2019 Community Health Needs Assessment

Kaiser Foundation Hospital: Woodland Hills

License number: 930000358

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

September 16, 2019

Kaiser Permanente Southern California Region Community Benefit

CHNA Report for KFH-Woodland Hills

Contents

I. Introduction/background

A. About Kaiser Permanente (KP)

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

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

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

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

B. About Kaiser Permanente Community Health

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

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

- Ensuring health access by providing individuals served at KP, or by our safety net partners, with integrated clinical and social services;
- Improving conditions for health and equity by engaging members, communities, and Kaiser Permanente's workforce and assets; and
- Advancing the future of community health by innovating with technology and social solutions.

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

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

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

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

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

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

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

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

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

II. Community served

A. Kaiser Permanente's definition of community served

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

B. Maps and description of community served

i. Maps

Figure A. KFH-Woodland Hills Service Area: West Ventura Area
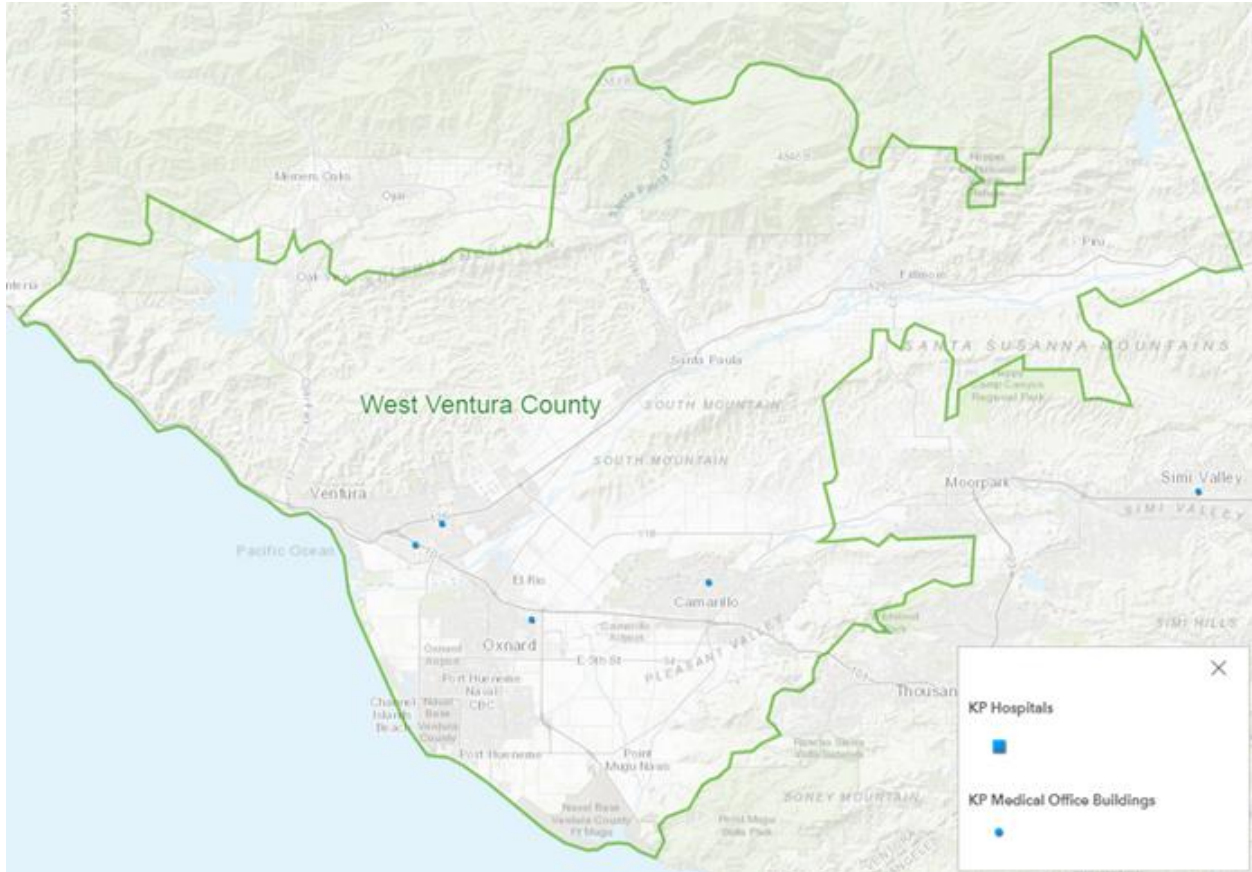
Figure B. KFH-Woodland Hills Service Area: Woodland Hills Area
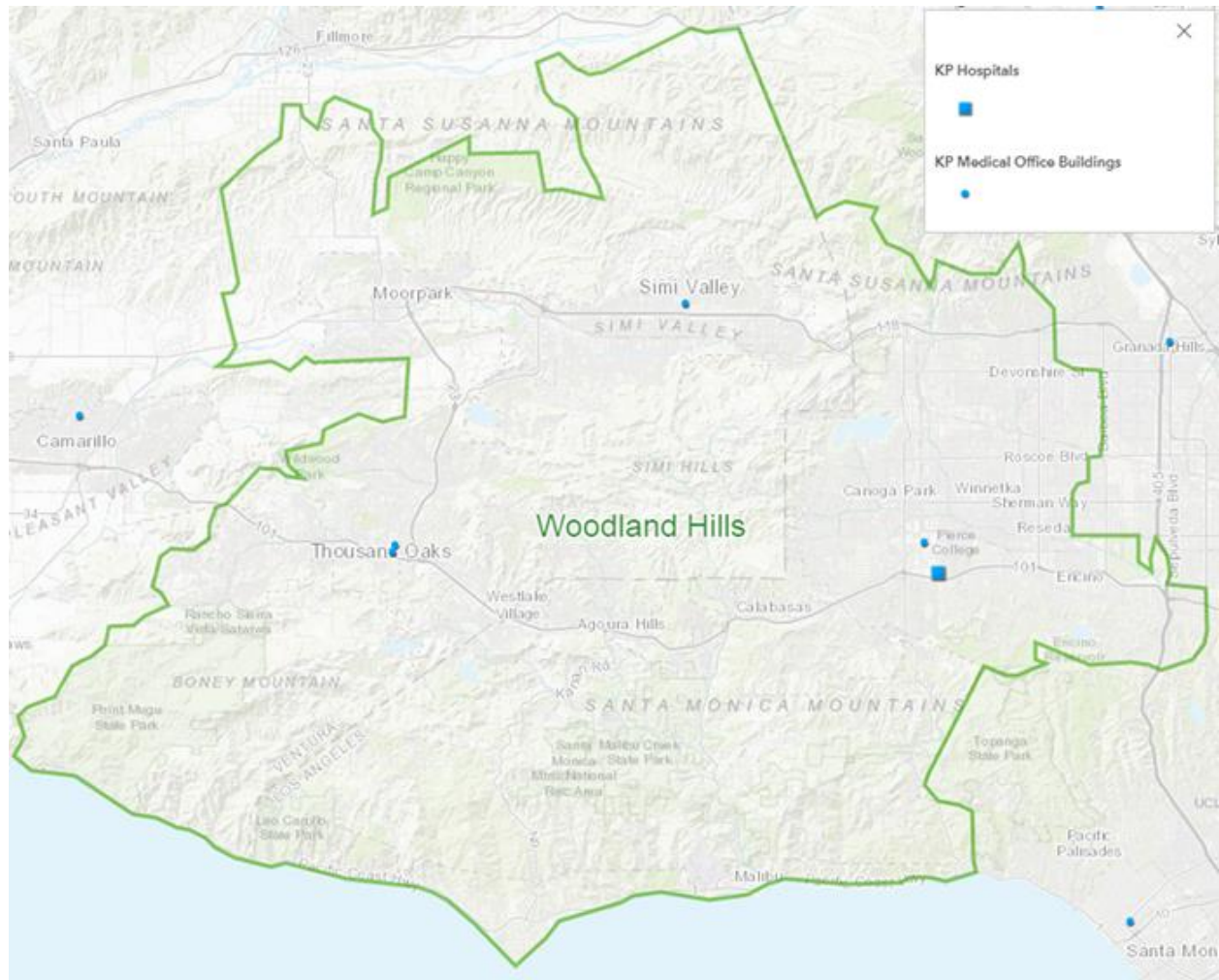
ii. Geographic description of the community served

The KFH-Woodland Hills service area includes the west end of the San Fernando Valley and Ventura County, including the communities of Agoura, Calabasas, Camarillo, Canoga Park, Chatsworth, Encino, Fillmore, Moorpark, Newbury Park, Northridge, Oxnard, Porter Ranch, Reseda, Santa Paula, Sherman Oaks (west), Simi Valley, Tarzana, Thousand Oaks, Topanga, Ventura, Winnetka, and Woodland Hills.

iii. Demographic profile of the community served

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

Table 1. Demographic profile: KFH-Woodland Hills[1]

Race/Ethnicity		Socioeconomic	
Total Population	944,593	Living in Poverty (<100% Federal Poverty Level)	10.32%
Asian	11.64%	Children in Poverty	12.59%
Black	3.05%	Unemployment	4.0%
Hispanic/Latino	26.17%	Uninsured Population	10.40%
Native American/Alaska Native	0.20%	Adults with No High School Diploma	10.70%
Pacific Islander/Native Hawaiian	0.12%		
Some Other Race	0.25%		
Multiple Races	2.94%		
White	55.63%		

Table 2. Demographic profile: KFH-West Ventura County[1]

Race/Ethnicity		Socioeconomic	
Total Population	502,738	Living in Poverty (<100% Federal Poverty Level)	13.49%
Asian	5.87%	Children in Poverty	20.32%
Black	1.96%	Unemployment	3.8%
Hispanic/Latino	55.40%	Uninsured Population	14.98%
Native American/Alaska Native	0.32%	Adults with No High School Diploma	22.50%
Pacific Islander/Native Hawaiian	0.14%		
Some Other Race	0.12%		
Multiple Races	2.11%		
White	34.08%		

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

iv. Severely under-resourced communities

Identifying disparities in the upstream factors that predict negative health outcomes is critical to Kaiser Permanente's community health mission. The maps below display the differences in opportunity for residents in the KFH-Woodland Hills service area to live a long and healthy life[2]. Areas in dark blue represent census tracts in the lowest quartile of health opportunity across California. These areas are severely under-resourced across multiple domains of the social predictors of health (e.g. economics, education, transportation, built environment, etc.).

Figure C. Under-Resourced Communities in KFH-Woodland Hills: West Ventura Area
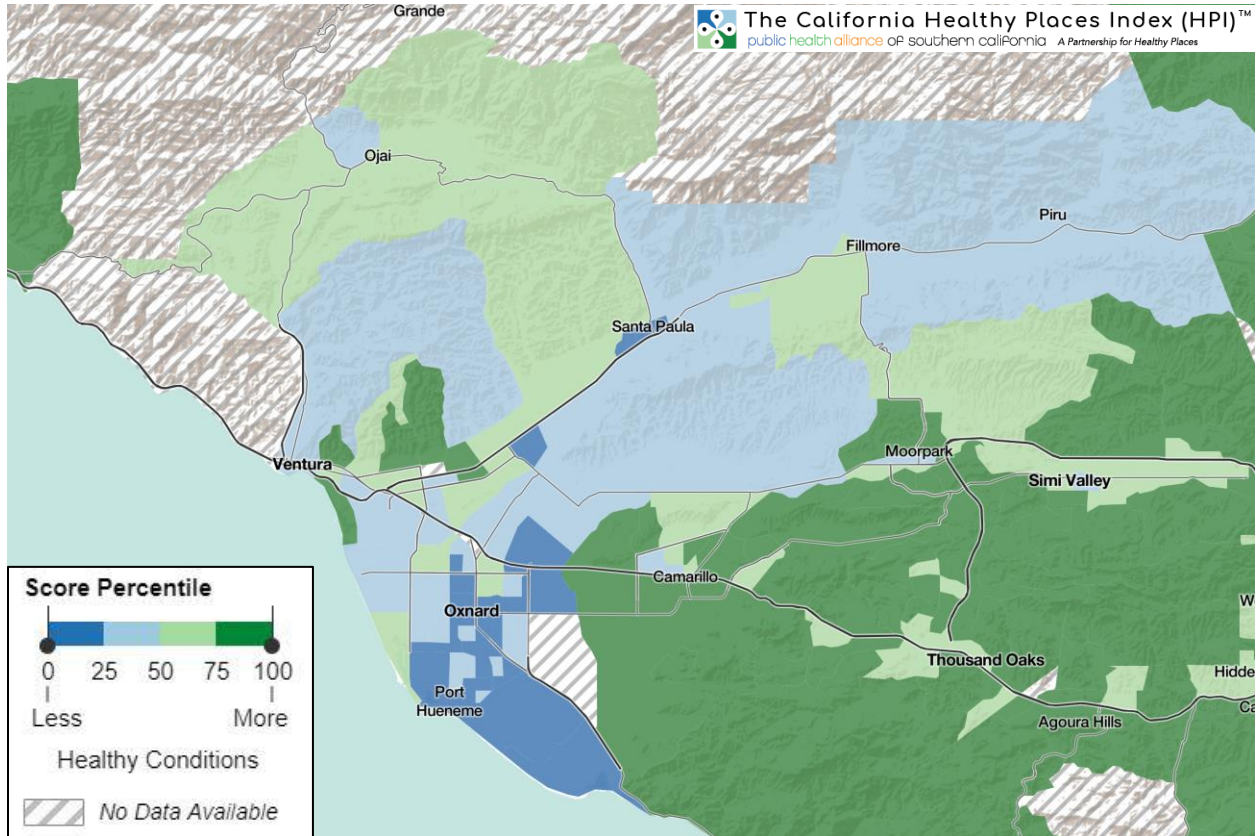
Source: The California Healthy Places Index, © 2018 Public Health Alliance of Southern California, http://healthyplacesindex.org/

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

Figure D. Under-Resourced Communities in KFH-Woodland Hills: Woodland Hills Area
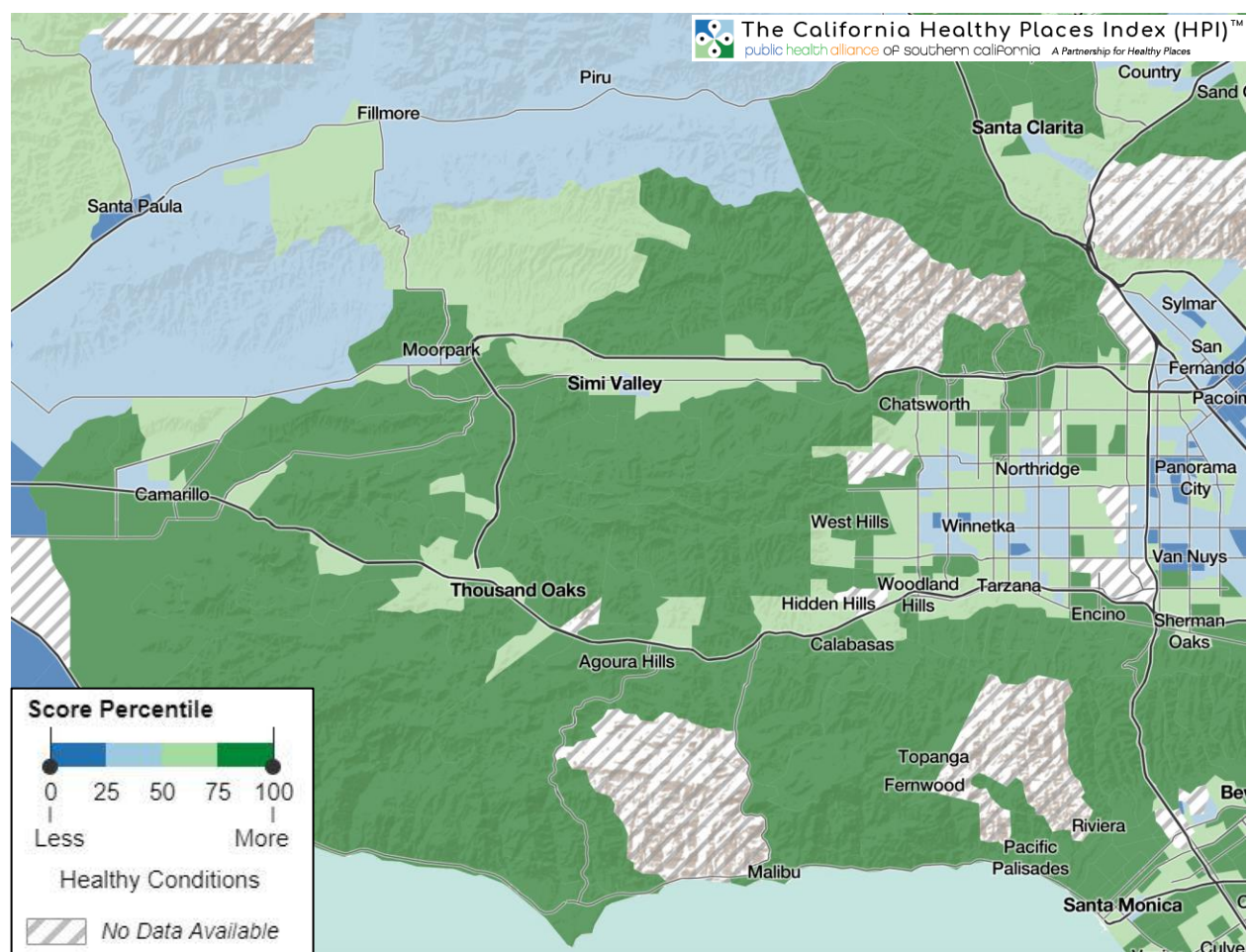
Major under-resourced communities in the KFH-Woodland Hills service area include:

- Canoga Park
- Fillmore
- Reseda
- Winnetka
- Oxnard
- Santa Paula

In aggregate, the KFH-Woodland Hills service area is in the 67th percentile for health opportunity in California with approximately 47,914 people living in a severely under-resourced area. In aggregate the KFH-West Ventura County Service Area is in the 55th percentile for health opportunity in California with approximately 173,813 people living in a severely under-resourced area.[3]

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

III. Who was involved in the assessment?

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

Collaborating Hospitals:
- Valley Care Community Consortium
- Ventura County Public Health

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

EVALCORP Research and Consulting was used to conduct the assessment within the Woodland Hills/West Ventura County service area. This consulting group was selected for its expertise and capacity to conduct large scale needs assessments and prioritization processes. All of EVALCORP's evaluation staff have Master's or Ph.D. level degrees in applied research, providing the firm with the necessary skill set and training to conduct this type of process that requires a need for both qualitative and quantitative data collection, coding, and analysis expertise. Staff working on the project have a cumulative total of over 50 years of evaluation and research experience and have engaged in over 20 needs assessment projects. EVALCORP employs a utilization-focused approach, meaning that staff first establish how clients intend to use the information (e.g. decision making, program operation improvements, documenting effectiveness, etc.) before designing or implementing data collection and reporting strategies. Additionally, staff is adept at crafting relevant questions to obtain the information required to address the issues at hand, then systematically compiling and organizing the information in a manner usable for the intended audience. Furthermore, EVALCORP has a reputation for gathering the most relevant information, then transforming the information gathered into meaningful and salient "stories" that appropriately convey the lived experiences and perceptions of the community.

IV. Process and methods used to conduct the CHNA

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

Figure E – Mixed-Method Assessment Approach to the CHNA

Secondary Data Analysis		Primary Data Collection and Analysis		Synthesis and Reporting
- Provided a bird's eye view of community health needs. - Conducted multi-dimensional health outcome comparisons. - Conducted regression analyses of social predictors of health.	Findings analyzed to create relevant lines of inquiry for community engagement.	- Provided a deep-dive exploration of community needs. - Employed strategic community sampling. - Ensured authentic engagement through culturally-competent protocols.	Findings analyzed to lift community voice.	- Provided meaningful understanding of lived experience, causes, disparities, and resources available to address health needs. - Combined bird's eye view + deep-dive data to tell community story.

A. Secondary data

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

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

ii. Methodology for collection, interpretation, and analysis of secondary data

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

1. Determine the geographic footprint of the most under-resourced communities in the KFH service area.

2. Identify the top social predictors of health (upstream factors) linked to community health outcomes in the KFH service area.

3. Provide an initial ranked list of health needs that could inform community engagement planning and the health need prioritization process for the KFH service area.

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

First, the most under-resourced geographic communities were identified utilizing the Public Health Alliance of Southern California's Healthy Places Index (HPI) mapping function. The

social predictors of health in this index include 25 indicators related to economic security, education, access to care, clean environment, housing, safety, transportation, and social support (please refer to Figures C and D to see these maps[4]).

Second, social predictors of health were used in multiple linear regression analyses to produce models identifying the social factors most predictive of negative health outcomes in KFH-Woodland Hills 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 Tables 3 and 4 to see results).

Third, health outcome indicators were analyzed across multiple dimensions including: absolute prevalence, relative service area prevalence to the state average, reduction of life expectancy (calculated through empirical literature on disability-adjusted life years), impact disparities across racial and ethnic groups, and alignment with county rankings of top causes of mortality (please refer to Tables 5 and 6 to see results).

Fourth, additional descriptive data were used to understand the demographics of the service area and provide context to findings from secondary and primary data analysis.
In sum, the use of secondary data in this CHNA process went beyond reporting publicly available descriptive data and generated new understandings of community health in the KFH service area. Secondary data analyses and visualization tools (a) synthesized a wide variety of available health outcome data to provide a bird's-eye view of the KFH service area needs and (b) provided a closer look at the impact of social factors that influence the opportunity of community residents in the service area to live long and healthy lives.

For further questions about the CHNA methodology and secondary data analyses, please contact CHNA-communications@kp.org.

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

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

Table 3. Social Factors Linked to Health Outcomes: West Ventura County Service Area

	More Poor Mental Health Days	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 Related
Lower Income	X		X	X	X	X	X			X	7
Fewer Bachelor's Degrees	X	X		X		X		X	X	X	7
Less Health Insurance			X	X	X				X		4
More Crowded Housing	X			X					X		3
More Homeownership					X	X	X				3
More Racial Segregation	X	X									2
Less Homeownership	X								X		2
More Bachelor's Degrees							X				1
More Beach/Park Access					X						1
Fewer Two Parent Households								X			1
Less Employment										X	1

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

Table 4. Social Factors Linked to Health Outcomes: Woodland Hills Service Area

	More Poor Mental Health Days	Heart Attack ER Visits	Higher Asthma Prevalence	Higher Obesity Prevalence	Higher Diabetes Prevalence	Higher Stroke Prevalence	Higher Cancer Prevalence	Higher Smoking Prevalence	More Pedestrian Injuries	Number of Outcomes Affected
Fewer Bachelor's Degrees	X	X	X					X	X	5
More Crowded Housing	X	X		X	X			X		5
Less Health Insurance	X		X	X	X			X		5
More Racial Segregation	X		X					X		3
Less Homeownership	X		X					X		3
Less Employment		X				X	X			3
More Homeownership					X	X	X			3
Lower Income				X	X	X				3
Less Park Access				X						1
Worse Air Quality			X							1
More Bachelor's Degrees							X			1
Less Crowded Housing							X			1

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]

Table 5. Health Outcome Comparison Table: West Ventura County Service Area

Health Outcome Category Name	Prevalence	Difference From State Average	Reduction in Length of Life Per Year	Worst Performing Race/Ethnicity vs. Average	Listen in Partner County Top 5 Cause of Death
Stroke*	4.0%	0.3% (Worse than CA)	57% Reduction	76% Worse than Average	Yes
Mental Health*	11.7%	-0.5% (Better than CA)	61.3% Reduction	43% Worse than Average	No
HIV/AIDS/STD	0.1%	-0.25% (Better than CA)	58.2% Reduction	211% Worse than Average	No
Obesity	28.1%	-1.5% (Better than CA)	37% Reduction	58% Worse than Average	No
Substance/Tobacco Use	5.9%	-1.07% (Better than CA)	69.7% Reduction	48% Worse than Average	No
Cancer*	3.6%	0.32% (Worse than CA)	51% Reduction	9% Worse than Average	Yes
Asthma	10.5%	-4.3% (Better than CA)	13.3% Reduction	92% Worse than Average	Yes
Diabetes*	8.5%	0.1% (Worse than CA)	24.1% Reduction	0% Worse than Average	No
CVD*	5.9%	-1.05% (Better than CA)	30% Reduction	16% Worse than Average	Yes
Maternal/Infant Health	6.3%	-0.5% (Better than CA)	17.9% Reduction	2% Worse than Average	No
Violence/Injury	0.0%	-0.001% (Better than CA)	13.2% Reduction	23% Worse than Average	No
Oral Health	8.6%	-2.7% (Better than CA)	2.8% Reduction	17% Worse than Average	No

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

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

Table 6. Health Outcome Comparison Table: Woodland Hills Service Area

Health Outcome Category Name	Prevalence in Service Area	Difference from State Average	Reduction in Life Expectancy	Worst Performing Race/Ethnicity vs. Average	Listed in Partner County Top 5 Cause of Death
Mental Health*	12.0%	-0.17% (Better than CA)	61.3% Reduction	62% Worse than Average	No
HIV/AIDS/STD	0.4%	0.04% (Worse than CA)	58.2% Reduction	211% Worse than Average	No
Stroke*	4.0%	0.3% (Worse than CA)	57% Reduction	47% Worse than Average	Yes
Cancer*	5.4%	2.06% (Worse than CA)	51% Reduction	29% Worse than Average	Yes
Obesity	20.5%	-9.1% (Better than CA)	37% Reduction	66% Worse than Average	No
Asthma	13.0%	-1.8% (Better than CA)	13.3% Reduction	87% Worse than Average	No
Substance/Tobacco Use	4.1%	-2.93% (Better than CA)	69.7% Reduction	48% Worse than Average	No
CVD*	6.2%	-0.75% (Better than CA)	30% Reduction	45% Worse than Average	Yes
Maternal/Infant Health	6.8%	0% (Same as CA)	17.9% Reduction	20% Worse than Average	No
Oral Health	10.6%	-0.7% (Better than CA)	2.8% Reduction	17% Worse than Average	No
Diabetes*	6.6%	-1.8% (Better than CA)	24.1% Reduction	6% Worse than Average	No
Violence/Injury	0.0%	-0.01% (Better than CA)	13.2% Reduction	30% Worse than Average	No

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

B. Community input

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

1. Why is the lack of higher education linked with a number of negative health outcomes in WH/WV?
2. What factors impede access to health care for low-income/Latino community members?
3. What factors contribute to poor health outcomes such as obesity and what assets exist in the community to address these health issues?
4. What specific stressors or circumstances contribute to poor mental health in WH/WV?
5. What factors contribute to housing issues in WH/WV and how does this contribute to chronic homelessness?
6. What are the most important needs of older adults in WH/WV?
7. How does a lack of transportation impact access to care and health outcomes in WH/WV?
8. What factors are leading to the high stroke prevalence and death rate in WH/WV (particularly in the black community)?
9. Why are cancer rates higher than average in WH/WV, and what resources does the community provide for screenings?

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

Figure F. Community Engagement Framework

Topic Areas of Assessment
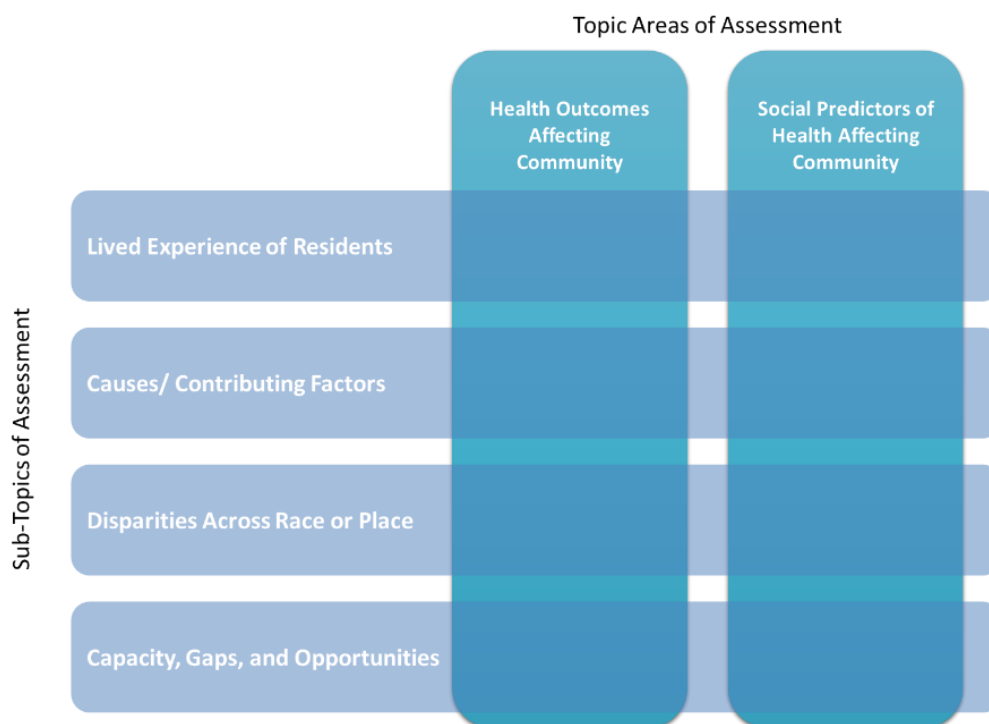
i. Description of who was consulted

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-Woodland Hills service area, community engagement efforts set out to target those geographies most under-resourced and where health outcomes were the poorest (see Figures C and D for maps referencing the most underserved areas of KFH-Woodland Hills). 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: key stakeholder interviews with Subject Matter Experts, focus groups with local community residents, and post-focus group surveys. Between October 2018 and January 2019, a total of 127 individuals were engaged in the Community Engagement Process; 16 Subject Matter Experts participated in interviews, and 111 residents participated in focus groups. Additionally, of the 111 residents, a total of 39 responded to the post focus group

survey (i.e., surveys were able to be collected at 3 of the 6 focus groups conducted) that asked respondents to rate their level of concern for a total 13 health concerns.

The purpose of the key stakeholder interviews was to identify predominant trends and assets related to health outcomes and social factors that provided an overall depiction of community conditions and factors that have the greatest impacts on health outcomes. The focus groups were designed to facilitate deeper inquiry into residents' lived experiences with one or more identified health needs, gathering information on perceptions of community assets, barriers to accessing resources, and potential recommendations for addressing gaps and barriers.

Data collected through the community engagement process was themed, coded, and organized within the SCAL CHNA Learning Framework to generate themes useful for answering strategic learning questions and ultimately informing an implementation strategy plan (see Figure F).

C. Written comments

Kaiser Permanente 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-Woodland Hills/West Ventura County had not received written comments about previous CHNA Reports. Kaiser Permanente will continue to track any submitted written comments and ensure that relevant submissions will be considered and addressed by the appropriate facility staff.

D. Data limitations and information gaps

As with any community needs assessment process, the data available for use is limited. For example, some data in the KP CHNA data platform 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.

Primary data collection limitations also included difficulties engaging the community. This was due to a number of reasons, but engagement was challenging primarily due to natural disasters in the region (wildfires), as many scheduled engagements had to be rescheduled for later dates.

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, EVALCORP worked in collaboration with Kaiser Permanente and the Community Benefit Manager, to review 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 served as a starting point for identifying the many health needs in the service area (see Appendix E for some examples). Using these secondary data, a series of "Strategic Learning Questions" were developed that reflected the areas the Community Benefit Manager wanted to engage in further inquiry about. These questions guided the community engagement process and informed the health prioritization process.

B. Process and criteria used for prioritization of health needs

A multi-step process was used to prioritize the health needs within the KFH-Woodland Hills. The prioritization process relied heavily on the secondary reports provided by Kaiser Permanente, as all health outcome data in the reports were ranked by several factors, including severity of need, magnitude, scale of need, and social factors impacting health outcomes. These rankings guided the prioritization process.

First, health outcomes that had the highest identified prevalence rose to the top of the list and were then assessed for severity of need. Thus, those health outcomes that had the highest prevalence and also the greatest severity of need were prioritized. Additionally, social factors impacting health outcomes were reviewed and incorporated into the prioritization process. At the conclusion of the community engagement process, emergent themes highlighting primary health concerns among the local community residents and subject matter experts were woven into the prioritization process to ensure health priorities were also reflective of primary community concerns. All of the aforementioned decision points were organized into a "Decision Matrix" utilized by the Community Benefit Manager and the consultant to facilitate the prioritization process. Figure G provides an at-a-glance overview of the decision steps guiding the prioritization process.

Figure G. Health Outcome Prioritization Decision Steps

Step 1: Health outcomes with highest prevalence were identified.

Step 2: High prevalence health outcomes were assessed to determine which had greatest severity.

Step 3: Soical factors impacting the greatest number of health outcomes were identified.

Step 4: The resulting list of high impact social factors was combined with the list of prevalent & severe health outcomes.

Step 5: The extent to which the needs in this list surfaced in the community engagement process was used to create the final list of priority needs.

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

The following seven health needs (i.e., health outcomes and social factors) were identified as priorities within the Woodland Hills Medical Center service area. Refer to Appendix C for full Health Need Profiles that provide more information for the identified health needs. Please note that Cardiovascular Disease, Obesity and Diabetes are combined into one Health Need Profile, as these diseases are interrelated.

Access to Care. Access to comprehensive, quality health care services is important for the achievement of health equity and for increasing the quality of life for everyone. Limited access to health care and compromised healthcare delivery impact people's ability to reach their full potential, negatively affecting their quality of life. Healthcare access and delivery, including primary and specialty care, is a health need locally, as demonstrated by high rates of preventable hospital events compared to the state average. Additionally, the community engagement process brought to light many concerns related to access to health and specifically the lacking quality of care.

Cardiovascular Disease (CVD). Cardiovascular disease can refer to a number of different health conditions including stroke, heart attack, arrhythmia, etc. Causes of cardiovascular disease include diabetes, diet, or hereditary factors, among other things. Social predictors that are linked to Heart Attack ER Visits are: fewer bachelor's degrees, more crowded housing, and less employment. Most recent data indicate that 6.2% of Woodland Hills Service area residents have heart disease. The average heart disease death rate is 104 per 100,000. Black residents of the area die of heart disease at above average rates. During the community engagement process, residents indicated that heart disease was among their primary concerns. Among focus group participants who completed a post focus group survey asking them to identify their

level of concern for various health outcomes, cardiovascular disease was among the top 5; with 74% indicating it was a concern for them.

Diabetes. Diabetes remains a major health concern at both a national and local level. If undiagnosed or left untreated, diabetes can lead to a number of serious health complications including kidney failure, heart attack, and stroke. Within the Woodland Hills area, 6.60% of adults aged 18 year or older have been told they have diabetes. Residents in the West Ventura area have a slightly higher percentage of adults being told they have diabetes, at 7.30%. While the social predictors linked to diabetes vary for both West Ventura and Woodland Hills across both areas, lower income was linked to a higher prevalence of diabetes. Additionally, among residents participating in the community engagement process, diabetes was one of the primary concerns and worries experienced impacting daily activities.

Economic Security (i.e. Housing/Homelessness). Research has increasingly shown how strongly social and economic conditions determine population health and differences in health among subgroups, much more so than medical care. Economic security is a health need locally, as marked by the percentage of residents who experienced food insecurity at some point during the past year, which is higher than the national benchmark. These various housing factors are linked to several health outcomes, including poor mental health days, obesity, and higher smoking prevalence. Furthermore, economic security, and the related aspects of increased housing prices, was reported as a major burden and cause for concern by all individuals who participated in the community engagement process, as all individuals expressed the severe impact rising housing prices are having on residents.

Educational Attainment. The literature and research indicate that educational attainment, specifically fewer bachelor's degrees, is linked to poorer health outcomes compared to individuals who have obtained higher education (i.e. Bachelor's Degree or higher). Negative health outcomes linked to lower education level are: poor mental health days, ER heart attack visits, asthma prevalence, smoking prevalence, and pedestrian injuries. Given the wide reach of this social predictor, additional work needs to be done in order to help support the attainment of higher education. Subject matter experts interviewed during the community engagement processes highlighted several barriers in attaining higher education and how this has larger impacts on the long-term health of an individual.

Mental Health. Poor mental health has become an ever-increasing concern and can have severely detrimental effects across all aspects of a person's life. The average suicide rate in the West Ventura area is 11.5 per 100,00 and in Woodland Hills it is 9 per 1000,000. Additionally, when looking at race/ethnicity groups that are most at risk of suicide, across both areas, Whites have above average suicide rates compared to other groups. Mental health has also been identified as a concern by local residents. Through the community engagement process, residents shared concerns about stress and anxiety and described the major impact these factors have on their daily lives. This health outcome was a primary concern among those who participated in the engagement process.

Obesity. Obesity is a concern, as it is a treatable and preventable health outcome that is the impetus to other more chronic health conditions. Specifically, obesity is tied to some of the previous health outcomes identified, namely diabetes and cardiovascular disease. By assessing upstream factors that are linked to obesity, prevention efforts or resources can be prioritized to address this health outcome. Recent data shows various social predictors are linked to obesity, including more crowded housing, fewer bachelor's degrees, less health insurance, lower income, and less beach/park access. Among adult residents in Woodland Hills, 20.5% are considered to be obese in comparison to 28.1% of residents in West Ventura. Across both Woodland Hills and West Ventura, Black and Hispanic/Latino residents are obese at above average rates. Additionally, among residents participating in the community engagement process, obesity was one of the primary concerns and worries expressed. Several residents shared environmental factors that contribute to this health concern.

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

The service area for KFH-Woodland Hills contains community-based organizations, government departments and agencies, hospital and clinic partners, and other community members and organizations engaged in addressing many of the health needs identified by this assessment. Key public resources available to respond to the identified health needs of the community are listed in Appendix D.

VI. KFH-Woodland Hills 2016 Implementation Strategy evaluation of impact

A. Purpose of 2016 Implementation Strategy evaluation of impact

KFH-Woodland Hills' 2016 Implementation Strategy Report was developed to identify activities to address the health needs identified in the 2016 CHNA. This section of the CHNA Report describes and assesses the impact of those activities. For more information on the KFH-Woodland Hills' 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-Woodland-Hills-IS-Report.pdf.

For reference, the list below includes the 2016 CHNA health needs that were prioritized to be addressed by KFH-Woodland Hills in the 2016 Implementation Strategy Report.

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

KFH-Woodland Hills 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-Woodland Hills tracks outcomes, including behavior and health outcomes, as appropriate and where available.

The impacts detailed below are part of a comprehensive measurement strategy for Community Health. Kaiser Permanente's measurement framework provides a way to 1) represent our collective work, 2) monitor the health status of our communities and track the impact of our work, and 3) facilitate shared accountability. We seek to empirically understand two questions: 1) how healthy are Kaiser Permanente communities, and 2) how does Kaiser Permanente contribute to community health? The Community Health Needs Assessment can help inform our comprehensive community health strategy and can help highlight areas where a particular focus is needed and support discussions about strategies aimed at addressing those health needs. As of the documentation of this CHNA Report in March 2019, KFH-Woodland Hills had evaluation of impact information on activities from 2017 and 2018. These data help us monitor progress toward improving the health of the communities we serve. While not reflected in this report, KFH-Woodland Hills will continue to monitor the impact of strategies implemented in 2019.

B. 2016 Implementation Strategy evaluation of impact overview

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

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

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

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

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

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

- Research: Deploying a wide range of research methods contributes to building general knowledge for improving health and health care services, including clinical research, health care services research, and epidemiological and translational studies on health care that are generalizable and broadly shared. Conducting high-quality health research and disseminating 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 99 grants amounting to a total of $5,406,307 in service of KFH-Woodland Hills 2016 health needs. Additionally, KFH-Woodland Hills has funded significant contributions to the California Community Foundation in the interest of funding effective long-term, strategic community benefit initiatives within the KFH-Woodland Hills service area. During 2017-2018, a portion of money managed by this foundation was used to award 24 grants totaling $3,915,536 in service of 2016 health needs.

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

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

C. 2016 Implementation Strategy evaluation of impact by health need

KFH-Woodland Hills Priority Health Needs

Need	Summary of impact	Examples of most impactful efforts
Access to Care	*During 2017 and 2018, Kaiser Permanente paid 23 grants, totaling $1,396,667 addressing the priority health need in the KFH-Woodland Hills service area. In addition, a portion of money managed by a donor advised fund at California Community Foundation was used to pay 7 grants, totaling $1,206,667 that address this need.*	**Providing Affordable Healthcare** Over two years (2017-2018), KFH-Woodland Hills has provided $28,042,136 in medical care services to 32,075 Medi-Cal recipients (both health plan members and non-members) and $12,963,371 in medical financial assistance (MFA) for 14,477 beneficiaries. **Building Primary Care Capacity~** The California Primary Care Association (CPCA) provides education, training, and advocacy to their member community health centers to best serve their low-income, underserved, and diverse patients. In 2018, Kaiser Permanente paid $126,666 to CPCA to: • Hold statewide convenings and conferences and topic-specific peer networks to support over 1,200 California community health centers. • Provide 90 in-person and web-based trainings to over 4,400 attendees and 2,890 individual instances of technical assistance. **Preserving and Expanding California Coverage Gains~** Insure the Uninsured Project (ITUP) works to preserve and expand access to health care and coverage in California and to reduce access barriers for uninsured and underinsured populations. Over two years (2017-2018), Kaiser Permanente paid $150,000 to ITUP to: • Conduct and disseminate health policy research. • Convene 13 regional statewide work groups. • Provide technical assistance to safety net providers and other stakeholders navigating health reform challenges. • Serve as a bridge between health policy and the health care sector to reach 19 million Californians. **Promoting Primary Health Care Services** Westminster Free Clinic (WFC) provides free primary health care and health related service including dental, vision, mental and behavioral health to uninsured patients and engage bilingual teen interns in targeted advocacy efforts to improve healthy food access in area Latino market. Over two years (2017-2018), Kaiser Permanente paid $40,000 to WFC to: • Provide free healthcare and health-related services to over 3,300 patients. • Facilitate chronic disease prevention programs (health education, Zumba, yoga, and diabetes clinic) for over 500 patients. • Conduct a year-long comprehensive chronic disease prevention program for 245 low-income uninsured individuals.

		• Partner with 30 teen promotores and 8 Latino markets in 5 cities of Ventura County to screen individuals for hypertension and diabetes and referring them to other community resources for further testing.
		Expanding Trainings to Assist the Elderly Caregivers Volunteers Assisting the Elderly (CVAE) provides transportation and other practical support to vulnerable, low-income senior population in Ventura County. The purpose of this volunteer-based program is to ensure access to healthcare, medical and lab appointments, shopping and pharmacy trips, as well as combating social isolation at no cost to the recipient. Over two years (2017-2018), Kaiser Permanente paid $40,000 to CVAE to: • Provide 500 seniors with practical living support and/or transportation to medical appointments, pharmacies, markets, etc. • Enroll 500 seniors in the program, of which 435 seniors remained living in their homes without transitioning into assisted living. • Recruit, screen, and train 41 new volunteers to work with seniors one-on-one.
Economic Security	*During 2017 and 2018, Kaiser Permanente paid 19 grants, totaling $586,970 addressing the priority health need in the KFH-Woodland Hills service area. In addition, a portion of money managed by a donor advised fund at California Community Foundation was used to pay 2 grants, totaling $400,000 that address this need.*	**Building the Capacity of Small Businesses** Kaiser Permanente promotes local economic development and enhances economic opportunity by helping to strengthen small business capacity. The Inner-City Capital Connections (ICCC) Program is an initiative that builds the capacity of local business located in economically underserved areas to access capital (financing) and grow their business. Over two years (2017-2018), KFH-Woodland Hills joined this county-wide initiative to: • Collectively enroll 299 businesses across the LA County initiative; 65% of participants are minority owned and 52% of participants are women owned.
		Contracting Social Enterprises 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. Over two years (2017-2018), KFH-Woodland Hills contracted with the following social enterprise(s): • Fleet Street Bikes where the Woodland Hills Public Affairs Department purchased bikes to auction off at sponsored events for nonprofit organizations and Fleet Street uses the proceeds to train at risk youth (including residents of Pacific Lodge Youth Services) on how to refurbish used bicycles and then donate them to people in need.

Building Safety Net Provider Capacity~*

The Charles Drew University of Medicine & Science's program works to alleviate the financial burden of undergraduate and graduate education that can prevent low socioeconomic students from completing their education. Recipients of these scholarships are required to work in the safety net for a period of 2 years following graduation. Over two years (2017-2018), Kaiser Permanente paid $666,667 to the university to:

- Award eight students a total of $215,833 in scholarships.
- Award 12 additional scholarships ranging from $3,750 to $14,833 to students in the programs of nursing, family nurse practitioner, physician assistant, or school of medicine.

Developing Workforce Pipeline for the Safety Net~*

The Community Clinic Association of Los Angeles County (CCALAC) aims to increase and develop the safety net health care workforce through a pipeline initiative. In 2018, Kaiser Permanente paid $250,000 to CCALAC to:

- Implement at least two student exposure programs, training rotations and experiential learning opportunities within member clinics annually for up to 40 students.
- Pilot a Nurse Practitioner Residency program that will provide 10 new graduates with a residency placement in five-member clinics annually.
- Develop an allied health training program to provide resources, trainings, and toolkits to strengthen clinic recruitment, onboarding, and retention efforts.

Training Leaders in Service of Community Health~

The Los Angeles Albert Schweitzer Fellowship (ASF) program aims to reduce disparities in health and healthcare by developing "leaders in service" who are dedicated to helping underserved communities. ASF selects Fellows from diverse universities and disciplines (i.e. medicine, dentistry, pharmacy, occupational therapy, psychology, public health, law, social work, etc.) annually to participate in the yearlong service project and awards each Fellow with a stipend of $2,500. For the 2017 to 2018 fellowship class, Kaiser Permanente paid $90,000 to ASF to:

- Recruit and train nine Fellows for the 2017-2018 fellowship class.
- Support the 2017-2018 fellowship class to develop a plan of action and implement a community project to address local unmet health needs.
- Review and prepare for the 2018-2019 fellowship class by selecting eight Fellows for year two.

Increasing Latino Medical School Applicants in California~

The Latino Physicians of California (LPOC)/MiMentor Partnership supports current and future Latino physicians through education, advocacy, and health policy. This is a culturally responsive mentoring program to increase underrepresented in medicine (UIM) applicants in California.

		LPOC will expand the Medical School Ready Program to increase the medical school readiness of UIM students through a year-long mentorship workshop series, supporting applicants through the entire medical school application process. In 2018, Kaiser Permanente paid $25,000 to LPOC to: • Enroll 45 UIM undergraduate and post-graduate students from Southern California into the Medical School Ready Series. • Enroll and train 45 physician mentors/coaches/advisors to mentor UIM medical school applicants.
		Promoting Self-Sufficiency Among Vulnerable Populations The Center for Living and Learning improves self-sufficiency and financial security for individuals transitioning from residential treatment facilities into the real-world. They focus on providing employment preparation, education and peer mentoring improve employment/health outcomes for those re-entering the community, recovering from substance abuse, mental health issues, or incarceration. Over two years (2017-2018), Kaiser Permanente paid $16,660 to Center for Living and Learning to: • Provide orientations on job readiness/peer support services for 182 people re-entering the community from residential drug treatment. • Offer individualized career counseling/job readiness preparation services for 62 people. • Support 47 individuals to gain and obtain employment.
Mental and Behavioral Health	*During 2017 and 2018, Kaiser Permanente paid 23 grants, totaling $1,023,454 addressing the priority health need in the KFH-Woodland Hills 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.*	**Strengthening Mental Health Policies and Practices in Schools~** Children Now educates policymakers, school district leaders, and other key stakeholders about best practices and policy solutions to address suspension and expulsion policies that disproportionately impact students of color, improve school climate, and increase students' access to mental health services. Over two years (2017-2018), Kaiser Permanente paid $150,000 to Children Now to: • Inform over 200 key legislators and stakeholders. • Support the California Department of Education in the development of the Whole Child Resource Map. • Lead committees for both the State School Attendance Review Board and the Superintendent's Mental Health Policy Workgroup.
		Improving Services for Human Trafficking Survivors~ The Coalition to Abolish Slavery and Trafficking (CAST) expands services to improve health outcomes for trafficking victims in Los Angeles County. CAST coordinates a continuum of care for trafficking victims by combining social, medical, and legal services with leadership and advocacy. In 2018, Kaiser Permanente paid $75,000 to CAST to: • Coordinate Whole Person Care services, including housing, food, medical, mental health, legal, education, and employment for 100 human trafficking survivors.

- Educate and advocate with policymakers, county officials, and community leaders on how to expand or improve access to emergency and permanent housing for victims.

Reducing Mental Health Stigma and Improving Resilience for LGBTQ Youth*

Village Family Services aims to reduce mental health stigma and improve resilience of LGBTQ youth by providing and linking LGBTQ youth to services promoting health, wellness, and healthy social engagement in a community environment, while striving to decrease incidence of homelessness for LGBTQ youth. In 2018, Kaiser Permanente paid $40,000 to Village Family Services to:

- Provide weekly support groups to 150 unduplicated LGBTQ youth and more specialized and individualized therapeutic services to at least 50 youth.
- Provide at least four "Family Pride" enhanced support workshops to at least 200 parents, caregivers and foster parents of LGBTQ youth.
- Conduct weekly educational outreach which will promote awareness and visibility of LGBTQ sensitivities targeting 500 people.
- Provide access to medical care for 500 LGBTQ youth by connecting them through the Drop-In Center to the Valley Community Healthcare.

Planning and Developing Safe Spaces for At-Risk Adolescents

One Step a la Vez supports low-income, agricultural, isolated under-served communities with case management and social and emotional support. Over two years (2017-2018), Kaiser Permanente paid $16,310 to One Step as la Vez to:

- Provide safe after school program to 140 vulnerable teens in an economically depressed and underserved agricultural area.
- Work with 28 teens on probation providing case management and referrals, family engagement, visits in the juvenile facility, mentoring and goal planning, transportation and assistance navigating the court system, court advocacy, and provided opportunities for service to the community.
- Conduct 6 Restorative Justice Circles aimed at at-risk youth.

Improving Accessibility Through 2-1-1

Interface Children and Family Services (ICFS) facilitates the 2-1-1 hotline that ensures text access to mental health services, housing, crises intervention and other health and human services. ICFS expanded the 2-1-1's referral helpline's two-way texting into a 24-hour service that links individuals in crisis with highly trained specialists who perform risk assessments and provide service referrals via text. Over two years (2017-2018), Kaiser Permanente paid $40,000 to ICFS to:

- Provide 4,200 adults with mental health services, crisis intervention, and/or housing support.

		• Provide 83 youth/transition-aged youth in crisis with mental health mental health services, crisis intervention, and/or housing related. • Contact "hard to reach" population including teens, victims of human trafficking, runaway homeless youth, and homeless adults.
Obesity/ HEAL/ Diabetes	*During 2017 and 2018, Kaiser Permanente paid 34 grants, totaling $2,399,216 addressing the priority health need in the KFH-Woodland Hills service area. In addition, a portion of money managed by a donor advised fund at California Community Foundation was used to pay 14 grants, totaling $2,268,869 that address this need.*	**Creating Opportunities for Active Living** This City of Ventura's Operation Splash program aims to increase opportunities for safe physical activity in low-income neighborhoods by offering underserved youth opportunities for aquatic skill acquisition and water safety instruction. Over two years (2017-2018), Kaiser Permanente paid $53,293 to the City of Ventura to: • Provide swimming lessons to 378 income-eligible 3rd to 5th graders. • Distribute 500 swim passes to youth and families. • Award 78 recreation scholarships, totaling $6,160. • Host two free family swim days with 500 youth and family participants. • Engage 500 children in "Rethink Your Drink" programming.
		Improving Access to Nutritious Foods~* California Food Policy Advocates (CFPA) is a statewide policy and advocacy organization that aims to improve the health and well-being of low-income Californians by increasing their access to nutritious, affordable food and reducing food insecurity. In 2018, KP paid $212,500 to CFPA to: • Lead the implementation workgroup for the Supplemental Drinking Water EBT benefit for approximately 40,000 Cal-Fresh households in Kern County. • Lead the implementation workgroup for the Cal-Fresh Fruit and Vegetable EBT pilot project for Southern California retailers.
		Advocating for Maternal, Infant, and Child Health~ The California WIC Association (CWA) supports efforts to increase local WIC agencies' capacity, increase state and federal decision makers' understanding of WIC services, and increase the capacity of community health centers to build a breastfeeding continuum of care in low-income communities. Over two years (2017-2018), Kaiser Permanente paid $100,000 to CWA to: • Pilot two video conferencing projects increasing awareness and consideration within the CA WIC community. • Collaborate with health centers to share WIC staff for nutrition and breastfeeding counseling (Watts Health Care and clinics in San Diego). • Work to strengthen ties with CPCA and present at CPCA's annual conference. • Visit all CA legislators with 44 appointments and drop-in visits. • Provide extensive information to legislators on nutrition and breastfeeding counseling, food benefits, local

economic impacts to grocers, health outcomes, access to Farmers markets, and updates on immigration threats.
- Participate in Capitol WIC Education Day in Sacramento with 50 attendees from 30 WIC agencies from all over the state.

Fighting Food Insecurity~

California Association of Food Banks' (CAFB) Farm to Family program's goal is to improve health food access by providing fresh produce to food banks, CalFresh outreach and enrollment, advocacy to support anti-hunger policies, and technical assistance to members. In 2018, Kaiser Permanente paid $95,000 to CAFB to:
- Distribute 250,000 pounds of subsidized fresh fruits and vegetables to 11-member food banks.
- Maintain the State Emergency Food Assistance Program to provide food and funding of emergency food to food banks.

Expanding Community Gardens

California State University, Northridge Foundation's (CSUN) Let's Eat Healthy initiative supports nutrition education, garden development, and the development of Wellness Councils at 5 sites including 3 schools in the high need area of Canoga Park. Over two years (2017-2018), Kaiser Permanente paid $40,000 to CSUN to:
- Enhance and build community gardens at five sites serving a total of approximately 2500 community members and engaging approximately 100 community members in garden maintenance harvesting and produce distribution.
- Conduct a peer to peer nutrition education program to parents at all five sites.
- Provide and facilitate Wellness Councils at each of the 5 sites.

Practicing Food Recovering and Redistribution

Kaiser Permanente envisions foodservices not only as the source of nutritious meals for their patients, staff and guests, but as a resource for local communities. Over two years (2017-2018), Kaiser Permanente partnered with Food Finders to:
- Recover 19,837.5 lbs of food and distribute to organizations serving individuals in the KFH-Woodland Hills region who face food insecurity.

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VII. Appendices

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 System	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	2012-2014
20.	FCC Fixed Broadband Deployment Data	2016
21.	Feeding America	2014
22.	FITNESSGRAM® Physical Fitness Testing	2016-2017
23.	Food Environment Atlas (USDA) & Map the Meal Gap (Feeding America)	2014
24.	Health Resources and Services Administration	2016
25.	Institute for Health Metrics and Evaluation	2014
26.	Interactive Atlas of Heart Disease and Stroke	2012-2014
27.	Mapping Medicare Disparities Tool	2015
28.	National Center for Chronic Disease Prevention and Health Promotion	2013
29.	National Center for Education Statistics-Common Core of Data	2015-2016
30.	National Center for Education Statistics-EDFacts	2014-2015
31.	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention	2013-2014
32.	National Environmental Public Health Tracking Network	2014
33.	National Flood Hazard Layer	2011

34.	National Land Cover Database 2011	2011
35.	National Survey of Children's Health	2016
36.	National Vital Statistics System	2004-2015
37.	Nielsen Demographic Data (PopFacts)	2014
38.	North America Land Data Assimilation System	2006-2013
39.	Opportunity Nation	2017
40.	Safe Drinking Water Information System	2015
41.	State Cancer Profiles	2010-2014
42.	US Drought Monitor	2012-2014
43.	USDA - Food Access Research Atlas	2014

ii. Additional sources

	Source	**Dates**
1.	California Department of Public Health	2016
2.	California Healthy Places Index	2018
3.	California HIV Surveillance Report	2015
4.	Office of Environmental Health Hazard Assessment	2011-2013

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	Interview	Counselor Student Assistance Program; Conejo Valley Unified School District	2	Minority and low income	Content Expert	12/21/18
2	Interview	Vice President of Programs & Director of Outpatient Services; Village Family Services	2	Minority, medically underserved, low income	Content Expert	1/23/19
3	Interview	Deputy Superintendent; Ventura County Office of Education	1	Minority, medically underserved, low income	Content Expert	10/19/18
4	Interview	Executive Director; NAMI	1	Minority, medically underserved, low income	Content Expert	10/22/18
5	Interview	Assistant Police Chief; Oxnard Police Department	1	Minority, medically underserved, low income	Content Expert	10/31/18
6	Interview	Public Health Director; Ventura County Department of Public Health	1	Health department representative	Content Expert	11/2/18
7	Interview	Homeless Assistance Coordinator; City of Oxnard	1	Minority, medically underserved, low income	Content Expert	11/5/18
8	Interview	Director of Student Support Services; Oxnard Union High School District	1	Minority, medically underserved, low income	Content Expert	11/13/18
9	Interview	Vulnerable Population Senior Deputy; Ventura County Sheriff's Office	1	Minority, medically underserved, low income	Content Expert	10/30/18
10	Interview	Epidemiologist; Ventura County Department of Public Health	1	Health Department Representative	Content Expert	11/16/18
11	Interview	Vulnerable Population Deputy; Ventura County Sheriff's Office	1	Minority, medically underserved, low income	Content Expert	11/19/18

12	Interview	Program and Clinical Director; Cancer Support Community	1	Minority, medically underserved, low income	Content Expert	12/12/18
13	Interview	Chief Resource Officer; Camarillo Healthcare District	1	Medically underserved and low income	Content Expert	12/14/18
14	Interview	Executive Director; Ventura County Transportation Commission	1	Minority, medically underserved, low income	Content Expert	1/14/19

Community residents

15	Focus group	Older Adult Focus Group	10	Medically underserved and low income	Represent-ative Member	11/27/18
16	Focus group	Older Adult Focus Group	13	Medically underserved and low income	Represent-ative Member	11/28/18
17	Focus group	African American Focus Group	20	Minority, medically underserved, low income	Represent-ative Member	12/30/18
18	Focus group	Latino Parent Focus Group	9	Minority, medically underserved, low income	Represent-ative Member	1/17/19
19	Focus group	Latino Resident Focus Group	14	Minority, medically underserved, low income	Represent-ative Member	1/17/19
20	Focus group	YMCA Resident Focus Group	6	Minority, medically underserved, low income	Represent-ative Member	2/7/19
21	Survey	Resident Post-Focus Group Survey	39	Minority, medically underserved, low income	Represent-ative Member	12/2018-1/2019

Appendix C. Health Need Profiles

I. Health Need Profile: Access to Health Care

Poor Health Care Quality has Large Impact on the Lives of Residents

Gabriela's Story... Her son woke up feeling sick and Gabriela thinks he has an ear infection. Instead of taking her son to the doctor, she tries to address his symptoms with natural remedies and keeps him home from school. Prior experience has taught Gabriela that this is the better route. In the past, she either hasn't gotten an appointment to see the doctor on short notice, arrives at the doctor's office and has to wait 2 hours to get care, or is sent to the Emergency Room where there are even longer wait times and a higher cost than seeing the physician. Gabriela's experience is not unique to her, as this theme came up repeatedly during focus groups conducted with local residents and interviews with local subject matter experts. **This document shares the lived experience of residents within the Woodland Hills Medical Center region.**

"

"I have to advocate for myself or I won't get any decent care. For the doctor to take me seriously, **I have to exaggerate my symptoms or lie about how long I've been experiencing the pain** so that the doctor will actually listen to me and not just write notes on the computer. I don't feel like I get good care or even that our doctors care about us. They just want to get us out as fast as possible and move on to the next patient. Our system is broken."

- Reseda Focus Group Participant

Health Care Barriers Experienced by Local Residents

Barriers to Accessing Quality Care...

Long Wait Times

"It's more of a burden going to the doctor because of the long wait times. I was at the doctor for 4 hours last time I went, and I was only with the doctor for 10 minutes."

"The referral process to get specialty services is long and difficult. It can take up to 8 weeks to get an appointment."

"It takes forever to get an appointment with your primary care physician. You have to make friends with the front desk staff so they can get you an appointment in a reasonable time. Then, they get in trouble for helping."

Poor Care

"I don't think doctors give you as much time as they used to. You go in, you fill out a form, and all you see them do is rush around or type on the computer. There is no focused care or attention. It's like they don't care about you."

"I've had bad experiences. Recently, I had an ear-ache, half my face hurt and the doctor told me I was just fine and gave me some Tylenol. The next day it got worse so I went to the emergency room where they took X-rays and told me I needed antibiotics because I had a really bad infection, that my doctor didn't even bother to check for. If my doctor had done a better check the day before, I could have avoided the high cost of the ER and could have avoided some of the severe pain."

High Cost of Services

"How the cost system is set up seems unjust. First, if you have insurance, you are paying for the health insurance through our employer or with Covered California, but we still have to pay our deductible before the insurance pays your medical expenses. It doesn't make any sense. Our health care system is just too expensive for low to moderate income families."

The above quotes were provided by focus group participants across the engagements.

Health Outcomes Linked with Less Access to Health Care

Access to health care and quality of care are social factors that impact health outcomes. Understanding the impact of social factors on specific health conditions can provide valuable information for addressing those issues.
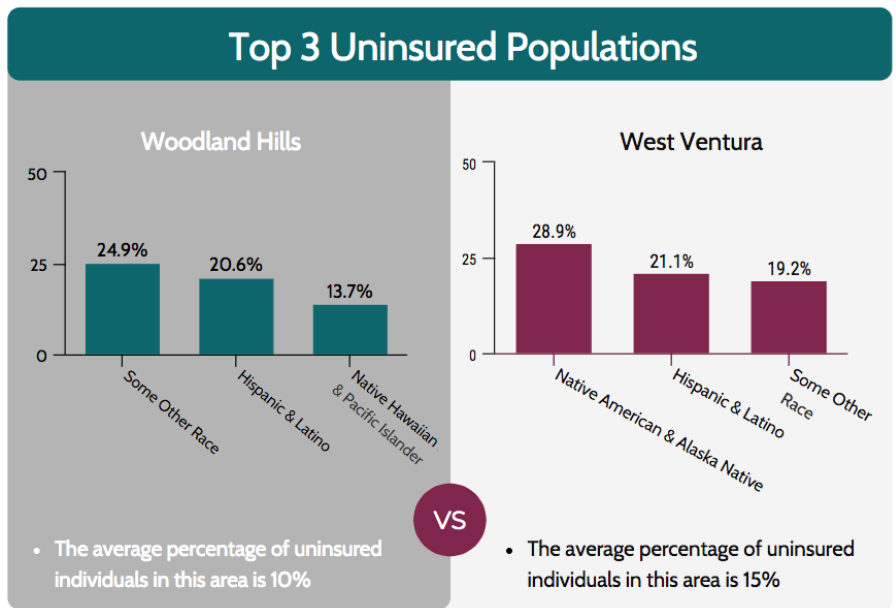
Less Access to Health Insurance is Linked to the Following Health Outcomes:	Higher Asthma Prevalence	Higher Obesity Prevalence
Higher Diabetes Prevalence	Higher Smoking Prevalence	Greater Number of Poor Mental Health Days

People and Places Affected – Access to Care

Which are the Most Vulnerable Populations?

In addition to the city of Woodland Hills and its surrounding areas, the Woodland Hills Medical Center also serves the following Ventura County communities: Fillmore, Moorpark, Oxnard, Santa Paula, Simi Valley, Thousand Oaks, and Ventura.

Given the different population compositions of the Woodland Hills area and the West Ventura area, the percentage of insured adults varies by region. See the figure to the right for the most vulnerable populations.

Top 3 Uninsured Populations

Woodland Hills
- Some Other Race: 24.9%
- Hispanic & Latino: 20.6%
- Native Hawaiian & Pacific Islander: 13.7%
- The average percentage of uninsured individuals in this area is 10%

VS

West Ventura
- Native American & Alaska Native: 28.9%
- Hispanic & Latino: 21.1%
- Some Other Race: 19.2%
- The average percentage of uninsured individuals in this area is 15%

Looking Ahead

Gaps and Areas for Improvement

Health care access is a large and complex issue that requires policy and systemic changes in order to be meaningfully addressed. Through the community engagement process, both residents and Subject Matter Experts described the need for improved health care access and better delivery of services. Given the extreme complexities of this issue, a first step could be to enhance health education and prevention services among the most vulnerable populations who might not have health insurance.

II. Health Need Profile: Cardiovascular Disease, Obesity, and Diabetes

Obesity and Diabetes Are Primary Concerns Among Local Residents

Evelyn's Story…A local Santa Paula mom, Evelyn worries about diabetes and obesity on a daily basis. Her family has a history of diabetes and she is concerned that her 4-year old daughter, Sarah will be affected. Evelyn works hard to make sure her daughter gets enough exercise and eats a healthy, well-balanced diet. But Sarah prefers to play indoors and with electronic devices, so getting her to be active is a constant struggle. Evelyn spends extra money to buy "organic" fruits and vegetables, because most produce is treated with chemicals and pesticides. Evelyn's experience reflects themes shared by both residents in community focus groups and local subject matter experts. This document shares the lived experience of residents within the Woodland Hills Medical Center region.

"
"My son's mother's side of the family suffers from diabetes. Several family members have Type I diabetes and they have to inject before they eat. I try to keep my kid as healthy as possible. There is a lot of discussion about diabetes and how it's tied to bad eating. I worry about my son daily because of his weight and his mom's side of the family. I know genetics play a role but the primary issue is to eat healthy and try to eat organic. But it's hard. It's a daily struggle."

-Focus Group Member; Oxnard

Understanding the Terminology

Obesity: A condition that occurs when a person carries excess weight. A body mass index (BMI) of 30 or over generally indicates the person is obese. Tied to Type 2 diabetes.

Diabetes: A condition where the body either doesn't make enough insulin or doesn't properly use the insulin it does produce, causing excess sugar to build up in the blood stream, impacting blood vessels.
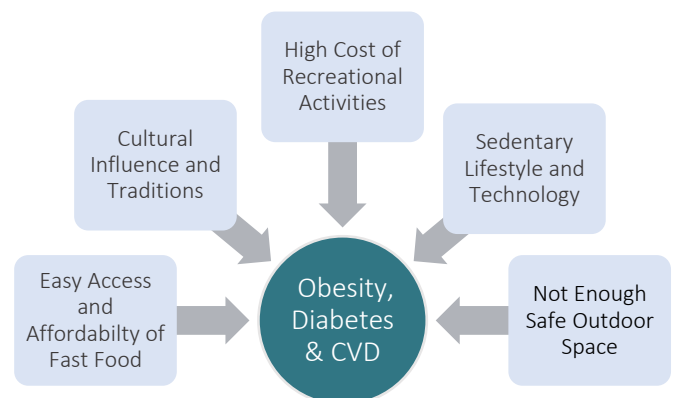
Cardiovascular Disease (CVD): Includes conditions that stem from narrowed or blocked blood vessels and can lead to heart attack, chest pains, or stroke.

How are these Outcomes Linked?

Obesity

Diabetes

CVD
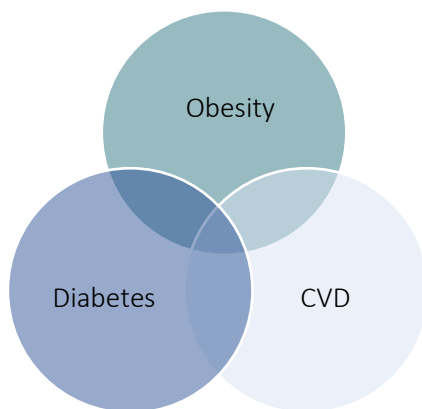
Each of these health outcomes have been identified as chronic health disorders (i.e. last for at least 3 months or longer) that are associated with one another. Obesity has been linked with both diabetes and cardiovascular disease (CVD). Additionally, research has shown that individuals with diabetes are at an increased risk for CVD.

Contributing Factors

High Cost of Recreational Activities

Cultural Influence and Traditions

Sedentary Lifestyle and Technology

Easy Access and Affordabilty of Fast Food

Obesity, Diabetes & CVD

Not Enough Safe Outdoor Space

Nearly all subject matter experts and residents said that diabetes, obesity, and heart disease are a large concern. For residents, these three health outcomes were among their top 5 concerns.

Social Factors and Their Impact on Health

Social factors are environmental conditions that impact health outcomes. Understanding the impact of environmental factors on specific health conditions can provide valuable information for addressing those issues. Social factors associated with obesity, diabetes, and heart attack ER visits are provided below:

Obesity
- Crowded housing
- Less health insurance
- Lower income
- Less park access

Diabetes
- Crowded housing
- Less health insurance
- Lower income
- More homeownership

Heart Attack ER Visits
- Crowded housing
- Fewer bachelor's degrees
- Less employment

People and Places Affected

Low Income Neighborhoods

- Residents who live in low-income neighborhoods expressed the greatest concerns with the unavailability of affordable healthy food.
- **Of note:** Santa Paula Residents who participated in a focus group spent a lot of time talking about obesity and diabetes and stressed how their environment contributes to this epidemic. Residents indicated that the City of Santa Paula lacks readily available, affordable food and access to fresh, high-quality produce. Focus group participants said that they have had to travel to neighboring cities, like Ventura, to get affordable groceries, or produce, that "doesn't go bad after a few days of having it at home." Residents also discussed the fact that many stores have closed or relocated to other cities due to city policies such as high rent, making it harder for residents to access what they need within their community.

Children

- Several focus group participants discussed an increase in obestity and diabetes among youth and young children. Discussions emerged around the current culture that children are growing up in and how a greater emphasis on technology is leading kids to spend less time outdoors or being active and more time watching television or playing on electronic devices. Interviewees and residents expressed the need for early intervention and education with young children in regards to eating healthy, nutritious meals and being physically active.

Specific Ethnic Groups (Hispanic/Latino and Black Residents)

- Local data show that Hispanic/Latino and Black residents suffer from obesity at higher rates than other ethnic groups.
- While Black residents comprise a smaller portion of the population, they are disproportionately affected by stroke. Chronic diseases typcially occur in higher rates among Blacks.

Selected Resources and Recommendations

Sample of Current Resources

Interviewees and participants identified the following existing resources and agencies that address cardiovascular disease, obesity, and diabetes:
Local grocery stores, farmer's markets, Kaiser Permanente, health fairs, and public outdoor spaces such as parks.

Recommendations

1. Provide more resources on healthy eating and foods
2. Interventions and education to youth to promote a healthy life-style at an early age
3. Incorporate "Fotonovela" Public Health messaging to provide healthy food resources to Hispanic/Latino families
4. Consider requiring apartment buildings to have a designated "play area" for youth and children

III. Health Need Profile: Educational Attainment

The Relationship Between Educational Attainment and Health Outcomes

Lucy's Story... A high school senior living in Santa Paula, Lucy wants to attend college and has the grades to do so. However, after she graduates, she gets a full-time job in order to help her family. It is a struggle for them to pay rent each month and having her income makes a big difference. Lucy hopes to go to college after working full time for a few years and setting aside some savings for her family, but she's worried that she won't be admitted to her school of choice after taking the time off. Lucy is frustrated with her circumstances, but still strongly believes in meeting her family obligations. Lucy's story reflects themes that came up repeatedly during focus groups conducted with local residents and interviews with local subject matter experts. This document shares the lived experience of residents within the Woodland Hills Medical Center region.

> "Educational attainment and life expectancy go hand-in-hand. I believe firmly that (and there is data that show this) life expectancy goes up the more education you have because you have more access to better jobs, knowledge, etc."
>
> **- Subject Matter Expert, Student Support Services**

> "Yes, I agree that educational attainment can influence health outcomes; but I think health can also influence education. For instance, we see kids with poor health who suffer academically all the time who have low attendance and low grades because of health issues."
>
> **- Subject Matter Expert, Ventura County Office of Education**

Community Member Concerns

During focus group discussions with residents, parents expressed worry about their children not receiving a proper education at the local middle and high schools. Specifically, one Oxnard father shared that his 15-year-old son feels bored at school because he isn't being challenged enough and that the teachers "tend to cater to the lowest performing students in the class." The general consensus of the group was that the school system doesn't support effective learning because the schools are overcrowded and teachers are often left feeling overwhelmed.
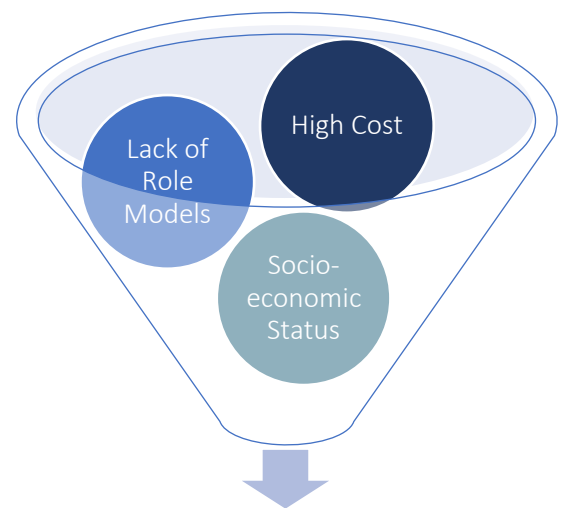
Barriers to Seeking Higher Education

(Lack of Role Models, High Cost, Socio-economic Status)

EDUCATIONAL Attainment

"The greatest predictor of educational attainment is the mother's education level." - Subject Matter Expert, Ventura County Office of Education

Social Factors and Their Impact on Health

Social factors are environmental conditions that impact health outcomes. Understanding the impact of environmental factors on specific health conditions can provide valuable information for addressing those issues. Health outcomes associated with lower educational attainment of lower bachelor's degrees are listed below.

Fewer Bachelor's Degrees Linked to the Following Health Outcomes:	Higher Asthma Prevalence	Higher Number of Heart Attack ER Visits
More Pedestrian Injuries	Higher Smoking Prevalence	Greater Number of Poor Mental Health Days

People and Places Affected

Low Income Families and those Experiencing Generational Poverty

- "We see that youth from low income families and those with generational poverty often don't have the luxury of college even being an option for them because they have to get a full time job after college to help provide for their families."
  - *Subject Matter Expert, Breakthrough Student Assistance Counselor*
- "Families in lower social-econmic status households don't generally seek preventative care because it's not a priority for them. So by the time they show up to the doctor they have a more severe illness or have developed a chronic disease."
  - *Subject Matter Expert, BreakThrough Student Assistance Counselor*

First-Generation Students from Immigrant Families

- "We also want to address the issue that some parents don't understand how the stystem works, so it's hard for them to help their children navigate the college application process. Families who have immigrated from other countries don't have a good sense of all that's involved in getting prepared for and applying to colleges. Our system and the requirements are very different from what happens in other countries. We need to provide more education to these families."
  - *Subject Matter Expert, Breakthrough Student Assistant Counselor*

Santa Paula and Fillmore

- "Youth in these areas have minimal access to education beyond high school. These cities have high numbers of low income families impacted by poor infrastructure, limiting their ability to access resources such as health care."
  - *Subject Matter Expert, Student Support Services*

Selected Resrouces and Recommendations

Current Resources

A selection of the available resources identified are below:
- ⟩ Ventura County Office of Education
- ⟩ Career Education Center: partnership between Ventura County Office of Education and Oxnard College
- ⟩ The Oxnard College Promise: program that provides a
- ⟩ year of free tuition to eligible youth
- ⟩ BreakThrough, Conejo Valley Unified School District

Recommendations

Participants and interviewees provided the following recommendations:

1. Provide more education about the college process to immigrant (Spanish-speaking) parents so that they can support their children in the process
2. Share information about college with students at younger ages so they learn what options are available to them and they can visualize themselves attending college

IV. Health Need Profile: Housing & Homelessness

Greatest Concern Among Residents is Rising Housing Prices

Sarah's Story...A local Reseda mom, Sarah is struggling to make ends meet due to the high cost of living. Her family of four lives in a one-bedroom apartment with little space or privacy. Sarah's children are unable to participate in sports due to the membership costs and participation dues. Taking her children outside to play or to a park is hard due to the large number of homeless people they encounter, who make her feel unsafe. Sarah tries to make good food choices for her family, but often can't afford healthy groceries due to other bills. Sarah's story is not unique, as these themes were shared repeatedly by residents in community focus groups and interviews with local subject matter experts. This document shares the lived experience of residents within the Woodland Hills Medical Center region.

> "Homelessness is one of the biggest problems in our community, one that is growing exponentially here as of late. Homeless encampments are one of the main concerns being expressed by residents."
>
> - Subject Matter Expert, Oxnard Police Department

> "Rent is a major worry. Housing prices in the area are just so high and it's really hard to find anywhere good to live in this city that's affordable and nice. Because of the high rent we've also been seeing local business having to leave the area because of the high prices."
>
> - Focus Group Member, Santa Paula

Housing Factors and Their Impact on Health

Stability. Housing instability has been linked to poor health and is associated with health problems among youth, including increased risk of teen pregnancy, early drug use, and depression. Individuals who are chronically homeless experience greater physical and mental issues and have higher mortality rates.

Quality. Substandard housing conditions such as poor ventilation, leaks, dirty carpets, pest infestation, and exposure to lead have adverse health impacts and are notably related to asthma. Crowding has been linked to physical illness and psychological distress.

Affordability. Over 40% of people living in southern California spend more than 30% of their income on housing costs. This leads to greater difficulty affording healthy food and appropriate health care and medication.
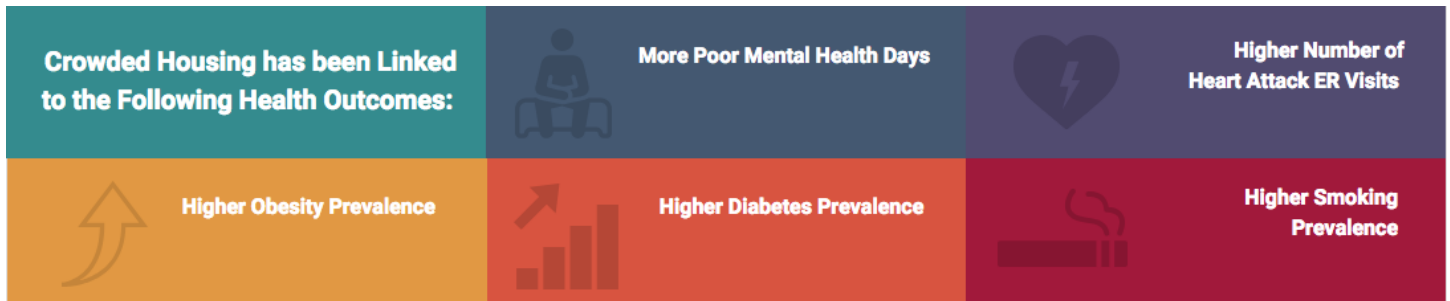
Neighborhoods. Studies have shown that having access to public transportation for commuting, grocery stores with healthy food options, and safe places to exercise are correlated with improved health outcomes.

! Nearly all subject matter experts and residents expressed concern about housing

Negative Health Outcomes Linked to Crowded Housing

Social factors of health are environmental factors (i.e. like crowded housing) that impact health outcomes. Understanding the impact of environmental factors on specific health conditions can provide valuable information for addressing those issues.

Crowded Housing has been Linked to the Following Health Outcomes:	More Poor Mental Health Days	Higher Number of Heart Attack ER Visits
Higher Obesity Prevalence	Higher Diabetes Prevalence	Higher Smoking Prevalence

People and Places Affected

Low Income Families

- "Our greatest need is affordable housing, the high rent is making living in this area largely unsustainable. Within the City of Oxnard, we have a lot of places that are particularly high density... You have several families living together in one apartment."
  - Subject Matter Expert, Oxnard Police Department
- "The housing shortage and inablity to pay rent impacts low income families the most. We've been seeing a lot of eviction notices within low income communities in Oxnard."
  - Subject Matter Expert, Homeless Assistance Coordinator

Homeless Individuals

- "When you look at housing issues in our cities, homelessness is the fastest growing issue." *- Subject Matter Expert, Oxnard Police Department*
- "Trends we're seeing with respect to the homeless population are: elderly Anglo woman over the age of 55, women with children, veterans, and individuals being released from prison." *- Subject Matter Expert, Homeless Assistance Coorindator*

Neighborhood and Environment

- "If residents live in unsettling environments and are always worried about safety, those concerns have long term effects on a person's health."
  - Subject Matter Expert, Oxnard Police Department
- "The growing homeless population comes with a number of public health concerns and also has a direct impact on outdoor spaces within our communities such as parks, sidewalks, open lots, etc." *- Subject Matter Expert, Vulnerable Populations Deputy*
- "An apartment environment doesn't generally allow for children to be active,which tends to impact their health and overall well-being." *- Focus Group Member*

Selected Resource and Recommendations

Current Resources

In regards to the housing issue, community members did not know of any resources to address this issue. In regards to homelessness, the following resources were identified: Lutheran Social Services, Manna Conejo Valley Food Bank, and Ventura County Behavioral Health Services. Additionally, the Ventura County Sheriff's Office and Oxnard Police Department have designated Vulnerable Population Deputies and Officers that address this issue.

Recommendations

Participants and interviewees provided the following recommendations:

1. Policy changes to address the issue of the ever-increasing cost of housing
2. Improve methods of tracking the homeless population
3. A collaborative multi-system approach, across county agencies, to address the homeless crisis

V. Health Need Profile: Mental Health

How Mental Health Impacts the Lives of Residents

Why we Care... Mental health issues are becoming ever more prominent in today's society. Nearly everyone is affected to some degree, from experiencing every-day stress, to more severe mental health issues that could contribute or lead to suicide. To understand how mental health impacts the lives of residents in the Woodland Hills Medical Center service area, a series of community member focus groups and interviews with local subject matter experts were conducted. This document shares the lived experience of residents within the Woodland Hills Medical Center region with mental health.

> "Mental health is a huge concern. Everyone has stressors in their life that impact their mental health. We need tools to cope that aren't just medicine"
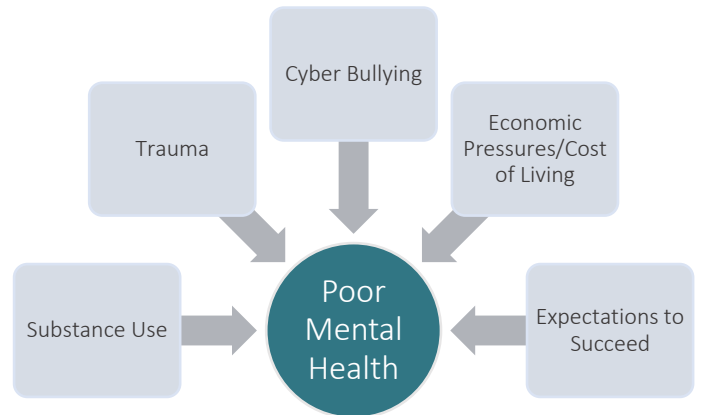>
> *- Focus Group Member, Reseda*

> "Families are struggling financially, many more families are homeless...this compounds any underlying issues they may be experiencing such as depression, PTSD, anxiety.""
>
> *- Subject Matter Expert, Local Health Department*

Concern About Mental Health

Nearly all community members and subject matter experts reported both that they were concerned about mental health and that it impacts their overall health and other areas of their lives.

Factors Impacting Mental Health

- Cyber Bullying
- Trauma
- Economic Pressures/Cost of Living
- Substance Use
- Expectations to Succeed

→ **Poor Mental Health**

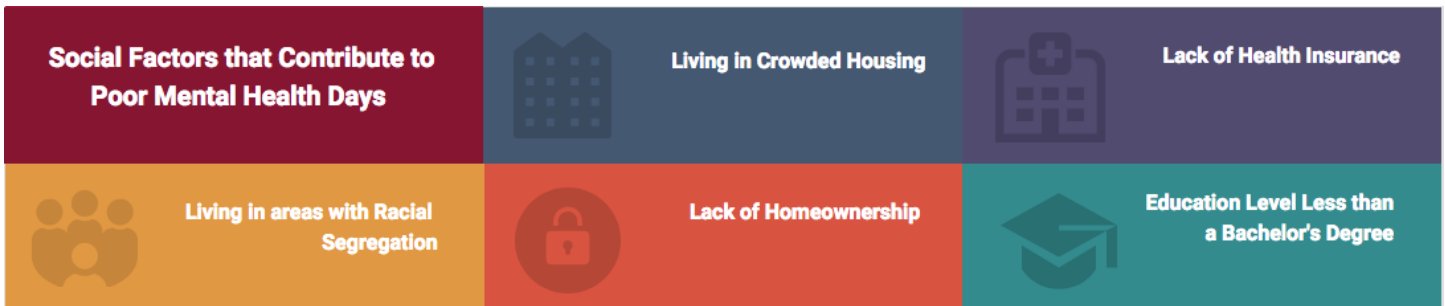## Reported Barriers to Accessing Mental Health Care

Cost

Location

Stigma

Additional barriers include: **long wait times to see a mental health professional** (up to a 2-month waiting period, in some cases), **staff shortages and staff burnout,** providers **not accepting subsidized insurance** such as Medicaid, and **prioritizing daily tasks over seeking mental health care.**

Social Factors and Their Impact on Health

Social factors of health are environmental factors (i.e., like crowded housing) that impact health outcomes. Understanding the impact of environmental factors on specific health conditions can provide valuable information for addressing those issues. Five social factors that impact mental health are provided below:

Social Factors that Contribute to Poor Mental Health Days	Living in Crowded Housing	Lack of Health Insurance
Living in areas with Racial Segregation	Lack of Homeownership	Education Level Less than a Bachelor's Degree

People and Places Affected by Mental Health

Youth
- "We are seeing an increase in suicidal ideation in children at a younger age. Five to ten years ago we were seeing it in high school, but now we are seeing it in elementary age children." - *Subject Matter Expert, Mental Health Outpatient Program*

Foster Youth
- "Kids who are in foster care are also a population that are very high need. We are seeing the spectrum of where some of these kids might end up if they don't get the interventions they need." - *Subject Matter Expert, Mental Health Outpatient Program*

Older Adults
- "I have anxiety, worry, and just have issues as a senior." - *Focus Group Member, Reseda*
- "I had a 95-year old neighbor who nine or ten months ago committed suicide. Long story short, he lost hope, he found no reason to go on living." - *Focus Group Member, Reseda*

Homeless Individuals
- "Well over 50% of homeless indivduals have a mental health or co-occuring disorder."
- *Subject Matter Expert, National Alliance on Mental Illness*

Low Socioeconomic Status Communities
- "The system is not well designed to meet the needs of low socioeconomic status persons." - *Subject Matter Expert, National Alliance on Mental Illness*

Specific Ethnic Groups (Asians, Latinos, Whites)
- "Within the Asian American community, they believe symptoms are somatic and that there is something wrong with them physically." - *Subject Matter Expert, National Alliance on Mental Illness*
- "There is deep stigma among the monolingual non-English speaking populations [which makes it difficult to address the mental health issues they experience]."
  - Subject Matter Expert, Mental Health Outpatient Program
- "Older white males, men in general, do not like to share about their mental health."
  - Subject Matter Expert, National Alliance on Mental Illness

Selected Resource and Recommendations

Sample of Current Resources

Interviewees and participants identified the following existing resources and agencies that address mental health issues: National Alliance on Mental Illness (NAMI), Hathaway Sycamore, San Fernando Community Clinic, and Village Family Services.

Recommendations to Address the Issue

1. Greater focus on preventative care
2. More education and awareness among populations at greatest risk of mental health issues to address ingrained stigma
3. Start a program where trained personnel such as counselors or therapists volunteer at community resource facilities (i.e. libraries, schools, health fairs) to teach about the skills needed to address anxiety

Appendix D. Community Resources

Identified need	Resource provider name	Summary description
Access to care	Los Angeles County Department of Health Services	Provides several no-cost and low-cost programs at county medical facilities, including ability to pay, pre-payment plan, mental health services, child delivery plan among other services.
	My Health LA	Provides primary care at no cost to eligible residents of LA County. MHLA is not an insurance but a health care program for the uninsured and un-insurable residents of the county
	Ventura Country Health Agency	The Ventura County Health Care Agency is a fully integrated health care system emphasizing a continuum of care beginning with preventive health programs and emergency medical services, followed by acute inpatient care, and, when needed, continuing to lifelong case management services for chronic illnesses.
Cardiovascular Disease/Obesity/ Diabetes	Los Angeles County Department of Parks and Recreation	Provides the public a wide variety of recreational opportunities including special programs for children and seniors and food programs and fitness classes
	Women, Infant & Children (WIC) Supplemental Program	Provides vouchers for healthy foods, support for breastfeeding, nutrition education, and helps with locating other health care and community services for children under 5 and women who are pregnant.
	LA Family Housing	LA Family Housing helps people transition out of homelessness and poverty through a continuum of housing enriched with support services.
	County of Ventura Human Services Agency	Connects individuals and families seeking help to a network of agencies that provide health care, mental health services, drug and alcohol abuse treatment, temporary housing, and seeks to help clients' secure permanent housing.
Mental health	Los Angeles County Department of Mental Health	Mental health services provided include assessments, case management, crisis intervention, medication support, peer support, psychotherapy and other rehabilitative services. Services are provided in a variety of settings including residential facilities, clinics, schools, hospitals, county jails, juvenile halls and camps, mental health courts, board and care homes, in the field and in people's homes.
	Ventura County Behavioral Health Department	Provides a system of coordinated services to meet the mental health and substance abuse treatment needs of Ventura County

Appendix E. Strategic Lines of Inquiry for Community Engagement

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

Overview of Question Design Process

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

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