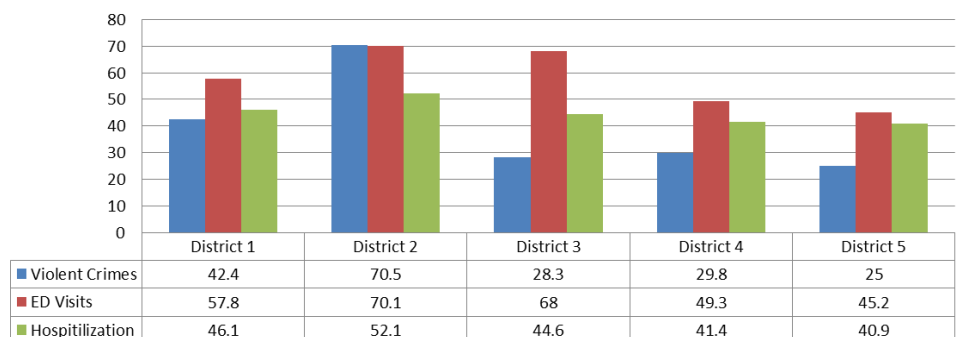
In Los Angeles County Service Planning Area 6, 12% of the adult population experiencing homelessness have a substance use disorder.

Source: 2018 Greater Los Angeles Homeless Count

In LA County, adults who reported using marijuana in the past year were more likely to report having depression (16.7%) and being at risk for major depression (16.3%) compared to those who did not use marijuana in the past year (7.6% and 11.1%, respectively).

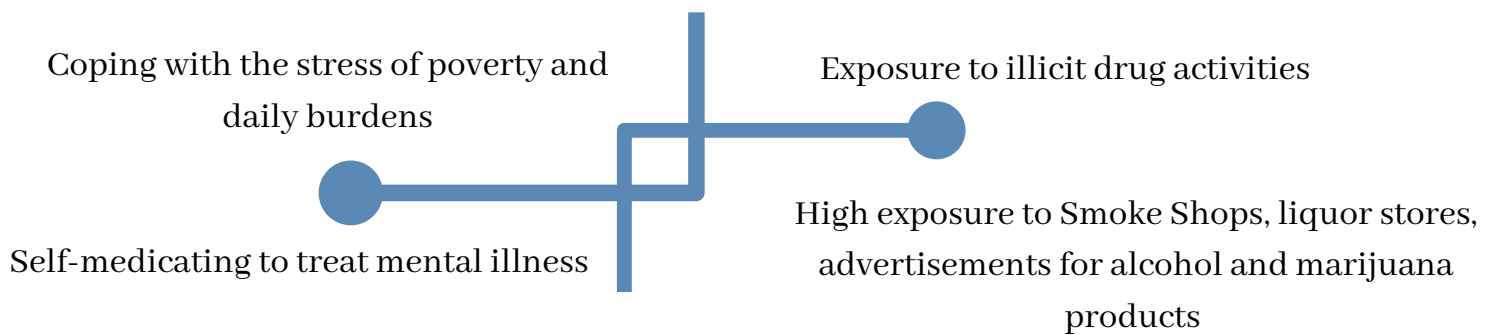
Source: LA County Health Survey 2015

Alcohol-related Consequences (rates per 10,000 population) by Supervisorial District, Los Angeles County, 2013



Source: LA County Department of Public Health "Alcohol Outlet Density and Alcohol-Related Consequences" 2013

Drivers of Substance Abuse



How the Community Experiences Substance Abuse

"I see kids and their parents that have to work two jobs can't be there afterschool to pick them up. So what they do is hang out they find friends from high school, or they hang around gangsters or people who do drugs and older people are introducing them to crystal meth, at 15-16, smoking weed, drinking. They're coming from a poor background, they don't have the chance and to have a nice life. They're sucked into whatever is out there. That's sad." - Transitional Age Youth Focus Group Participant

People feel unsafe and worry about the police unfairly targeting their family members and loved ones. They perceive a general breakdown in family relationships.

People also noted drug use within their local homeless communities, noting criminal activity and sometimes violence where there is increased drug activity. This leads residents to shy away from fully utilizing health-promoting community resources.

Illicit drug activities create an environment of increased police presence that can have rippling negative consequences for those caught in the middle.

"They get exposed to drugs. Drugs is something that will forever go on. It's messing up families, it's breaking up homes it's making people homeless, because they can't break that cycle of not knocking the habit that they know is not healthy which makes them unhealthy. They're abusing their substance." - Transitional Age Youth Focus Group Participant



Community Recommendations for Addressing Substance Abuse

- Ensure there are more Alcoholic Anonymous meetings in the local community.
- Increase education and awareness about the pitfalls of substance abuse.
- Provide more resources for people that are experiencing substance abuse issues (e.g., anonymous clean needle exchanges).
- Create pathways out of poverty (e.g., job training and placement assistance).



The qualitative data, quotes, and recommendations on this page came from key informant interview, resident focus groups, and community surveys conducted in the under resourced areas of the KFH - West Los Angeles Service Area. For questions about or how to access the full report contact CHNA-communications@kp.org.

Appendix D. Community resources

The table below provides some examples of key resources available to address priority health needs. It is not an exhaustive list.

Identified Need	Resource Provider Name	Summary Description
1. Access to Care	Southside Coalition of Community Health Centers	A coalition of eight Federally Qualified Health Centers (FQHCs) serving the needs of low-income and uninsured South Los Angeles residents. https://southsidecoalition.org/
	Community Clinic Association of Los Angeles County (CCALAC).	CCALAC is a membership association of community health centers. It provides a range of trainings, technical assistance and resources to support community health centers in providing high quality affordable health care to low-income and underinsured residents in LA County. https://ccalac.org/
2. Substance Abuse	Asian American Drug Abuse Program (AADAP).	AADAP is a non-profit organization dedicated to serving Asian Pacific Islanders and other under-served communities with substance abuse services throughout La County. AADAP offers preventive education and substance abuse treatment for youth and adult in multiple locations in the South Los Angeles area. http://www.aadapinc.org/
	Watts Healthcare Corporation – House of Uhuru	The House of Uhuru is a division of Watts Healthcare Corporation. It provides compressive culturally sensitive prevention, education, and treatment in the South LA area. Services include residential treatment program for men, women and women with children ages 0-5 among other services. http://houseofuhuru.org/
3. Mental Health	Open Paths Counseling Center	Open Path offers sliding-scale counseling for individuals and families, free therapy programs for at-risk children and youth in local schools, and training program for bilingual graduate students. Service locations include Culver City, Inglewood, Lenox and Venice. https://openpaths.org/
	Airport Marina Counseling Center (AMCS)	AMCS provides affordable community based mental health services and trains mental health therapists. AMCS provides services to residents of various communities in KFH-West Los Angeles service area, including Inglewood, Culver City, El Segundo, South LA and Westchester, among others. https://www.amcshelps.com/
	Department of Mental Health (DMH) – Health Neighborhoods	DMH provides mental health services to individuals experiencing mental health conditions. The Health Neighborhoods initiative brings clinical and service providers together to increase their capacity to prevent and manage mental health conditions in specific communities. https://dmh.lacounty.gov/about/health-neighborhoods/
4. Obesity and Diabetes	Black Women for Wellness (BWW)	BWW is community-based organization dedicated to improving the health and well-being of Black women and girls through health education, empowerment and advocacy. BWW services include Sisters in Motion and Kitchen Divas programs focusing on decreasing heart disease, high blood pressure, diabetes and obesity through nutrition education, lifestyle changes, prevention and physical activity. https://www.bwwla.org/
	Metropolitan YMCA and Santa Monica YMCA	The metropolitan YMCA offers access to safe physical exercise and school physical activity programs for low-income residents at various locations in KFH-West Los Angeles service area. https://www.yocala.org/ Additionally, the Santa Monica YMCA offers the Center for Disease Control Diabetes Prevention Program (DPP) and provides scholarships for low-income residents diagnosed as pre-diabetic.

Community Health Needs Assessment Report for KFH-West Los Angeles

Identified Need	Resource Provider Name	Summary Description
		http://welcome.ymcasm.org/programs/diabetes-prevention-program/
5. Food Insecurity	The Los Angeles Regional Food Bank	Through the Rapid Food Distribution program, the LA Regional Food Bank distributes nutritious fruits, vegetables and other perishable foods out to more than 625 agencies at more than 800 sites throughout LA County. https://www.lafoodbank.org/
	Los Angeles County Department of Public Social Services (DPSS)	DPSS enrolls low-income eligible residents in food assistance and other social services programs. This agency administers the CalFresh program, federally known as the Supplemental Nutrition Assistance Program (SNAP). This program issues monthly electronic benefits that can be used to buy most foods at many markets and food stores. https://www.yourbenefits.laclrs.org/ybn/Index.html
6. Housing Insecurity	Strategic Actions for a Just Economy (SAJE)	SAJE is a non-profit organization in South Los Angeles promoting economic justice through tenant rights education and advocating for healthy and equitable housing developments. http://www.saje.net/
	United Neighbors in Defense Against Displacement (UNIDAD)	UNIDAD is a coalition of residents and organizations dedicated to preventing the displacement of residents in South Central Los Angeles and to improving the health and economic well-being of low-income communities of color through responsible development. http://www.unidad-la.org
7. Diversity, Equity and Inclusion	Social Justice Learning Institute	SJLI is dedicated to improving the education health and well-being of youth and communities of color by empowering residents to enact social change through research training and community mobilization. Their primary service area is the City of Inglewood. http://sjli.org/
	Community Coalition (COCO)	COCO is dedicated to transforming negative social and economic conditions that foster addiction crime violence and poverty in South Los Angeles by organizing residents and influencing public policy. http://cocosouthla.org/
8. Employment and Education	AL Wooten Jr. Heritage Center	Al Wooten Center provides free and low-cost afterschool and summer programs for boys and girls grades 3-12. The Center serves about 400 youth annually in South Los Angeles. My CollegeTrek and SAT-prep programs focus on career development and college graduation. https://www.wootencenter.org/
	The Los Angeles Brotherhood Crusade	Brotherhood Crusade offers Youth development programs and manages a YouthSource Center to increase opportunities for economic development in the South Los Angeles communities. https://brotherhoodcrusade.org/

Appendix E – Strategic Lines of Inquiry for Community Engagement

Southern California Kaiser Permanente’s approach to the 2019 CHNA employed a mixed-methods sequential explanatory assessment design intended to produce the most accurate, vivid, and meaningful story of community health possible. This appendix reports an overview of the assessment design and the lines of inquiry 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 for a relevant community engagement plan. For example, Kaiser Permanente social workers might have reviewed the data during this phase and provided an observation that immigration policies could be influencing Hispanic/Latino residents’ willingness to access care.
- Across these internal data reflection sessions, consultants synthesized strategic lines of inquiry and re-framed the work as a driving force behind community engagement planning. These strategic questions were also designed to go beyond secondary data to focus on the human perspective and experience. Strategic questions targeted the root causes of health needs, racial/ethnic disparities, 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 relevant and rich insight about the topic, and b) tailored interview and focus group protocols for engagement participants that would surface insights in a conversational 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 the issues in truth and community relevance.
- Regardless of the strategic focus, the engagements also provided the opportunity for the community to raise any other health needs not targeted through the strategic lines of inquiry. These data were also included primary data analysis and reporting.