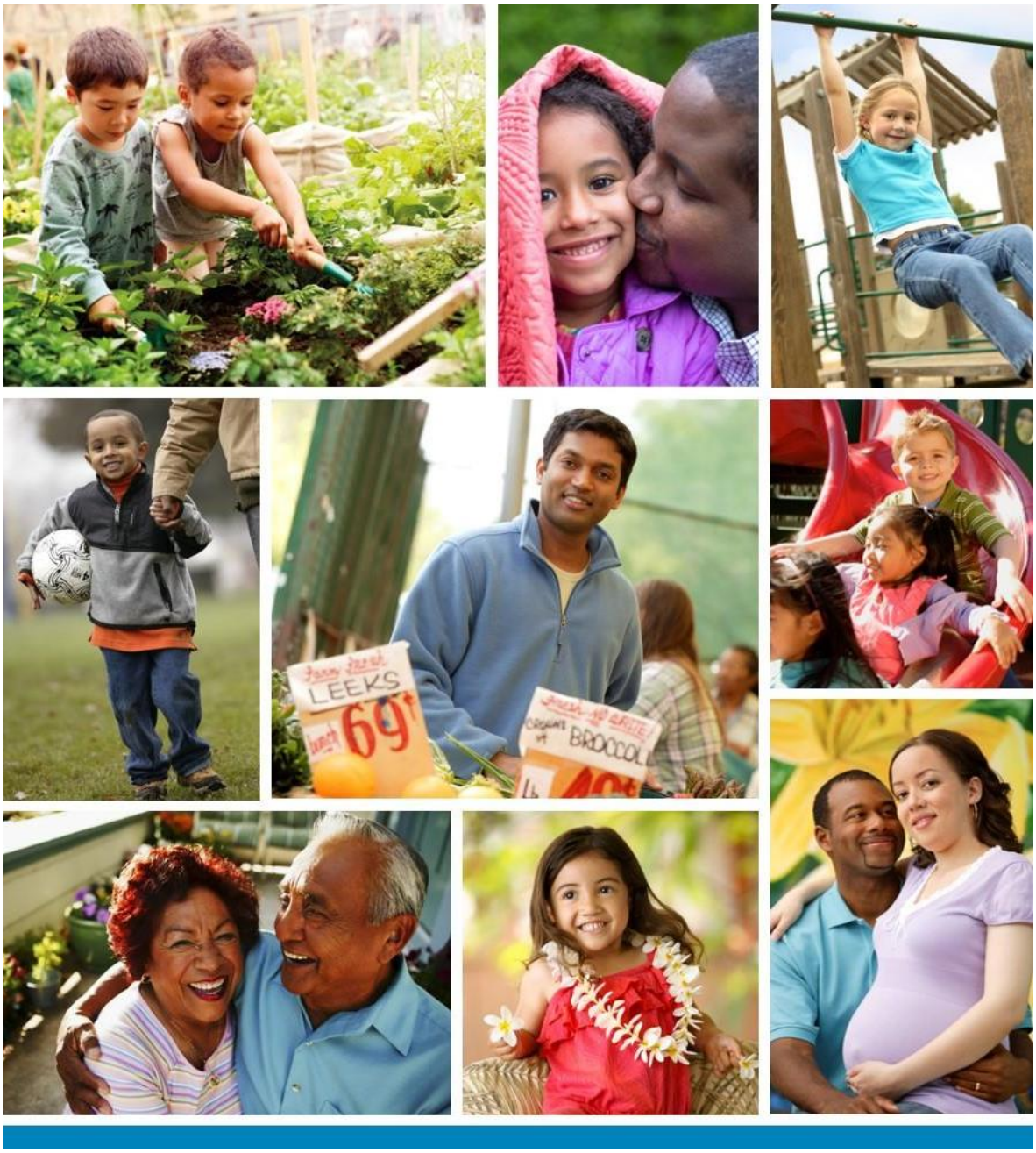


2019 Community Health Needs Assessment

Kaiser Foundation Hospital: Downey Medical Center

License number: 930000078

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

September 16, 2019

KAISER PERMANENTE®

Kaiser Permanente Southern California Region Community Benefit

CHNA Report for KFH-Downey

Contents

I. Introduction/background

A. About Kaiser Permanente (KP)

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

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

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

Care for members and patients is focused on their Total Health and guided by 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-Downey 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

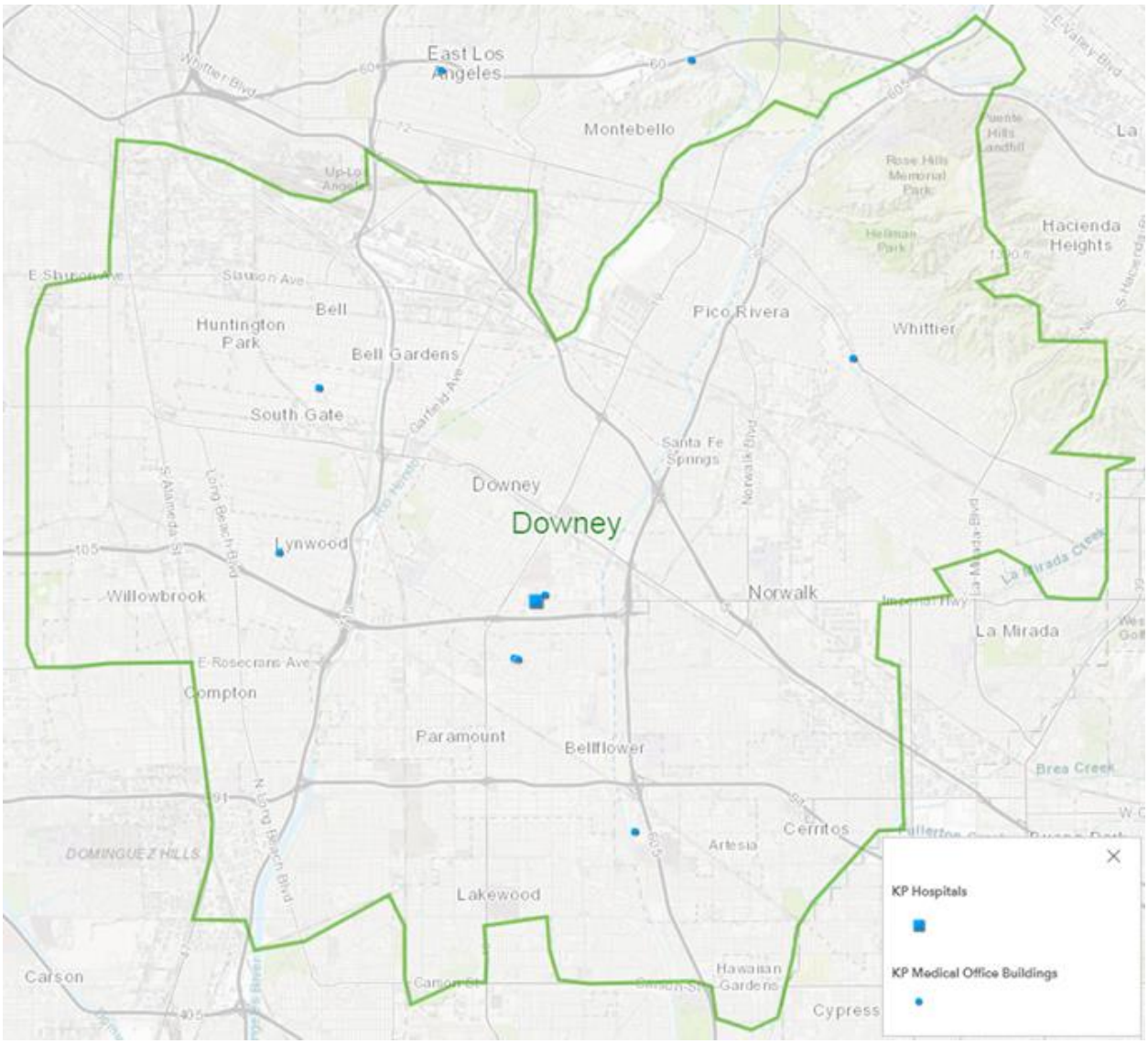
A. Kaiser Permanente's definition of community served

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-Downey Service Area



ii. Geographic description of the community served

The KFH-Downey service area includes Artesia, Bell, Bell Gardens, Bellflower, Cerritos, Commerce, Compton, Cudahy, Downey, Florence-Graham, Hawaiian Gardens, Huntington Park, Lakewood, Lynwood, Maywood, North Long Beach, Norwalk, Paramount, Pico Rivera, Santa Fe Springs, South Gate, portions of South Los Angeles, Vernon, Watts, Whittier, and Willowbrook. The service area consists of portions of Service Planning Area's (SPA's) 6 and 7 in Los Angeles County.

iii. Demographic profile of the community served

The following table includes race, ethnicity, and additional socioeconomic data for the KFH-Downey 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-Downey[1]

Race/Ethnicity		**Socioeconomic**	
Total Population	1,512,831	Living in Poverty (<100% Federal Poverty Level)	19.78%
Asian	7.33%	Children in Poverty	28.75%
Black	7.50%	Unemployment	4.10%
Hispanic/Latino	73.81%	Uninsured Population	18.64%
Native American/Alaska Native	0.21%	Adults with No High School Diploma	33.60%
Pacific Islander/Native Hawaiian	0.30%		
Some Other Race	0.24%		
Multiple Races	0.89%		
White	9.73%		

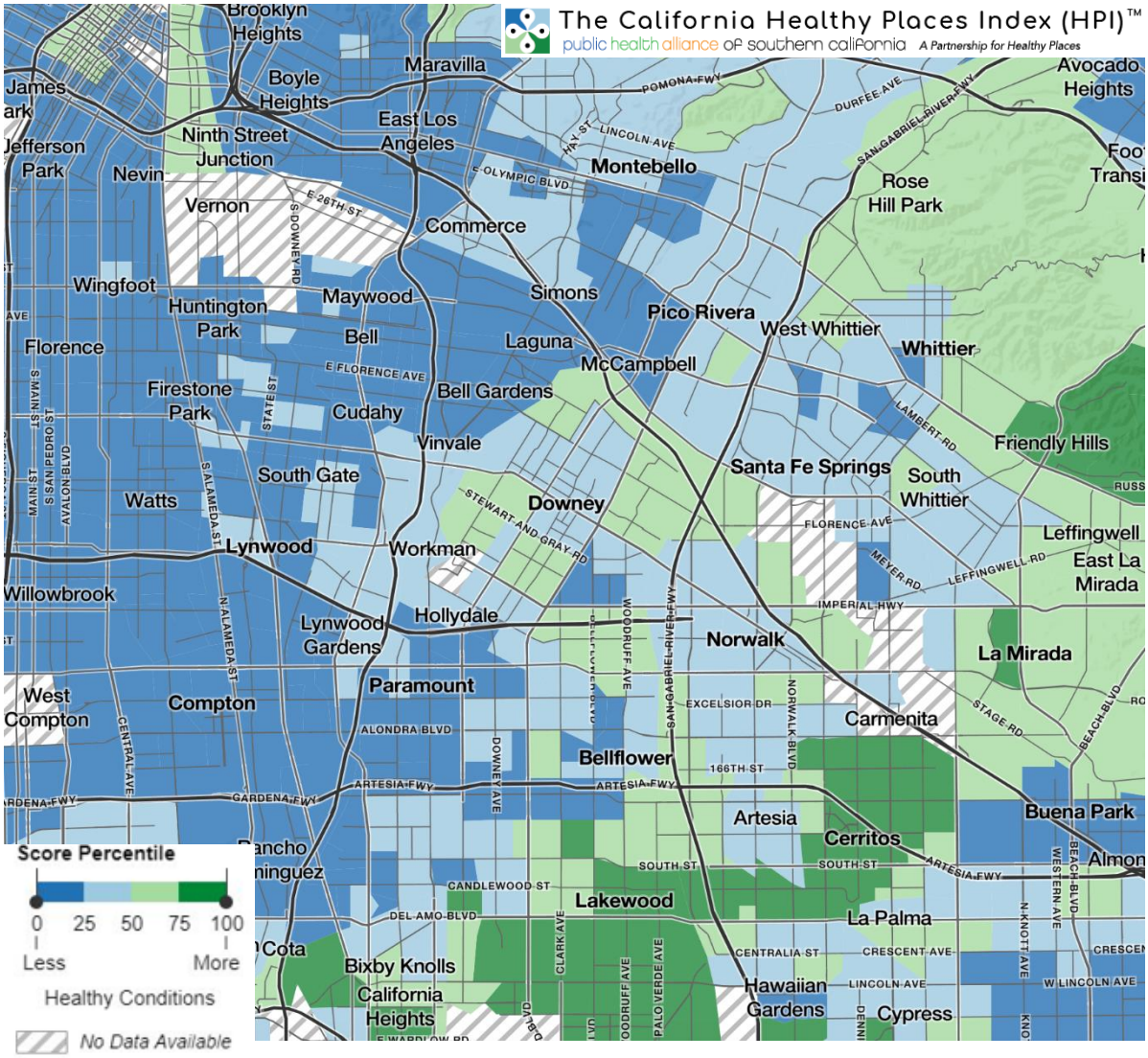
The opportunity to live a long and healthy life is powerfully influenced by a wide range of social factors including economics, education, transportation, built environment, and access to care.[2] In aggregate, residents living in the **KFH-Downey service area** are in the **29th percentile** for health opportunity[3] among all California residents, with approximately **782,374** people living in severely under-resourced census tracts. In effect, this means that on average, seven out of ten Californians have a greater opportunity to live a long, healthy life in comparison to residents living in this service area.

iv. Severely under-resourced communities

Identifying disparities in the upstream factors that predict negative health outcomes is critical to Kaiser Permanente's community health mission. The map below displays the differences in opportunity for residents in the KFH-Downey service area to live a long and healthy life[1]. Areas in dark blue represent census tracts in the lowest quartile of health opportunity across California. These areas are severely under-resourced across multiple domains of the social predictors of health (e.g., economics, education, transportation, built environment).

[1] American Community Survey (2012-2016).
[2] Please read more about the strong scientific evidence for these relationships here.
[3] As described by the California Healthy Places Index.

Figure B – Under-Resourced Communities in KFH-Downey



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

III. Who was involved in the assessment?

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

KFH-Downey community benefit manager and other internal hospital staff helped to coordinate and observe community engagement activities. KFH-Downey collaborated with PIH Health Hospitals, St. Francis Medical Center and their consultant supporting their CHNA process, Biel Consulting, Inc. on the primary data collection. Additionally, other community partners contributed time and resources to assist with primary data collection by hosting focus groups and supporting participant recruitment:

- Interfaith Food Center, Santa Fe Springs
- Kaiser Permanente Watts Counseling and Learning Center

- Compton YouthBuild
- Los Angeles County Service Area 7 - Health Action Lab Coalitions

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

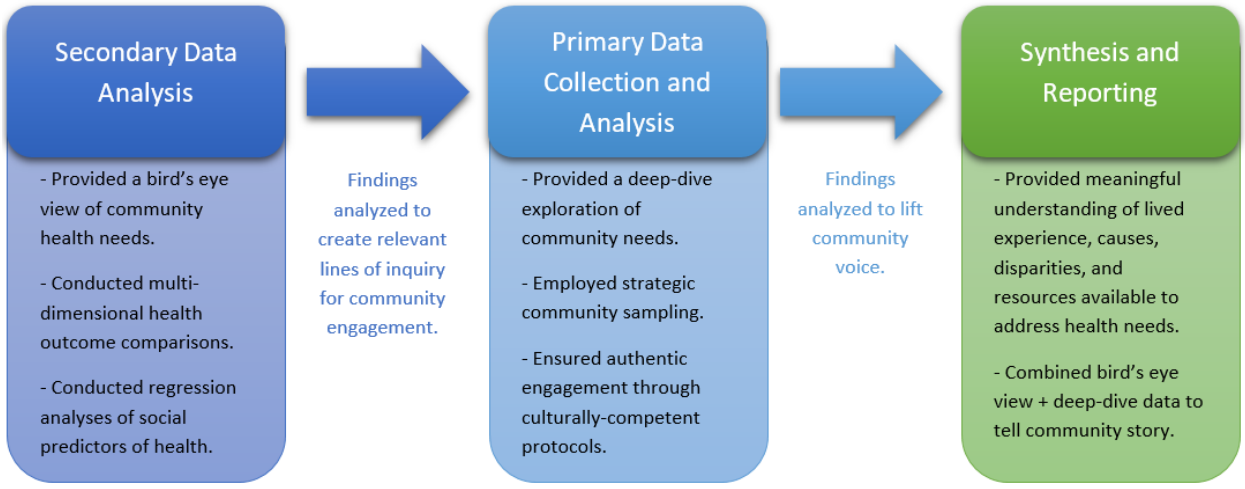
A-Cubed Consulting, Inc. (A3) was contracted to conduct the CHNA for KFH-Downey. A3 believes in taking a participatory and use-focused approach to evaluation. Those doing the work should be involved in telling the story. A3 believes that the components of organizational development, research, and evaluation each play a pivotal role in the evaluation process. Ama Atiedu, CEO and Project Manager, has more than 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-Downey's CHNA include:

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

IV. Process and methods used to conduct the CHNA

KFH-Downey 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-Downey 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]).

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-Downey 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.

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

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

Table 2 – Social Factors Linked to Health Outcomes

	More Poor Mental Health Days	More Heart Attack ER Visits	Higher Asthma Prevalence	Higher Obesity Prevalence	Higher Diabetes Prevalence	Higher Stroke Prevalence	Higher Cancer Prevalence	Higher Percentage of Babies Born with Low Birth Weight	Higher Smoking Prevalence	More Pedestrian Injuries	Number of Outcomes Affected
Lower Income	X		X	X	X	X		X	X	X	8
More Racial Segregation	X		X	X	X	X		X	X	X	8
More Crowded Housing	X		X	X	X				X	X	6
Fewer Bachelor’s Degrees	X	X		X		X					4
More Homeownership					X	X	X				3
Less Employment			X			X			X		3
Fewer Two Parent Households		X								X	2
More Insurance							X				1
More Bachelor's Degrees							X				1
Less Crowded Housing							X				1
Less Park Access		X									1
Worse Air Quality								X			1
Less Homeownership			X								1

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

The following table ranks health needs based on several principle values: The prevalence of the health outcome compared to the California state average, the impact of the health outcome on length and quality of life, the disparity of disease prevalence across racial/ethnic groups, and the alignment with county rankings of top causes of mortality.[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
Obesity	34.9%	5.3% (Worse than CA)	37% Reduction	26% 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
Asthma	13.5%	-1.3% (Better than CA)	13.3% Reduction	66% Worse than Average	No
Diabetes*	11.9%	3.5% (Worse than CA)	24.1% Reduction	8% Worse than Average	No
Maternal/Infant Health	7.1%	0.3% (Worse than CA)	17.9% Reduction	32% Worse than Average	No
Substance/Tobacco Use	4.0%	-3.04% (Better than CA)	69.7% Reduction	48% Worse than Average	No
Cancer*	2.7%	-0.64% (Better than CA)	51% Reduction	32% Worse than Average	Yes
CVD*	4.4%	-2.55% (Better than CA)	30% Reduction	30% Worse than Average	Yes
Oral Health	11.6%	0.3% (Worse than CA)	2.8% Reduction	17% Worse than Average	No
Violence/Injury	0.0%	-0.01% (Better than CA)	13.2% Reduction	30% Worse than Average	No

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

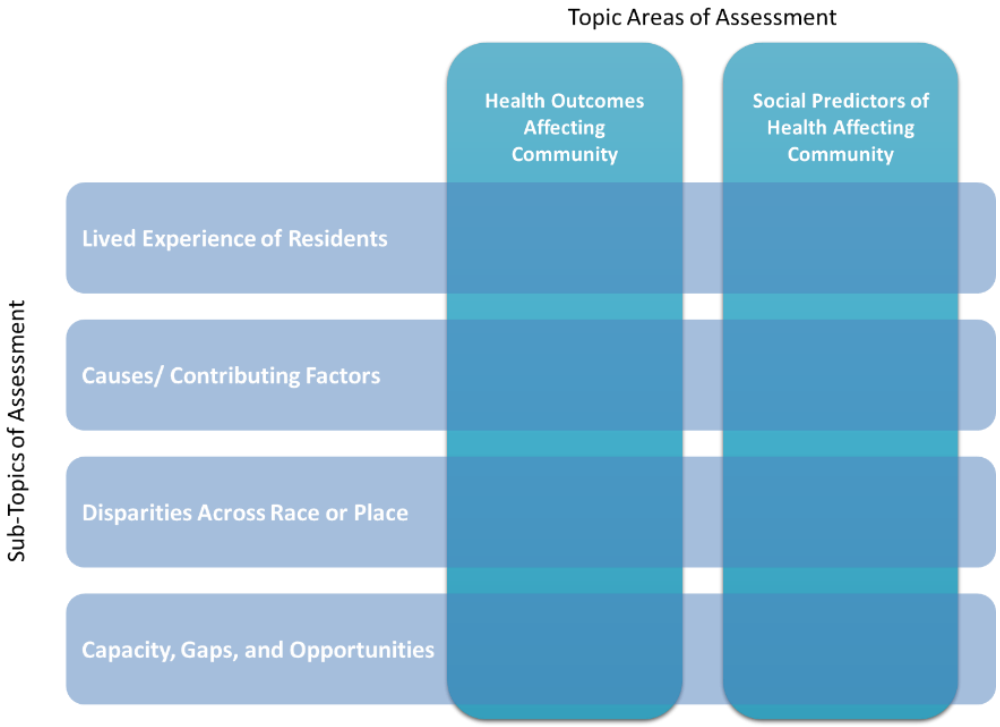
B. Community input

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. When thinking about mental health, what is the most pressing concern (e.g., access, specific mental health issues, and stigma) for the school age population?
    a. What factors contribute to these issues?
2. What barriers exist to accessing mental health care/services?
3. How do inequalities and disparities affect the community's access to health care? (not insured as well underinsured)
    a. How is this experienced by the community?
4. What are the barriers to accessing health care (e.g., education, navigating the health care system, access to specialty care)?
5. How are immigration laws impacting the communities' willingness to access resources they may need (e.g., health care, food assistance)? How do you address those fears?
6. How does economic insecurity impact the daily lives of low-income community members, and what factors contribute to economic insecurity?
7. How do the low graduation rates impact individuals' ability to achieve economic security in the community? (Are community members able to get a job, what channels exist for those who don't have a high school diploma?)
8. What factors contribute to food insecurity?
9. What external assets, capacities and resources are available to address the issue of food insecurity?
10. What factors are impacting high school completion rates in communities where the graduation rate is below the county average?
11. To what extent is education attainment a priority where graduation rates lower than the county average?
    a. What other needs/issues take priority?
    b. What additional support do families need to help their students?
12. What work is being done in the community to address homelessness and what opportunities exist to partner with large anchor institutions and other community organizations?

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-Downey 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-Downey). 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 (82%) represented the community service providers. 18% represented community residents (adult and youth), including Spanish speaking residents. Additionally, engagements were conducted in five cities within the KFH-Downey 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-Downey 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

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

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

These strategic lines of questioning helped guide primary data collection, where input was gathered from persons serving or residing in the KFH-Downey 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-Downey and its community partners were positioned to meaningfully act on the need and could align resources to make feasible impact. Those health needs that were rated as having sufficient organizational and community readiness for response were advanced through the prioritization process.

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

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

- Access to Care
- Education and Employment
- Food Security
- Housing and Homelessness
- 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, and social health and overall quality of life. This issue of access is comprised of many factors, including but not limited to affordability, treatment by health care professionals, ability to navigate the system, and availability of services. Indicators such as rates of uninsured and utilization of various types of care help to gage accessibility of health care within communities. In the KFH-Downey service area, racial/ethnic disparities among the uninsured population greatly impact people of color, particularly Native American/Alaskan Native and Hispanic/Latino residents. Community input sessions shed light on growing concerns and fears of accessing care due to immigration laws.

Education and Employment. Education and employment are interrelated and together impact one's socioeconomic status. A growing body of evidence demonstrates the advantages afforded those with more education and better employment, such as more resources to support healthy habits, reduced stress, stronger social and psychological skills, and larger social networks.[6] Conversely, individuals with less education and employment are more likely to have less access to food, health care, and other community resources. They also have fewer choices when it comes to their environment, often not being able to choose safer neighborhoods or neighborhoods with less exposure to environmental toxins. Using high school graduation rates as an indicator, KFH-Downey service area experiences higher rates of individuals with no high school diploma, as compared to regional and state rates (33.6% vs. 19.6 and 17.9, respectively). These findings were underscored by themes from community input sessions, highlighting challenges community residents face to graduate high school and find employment.

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

Food Security. Food is an integral part of one's health, as research has demonstrated the link between health and diet. Low income communities struggle with having enough to eat as well as accessing healthy food options. Research has shown that individuals experiencing food insecurity, or those not able to afford enough to eat, have increased risk for obesity and higher rates of chronic disease. In the KFH-Downey service area, SPA 6 and 7 have the second highest rates of food insecurity in southern California (CHIS 2015). During community input sessions participants highlighted barrier to accessing food resources, including fear of deportation.

Housing and Homelessness. The cost of housing continues to be a large financial burden particularly for low income families. In Los Angeles County, it has been estimated that renters need to earn $46.15 per hour to afford the median monthly rent. This is more than four 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.[7] In the KFH-Downey service area, the rates of homelessness continue to increase, with African American and Hispanics/Latinos experiencing higher rates of homelessness. These disparities were also highlighted during community input sessions.

Mental Health. Poor mental health is a leading cause of disability in many developed countries, greatly impacting 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-Downey service area residents experience 3.7 poor mental health days per month, similar to state and regional averages of 3.65 and 3.69. Community input participants shared stories about high rates of violence and social inequities in the community and the impact on mental health.

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

The service area for KFH-Downey 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-Downey 2016 Implementation Strategy evaluation of impact

A. Purpose of 2016 Implementation Strategy evaluation of impact

KFH-Downey'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-Downey'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

[7] 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-Downey-IS-Report.pdf. For reference, the list below includes the 2016 CHNA health needs that were prioritized to be addressed by KFH-Downey in the 2016 Implementation Strategy Report.

1. Access to Care
2. Obesity/HEAL/Diabetes
3. Mental and Behavioral Health
4. Community Safety/Violence Prevention
5. Sexually Transmitted Infections (STI)

KFH-Downey 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-Downey 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-Downey 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-Downey will continue to monitor impact for strategies implemented in 2019.

B. 2016 Implementation Strategy evaluation of impact overview

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

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

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

Grantmaking: For 70 years, Kaiser Permanente has shown its commitment to improving community health through a variety of grants for charitable and community-based organizations. Successful grant applicants fit within funding priorities with work that examines social predictors of health and/or addresses the elimination of health disparities and inequities. From 2017-2018, KFH-Downey paid 91 grants amounting to a total of $5,588,394 in service of 2016 health needs. Additionally, KFH-Downey has funded significant contributions to California Community Foundation in the interest of funding effective long-term, strategic community benefit initiatives within KFH-Downey. During 2017-2018, a portion of money managed by this foundation was used to pay 27 grants totaling $4,196,389 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-Downey leveraged significant organizational assets in service of 2016 Implementation Strategies and health needs. See table below for illustrative examples.

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

Need	Summary of impact	Examples of most impactful efforts
Access to Care	*During 2017 and 2018, Kaiser Permanente paid 19 grants, totaling $1,285,652 addressing the priority health need in the KFH-Downey service area. In addition, a portion of money managed by a donor advised fund at California Community Foundation was used to pay 10 grants, totaling $1,656,667 that address this need.*	**Providing Affordable Healthcare** In 2018, KFH-Downey provided $27,051,934 in medical care services to 41,075 Medi-Cal recipients (both health plan members and non-members) and $8,059,832 in medical financial assistance (MFA) for 8,002 beneficiaries.
		Building Primary Care Capacity The California Primary Care Association (CPCA) provides education, training, and advocacy to their member community health centers to best serve their low-income, underserved, and diverse patients. In 2018, Kaiser Permanente paid $126,666 to CPCA to: • Hold statewide convenings and conferences and topic-specific peer networks to support over 1,200 California community health centers. • Provide 90 in-person and web-based trainings to over 4,400 attendees and 2,890 individual instances of technical assistance.
		Improving Patient and Provider Experience St. John's Well Child and Family Center is an independent community health center. They serve patients of all ages through a network of Federally Qualified Health Centers and school-based clinics. In 2018, Kaiser Permanente paid $50,000 to St. John's Well Child and Family Center to: • Hire a bilingual Patient Navigator who provided patient portal enrollment and instruction to 5,825 adult patients; assisted 2,952 patients with completing a pre-medical visit survey; and referred 1,780 patients to supportive services, including health education classes, case management, benefit enrollment, mental health and dental care.
		Collaborating Around Homelessness Connecting the Dots Homelessness Coalition links internal Kaiser Permanente operational leaders to community-based resources that can help meet the needs of homeless individuals. Over two years (2017-2018), KFH-Downey leadership organized the Connecting the Dots Coalition through a series of eleven community conversations aimed at identifying gaps in community resources for homeless

Need	Summary of impact	Examples of most impactful efforts
		individuals and working together to find better ways to connect individuals with housing support programs and clinical care.
		Preserving and Expanding California Coverage Gains Insure the Uninsured Project (ITUP) works to preserve and expand access to health care and coverage in California and to reduce access barriers for uninsured and underinsured populations. Over two years (2017-2018), Kaiser Permanente paid $150,000 to ITUP to: • Conduct and disseminate health policy research. • Convene 13 regional statewide work groups. • Provide technical assistance to safety net providers and other stakeholders navigating health reform challenges. • Serve as a bridge between health policy and the health care sector to reach 19 million Californians.
Healthy Eating Active Living	*During 2017 and 2018, Kaiser Permanente paid 39 grants, totaling $2,715,242 addressing the priority health need in the KFH-Downey service area. In addition, a portion of money managed by a donor advised fund at California Community Foundation was used to pay 13 grants, totaling $2,254,722 that address this need.* *Additionally, we are leveraging all of our organizational assets in Downey to address this need.*	**Addressing Health Needs** Watts Healthcare Corporation is a Federally Qualified Health Center dedicated to serving the underinsured and uninsured community surrounding Watts. Over two years (2017-2018), Kaiser Permanente paid $25,000 to Watts Healthcare Corporation to: • Address the complex needs of the clinic's diabetic patients. • Identify patients with high Hemoglobin A1C (more than 9) and provided education, exercise, peer support, and nutrition counseling. • Hire a full-time diabetes project coordinator and began implementation of the group visit model for their patients.
		Advocating for Maternal, Infant, and Child Health The California WIC Association (CWA) supports efforts to increase local WIC agencies' capacity, increase state and federal decision makers' understanding of WIC services, and increase the capacity of community health centers to build a breastfeeding continuum of care in low-income communities. Over two years (2017-2018), Kaiser Permanente paid $100,000 to CWA to: • Pilot two video conferencing projects increasing awareness and consideration within the CA WIC community. • Collaborate with health centers to share WIC staff for nutrition and breastfeeding counseling (Watts Health Care and clinics in San Diego). • Work to strengthen ties with CPCA and present at CPCA's annual conference. • Visit all CA legislators with 44 appointments and drop-in visits. • Provide extensive information to legislators on nutrition and breastfeeding counseling, food benefits, local economic impacts to grocers, health outcomes, access to Farmers markets, and updates on immigration threats. • Participate in Capitol WIC Education Day in Sacramento with 50 attendees from 30 WIC agencies from all over the state.

Need	Summary of impact	Examples of most impactful efforts
		Fighting Food Insecurity California Association of Food Banks' (CAFB) Farm to Family program's goal is to improve health food access by providing fresh produce to food banks, CalFresh outreach and enrollment, advocacy to support anti-hunger policies, and technical assistance to members. In 2018, Kaiser Permanente paid $95,000 to CAFB to: • Distribute 250,000 pounds of subsidized fresh fruits and vegetables to 11 member food banks. • Maintain the State Emergency Food Assistance Program to provide food and funding of emergency food to food banks.
		Collaborating Around Food Insecurity The Los Angeles Service Planning Area (SPA) 7 Food Security Coalition is focused on addressing food insecurity and increasing access to healthy foods in the communities of Bellflower, Downey, Norwalk, Whittier, Santa Fe Springs, Los Nietos and Walnut Park. The food security coalition is committed to addressing food insecurity within SPA 7 by utilizing best practices, such as increasing CalFresh enrollment and the promotion and utilization of the Free Summer Meal program. The summer meal program was promoted within Kaiser Permanente Downey Medical Center pediatric departments, and in 2018, 45 individuals representing 15 local agencies attended CalFresh enrollment training to help build enrollment capacity in the community.
		Promoting Food Recovery and Redistribution Kaiser Permanente envisions foodservices not only as the source of nutritious meals for their patients, staff and guests, but as a resource for local communities. Over two years (2017-2018), Kaiser Permanente partnered with Food Finders to: • Recover 29,309 pounds of food and distribute to nonprofit organizations serving individuals in the KFH-Downey region who face food insecurity.
Mental and Behavioral Health	*During 2017 and 2018, Kaiser Permanente paid 21 grants, totaling $1,060,500 addressing the priority health need in the KFH-Downey 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.*	**Providing Mental Health Programs for Students, Families, and Teachers** Community Family Guidance Center (CFGC) aims to support the success of children and families by reducing the impact of childhood trauma and abuse, encouraging the development of positive social and emotional skills, and strengthening healthy family relationships. In 2018, Kaiser Permanente paid $50,000 to CFGC to: • Establish a presence at LAUSD schools in the cities of Cudahy and Bell. Corona Elementary school in Bell and Jaime Escalante Elementary school in Cudahy benefited from the presence of CFGC clinicians on campus. • Offer Triple P, an evidence-based parenting program, for families, conduct trainings for teachers and staff on stress, self-care and mindfulness, and work with administration, school counselors and Department of Child & Family Services social workers to coordinate mental health services for students in need.

Need	Summary of impact	Examples of most impactful efforts
		Building Community Capacity to Address Mental Health Charles Drew University of Medicine and Science in partnership with the California Black Women's Health Project and the Black Beauty Shop Health Foundation works to reduce mental health stigma and improve resilience for black women living in SPA 6 through their Mindful Beauty program. The program consists of a seven week culturally competent educational program designed to build community capacity and social support systems. In 2018, Kaiser Permanente paid the university $40,000 to: • Train stylists about depression and resources for mental health care services. • Prepare stylists to recommend available mental health care services to their clients and act as mediators to help increase the behavioral intention of their clients to seek mental health care treatment.
		Strengthening Mental Health Policies and Practices in Schools Children Now educates policymakers, school district leaders, and other key stakeholders about best practices and policy solutions to address suspension and expulsion policies that disproportionately impact students of color, improve school climate, and increase students' access to mental health services. Over two years (2017-2018), Kaiser Permanente paid $150,000 to Children Now to: • Inform over 200 key legislators and stakeholders. • Support the California Department of Education in the development of the Whole Child Resource Map. • Lead committees for both the State School Attendance Review Board and the Superintendent's Mental Health Policy Workgroup.
		Collaboration Around Mental Health The Los Angeles County Service Area (SA) 7 Mental Health - Health Action Lab strives to understand the mental health needs of SA 7 communities and works collaboratively to address gaps in services. The Mental Health - Health Action Lab hosted a case management symposium in 2017 designed to create awareness among case managers of community resources and case management best practices. The symposium was held October 24, 2017 with 159 attendees representing case managers from area nonprofits. A member of the KFH-Downey community health department served on the planning committee, and Wendy M. DeVreugd, RN, Assistant Medical Center Administrator of Operations and Continuing Care was the keynote speaker at the event.
Violence Prevention	*During 2017 and 2018, Kaiser Permanente paid 8 grants, totaling $200,000 addressing the priority health need in the KFH-Downey service area. In addition, a portion of money managed by a donor advised*	**Mentoring Opportunities for Underserved Populations** Elevate Your Game provides one-on-one and small group mentoring and internships for underserved urban students to lift up their grades, attendance, and maturity to empower them to be leaders. Over two years (2017-2018), Kaiser Permanente paid $70,000 to Elevate your Game to: • Mentor over 400 students.

Need	Summary of impact	Examples of most impactful efforts
	fund at California Community Foundation was used to pay 1 grant, totaling $45,000 that addresses this need.	• Mobilize other organizations to mentor over 1,047 youth during the two-year period. **Building Life Skills for Students** Urban Compass provides students opportunities to visit local colleges, including Loyola Marymount University, West Los Angeles College and Pasadena City College In 2018, Kaiser Permanente paid Urban Compass $50,000 to: • Provide Saturday workshops which focused on leadership, life skills, college planning, understanding A-G requirements, social emotional wellbeing and career exploration.
		Providing Safe Environments for At-Risk Youth: The GRYD Foundation holds Summer Night Lights (SNL) programming to provide extended recreational, athletic, artistic, and health and wellness programming and linkages to community resources throughout the City of Los Angeles. Over two years (2017-2018), Kaiser Permanente paid $90,000 to SNL to: • Support case management services to 86 at risk-youth. • Serve 434,644 total meals across 32 sites with a variety of healthy choices. • Provide Zumba, Play Rugby, Go Stadia Go, Dance, and Yoga for 9,385 community members. • Engage 695,430 community members across all SNL sites.
Sexually Transmitted Infections (STIs)	*During 2017 and 2018, Kaiser Permanente paid 4 grants, totaling $327,000 addressing the priority health need in the KFH-Downey service area.*	**Supporting STI Prevention** South Central Family Health Center is a Federally Qualified Health Center that provides comprehensive health services in the historically underserved and uninsured population of South Los Angeles. In 2017, Kaiser Permanente paid $17,000 to South Central Family Health Center to: • reduce infection rates, improve screening rates, and increase awareness about sexually transmitted infections in Huntington Park and Cudahy for youth age 13-24 years. Part of the approach was to hire and train youth to serve as peer health educators at Elizabeth Learning Center and Linda Marquez High School. The curriculum focuses on STI prevention and abstinence. The youth worked in their school environment to raise STI awareness among peers. **Youth Training on STI Prevention** Black Women for Wellness is committed to the health and well-being of black women and girls through health education, empowerment and advocacy. In 2017, Kaiser Permanente paid $20,000 to Black Women for Wellness to: • Provide technical training to ten youth, who became sexual health peer educators in south Los Angeles. These youth educators facilitated comprehensive sexual health presentations to 526 youth over the course of the grant period. • Conduct weekly sexual health workshops reaching 290 students at Locke High School in Watts and participated in four

Need	Summary of impact	Examples of most impactful efforts
		community health fairs reaching over 650 individuals with youth-centric messages about sexually transmitted infection prevention education.

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
2.	California Department of Public Health	2016
3.	California Healthy Places Index	2018
4.	California HIV Surveillance Report	2015
5.	Office of Environmental Health Hazard Assessment	2011-2013
6.	Los Angeles County Department of Public Health	2015
7.	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	*Key Informant Interview*	*Public Health Nurse, Los Angeles County Department of Public Health*	*1*	*Health department*	*Leader*	*10/18/18*
2	*Key Informant Interview*	*Division of Community Engagement Assistant Director, Charles Drew University*	*1*	*Minority* *Low income*	*Leader*	*10/19/18*
3	*Key Informant Interview*	*Executive Director, Elevate your Game*	*1*	*Minority* *Low income*	*Leader*	*10/19/18*
4	*Key Informant Interview*	*Outreach Manager, WIC*	*1*	*Low income*	*Leader*	*10/30/18*
5	*Focus Group*	*Food Security Coalition, Health Action Lab*	*11*	*Low income*	*Leader*	*11/2/18*
6	*Focus Group*	*Chronic Disease Prevention Coalition, Health Action Lab*	*14*	*Medically underserved*	*Leader*	*11/6/18*
7	*Focus Group*	*Mental Health and Substance Use Coalition, Health Action Lab*	*12*	*Medically underserved*	*Leader*	*11/6/18*
8	*Focus Group*	*Staff, Interfaith Food Center*	*5*	*Low income*	*Leader*	*11/13/18*
9	*Focus Group*	*Staff, Kingdom Causes*	*6*	*Medically underserved*	*Leader*	*11/10/18*
10	*Focus Group*	*Staff, Watts Counseling and Learning Center*	*6*	*Medically underserved*	*Leader*	*12/5/18*
11	*Focus Group*	*Staff from local organizations, Connect the Dots Coalition*	*21*	*Medically underserved*	*Leader*	*1/24/19*
12	*Online Survey*	*Multiple stakeholders, Core Learning Question Survey*	*12*	*Medically underserved* *Low income*	*Leader*	*1/25 - 2/9/19*
Community residents						
13	*Focus Group*	Clients, Watts Counseling and Learning Center	*6*	*Minority* *Medically underserved* *Low income*	*Representative member*	11/13/18
14	*Focus Group*	Spanish-speaking Clients, Interfaith Food Center	*4*	*Minority* *Low income*	*Representative member*	*11/28/18*
15	*Focus Group*	*Youth, Compton YouthBuild*	*10*	*Minority* *Low income*	*Representative member*	*12/5/18*

Appendix C. Health Need Profiles

Health Outcome

Access to Care

Focus groups, one on one conversations, and online surveys with community residents and public health professionals provided insight into the issues and solutions to address access to care.

Community Voices: Raising Issues and Offering Solutions

ISSUES

Low literacy and education make navigating health care difficult

"I think that lack of cultural humility on the part of the healthcare system, being herded, or the limited health literacy of residents understanding their health, or even prioritizing health [are barriers to accessing care]." -Community leader

Long wait lists detour people from accessing health care

"We do offer free services, counseling, we don't have domestic violence and anger management classes. But then we also have a long wait list because we offer free services."

-Service provider

Misinformation about immigration laws causes fear

"I think a challenge that wasn't as prevalent last time the assessment happened was the fear of deportation. I don't know if you'll be as successful this time going around at gathering information from that population." -Service provider

Emergency room as primary care

"Well I think one of the things that we've seen in Downey is using the emergency room at the hospitals as their day-to-day medical provider. It would be better if they went to a clinic."

-Service provider

SOLUTIONS

More patient navigation

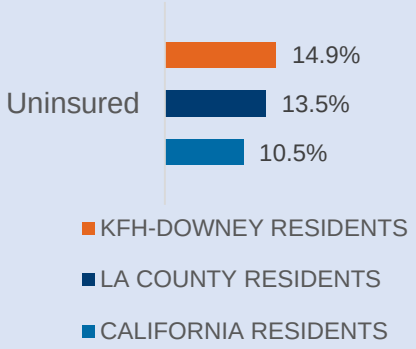
"Maybe a patient navigator, a case manager, a social worker, a therapist can be that point of contact to help [patients]. I think hospitals can provide that." -Service provider

Increase access to care through technology

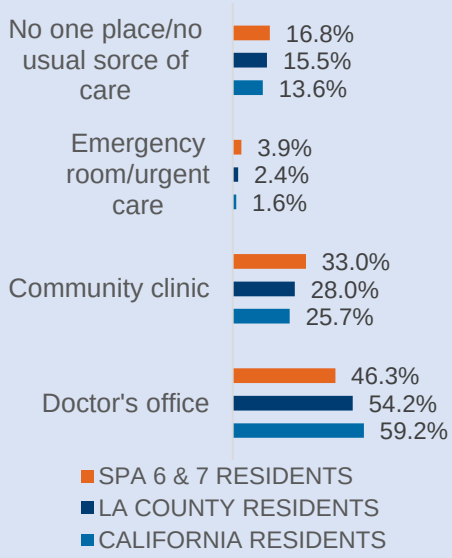
"A unique opportunity would be to maybe deploy e-resources so you don't have to go to a doctor's office now for you to be seen. It could be on your phone or on your computer."

-Service provider

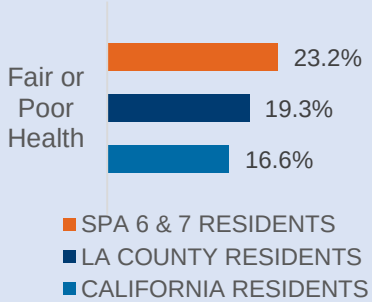
No Health Insurance[1]



Where People Go for Care[2]



Communities Perception of Health Status[2]



Barriers to accessing care

There are a variety of reasons why people may not access care. Participants in the community input sessions highlighted the following barriers:

Lack of Transportation

Education and Literacy

Fear of Deportation

Disparities in access to care

Health insurance status serves as an indicator that helps to paint a picture of the accessibility of care among various groups. Within the KFH – Downey service area, Hispanic and Latinos, households with income less than 100% of the federal poverty level, unemployed adults, and those with no high school diploma are more likely to be uninsured. Cost is the number one reason for lack of health insurance reported by residents in SPA 6 and 7[2].

Disparities in Uninsured Rates among Vulnerable Populations in KFH-Downey Service Area[3]

35%	of those unemployed are uninsured.
25%	of those with less than a HS diploma are uninsured.
17%	of those under the federal poverty level are uninsured.
16%	identifying as Hispanic / Latino are uninsured.

What work is underway within Kaiser Permanente to address access to care needs?

Kaiser Permanente is working to address the access to care needs of the community at a national, regional, and local level.

- Medical Financial Assistance Program
- Community Benefit grants to local Federally Qualified Health Centers (FQHC)
- Grants and technical assistance to county level clinic associations (ex. Community Clinic Association of Los Angeles County)

Who are potential partners in the community?

KFH–Downey medical center partners with organizations to address access to care for the community.

- Lestonnac Free Clinic
- Family Health Care Centers of Greater Los Angeles
- Los Angeles Christian Health Centers

References:

1. *U.S. Census Bureau, American Community Survey, 2013 – 2017*
2. *California Health Interview Survey, 2017. http://ask.chis.ucla.edu*
3. *U.S. Census Bureau, American Community Survey, 2012 - 2016*

Social Predictor of Health

Education & Employment

Focus groups, one-on-one conversations, and online surveys with community residents and public health professionals provided insights into the lived experiences and impact of education and employment on the community.

Community Voices: Raising Issues and Offering Solutions

ISSUES

Lack of parent engagement

"Unfortunately, there's not a whole lot of involvement. It seems like the older the kids get, the less the parents are involved. That's what I've observed." –Service provider

The employed still struggle

"The first story that comes to mind is a mom who lives in Nickerson Gardens [housing development]. She had a full-time job. She had five kids. She worked at a factory. She didn't have a car…Even with a full-time job and kids, she couldn't provide food and just basic needs. She talked about how she reflected on those challenges. She had to pay transportation, pay for food, pay for rent, and so much. She couldn't make ends meet." -Community leader

Social inequities impact educational attainment and employment

"Watts has the lowest life expectancy in the city of L.A. How is it that we're a 2.12 square mile neighborhood with the most dense low income housing? There's four developments in the neighborhood. Whoever planned or designed the area already set it up to be really high poverty. The policies that have designed that created the neighborhood. Then the symptoms and the outcomes of that poor public policy are poverty, limited proficiency, low educational attainment." -Community leader

SOLUTIONS

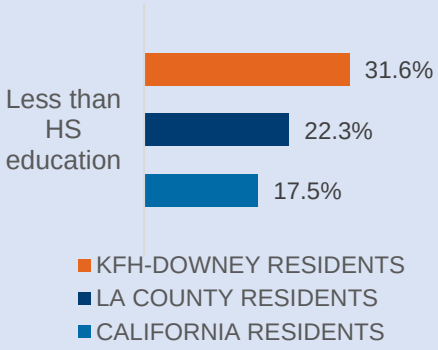
Positive adult interactions at school

"Many of them are not motivated academically, are coming in with very little support from anywhere, and our organization provides this. Mentors supply that support." -Service provider

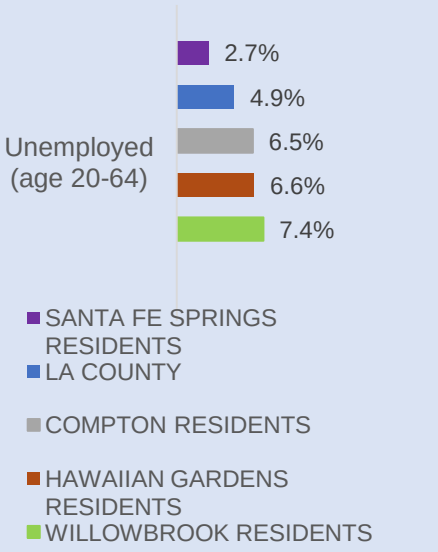
More job training and career development

"That never happens in a traditional school…it's like a monthly thing [job fairs]…another thing about being here [non traditional high school]…we have a person here that helps you build your resume and gets you work-ready." -Local student

High School Graduation Rates[1]



Unemployment Rates[2]

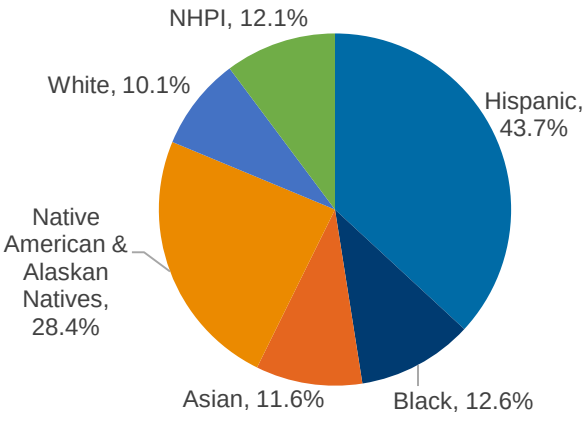


Department of Labor [who report unemployment rates] doesn't include formerly incarcerated or long term unemployed…. two populations who are already a large representation of who lives in the area."
-Community leader

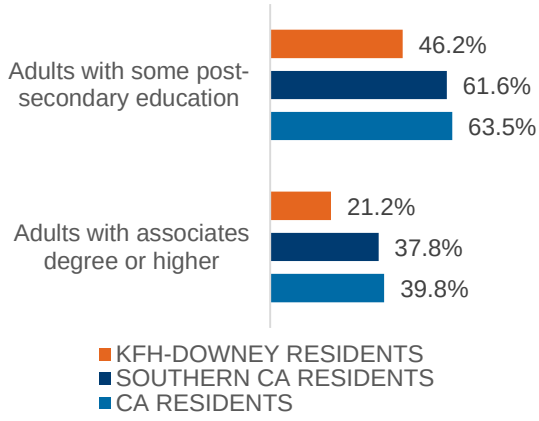
Disparities in education

Within the **KFH-Downey service area**, **racial/ethnic and geographic disparities** exist for educational attainment and unemployment**. Hispanic adults** are **more likely** to have **not graduated from high school.** Additionally**, KFH-Downey service area residents** are **less likely** to obtain **post secondary degrees** when compared to their **regional and state counterparts**.

Adults with No High School Diploma[3]



Adults with More than High School Diploma[3]



Health impacts of education and employment

In the **KFH–Downey service area**, **fewer Bachelor's degrees and unemployment** are linked to many poor health outcomes including:

- Poor mental health days
- Stroke
- Obesity
- Heart attack emergency room visits
- Asthma
- Smoking

What work is underway within Kaiser Permanente to address education and employment?

Kaiser Permanente is working to address the education and employment needs of the community at a national, regional, and local level.

- Thriving Schools Initiative
- Kaiser Permanente Summer Youth Employment Program
- Southern California Permanente Medical Group - Hippocrates Circle Program

Who are potential partners in the community?

KFH–Downey Medical Center partners with organizations to address education and employment services for the community.

- Partnership with social enterprise organizations such as Good Soil and Black Coffee
- Compton Youth Build
- Area school districts

References:

1. *U.S. Census Bureau, American Community Survey, 2013 – 2017*
2. *California Employment Development Department, Labor Market Information, Jan 2019. www.labormarketinfo.edd.ca.gov/cgi/dataanalysis/AreaSelection.asp?tableName=labforce*
3. *U.S. Census Bureau, American Community Survey, 2012 - 2016*

Social Predictor of Health

Food Security

Focus groups, one-on-one conversations, and online surveys with community residents and public health professionals provided insights into the lived experiences and impact of food insecurity on the community.

Community Voices: Raising Issues and Offering Solutions

ISSUES

Fixed income, and low or lost wages

"I've been working with several food banks, and what you see is a lot of the elderly participating in those programs because their income is so limited that they're not able to get by just with the income they might be getting from Social Security."

-Service provider

Lack of affordable housing

"I think our families a lot of times, like 30 or 40 percent [of their income] is just going towards housing just trying to cover and sustain a roof over their heads. So they're struggling, not only are they dealing with food insecurity, but they're also struggling financially." –Service provider

Fear of deportation

"Just to give you an example, we have an employee who is a second generation US citizen. Her mom is a US citizen. She married an immigrant…has two kids…works part-time with us, so she was able to participate, qualifying for WIC and qualifying for CalFresh. She was just so afraid preparing for the final interview for her husband to become a permanent legal resident that she terminated all the programs, because of all the things that she was hearing." –WIC staff

Poor nutrition

"So then people also tend to struggle with getting the proper nutrition when they have food insecurity. And then that leads to medical conditions and conditions like diabetes and high blood pressure." -Service provider

SOLUTIONS

Food recycling programs

"I think right now, there's push for food recycling, county-wide or state-wide. I think everyone's on board as they need to deal with their surplus. So that's a big help." -Service provider

Federal food assistance programs

"CalFresh program has the Farmers Market Match Program that allows them [participants] to get healthy food at a Farmers' Market and they'll match, they'll add money towards ... you could double your money used at the Farmers' Market, sort of." -Service provider

Food Insecurity[1]

42%

of households in SPA 6 & 7 are not able to afford enough to eat.

Food Stamps[2]

33%

of households in SPA 6 & 7 receive Food Stamps, government issued assistance exchangeable for food.

WIC[1]

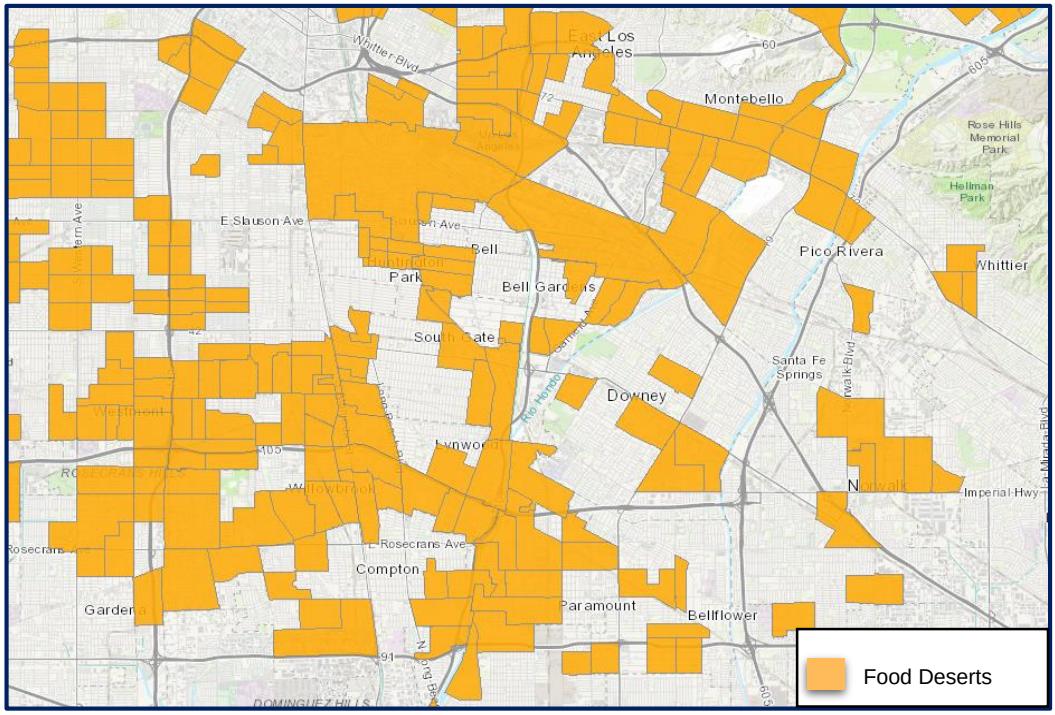
29%

of households in SPA 6 & 7 receive WIC benefits, federal food assistance for pregnant or breastfeeding women and children under the age of 5.

Note: The stats above reflects figures for individuals/families with incomes < 200% of FPL, which equates to $51,000 for a family of four

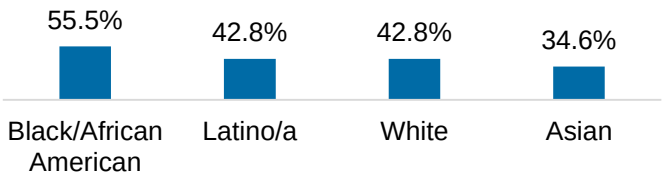
Disparities in food insecurity

In the KFH-Downey service area, the populations most effected by food insecurity are those in under-resourced communities and African American residents.



As shown in the map[3], under-resourced communities in KFH-Downey service area like **Huntington Park, Lynwood, Paramount, South Gate, and Willowbrook** have more areas that are classified as food deserts (orange), areas with limited access to affordable and nutritious foods.

Racial/Ethnic Disparities among Food Insecurity Residents in KFH-Downey Service Area (with household income <200% FPL)[4]



Health impacts of food insecurity

Food insecurity is linked to the following poor health outcomes[5]:

- Diabetes
- Heart disease
- Obesity
- High blood pressure

What work is underway within Kaiser Permanente to address food insecurity?

Kaiser Permanente is working to address the food insecurity needs of the community at a national, regional, and local level.

- Food security screening at well child visits
- Food recovery efforts managed by hospital Food and Nutrition services
- City Health Initiative (CityHealth)
- Food Security Coalition of SPA 7

Who are potential partners in the community?

KFH–Downey Medical Center partners with organizations addressing food insecurity in the community.

- Interfaith Food Center
- PHFE –WIC Program
- Food Help Food Bank in Downey
- Food Finders

References

1. California Health Interview Survey, 2017. http://ask.chis.ucla.edu
2. California Health Interview Survey, 2016. http://ask.chis.ucla.edu
3. USDA Economic Research Services, ESRI. (2015).
4. The California Health Interview Survey. (2013-2017). Retrieved from: askchis.ucla.edu Note: Some groups are excluded because there was not enough data to produce statistically stable estimates.
5. LA Health - Food Insecurity in Los Angeles published by County of Los Angeles Public Health. (2017).

Social Predictor of Health

Housing & Homelessness

Focus groups, one-on-one conversations, and online surveys with community residents and public health professionals provided insights into the lived experiences and impact of housing insecurity on the community.

Community Voices: Raising Issues and Offering Solutions

ISSUES

Slow pace of the housing process

"It is very challenging when you do start getting [clients] connected to resources in a non-emergency setting, just for physicals, labs, mental health appointments, and they're starting to do a little better. They start getting impatient on their housing. Then they start getting frustrated, and they're like, "I'm never going to get housed. The system doesn't care about me."
-Service provider

Challenges housing homelessness individuals

"Sometimes it feels like everything has to align properly because there's times where somebody says, "I'm ready to go. I'm ready to do this," and so they're here, but then there aren't any resources available." *-Service provider*

Nimbyism and stigma pose barriers

"It was already hard convincing landlords to work with Section 8 because there's such a bad stigma with what that is. If there's a bunch of people who are applying for it, why would you take Section 8, when you could just have somebody with a normal rental history?" *-Formerly homeless resident*

SOLUTIONS

More affordable housing

"If I'm homeless in Commerce, the odds are I'm a Commerce resident, so don't tell me I have to move to Huntington Park or South Gate. I want to stay in Commerce. That's another challenge, because our communities don't have affordable housing." *-Service provider*

Case management to help keep people housed

"We found when we are able to get somebody into permanent housing, the need for ongoing retention case management to follow up with them and to basically hand hold has been really critical." *-Service provider*

Education to address nimbyism

"The thing that is needed is a supportive community that interacts with the people who are homeless, who are really marginalized, who are use to people not willing to make eye contact with them or talk to them, or who continue to make them feel less than human." *–Parent of formerly homeless resident*

Affordable Housing

Median monthly rent in LA County[1]:

$2,400

Renters would need to make annually[1]:

$96,000

Mean annual income for KFH-Downey Service Area[2]:

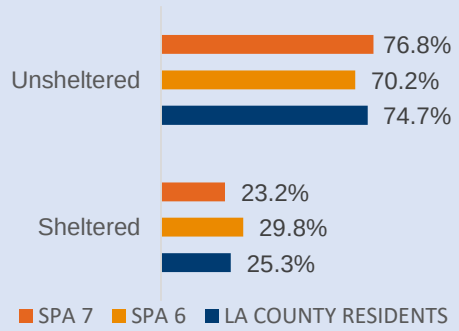
$70,370

Homelessness[3]

2018 Homeless Count

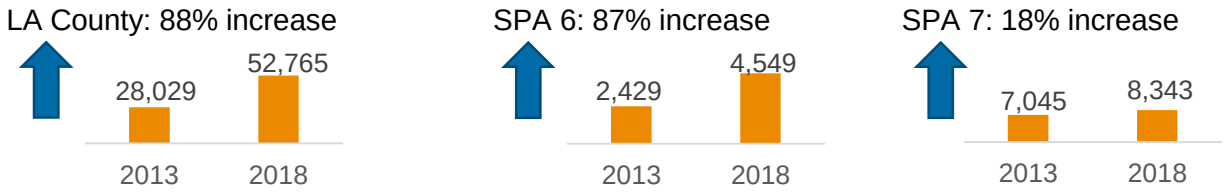
SPA 6	8,343 (16% of county's homeless)
SPA 7	4,569 (9% of county's homeless)
LA County	52,765

Shelter[3]



Trends in homelessness

Number of Adults Who are Homeless or Not Having Their Own Place to Live or Sleep in the Past Five Years[3]



Disparities in homelessness

Many vulnerable groups are impacted by homelessness. In the KFH-Downey service area, these include[3]:

92% SPA 6
70% SPA 7
are Latino/a and African American

17% SPA 6
19% SPA 7
have a serious mental illness

5% SPA 6
7% SPA 7
are veterans

12% SPA 6
12% SPA 7
have a physical disability

Portrait of homelessness

When asked to describe the type of individual experiencing homelessness that they encounter, service providers often describe a profile similar to the following:

"This is a gentleman, typically around age 50, Latino/Hispanic. Primary medical concern is untreated diabetes. He's single. There are often concerns with alcohol, major depression or some signs of different psychotic symptoms, oftentimes related and intermixed with mood disorders. He is ambulatory and is fully independent, can move around. No high school diploma, often around ninth grade level of education. Primary source of healthcare is the emergency room. He likely has MediCal, General Relief, and food stamps that are around about $196 a month. The community that he's established is in encampments with his other homeless neighbors. He is a resourceful person, but may have distrust of authority and other systems because of his experience with their lack of follow through." –Service Providers

What work is underway within Kaiser Permanente to address housing insecurity?

Kaiser Permanente is working to address housing insecurity in the community at a national, regional, and local level.

- Thriving Communities Fund
- Connecting the Dots Coalition
- Community Solutions' Built for Zero Initiative

Who are potential partners in the community?

KFH-Downey Medical Center partners with organizations providing housing or homeless services for the community.

- Our Place Housing Solutions
- Helpline Youth Counseling
- PATH
- Los Angeles County Department of Public Health
- St. Johns Well Child and Family Center
- Whittier First Day Shelter
- Cal Recup Care

References
1. Los Angeles County's Housing Emergency and Proposed Solutions published by California Housing Partnership Corporation. (2018). Retrieved from: 1p08d91kd0c03rlxhmhtydpr-wpengine.netdna-ssl.com/wp-content/uploads/2018/05/Los-Angeles-2018-HNR.pdf
2. U.S. Census Bureau, American Community Survey, 2012 – 2016
3. 2018 Greater Los Angeles Point-In-Time Count conducted in January 2018. http://www.lahsa.org/homeless-count/ to view and download data

Health Outcome

Mental Health

Focus groups, one-on-one conversations, and online surveys with community residents and public health professionals provided insights into the impact of poor mental health on the community.

Community Voice: Raising Issues and Offering Solutions

ISSUES

Trauma and the need for more mental health services

"There's a big need for grief groups, because there's a lot of violence...In my caseload I had a client that had three sons that had been murdered." -Service provider

Unmet social needs impact mental health

"I didn't know that she [client] didn't have a bed, and she was sleeping on the floor at home and all of this stuff was happening. How they had to sell furniture, or her mom sold the furniture, so that they can have some kind of food."

-Service provider

Stigma continues to be an issue, particularly for some racial/ethnic groups

"And for the African American family, there's just the stigma that, you know, what goes on in our house stays in our house. And then there's the stigma on mental health, that you're crazy if you go to see someone." –Community resident

SOLUTIONS

Improve communication between hospitals and community organizations

"One of the things I think could be helpful is maybe create a partnership between [hospitals and community organizations], especially the discharge planners and social workers in the hospitals who have an orientation on various services that are offered in the community." -Service provider

Use of health navigators, such as promotoras

"The people who are working with the promotoras - they [residents] feel like they're connected, they trust them."

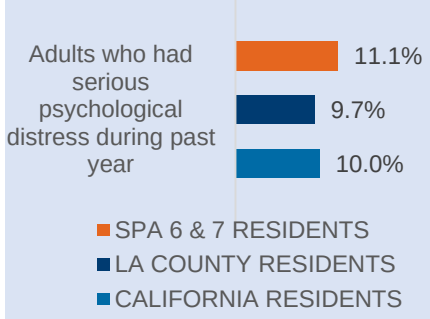
-Service provider

Schools need support to address mental health

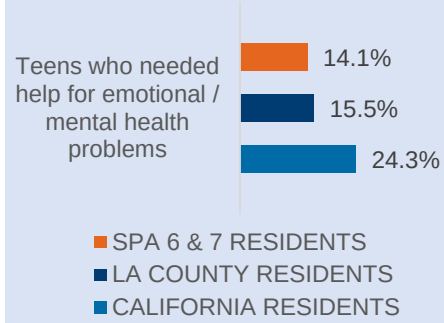
"And psychologists to do psychological assessments, you know, so that we don't have to send them out... 'cause some of the schools do them, but, you know, especially when you look at the schools in this area, they're overloaded."

-Service provider

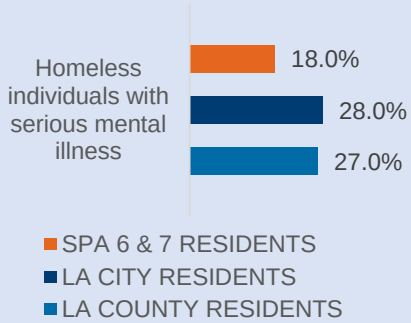
Mental Health among Adults[1]



Mental Health among Youth[1]



Mental Health among Homeless Individuals[2]



Social inequalities and violence connected to poor mental health

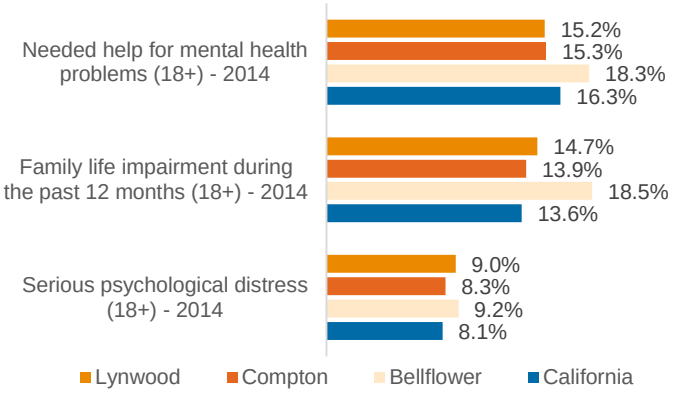
Risk factors for many common **mental health disorders** are **associated with social inequalities**.[4] Experiencing **poor mental health days,** for example, has been shown to be strongly **linked to following social indicators:**

- Racial segregation
- Level of education
- Low income
- Housing status
- Access to care

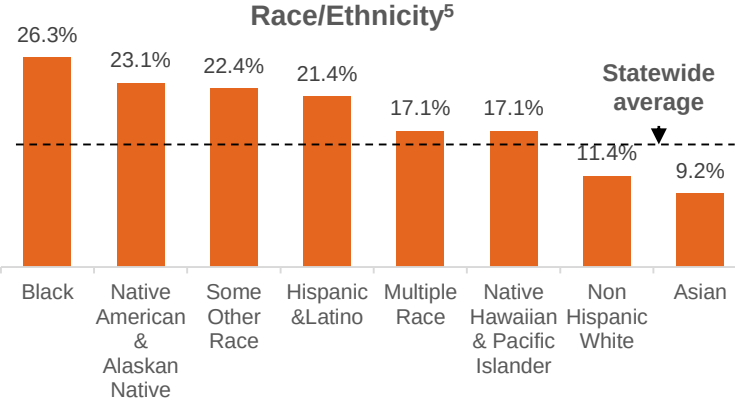
Disparities in mental health

Underserved communities within the KFH – Downey service area experience **high rates of poor mental health**. These findings are consistent with national trends in health outcomes, as these communities are also experiencing **high rates of violence** and **social inequities** across multiple indicators, such as poverty.

Mental Health Needs by City[4]



KFH-Downey Service Area Population Below Poverty by Race/Ethnicity[5]



What work is underway within Kaiser Permanente to address mental health?

Kaiser Permanente is working to address the mental health needs of the community at a national, regional, and local level.

- Watts Counseling and Learning Center
- Thriving Schools Initiative
- Kaiser Permanente Educational Theater
- National campaign to address mental health stigma (Findyourwords.org)

Who are potential partners in the community?

KFH–Downey Medical Center partners with organizations throughout the community to provide mental health services.

- California Department of Public Health
- PIH Health
- Community Family Guidance Center
- Helpline Youth Counseling
- Centinela Youth Services

References:
1. California Health Interview Survey, 2017. http://ask.chis.ucla.edu
2. 2018 Greater Los Angeles Point-In-Time Count conducted in January 2018. http://www.lahsa.org/homeless-count/ to view and download data
3. World Health Organization and Calouste Gulbenkian Foundation. Social determinants of mental health. Geneva, World Health Organization, 2014.
4. California Health Interview Survey, 2017. http://ask.chis.ucla.edu
5. U.S. Census Bureau, American Community Survey, 2012 - 2016

Appendix D. Community resources

Identified need	Resource provider name	Summary description
Access to care	Family Health Care Centers of Greater Los Angeles (FHCCGLA)	FHCCGLA is a Federally Qualified Health Center (FQHC) providing quality health services on a sliding fee scale to anyone, regardless of their ability to pay. The health center is funded by federal monies, grants specifically for care of low income and homeless patients, insurance reimbursement for care and donations.
	St. John's Well Child and Family Center (SJWCFC)	SJWCFC is an FQHC with school-based clinics that span the breadth of Central and South Los Angeles and Compton. In addition to providing a broad array of primary care services, SJWCFC places a high priority on developing supportive services to address families' educational, socio-economic, and mental health needs.
Education and Employment	Compton YouthBuild	Compton YouthBuild provides rigorous educational and occupational opportunities for youth ages 16+ who are invested in creating a sustainable future for themselves, their families and communities.
	Kaiser Permanente Watts Counseling and Learning Center	The Watts Counseling and Learning Center is a nonprofit Community Benefit program of Kaiser Permanente Southern California. The Center empowers multi-generational individuals and families to cope with stresses and barriers through counseling, educational therapy, child development, and outreach.
	Good Soil Industries	Good Soil Industries is a social enterprise landscaping company that provides residential and commercial lawn care and yard maintenance. They also provide job training, life skills, and family strengthening classes to help low-income men with employment barriers work their way out of poverty.
Food Security	Los Angeles County Service Area 7 Food Security Coalition	The Food Security coalition is committed to addressing food security/insecurity related issues by increasing awareness, facilitating communication and collaboration among partners, connecting community members to existing resources, understanding the food insecurity needs of target cities from the perspective of community residents, and researching the best practices for addressing those needs.
	Interfaith Food Center	The Interfaith Food Center is a non-faith-based, non-profit charity organization dedicated to meeting the needs of our hungry and homeless neighbors in Whittier, La Mirada and Santa Fe Springs. Annually, IFC places more than three million pounds of food in the hands of struggling families and individuals.
Housing Security	Our Place Housing Solutions	Our Place Housing serves as a Community Housing Development Organization seeking housing justice for our neighbors in Bellflower. This organization seeks to preserve and create new affordable housing that impacts individuals and empowers and strengthens neighborhoods and communities.
	Whittier First Day Shelter	First Day serves approximately 2,300 unduplicated individuals through outreach, homelessness prevention, housing, health, advocacy, and other services. They also serve the Greater Whittier network of providers and community members as a leader in cross-sector convening, information sharing, and volunteer coordination.
Mental Health	Community Family Guidance Center	Community Family Guidance Center provides affordable, high quality, culturally sensitive mental health services to children and their families.

Identified need	Resource provider name	Summary description
		Their philosophy is that all children and families can be healthy, happy, and successful with the appropriate skills and support.
	Helpline Youth Counseling Center (HYC)	HYC eliminates barriers and creates opportunities for at-risk, low income children, youth and their families through counseling services. Through its comprehensive and holistic array of programs, HYC supports and strengthens families and their resources to enhance their resiliency and help them attain self-sufficiency.

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.