



2019 Community Health Needs Assessment

Kaiser Foundation Hospital: Baldwin Park Medical Center

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

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Kaiser Permanente Southern California Region Community Benefit CHNA Report for KFH-Baldwin Park

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I. Introduction/background

A. About Kaiser Permanente (KP)

Founded in 1942 to serve employees of Kaiser Industries and opened to the public in 1945, Kaiser Permanente is recognized as one of America's leading health care providers and nonprofit health plans. We were created to meet the challenge of providing American workers with medical care during the Great Depression and World War II, when most people could not afford to go to a doctor. Since our beginnings, we have been committed to helping shape the future of 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-Baldwin Park will develop an implementation strategy for the priority health needs the hospital will address. These strategies will build on Kaiser Permanente's assets and resources, as well as evidence-based strategies, wherever possible. The Implementation Strategy will be filed with the Internal Revenue Service using Form 990 Schedule H. Both the CHNA and the Implementation Strategy, once they are finalized, will be posted publicly on our website, <https://www.kp.org/chna>

II. Community served

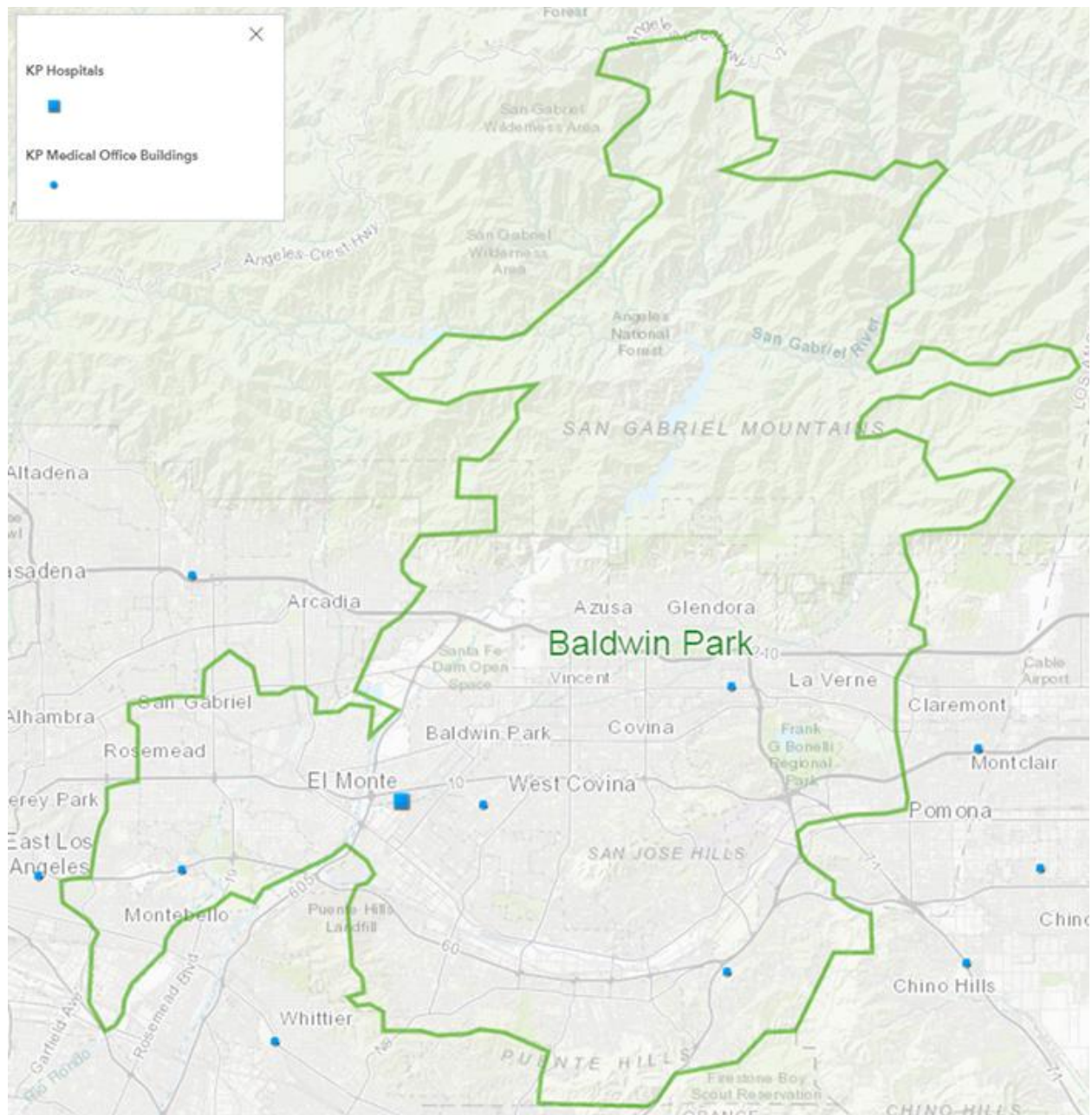
A. Kaiser Permanente's definition of community served

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

B. Map and description of community served

i. Map

Figure A – KFH-Baldwin Park Service Area



ii. Geographic description of the community served

The KFH-Baldwin Park service area includes Azusa, Baldwin Park, Bradbury, Covina, Diamond Bar, Duarte, El Monte, Glendora, Hacienda Heights, Irwindale, Industry, La Puente, La Verne, Montebello, Monterey Park, Pico Rivera, Pomona, Rosemead, Rowland Heights, San Dimas, San Gabriel, South El Monte, Temple City, Valinda, Walnut, and West Covina.

iii. Demographic profile of the community served

The following table includes race, ethnicity, and additional socioeconomic data for the KFH-Baldwin Park 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-Baldwin Park¹

| Race/Ethnicity | | Socioeconomic | |
|----------------------------------|-----------|---|--------|
| Total Population | 1,191,524 | Living in Poverty (<100% Federal Poverty Level) | 13.88% |
| Asian | 28.25% | Children in Poverty | 19.94% |
| Black | 2.08% | Unemployment | 4.10% |
| Hispanic/Latino | 52.94% | Uninsured Population | 15.15% |
| Native American/Alaska Native | 0.25% | Adults with No High School Diploma | 23.60% |
| Pacific Islander/Native Hawaiian | 0.21% | | |
| Some Other Race | 0.15% | | |
| Multiple Races | 1.35% | | |
| White | 14.77% | | |

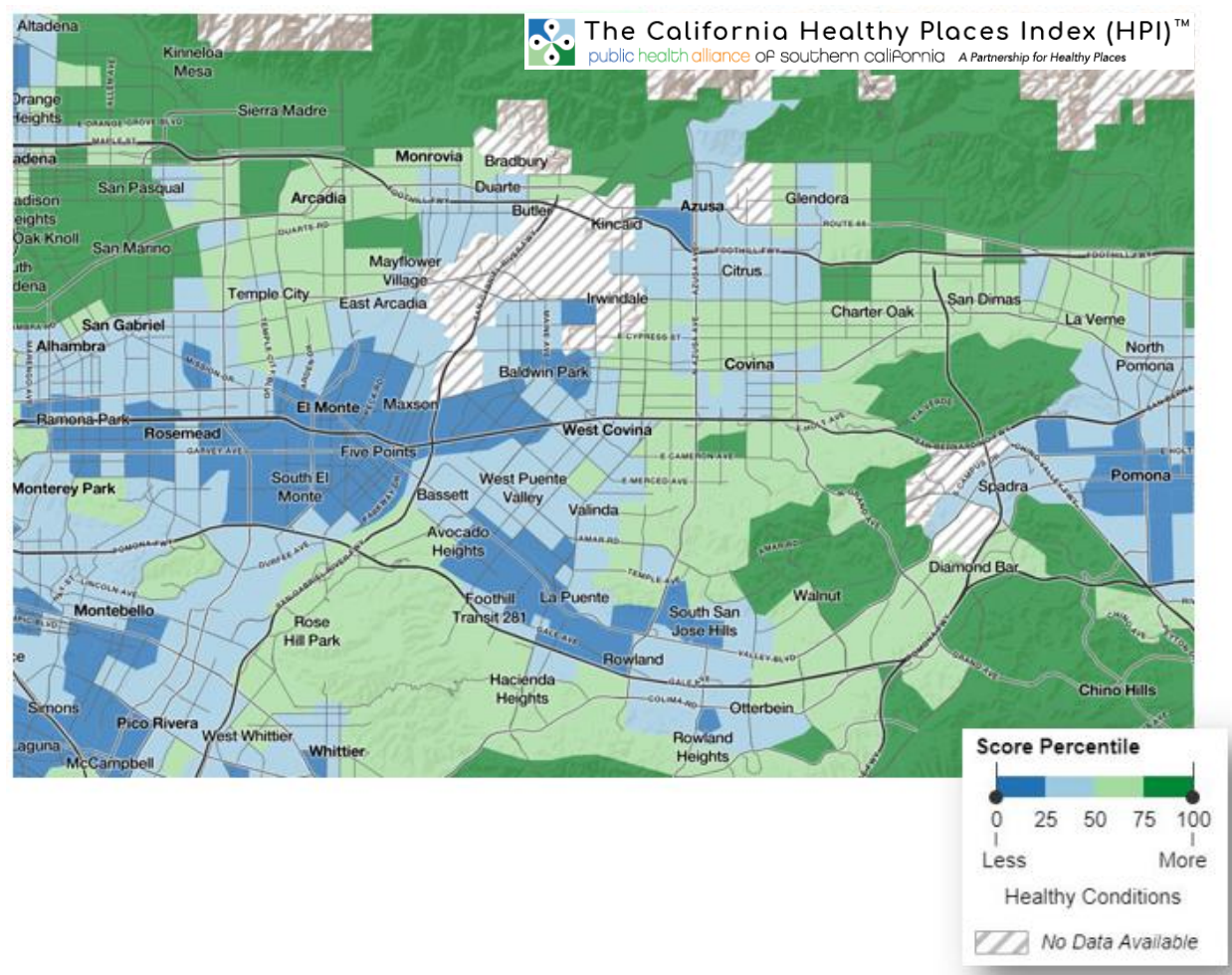
iv. Severely under-resourced communities

Identifying disparities in the upstream factors that predict negative health outcomes is critical to Kaiser Permanente's community health mission. The map below displays the differences in opportunity for residents in the KFH-Baldwin Park service area to live a long and healthy life². Areas in dark blue represent census tracts in the lowest quartile of health opportunity across California. These areas are severely under-resourced across multiple domains of the social predictors of health (e.g. economics, education, transportation, built environment etc.).

¹ American Community Survey (2012-2016).

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

Figure B – Under-Resourced Communities in KFH-Baldwin Park



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

Major under-resourced communities in the KFH-Baldwin Park service area:

- Azusa
- Baldwin Park
- El Monte
- Industry
- La Puente
- South El Monte

In aggregate, the KFH-Baldwin Park service area is in the **42nd percentile** for health opportunity in California with approximately **329,903** people living in a severely under-resourced area³. In effect, this means that nearly 6 in 10 Californians have a greater opportunity to live a long and healthy life than residents in the KFH-Baldwin Park service area.

³ Calculations are estimates based on population-weighted [HPI](http://healthyplacesindex.org/) 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

KFH-Baldwin Park collaborated with community partners, who contributed time and resources to assist with the primary data collection by hosting focus groups and participant recruitment:

- San Gabriel Valley Consortium on Homelessness
- San Gabriel Valley Mental Health Consortium
- National Alliance on Mental Illness (NAMI)

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

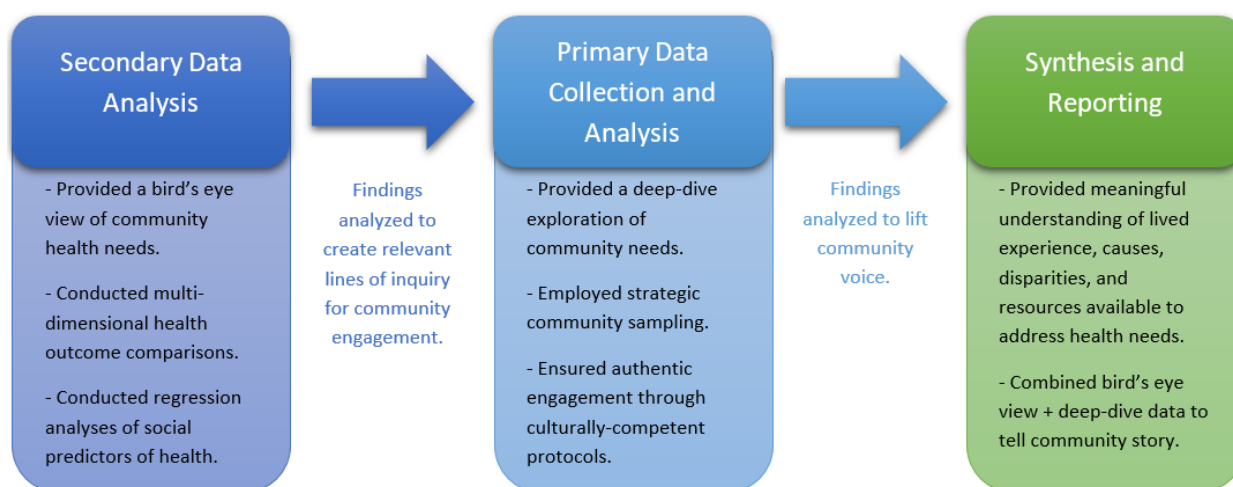
A-Cubed Consulting, Inc (A3) was contracted to conduct the CHNA for KFH-Baldwin Park. A3 believes in taking a participatory and use-focused approach to evaluation. Those doing the work should be involved in telling the story. A3 also believes that the components of organizational development, research,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

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

IV. Process and methods used to conduct the CHNA

KFH-Baldwin Park 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 were analyzed to provide a bird's eye view of the most pressing health issues across the service area and raise strategic lines of inquiry for community engagement. Findings from both the secondary and primary data collection processes were then combined to produce a robust story of community health needs (see Figure C below).

Figure C – Mixed-Method Assessment Approach to the CHNA



A. Secondary data

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

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

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

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

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

First, the most under-resourced geographic communities were identified utilizing the Public Health Alliance of Southern California's Healthy Places Index (HPI) [mapping function](#). The social predictors of health in this index include 25 indicators related to economic security, education, access to care, clean environment, housing, safety, transportation, and social support. (Please refer to Figure B to see this map.⁴)

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

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

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

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

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

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

Table 2 – Social Factors Linked to Health Outcomes

| | More Poor Mental Health Days | More Heart Attack ER Visits | Higher Asthma Prevalence | Higher Obesity Prevalence | Higher Diabetes Prevalence | Higher Cancer Prevalence | Higher Percentage of Babies Born with Low Birth Weight | Higher Smoking Prevalence | More Pedestrian Injuries | Number of Outcomes Related |
|---------------------------------|------------------------------|-----------------------------|--------------------------|---------------------------|----------------------------|--------------------------|--|---------------------------|--------------------------|----------------------------|
| Fewer Bachelor's Degrees | X | X | | X | X | | X | X | | 6 |
| More Crowded Housing | X | X | X | X | | | | X | | 5 |
| Less Employment | X | | X | X | | | | | X | 4 |
| Less Health Insurance | X | | X | | | | | X | | 3 |
| Lower Income | | X | | X | X | | | | | 3 |
| More Racial Segregation | | | X | X | | | | | | 2 |
| Worse Air Quality | | | | | | | X | | | 1 |
| Less Crowded Housing | | | | | | X | | | | 1 |
| More Health Insurance | | | | | | X | | | | 1 |

How do my health needs compare based on KP Community Health values?

The following table ranks health needs based on several principle values: The prevalence of the health outcome compared to the California state average, the impact of the health outcome on length and quality of life, the disparity of disease prevalence across racial/ethnic groups, and the alignment with county rankings of top causes of mortality.⁵

Table 3 – Ranked Health Outcome Comparison Table

| Health Outcome Category Name | Prevalence | Difference From State Average | Reduction in Length of Life Per Year | Worst Performing Race/Ethnicity vs. Average | Listed in Partner County Top 5 Cause of Death |
|-------------------------------|------------|-------------------------------|--------------------------------------|---|---|
| Mental Health* | 12.3% | 0.17% (Worse than CA) | 61.3% Reduction | 68% Worse than Average | No |
| Stroke* | 4.0% | 0.3% (Worse than CA) | 57% Reduction | 42% Worse than Average | Yes |
| HIV/AIDS/STD | 0.6% | 0.18% (Worse than CA) | 58.2% Reduction | 211% Worse than Average | No |
| Obesity | 23.9% | -5.7% (Better than CA) | 37% Reduction | 52% Worse than Average | No |
| Cancer* | 3.6% | 0.25% (Worse than CA) | 51% Reduction | 32% Worse than Average | Yes |
| Diabetes* | 12.2% | 3.8% (Worse than CA) | 24.1% Reduction | 8% Worse than Average | No |
| CVD* | 5.4% | -1.55% (Better than CA) | 30% Reduction | 45% Worse than Average | Yes |
| Maternal/Infant Health | 7.1% | 0.3% (Worse than CA) | 17.9% Reduction | 32% Worse than Average | No |
| Substance/Tobacco Use | 3.0% | -4.02% (Better than CA) | 69.7% Reduction | 48% Worse than Average | No |
| Oral Health | 11.6% | 0.3% (Worse than CA) | 2.8% Reduction | 17% Worse than Average | No |
| Asthma | 12.6% | -2.2% (Better than CA) | 13.3% Reduction | 26% Worse than Average | No |
| Violence/Injury | 0.0% | -0.0008% (Better than CA) | 13.2% Reduction | 30% Worse than Average | No |

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

B. Community input

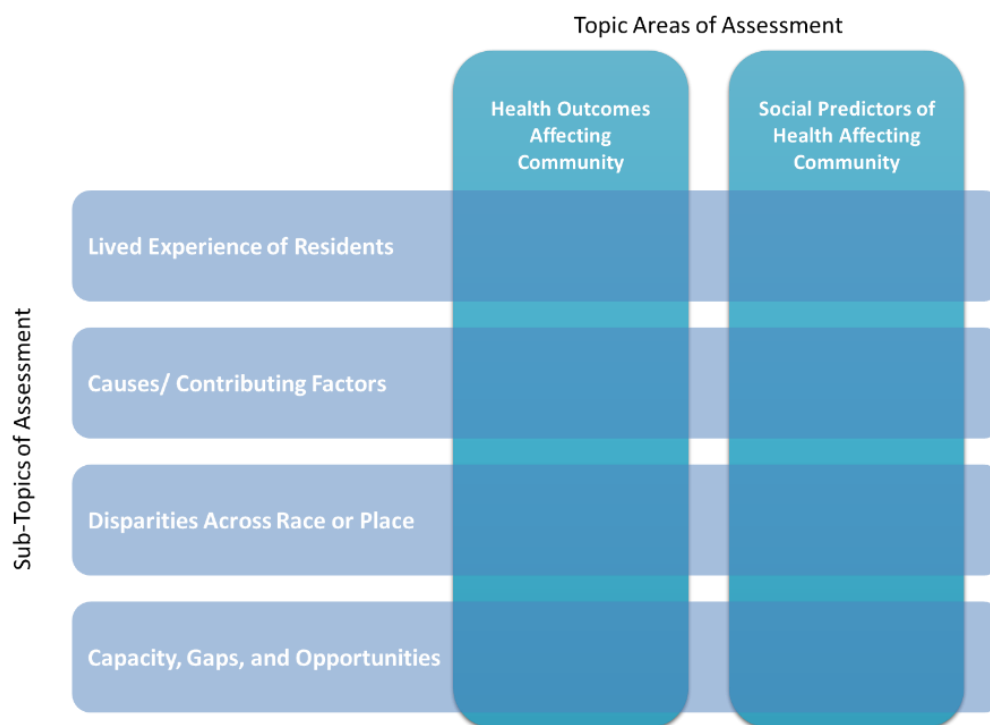
Secondary data analyses produced high-level findings about community health needs. These findings were used to create targeted lines of inquiry intended to learn more about the story of community health by exploring the lived experience of community members, the causes of health needs, the racial or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

1. What social determinants influence poor mental health?
 - a. How does more crowded housing, fewer bachelor's degrees, less health insurance, and less employment contribute to poorer mental health days?
 - b. What does the community see as the social predictors for poor mental health?
 - c. Do these social predictors make sense to them? Why or why not?
2. How does the community currently use mental health services?
 - a. Are there barriers to access or utilization in this service area?
 - b. For youth? For seniors? For homeless population?
3. What current programs/efforts exist for mental health services?
 - a. For youth? For seniors? For homeless population?
4. How is mental health experienced and perceived in the community?
 - a. What is the mental health stigma (self, public, institutional) in the community?
5. What is causing the crowded housing?
 - a. What populations are most impacted?
 - b. Which communities are most impacted?
 - c. What does the community need to address crowded housing?
 - d. What current efforts/resources/assets are available to address crowded housing?
 - e. How is crowded housing connected to health outcomes?
6. What resources are available to addressing homelessness in the area?
 - a. Are there certain areas with a high density of homeless population?
 - b. How are they connected to resources?
7. What are the facilitating factors and/or barriers to higher education attainment?
 - a. What are the demographics of those obtaining higher education?
 - b. Are there disparities based on race, gender, income, etc.?
 - c. What current resources/assets are available to support higher education attainment?
8. What are the facilitating factors and/or barriers to gaining employment?
 - a. Are communities working locally, or do community members find work outside the service area?
 - b. What are the types of employment opportunities available in the service area?
 - c. What are the disparities among these opportunities?
9. Why are KFH-Baldwin Park members experiencing a higher prevalence of adult diabetes, hypertension, and obesity compared to state and Southern California residents?
10. What are the barriers to access and retention of health insurance and healthcare services?
 - a. How are current immigration policies impacting communities in accessing healthcare services?
 - b. What populations are most impacted?

- c. What current resources/assets are available to increase access, linkage, and retention to health insurance?

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

Figure D – Community Engagement Framework



- i. Description of who was consulted

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

The majority of individuals (93%) represented community residents (adult and youth) as service providers. One focus group included only youth community members. Additionally, engagements were conducted in multiple cities within the KFH-Baldwin Park service area community (geography).

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

ii. Methodology for collection and interpretation

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

In seeking community input to help answer strategic lines of inquiry, primary data was collected through key informant interviews, focus groups, and online surveys. All primary data collection activities were confidential and voluntary. Key informant interviews consisted of one-hour telephone calls with select community leaders possessing expertise in a specific health need or social predictor of health. Focus groups were facilitated group discussions with service providers or community residents centered on a particular health topic. Groups lasted 30 minutes to an hour. When feasible, preexisting meetings or gatherings of community stakeholders, like coalition meetings, were capitalized on. Online surveys were sent to a diverse group of stakeholders to obtain information on the most pressing health concerns facing the community, contributing factors, and availability of resources to address health concerns.

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

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

C. Written comments

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

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

D. Data limitations and information gaps

As with any community needs assessment process, the data available for use is limited. In the KP CHNA data platform, for example, some data were only available at a county level, making an accurate translation to neighborhood-level health needs challenging. In the Healthy Places Index platform, census tracts with very low populations were represented as missing data (to reduce unreliability of measurement). This caused under-sampling of rural areas. In both platforms, disaggregated data around age, ethnicity, race, and gender were not available for

many indicators which limited the ability to examine disparities of health within the community. Additionally, data in both platforms were not often collected on a yearly basis and therefore may not represent 2018 values.

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

A. Identifying community health needs

i. Definition of "health need"

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

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

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

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

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

B. Process and criteria used for prioritization of health needs

The full list of health outcomes and social indicators identified in the secondary data analysis, along with any additional needs identified by internal and external stakeholders, was prioritized in the following process. First, a multi-dimensional analysis of secondary data ranked health outcomes using five comparison criteria: absolute prevalence rates in the service area, prevalence rate comparison to state average, severity (measured by reduction of life expectancy), racial/ethnic disparities, and whether the health need was listed as a top five cause of death by the Los Angeles County Department of Public Health. Rankings across each of the criterion were summed with equal weighting, resulting in a total ranking score. Those health outcomes falling to the lower half of the list were removed from priority consideration. Social predictors of health were ranked by the number of connections to negative health outcomes (please see Tables 2 and 3 for details of these analyses). Those social predictors of health falling to the lower half of the list were removed from priority consideration.

Next, the list of health outcomes and social predictors of health were rated on the extent to which KFH-Baldwin Park and its community partners were positioned to meaningfully act on the need and could align resources to make feasible impact. Those health needs that were rated as

having sufficient organizational and community readiness for response were advanced through the prioritization process.

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

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

- Access to Care
- Educational Attainment
- Livable Wage Employment
- Housing Insecurity
- Mental Health

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

Access to Care. Access to health care greatly impacts one's physical, mental, social health, and overall quality of life. This issue of access is comprised of many factors, including affordability, quality of treatment, ability to navigate the system, and availability of services. Indicators such as rates of uninsured and utilization of various types of care help to gauge accessibility of health care within communities. In the KFH-Baldwin Park service area, CHNA secondary data analyses found that census tracts with less health insurance tended also to have several worse health outcomes⁶. During community engagement, findings revealed that those who are members of marginalized groups, including LGBTQ+, undocumented, and racial minorities, and low-income residents often avoid seeking care. Community input sessions shed light on residents' lack of trust towards the health care institutions.

Educational Attainment. Social factors such as education play a big role in one's health. Evidence shows that higher education attainment improves health directly and indirectly, enhancing non-cognitive and cognitive skills and providing greater access to economic resources⁷. Those with higher education may have an advantage when navigating the healthcare system and have the financial resources to access quality care. Specifically, in the KFH-Baldwin Park service area, census tracts with fewer bachelor's degrees are also associated with higher rates of obesity, higher rates of diabetes, smoking, babies born with low birth weights, poor mental health days, and emergency room visits due to heart attack⁸. These findings were underscored by themes from community input sessions, highlighting challenges community residents face to obtaining higher than a high school education, particularly among low-income residents.

Livable Wage Employment. Research shows that workers with good paying jobs are able to live in healthier neighborhoods, provide their children with better education and childcare, purchase nutritious foods, tend to have longer lifespans, and have access to affordable health

⁶ U.S. Census Bureau, *American Community Survey, 2012 - 2016*

⁷ Ross, C. E., & Wu, C. L. (1995). The links between education and health. *American sociological review*, 719-745.

⁸ U.S. Census Bureau, 2011-2015 American Community Survey 5-Year Estimates

insurance. Conversely, those who are classified as “working poor” tend to access preventive services less. Additionally, unemployment has been connected to higher rates of stress-related health conditions (e.g., stroke) and mental health issues⁹. In the census tracts, lower rates of employment are also associated with more pedestrian injuries, a higher prevalence of asthma, more poor mental health days, and higher rates of obesity. During community input sessions participants highlighted challenges to finding employment, including use of more automation which is requiring workers to have advanced skills to gain employment.

Housing Insecurity. The cost of housing continues to be a large financial burden, particularly for low-income families. In Los Angeles County, renters need to earn an estimated \$46.15 per hour to afford the median monthly rent. This is more than 4 times local minimum wage. Low income renters can spend up to 71% of their income on rent, leaving little left for health care bills, food, and transportation. The current demand for affordable housing exceeds existing inventory, with a gap of 500,000 homes.¹⁰ In the KFH-Baldwin Park service area, the rates of homelessness continue to increase, and many families and seniors are one financial challenge away from being homeless. These challenges were also highlighted during community input sessions.

Mental Health. Poor mental health is a leading cause of disability in many developed countries, and greatly impact one's physical health. A growing body of evidence demonstrates a strong association between poor mental health and chronic conditions, such as cardiovascular disease, diabetes, asthma, and some cancers. Within the KFH-Baldwin Park service areas, residents experience more poor mental health days per month than the state and regional averages. Community engagement findings suggest that low-income residents and people of color within the KFH-Baldwin Park service area experience disproportionately high rates of poor mental health. Community input participants shared that lack of financial and social resources pose challenges and a barrier for improving one's wellbeing.

D. Community resources potentially available to respond to the identified health needs
The service area for KFH-Baldwin Park contains community-based organizations, government departments and agencies, hospital and clinic partners, and other community members and organizations engaged in addressing many of the health needs identified by this assessment.

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

VI. KFH-Baldwin Park 2016 Implementation Strategy evaluation of impact

A. Purpose of 2016 Implementation Strategy evaluation of impact

KFH-Baldwin Park's 2016 Implementation Strategy Report was developed to identify activities to address health needs identified in the 2016 CHNA. This section of the CHNA Report describes and assesses the impact of these activities. For more information on KFH-Baldwin Park's Implementation Strategy Report, including the health needs identified in the facility's 2016 service area, the health needs the facility chose to address, and the process and criteria used for developing Implementation Strategies, please visit

⁹ Why Education Matters to Health - Exploring the Causes published by Virginia Commonwealth University's Center on Society and Health. (2014).

¹⁰ Source: Los Angeles Housing Partnership. 2018. Los Angeles County's Housing Emergency and Proposed Solutions.

<https://about.kaiserpermanente.org/content/dam/internet/kp/comms/import/uploads/2013/10/KFH-Baldwin-Park-IS-Report.pdf>. For reference, the list below includes the 2016 CHNA health needs that were prioritized to be addressed by KFH-Baldwin Park in the 2016 Implementation Strategy Report.

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

KFH-Baldwin Park 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-Baldwin Park tracks outcomes, including behavior and health outcomes, as appropriate and where available.

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

As of the documentation of this CHNA Report in March 2019, KFH-Baldwin Park 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-Baldwin Park will continue to monitor impact for strategies implemented in 2019.

B. 2016 Implementation Strategy evaluation of impact overview

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

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

- **Medicaid:** Medicaid is a federal and state health coverage program for families and individuals with low incomes and limited financial resources. KFH provided services for Medicaid beneficiaries, both members and non-members.
- **Medical Financial Assistance:** The Medical Financial Assistance (MFA) program provides financial assistance for emergency and medically necessary services, medications, and supplies to patients with a demonstrated financial need. Eligibility is based on prescribed levels of income and expenses.
- **Charitable Health Coverage:** Charitable Health Coverage (CHC) programs provide health care coverage to low-income individuals and families who have no access to public or private health coverage programs.
- **Workforce Training:** Supporting a well-trained, culturally competent, and diverse health care workforce helps ensure access to high-quality care. This activity is also essential to making progress in the reduction of health care disparities that persist in most of our communities.
- **Research:** Deploying a wide range of research methods contributes to building general knowledge for improving health and health care services, including clinical research, health care services research, and epidemiological and translational studies on health care that are generalizable and broadly shared. Conducting high-quality health research and disseminating its findings increases awareness of the changing health needs of diverse communities, addresses health disparities, and improves effective health care delivery and health outcomes

Grantmaking: For 70 years, Kaiser Permanente has shown its commitment to improving community health through a variety of grants for charitable and community-based organizations. Successful grant applicants fit within funding priorities with work that examines social predictors of health and/or addresses the elimination of health disparities and inequities. From 2017-2018, Kaiser Permanente paid 114 grants amounting to a total of \$4,035,783 in service of KFH-Baldwin Park's 2016 health needs. Additionally, KFH-Baldwin Park has funded significant contributions to the California Community Foundation in the interest of funding effective long-term, strategic community benefit initiatives within KFH-Baldwin Park. During 2017-2018, a portion of money managed by this foundation was used to pay 25 grants totaling \$3,468,683 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-Baldwin Park leveraged significant organizational assets in service of 2016 Implementation Strategies and health needs. See table below for illustrative examples.

Collaborations and partnerships: Kaiser Permanente has a long legacy of sharing its most valuable resources: its knowledge and talented professionals. By working together with partners (including nonprofit organizations, government entities, and academic institutions), these collaborations and partnerships can make a difference in promoting thriving communities that produce healthier, happier, more productive people. From 2017-2018, KFHBaldwin Park 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-Baldwin Park Priority Health Needs

| Need | Summary of impact | Examples of most impactful efforts |
|-------------------------------|---|---|
| Obesity/ HEAL/ Diabetes | <i>During 2017 and 2018, Kaiser Permanente paid 41 grants, totaling \$1,571,892 addressing the priority health need in the KFHBaldwin Park service area. In addition, a portion of money managed by a donor advised fund at California Community Foundation was used to pay 11 grants, totaling \$1,447,016 that address this need.</i> | <p><u>Advocating for Maternal, Infant, and Child Health~</u> The California WIC Association (CWA) supports efforts to increase local WIC agencies' capacity, increase state and federal decision makers' understanding of WIC services, and increase the capacity of community health centers to build a breastfeeding continuum of care in low-income communities. Over two years (2017-2018), Kaiser Permanente paid \$100,000 to CWA to:</p> <ul style="list-style-type: none"> • Pilot two video conferencing projects increasing awareness and consideration within the CA WIC community. • Collaborate with health centers to share WIC staff for nutrition and breastfeeding counseling (Watts Health Care and clinics in San Diego). • Work to strengthen ties with CPCA and present at CPCA's annual conference. • Visit all CA legislators with 44 appointments and drop-in visits. • Provide extensive information to legislators on nutrition and breastfeeding counseling, food benefits, local economic impacts to grocers, health outcomes, access to Farmers markets, and updates on immigration threats. • Participate in Capitol WIC Education Day in Sacramento with 50 attendees from 30 WIC agencies from all over the state. <p><u>Fighting Food Insecurity~</u> California Association of Food Banks' (CAFB) Farm to Family program's goal is to improve health food access by providing fresh produce to food banks, CalFresh outreach and enrollment, advocacy to support anti-hunger policies, and technical assistance to members. In 2018, Kaiser Permanente paid \$95,000 to CAFB to:</p> <ul style="list-style-type: none"> • Distribute 250,000 pounds of subsidized fresh fruits and vegetables to 11 member food banks. • Maintain the State Emergency Food Assistance Program to provide food and funding of emergency food to food banks. <p><u>Growing Gardens:</u> Eco Urban Gardens aims to improve healthy eating habits for students in the El Monte Union High School District to prevent obesity, diabetes, and chronic illnesses. In 2018, Kaiser Permanente paid \$10,000 to Eco Urban Garden to:</p> |

| Need | Summary of impact | Examples of most impactful efforts |
|----------------|--|--|
| | | <ul style="list-style-type: none"> teach students how to cultivate gardens, grow crops, and harvest for the culinary arts kitchen at two sites: Best of Thymes and Arroyo Garden. <p>At the Best of Thymes site:</p> <ul style="list-style-type: none"> over 720 students will plant vegetables to prep more than 200 healthy meals weekly and harvest 36 beds with winter crops, herbs, and edible flowers 2,200 volunteer hours will be spent in the garden <p>At the Arroyo Garden site:</p> <ul style="list-style-type: none"> 900 students will cultivate and harvest crops for the culinary arts kitchen and 160 students will prep over 320 healthy meals weekly <hr/> <p><u>Promoting Food Recovery and Redistribution</u></p> <p>Kaiser Permanente envisions foodservices not only as the source of nutritious meals for their patients, staff and guests, but as a resource for local communities. Over two years (2017-2018), Kaiser Permanente partnered with Food Finders to:</p> <ul style="list-style-type: none"> Recover 4,558.5 lbs of food and distribute to organizations serving individuals in the KFH-Baldwin Park region who face food insecurity. |
| Access to Care | <p><i>During 2017 and 2018, Kaiser Permanente paid 27 grants, totaling \$1,165,667 addressing the priority health need in the KFH-Baldwin Park service area. In addition, a portion of money managed by a donor advised fund at California Community Foundation was used to pay 9 grants, totaling \$1,381,667 that address this need.</i></p> | <p><u>Providing Affordable Healthcare</u></p> <p>Over two years (2017-2018), KFH-Baldwin Park provided \$34,421,975 in medical care services to 47,922 Medi-Cal recipients (both health plan members and non-members) and \$12,807,868 in medical financial assistance (MFA) for 18,861 beneficiaries.</p> <hr/> <p><u>Building Primary Care Capacity~</u></p> <p>The California Primary Care Association (CPCA) provides education, training, and advocacy to their member community health centers to best serve their low-income, underserved, and diverse patients. In 2018, Kaiser Permanente paid \$126,666 to CPCA to:</p> <ul style="list-style-type: none"> Hold statewide convenings and conferences and topic-specific peer networks to support over 1,200 California community health centers. Provide 90 in-person and web-based trainings to over 4,400 attendees and 2,890 individual instances of technical assistance. <hr/> <p><u>Preserving and Expanding California Coverage Gains~</u></p> <p>Insure the Uninsured Project (ITUP) works to preserve and expand access to health care and coverage in California and to reduce access barriers for uninsured and underinsured populations. Over two years (2017-2018), Kaiser Permanente paid \$150,000 to ITUP to:</p> <ul style="list-style-type: none"> Conduct and disseminate health policy research. Convene 13 regional statewide work groups. Provide technical assistance to safety net providers and other stakeholders navigating health reform challenges. |

| Need | Summary of impact | Examples of most impactful efforts |
|------------------------------|--|--|
| | | <ul style="list-style-type: none"> Serve as a bridge between health policy and the health care sector to reach 19 million Californians. <p><u>Connection to Care:</u> Garfield Health Center's (GHC) Connection to Care program is a comprehensive outreach and enrollment program to improve access to preventive and primary health care, including behavioral and oral health care services for low-income, under and uninsured families, adults, and seniors. In 2018, Kaiser Permanente paid \$7,500 to Garfield Health Center to:</p> <ul style="list-style-type: none"> Refer 1,000 individuals to GHC's health care services during outreach in the field Conduct a minimum of 400 medical, dental and/or mental health screenings during outreach at health fairs, schools, and other community events Conduct three monthly health education sessions <p><u>Building the Capacity of Small Businesses</u> Kaiser Permanente promotes local economic development and enhances economic opportunity by helping to strengthen small business capacity. The Inner-City Capital Connections (ICCC) Program is an initiative that builds the capacity of local business located in economically underserved areas to access capital (financing) and grow their business. From 2016 to 2018, Kaiser Permanente joined this county wide initiative to:</p> <ul style="list-style-type: none"> Enroll 299 businesses, of which 65% of participants are minority owned and 52% of participants are women owned. |
| Mental and Behavioral Health | <p><i>During 2017 and 2018, Kaiser Permanente paid 27 grants, totaling \$954,055 addressing the priority health need in the KFH-Baldwin Park service area. In addition, a portion of money managed by a donor advised fund at California Community Foundation was used to pay 3 grants, totaling \$240,000 that address this need.</i></p> | <p><u>Strengthening Mental Health Policies and Practices in Schools~</u> Children Now educates policymakers, school district leaders, and other key stakeholders about best practices and policy solutions to address suspension and expulsion policies that disproportionately impact students of color, improve school climate, and increase students' access to mental health services. Over two years (2017-2018), Kaiser Permanente paid \$150,000 to Children Now to:</p> <ul style="list-style-type: none"> Inform over 200 key legislators and stakeholders. Support the California Department of Education in the development of the Whole Child Resource Map. Lead committees for both the State School Attendance Review Board and the Superintendent's Mental Health Policy Workgroup. <p><u>Building Cultural Competency in the Mental Health Workforce*</u> Foothill Family Services Mental Health Workforce Development Project trains and educates direct service staff, including graduate interns, to be culturally competent and current in evidence-based practices. In 2018, Kaiser Permanente paid \$40,000 to:</p> <ul style="list-style-type: none"> Increase the number of clinical training sessions to fifteen. Increase the number of graduate interns (e.g., MFT or MSW) recruited by 10% annually. Train and educate over 200 direct service staff. <p><u>Implementing Social Emotional Health Survey for Students</u></p> |

| Need | Summary of impact | Examples of most impactful efforts |
|-------------------|--|---|
| | | <p>Baldwin Park Unified School District (BPUSD) aims to reduce the type and severity of mental health concerns by helping school mental health teams assess students' personal and social strengths, in addition to psychological distress and risk factors. In 2018, Kaiser Permanente paid \$15,000 to BPUSD to:</p> <ul style="list-style-type: none"> • Implement the Covitality Social Emotional Health Survey for 9th and 10th grade students as a universal mental health screener. • High School and BPUSD staff will review and analyze all student reports. • High School mental health staff will meet with students with high levels of distress. |
| Economic Security | <p><i>During 2017 and 2018, Kaiser Permanente paid 19 grants, totaling \$344,169 addressing the priority health need in the KFH-Baldwin Park 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.</i></p> | <p><u>Raising Awareness of the California Earned Income Tax Credit~</u> Golden State Opportunity (GSO) leads and supports efforts related to economic security such as job creation, community development, and distribution of benefits. In 2018, Kaiser Permanente paid \$75,000 to GSO to:</p> <ul style="list-style-type: none"> • Support GSO's efforts to expand its innovative California Earned Income Tax Credit (Cal EITC) outreach and education. • Inform 250,000 low-income workers on Cal EITC eligibility and benefits through digital advertising, peer-to-peer text messaging, and grassroots outreach. • Train 25 community partners on smart digital targeting, community messaging, and peer-to-peer text messaging to outreach and engage in the Cal EITC campaign. <p><u>Food for All in Southern California:</u> California Food Policy Advocates (CFPA) is a statewide policy and advocacy organization that aims to improve the health and well-being of low-income Californians by increasing their access to nutritious, affordable food and reducing food insecurity. In 2018, Kaiser Permanente paid \$212,500 to CFPA to:</p> <ul style="list-style-type: none"> • Lead the implementation workgroup for the 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. • Produce and distribute two reports that increase knowledge among administrators, advocates, and the public about county by county Cal-Fresh utilization and underutilization. <p><u>Emergency Assistance Center for the Homeless:</u> The East San Gabriel Valley Coalition for the Homeless (ESGVCH) aims to support individuals experiencing homelessness to maintain stability and gain self-sufficiency by providing shelter, alleviating hunger, assisting with basic needs and housing. ESGVCH's Emergency Assistance Center provides homeless individuals with and families with access to hygienic care, food, and resources for shelter. The Bridge Program provides emergency housing and case management. In 2018, Kaiser Permanente paid \$12,000 to ESGVCH to:</p> |

| Need | Summary of impact | Examples of most impactful efforts |
|------|-------------------|--|
| | | <ul style="list-style-type: none"> • Provide referrals and resources to human services agencies who may assist with permanent housing and supportive services, such as rental assistance, affordable childcare, and job assistance. • Provide opportunity for personal hygiene to promote health and enhance self-esteem. • Provide emergency shelter through motel vouchers. <p><u>Building the Capacity of Small Businesses</u></p> <p>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-Baldwin Park joined this county-wide initiative to:</p> <ul style="list-style-type: none"> • Collectively enroll 299 businesses across the LA County initiative; 65% of participants are minority owned and 52% of participants are women owned |

VII. Appendices

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

Appendix A. Secondary data sources and dates

i. Secondary sources from the KP CHNA Data Platform

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

ii. Additional sources


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

Appendix B. Community input tracking form

| | Data collection method | Title/name | Number | Target group(s) represented | Role in target group | Date input was gathered |
|----------------------------|-------------------------|--|--------|--|----------------------|-------------------------|
| Organizations | | | | | | |
| 1 | Online Survey | University and school district representatives, Chronic Disease Champions, Department of Public Health, Core Learning Question Surveys | 6 | Health department Minority Medically underserved Low income | Leaders | 10/1/18-1/31/19 |
| 2 | Key Informant Interview | Executive Director, Learning Centers at Fairplex | 1 | Low income | Leader | 10/16/18 |
| 3 | Key Informant Interview | Superintendent, Bassett Unified School District | 1 | Minority Low income | Leader | 10/16/18 |
| 4 | Key Informant Interview | Superintendent, Baldwin Park Unified School District | 1 | Minority Low income | Leader | 10/17/18 |
| 5 | Key Informant Interview | Interim Executive Director, San Gabriel Valley Consortium on Homelessness | 1 | Minority Medically underserved Low income | Leader | 10/22/18 |
| 6 | Key Informant Interview | Former President and team, San Gabriel Valley Economic Partnership | 2 | Minority Low income | Leader | 10/22/18 |
| 7 | Key Informant Interview | Director of Education Pathways, Workforce Development Committee | 1 | Minority Low income | Leader | 10/24/18 |
| 8 | Key Informant Interview | Executive Director, Bright Prospect | 1 | Minority Medically underserved Low income | Leader | 10/24/18 |
| 9 | Key Informant Interview | President and Chief Executive Officer, Mt. San Antonio College | 1 | Minority Low income | Leader | 10/25/18 |
| 10 | Key Informant Interview | Senior Policy Manager, Asian Americans Advancing Justice | 1 | Minority Medically underserved Low income | Leader | 10/29/18 |
| 11 | Focus Group | Multiple organizations focused on access to health, Access to Health Focus Group | 10 | Minority Medically underserved Low income | Leaders | 11/29/18 |
| 12 | Focus Group | Multiple organizations focused on workforce development, Workforce Development Focus Group | 5 | Minority Medically underserved Low income | Leaders | 11/29/18 |
| 13 | Focus Group | San Gabriel Valley Consortium on Homelessness, Mental Health Focus Group | 21 | Minority Medically underserved Low income | Leaders | 12/12/18 |
| 14 | Focus Group | San Gabriel Valley Mental Health Consortium | 9 | Minority Medically underserved | Leaders | 12/13/18 |
| Community residents | | | | | | |
| 15 | Focus Group | Youth from NAMI on Campus student group, Youth Mental Health Focus Group | 12 | Minority Medically underserved Low income | Representatives | 1/14/19 |

Appendix C. Health Need Profile

Lack of Access to Care is Predictive of Negative Health Outcomes

 Lack of access to care can influence health outcomes. In the KFH-Baldwin Park, census tracts with less health insurance also tend to have:



More poor mental health days¹

Higher asthma prevalence²

Higher obesity prevalence³



More pedestrian injuries⁴

There are a variety of reasons why people may not access care. Research on these reasons suggests that negative perceptions of care, low perceived need, and traditional barriers like lack of funds or insurance are some of the reasons people don't access care.⁵



Residents Are Avoiding Care

Community members shared that many **residents feel a lack of trust** towards the health care institutions. This trust gap often stemmed from fears over immigration status, and negative experiences with clinicians. Additionally, residents worry about the costs of care.

Distrust of Medical System



"I wanted to talk about stigma and shame, which is something we encounter a lot with our patients as a barrier. And fear as well. Just the stigma of seeking out sexual health or reproductive health, the shame associated with that. For our LGBTQ patients, they've been perhaps traumatized in the past by medical care they received because their sexuality or gender is not even acknowledged. And then we are also seeing, not just from our patients who have an undocumented status, but who are immigrants, fear of seeking healthcare in the climate we're in right now. Just avoiding care." - Service Provider

Health Care Costs are High



"They don't even go to a doctor because they think about the cost. That's just an extra cost when they're spending on every thing else that they do. Sometimes they have two jobs and they are just making ends meet. It's not in their budget so they just avoid it." - Service Provider

Statistics for KFH – Baldwin Park⁶



26% of adults have some difficulty accessing care



15% of children have some difficulty accessing care



10% of children were unable to afford dental care and check-ups



6% of children were unable to afford seeing a doctor for an illness



7% of children were unable to afford prescription medicines

Inequity Focus: Marginalized Groups



Members of marginalized groups, in particular, are avoiding care (e.g. LGBTQ+, undocumented, and racial minorities).

"Health barriers and disparities are generally created by intersectional issues that include racism and bigotry, income inequalities, housing and food insecurities, language and transportation barriers, unemployment or underemployment, lack of insurance, and lack of education, etc... marginalized people have become far more likely to avoid health care. Those most affected include immigrant families (regardless of their citizenship status), LGBTQ+ people, and low-income and uninsured women and young people." - Service Provider

Opportunity: Providing Services Outside the Traditional Clinical Setting

Meeting the community "where they are" is one useful approach to providing care. For example, providing services at schools or in waiting rooms.



"While they're in the meeting area waiting, we actually have [nursing] students come out and interact with them and try to get them to get screened and we've come across a large, number of people that didn't even know they had hypertension. We have a nurse on site in case they need to see a specialist. We have workshops on mental health in waiting areas so they really can't go anywhere. Now that we're having them in the waiting area we're getting the conversation started with our community. They're actually asking questions and the resources and where to go."

- Service provider

Opportunity: More Culturally Competent Health Care Providers

The KFH - Baldwin Park needs more health care providers to meet the demand. Especially, health care workers that are culturally competent. Currently, a lot of resources go to other areas of Los Angeles County.



"We're kind of cut off from the networks that exist in Los Angeles and our community has its own identity, it's nebulous a little.... Then [there are] cultural divisions and I think because of that there's not a built-up healthcare network within the [KFH- Baldwin Park]." - Service Provider

Inequity Focus: Low Income Residents



Residents struggle to afford health care costs and therefore avoid seeking services. Moreover, insurance often inadequately covers health care costs.

"Many of our workers cannot afford to pay health insurance fees. Therefore, when they are sick, hospital visits are minimal at most and continuous health care screenings are non-existent. Lack of affordable housing and rising rent costs impact workers' health issues because family resources are limited to cover these expenses which limit[s] the opportunities to invest in nutritious foods and health care expenditures." - Service Provider

Opportunity: More Services that Help Residents Navigate Care Options

Health care navigators and promotoras help community members find and use the services they need.



"[We need more] health navigators or promotoras - I mean just the navigation involved in the healthcare network is a huge challenge for our patients. And we're really seeing that we've had to invest a lot in that after ACA went into effect because we're seeing so many more patients in our health centers." - Service Provider

Residents need more health care navigators they can trust to help them work through the health care system.



"There's a need for promotoras or health navigators because these issues are so difficult to deal with people need to know that they have a voice and in order to do that the need to have an advocate there for them helping them along the path."

- Service Provider

Sources

1. Behavioral Risk Factor Surveillance System (2015)
2. California Health Interview Survey (2014)
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4. National Vital Statistics System (2011- 2015)
5. Taber, J. M., Leyva, B., & Persoskie, A. (2015). Why do people avoid medical care? A qualitative study using national data. *Journal of general internal medicine*, 30(3), 290-297.
6. 2015 Los Angeles County Health Survey. Service Planning Area 3. Office of Health Assessment and Epidemiology, Los Angeles County Department of Public Health.

Low Educational Attainment is Predictive of Negative Health Outcomes



In the KFH - Baldwin Park service area census tracts with **fewer bachelor's degrees** are also associated with:



Higher rates of obesity¹



Higher rates of diabetes¹



Higher rates of smoking²



Increased rates of low birth weights³



More poor mental health days⁴

More ER visits due to heart attack⁵

Evidence shows that higher educational attainment improves health both directly and indirectly.⁶

Residents Lack Adequate Support Systems & Soft Skills

Community members shared that many students do not have the necessary support systems (e.g., family support, community support) to enter and persist through college. Additionally, some students lack the life skills needed to push through the challenges necessary to obtain a higher education.

Lack of Support Systems



"Where we go wrong is when students feel disenfranchised. When they may not have support at home...where they don't have the ability to see themselves as successful...[They need to have] that internal motivation to do the hard work and get it done." –Service Provider

"[The] initial shock of higher standards [in college] can be demoralizing unless there is support." –Superintendent

Lack of Soft Skills



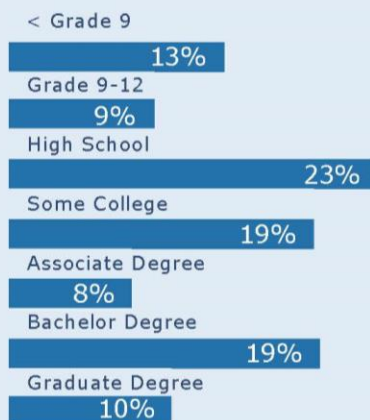
"[Students] don't know how to manage their time...to learn accountability and be self-accountable...to navigate through the social parts of college...They didn't understand the financial impact that it would have on themselves or their family...When they get to college and the workload in college becomes so much stronger, so much heavier, I don't know that they always know how to navigate that." –Superintendent

"[Students need] those intangibles and attributes that we were talking about: can they collaborate, can they communicate effectively, can they creatively problem solve...whether or not they can self regulate themselves if in fact they fall down, can they get back up?" –Superintendent

Education in KFH - Baldwin Park

Most people in the KFH - Baldwin Park service area do not have a college degree or higher.

Level of Education⁷



Community members believe that with more education comes more awareness of health:

"An education is about awareness and so when you're engaged with an educational process you're learning... It just broadens your perspective. It allows you to be engaged with information that you wouldn't otherwise be engaged... people are more inclined to want to feel better about themselves so then they're going to take better care of themselves."

–Superintendent

Sources

1. California Health Interview Survey (2014)
2. California Tobacco Control Program California Department of Public Health (2016)
3. National Vital Statistics System (2008- 2014)
4. Behavioral Risk Factor Surveillance System (2015)
5. CalEnviroScreen 3.0 (2011-2013)
6. Ross, C. E., & Wu, C. L. (1995). The links between education and health. American sociological review, 719-745.

Low Income Students Require Additional Services to be Successful



Support is needed to address the additional stressors low-income students often need to manage.

"There are kids that go to school hungry. There are kids that are homeless...Those kind of barriers make it more difficult for kids to graduate. When they don't have the right clothes to wear, they're not eating right. They don't have a place to study...They might not have transportation. They might not even be well. They might not have healthcare."

–Service Provider

Opportunity: Partnerships Are Effective

Schools, nonprofits, businesses, and other organizations have started collaborating with each other to provide better resources.



"Collaborations with outside businesses. Collaboration with government agencies... The ability to be the recipients of grants... Collaborations with local universities, local community colleges [have all helped us implement our programming.]"

– Superintendent

Opportunity: More Exposure to Career Paths

Community members want students to have more opportunities to explore various career paths. This may include shadowing, internships, vocational training, etc.



"If they're not exposed to different career paths, then they're never going to know [about the various career paths out there]."

–Service Provider

Opportunity: More Community Support

The community needs to support students that may not have support at home. This may take the form of encouragement, but also resources that address social predictors of health.



"In communities where we have higher incidences of students dropping out of high school and will have all of the other social ills that go along with that because there's a long list of them, those are communities that need community support. It's not just they need more educational programs, they need sort of that village around them."

–Service Provider

Low-income Students Often Cannot Rely on Families for Support



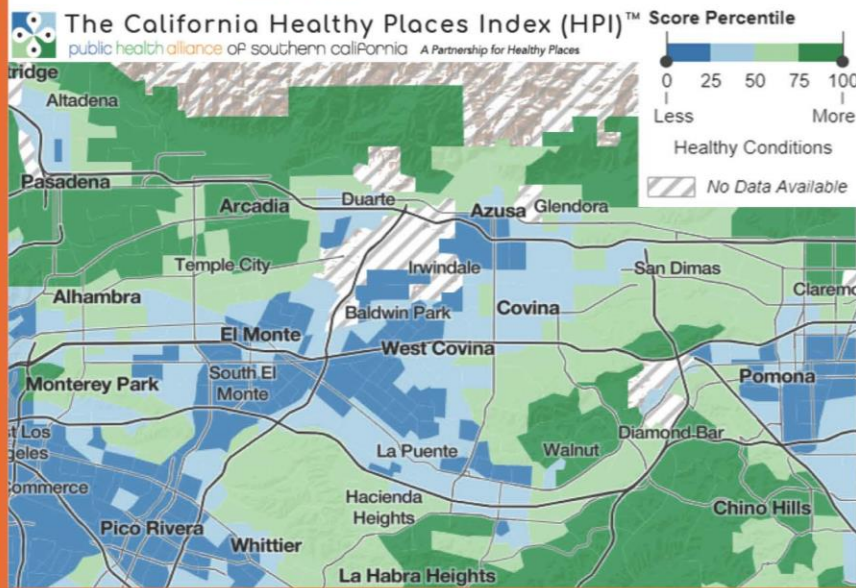
Students may not be able to rely on their families for financial and emotional support. These students need to seek guidance and resources elsewhere.

"I was still a full-time student and working three part-time jobs, not only to support myself academically and my expenses, but [also] to help my mother who was unemployed during a difficult situation. So, many of our students not only support themselves, but they [also] support their families as well while in college."

–Service Provider

Educational Attainment Across the KFH - Baldwin Park⁸

The map below shows the percentage of people over age 25 with a bachelor's education or higher.⁹ The **dark green** areas have a higher percentage of bachelor's education or higher compared to the **dark blue** areas.



Opportunity: Educating Parents Works

Parents can be an asset for students. Building their understanding has been helpful.



"[We help] the parents really understand what's going on so that they can help their students...That collaboration in partnership helps tremendously and helping our students continue with their education."

–Service Provider

Sources

7. San Gabriel Valley (SGV) Community Profile 2018 by SGV Economic Partnership <http://www.sgvpowersite.com/community-profile.html?icTool=community-profile&geoId=r765&geoEntId=765>
8. 2018 Public Health Alliance of Southern California <https://map.healthypacesindex.org/>
9. U.S. Census Bureau, 2011-2015 American Community Survey 5-Year Estimates

Employment is Connected to Health Outcomes



In the KFH - Baldwin Park service area, census tracts with lower rates of employment are also associated with more **pedestrian injuries**,¹ a higher prevalence of **asthma**,² more **poor mental health** days,³ and also have higher rates of **obesity**.⁴



Furthermore, evidence suggests that workers with "higher paying" jobs are: (1) able to live in healthier neighborhoods, (2) able to provide their children with better education and childcare, (3) able to purchase nutrient rich foods, and (4) able to have more access to affordable health insurance. Conversely, research suggests that workers with "lower paying" jobs tend to access preventive services less and have adverse health outcomes. Plus, unemployment has been connected to higher rates of stress-related health conditions (e.g. stroke) and mental health issues.⁵



A Changing Economy is Leaving Residents Behind

The KFH - Baldwin Park service area job market is evolving and using more automation which is requiring workers to have advanced skills to gain employment.

Residents Need More Skills & Experience



"[Young adults have] gotten education and it's hard for them to find employment, because they don't have the professional experience... They're not able to find jobs." – Service Provider

"[Skilled workers] go to where the jobs are... They don't typically stay and work in the [KFH- Baldwin Park service area]... We don't think that we are producing enough talent, yet, for the [available] jobs."

- San Gabriel Valley Economic Partnership Member

Automation is Reducing the Number of Jobs Available



"[A]utomation, that has taken a huge number of jobs out of [manufacturing]... We're having to train people in a completely different skillset to be able to operate a lot of the automated equipment and robotic equipment."

- San Gabriel Valley Economic Partnership Member

Jobs in the KFH - Baldwin Park⁶

The KFH - Baldwin Park service area has a labor force of 1,075,814 people. A majority of community members work in the retail or health care industry. Most have roles in admin or sales.

Jobs by Industry



Jobs by Occupation



Though more jobs are expected in the KFH - Baldwin Park service area over the next year, wages are expected to remain flat.⁷

Need: Low resource areas



Overall, the KFH - Baldwin Park needs more resources. Particularly the geographical areas that have many lower income residents.

Community members felt that the KFH - Baldwin Park service area receives less resources than other areas of Los Angeles county: *"because LA County is so big... a lot of the stuff is in LA city and it's almost like it would be helpful if a lot of services were set to a geographical area of LA County."* - San Gabriel Valley Economic Partnership Member

There are also some areas within the KFH - Baldwin Park service area that experience more unemployment than others. Below is a list of the areas with most unemployment.⁷

Highest Unemployment

| | |
|--------------|------|
| Irwindale | 6.1% |
| Baldwin Park | 6.1% |
| West Covina | 5.7% |
| El Monte | 5.7% |
| Covina | 5.5% |

Opportunity: Job Training Programs

Job training programs introduce community members to new opportunities, and allow them to begin building the necessary skills to obtain a position in a specialized field.



"[Job training programs] help students be able to explore the career itself, come out with some skills, but then also come out with some kind of certification that demonstrates to a potential employer that this student does indeed have skills."
- Education Provider

Community members want more job training programs that will expose people to new positions and allow them to build their skills.



"A workforce development grant... If Kaiser saw that creating their own pipeline from this region was important enough... [Students] don't know that there's people that cook inside the hospitals, like dietitians, or accountants, and IT, you know real estate. There's all kinds of jobs in the health system."
- San Gabriel Valley Economic Partnership Member

Need: Educating residents on the job market and connecting them to services that help find employment



Some community members have a limited understanding of the job market, and what is necessary to obtain the right skills.

"We have those populations... the limited English, the lower income, the lower high school... it's much more difficult to get those populations... into one of those high tech, special skilled, jobs, because that will require training programs and there's not enough training programs for them."

- San Gabriel Valley Economic Partnership Member

Employment Across the KFH - Baldwin Park⁸

The map below shows the percentage of people aged 25-64 who are employed within each census tract.⁹ The **dark green** areas have higher employment rates compared to the **dark blue** areas.



Sources

1. National Vital Statistics System (2011- 2015)
2. California Health Interview Survey (2014)
3. Behavioral Risk Factor Surveillance System (2015)
4. California Health Interview Survey (2014)
5. Foundation, R. W. (2013). How Does Employment, or Unemployment, Affect Health?
6. San Gabriel Valley (SGV) Community Profile 2018 by SGV Economic Partnership <http://www.sgvpowersite.com/community-profile.html?icTool=community-profile&geoId=r765&geoEntId=765>
7. Los Angeles County Economic Development Corporation (2018) 2018 SGV Economic Forecast Summit.
8. 2018 Public Health Alliance of Southern California <https://map.healthypacesindex.org/>
9. U.S. Census Bureau, 2011-2015 American Community Survey 5-Year Estimates

Housing Insecurity Negatively Influences Health



In the KFH - Baldwin Park service area, census tracts with more crowded housing also tend to experience or have:



More poor mental health days¹

More heart attack ER visits²



Higher asthma prevalence³

Higher obesity prevalence³

Higher smoking prevalence⁴



Evidence also suggests that housing quality is related to morbidity from infectious diseases, chronic illnesses, injuries, poor nutrition, and mental disorders.⁵ Furthermore, homeless individuals experience more chronic medical illnesses, psychopathy, and substance use.⁶



Many Community Members Are On The Brink of Homelessness

Community members shared that many families and individuals are living in crowded homes due to the lack of affordable housing and low wages.

Crowded Housing



"The homeless [individuals] we see in the street are just the tip of the iceberg. Beneath the surface, are the many, many, many families who are in... overburdened housing where multiple families live together in crowded conditions... I think part of it is yeah, the lack of affordable housing... I really think [there's a lack of training for] jobs... [we need to make] sure we have a workforce that's actually prepared for twenty first century jobs." – Service Provider

Low Wages & Lack of Affordable Housing



"Often times, they [live] in substandard housing, so they're in an apartment building that's not well maintained. They can barely afford it... they're spending a high percentage of their income on rent. Many times [when] their rent goes up, they're [usually] evicted." – Service Provider

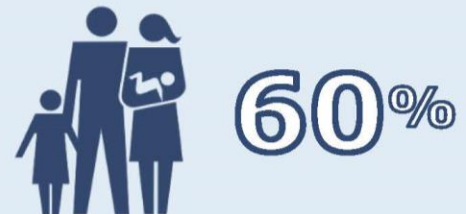
"Obviously a big part of it is the affordability factor as well... that means that somebody making minimum [wage] would have to work essentially 90 hours a week in order to afford the average two bedroom apartment, which obviously a single mom or dad wouldn't be able to do." – Service Provider

Homelessness in the KFH – Baldwin Park⁷

There is growing concern about the many families whom are on the brink of homelessness.



23% of homeless families are unsheltered



60% of homeless families include children under 18

Community members are also concerned about the increased number of seniors becoming homeless. There are 402 homeless seniors. This is a 114% increase in 2018 since 2017.



Increase from 2017 to 2018

Families & Seniors are Particularly at Risk of Homelessness



Many families and seniors are one financial challenge away from being homeless.

"You have a density of the population... on the brink of homelessness due to economic conditions... so any kind of light change to their economic conditions [including] health conditions, medical conditions, medical bills, transportation or health of a loved one or caretaker or a guardian [can lead to homelessness.]" – Service Provider

Opportunity: More Collaboration is Needed

Organizations have started to partner with each other to provide services and support the affordable housing. More collaboration is needed as there is still some lack of awareness about the services available.



"Establish collaborative partnerships with local agencies in terms of service delivery." – Service Provider

Opportunity: More Affordable Housing

More affordable housing needs to be built. This often takes collaboration between many partners to build community acceptance, find funding, and identify opportunities to build.



"[In order to build housing there needs to be] a piece of land that makes sense. Maybe it's being donated or being provided or provided at low cost. Secondly, we [need to] identify the funding sources that line up with the target population... The third factor is public will. Having the buy-in from the community to be able to make it happen... It's really a matter of where the opportunity is." – Service Provider

Opportunity: Education about Affordable Housing

There is a need to educate others about what affordable housing is and who it is for. Those opposed may not realize that affordable housing would help those who are already their neighbors.



"We've managed to put a stigma on affordable housing... everybody instinctively doesn't want it next to them. Yet, it is next to them already. It's just not [obvious], it's the 16 people in three rooms... somehow people believe it's not for their neighbors. It's for someone else, and they are bad. We have to work through that stigma... that initial reaction is there's something wrong with people if they need affordable housing. Yet, they're our neighbors." – Service Provider

Low Income Residents are Especially Vulnerable

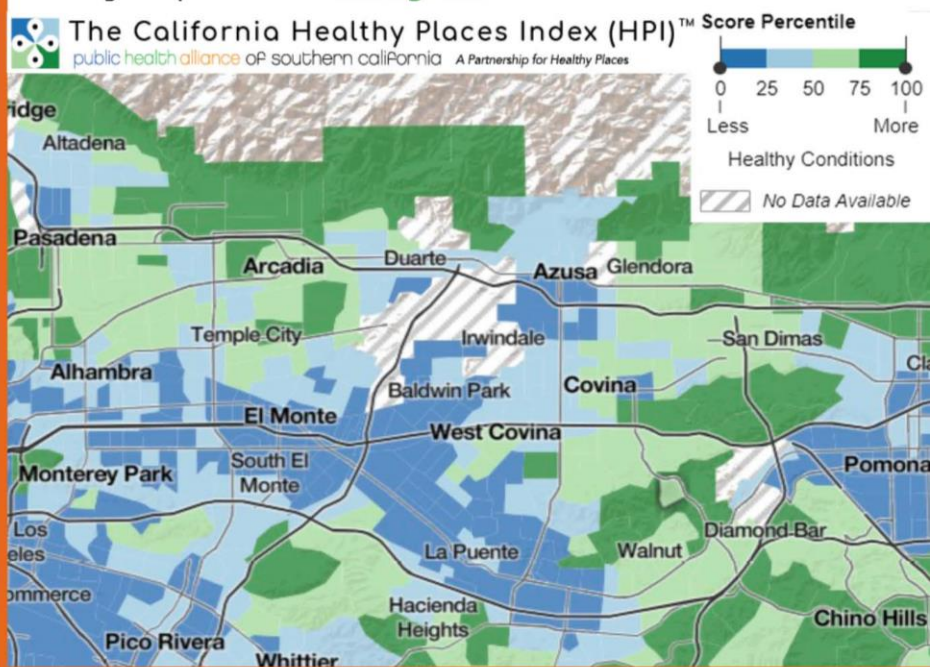


Low-income workers rely on each other to obtain housing. If one person in a group experiences a challenge, they all do.

"There are a lot of individuals and particularly families that were already near some homelessness and any number of variables sort of tip the scale... [When] one individual becomes homeless usually it's associated with multiple individuals, [including] in this case, families and more specifically children." – Service Provider

Crowded Housing in KFH - Baldwin Park⁸

The map displays crowding housing as defined as 1 or less occupant per room.⁹ The **dark blue** areas have a higher percentage of crowded housing compared to the **dark green** areas.



Sources

1. Behavioral Risk Factor Surveillance System (2015)
2. CalEnviroScreen 3.0 (2011-2013)
3. California Health Interview Survey (2014)
4. California Tobacco Control Program California Department of Public Health (2016)
5. Krieger, J., & Higgins, D. L. (2002). Housing and health: time again for public health action. *American journal of public health*, 92(5), 758-768.
6. Schanzer, B., Dominguez, B., Shrout, P. E., & Caton, C. L. (2007). Homelessness, health status, and health care use. *American Journal of Public Health*, 97(3), 464-469.
7. Homeless Count 2018: <https://www.lahsa.org/documents?id=2030-2018-greater-los-angeles-homeless-count-service-planning-area-3.pdf>
8. 2018 Public Health Alliance of Southern California <https://map.healthyplacesindex.org/>
9. U.S. Census Bureau, 2011-2015 American Community Survey 5-Year Estimates

Poor Mental Health is Predictive of Negative Health Outcomes



In the KFH - Baldwin Park, census tracts with more poor mental health days also tend to experience or have:¹



More crowded housing



Fewer bachelor degrees



Less insurance

Less employment

Studies have found that poverty is directly and indirectly associated with poor mental health.²

Lack of Financial and Social Resources Compounds Mental Health Issues Among Residents

Community members described a lack of both financial and social resources as both an impetus for mental health challenges and a barrier for improving one's wellbeing.

Stigma & Lack of Social Support Act as Barriers



"[If someone experiences mental health challenges,] she might have a social drawback and she will isolate herself from her friends and family, and she'll stop participating in things that she used to." – High school student

"In the school system we're trying to teach everyone about mental health, and then helping the parents come to understand that, and getting services for their child. So I guess I'm saying there's ignorance at all levels. There's a lack of knowledge in the whole system, so that children can be referred when needed, being able to talk to parents and guardians, and then for the students themselves, understanding [their mental health is important] so that they can refer themselves, or access services. And that is all wrapped up in stigma and shame and fear." – Service Provider

Financial Insecurity Contributes to Poor Mental Health



"A lower wage within a family is related to a lot of other issues. So, lack of insurance, lack of higher education, and all of those issues combined that can contribute to poor mental health. There's also poverty tied to that, and that's a risk factor, and as we talked about another risk factor... immigration status or first generation status might be influencing more mental health days. Especially given that there is a lot of immigrants in the service area." – Service Provider

Mental Health Statistics



1 in 5 Americans experience mental illness each year³



67% of adults with a serious mental illness receive mental health treatment⁴



Adults living with serious mental illness die 10 - 20 years earlier⁵



Suicide is the 10th leading cause of death in America⁶



Suicide is the second leading cause of death for people ages 10 to 34 years⁶



50% of adolescence have a mental disorder⁷

Low Income Residents Face Particular Challenges Around Mental Health



Those with lower financial resources not only often lack the means to obtain help but also experience more stressors that can further perpetuate the problem.

"There's also low [socioeconomic status], so when families are struggling to survive financially, they might be less likely to seek out mental health services. And there's a lack of trust. So they might not trust you as a resource, when they're dealing with mental health issues." - Service Provider

The Centers for Disease Control and Prevention (CDC) has also found a connection between poverty and mental health issues. One report shared that poverty was connected to mental, behavioral, and developmental disorders (MBDDs) in children.⁸ Another report showed that adults with lower family incomes had higher rates of depression.⁹

Opportunity: More Collaboration

The organizations currently in the area need to know about each other and help guide community members more effectively.



"There seems to be an overall lack of articulation within the system of providers. So, if I'm a Kaiser patient, and I can't get in, I should be able to access services at a community agency. But that kind of articulation doesn't occur. So, to me that is a system issue." - Service Provider

"The hot term is 'silos'. There's lots of agencies getting funding, or mental health professionals who all focus on our own area. And there's the ability that we need to step out and be able to do more collaboration. To speak about what we can offer each other, in a more powerful, synergistic kind of way, [and] give support to families." - Service Provider

Sources

1. U.S. Census Bureau, 2011-2015 American Community Survey 5-Year Estimates
2. Santiago, C. D., Kaltman, S., & Miranda, J. (2013). Poverty and mental health: how do low-income adults and children fare in psychotherapy?.
3. "Mental Health Statistics," National Institute of Mental Health. <https://www.nimh.nih.gov/health/statistics/mental-illness.shtml> (2019)
4. Substance Abuse and Mental Health Services Administration. (2018). Key substance use and mental health indicators in the United States: Results from the 2017 National Survey on Drug Use and Health. <https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHFFR2017/NSDUHFFR2017.pdf>.
5. Chesney, E., Goodwin, G. M., & Fazel, S. (2014). Risks of all-cause and suicide mortality in mental disorders: a meta-review.
6. National Center for Health Statistics (NCHS), National Vital Statistics System, 10 Leading Causes of Death, United States, 2017, All Races, Both Sexes

Mental Health Issues Present Unique Challenges in Communities of Color



Communities of color experience both stigma around mental health and the lack of resources to seek help.

"There's stigma, fear, and shame that makes it harder for people to want to reach out for those services, and those things are connected to cultural experience. And that is tied to communities of color and needing assistance." - Service Provider

"Poverty is a risk factor. Especially for people of color, we notice a lot of inequalities, so it's a huge risk factor." - Service Provider

"In certain communities, you just need to get over it. You have greater priorities. We need to feed ourselves, and mental health is not a priority." - Service Provider

Opportunity: More & Consistent Funding

Effective programs and services need to be funded so that community members can have access to affordable services, but also so that service providers can effectively refer community members.



"Mental Health, we have some funding in order to do early prevention. A little bit. But I think probably this is a good opportunity for Kaiser, City Hope, and all these agencies to do early prevention." - Service Provider

"Funding is cut all the time. So then a program that was great and amazing last year is gone this year, and that makes it really hard." - Service Provider

7. Merikangas KR, He JP, Burstein M, Swanson SA, Avenevoli S, Cui L, Benjet C, Georgiades K, Swendsen J. Lifetime prevalence of mental disorders in U.S. adolescents: results from the National Comorbidity Survey Replication-Adolescent Supplement (NCS-A).
8. Cree, R. A., Bitsko, R. H., Robinson, L. R., Holbrook, J. R., Danielson, M. L., Smith, C., ... & Peacock, G. (2018). Health care, family, and community factors associated with mental, behavioral, and developmental disorders and poverty among children aged 2-8 years—United States, 2016.
9. Brody, D. J., Pratt, L. A., & Hughes, J. P. (2018). Prevalence of Depression Among Adults Aged 20 and Over: United States, 2013-2016.

Appendix D. Community resources

| Identified need | Resource provider name | Summary description |
|-------------------------|---|--|
| Access to Care | Garfield Health Center | Garfield Health Center provides comprehensive services to low-income, underserved patients and families. This includes, but is not limited to, medical, dental, and mental healthcare. |
| | Foothill AIDS Project (FAP) | FAP offers a full spectrum of programs and services that empower clients in three counties to manage their own long-term health goals. Integrated treatment and chronic care management, paired with stable housing planning and outreach, provide many tools for people living with HIV/AIDS to live longer, healthier, and more stable lives. |
| Educational Attainment | Learning Centers at Fairplex | The Learning Centers provides a wide spectrum of innovative and enriching educational experiences that bring learning to life, benefit our diverse communities, and prepare our participants for success. More than 180,000 community members benefit from TLC programs each year — a substantial number of individual lives touched by a single organization! TLC's programs range from early childhood education to career readiness. |
| | Bright Prospect | Bright Prospect empowers high potential, low-income students to gain admission, succeed and graduate from four-year colleges and universities by providing a comprehensive counseling and support system throughout their high school and college years. |
| Livable Wage Employment | Asian Americans Advancing Justice | Asian Americans have been part of the American story since its earliest days and are now the U.S.'s fastest-growing racial group with the potential and power to shape our nation and the policies that affect us. Their mission is to advance civil and human rights for Asian Americans and build and promote a fair and equitable society for all. |
| | Pomona Economic Opportunity Center (PEOC) | The PEOC is a non-profit day labor organization whose mission is to provide an opportunity for day laborers to find safe work at a fair wage, to obtain new trades and skills that improve their employability and quality of life, and to improve overall conditions for immigrant workers. The PEOC is made up of day laborers, household workers, other low-wage, immigrant workers, community leaders, students from Claremont Colleges, and supporters of worker and immigrants' rights leaders. |
| Housing Insecurity | San Gabriel Valley Consortium on Homelessness | San Gabriel Valley Consortium on Homelessness facilitates partnerships, educates the community and member agencies, and advocates for appropriate housing and services in the San Gabriel Valley. The Consortium has over 150 agency members and plans for continued growth as the broker of services and information relating to homelessness in the San Gabriel Valley. |
| | Foothill Unity | Founded in 1980, Foothill Unity Center is the primary provider of food, case management/crisis help, and access to health care resources across eleven San Gabriel Valley cities in Los Angeles County. As the federally designated Community Action Agency for the Foothill Area, 79% of clients are at or below the National Poverty Level. |
| Mental Health | California Mental Health Connection | California Mental Health Connection is a fully accredited, State Certified for SED care, that provides out-patient therapy to families, children, adolescents, and adults. They appropriate a large percentage of services, free of charge, to individuals and families with low, or no income. Their conviction is to ensure that every individual receives treatment. |
| | NAMI Pomona Valley | The Pomona Valley affiliate of the National Alliance on Mental Illness (NAMI Pomona Valley) is a nonprofit California corporation serving Pomona Valley and the surrounding communities, and dedicated to improving the quality of life for people affected by mental illness and their loved ones through support, education, and advocacy. NAMI is the nation's largest grassroots mental health organization dedicated to building better lives for the millions of Americans affected by mental illness. |

Appendix E. Strategic Lines of Inquiry for Community Engagement

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

Overview of Question Design Process

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