2019 Community Health Needs Assessment

Kaiser Foundation Hospital: Los Angeles

License number: 930000077

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

September 16, 2019

Kaiser Permanente Southern California Region Community Benefit

CHNA Report for KFH-Los Angeles

Contents

I. Introduction/background

A. About Kaiser Permanente (KP)

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

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

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

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

B. About Kaiser Permanente Community Health

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

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

- Ensuring health access by providing individuals served at KP or by our safety net partners with integrated clinical and social services;

- Improving conditions for health and equity by engaging members, communities, and Kaiser Permanente's workforce and assets; and
- Advancing the future of community health by innovating with technology and social solutions.

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

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

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

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

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

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

In addition to reviewing and analyzing secondary data, each KFH facility, individually or with a collaborative, collected primary data through key informant interviews, focus groups, and surveys. Primary data collection consisted of reaching out to local public health experts, community leaders, and residents to identify issues that most impacted the health of the

community. The CHNA process also included an identification of existing community assets and resources to address the health needs.

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

In conjunction with this report, KFH-Los Angeles will develop an implementation strategy for the priority health needs the hospital will address. These strategies will build on Kaiser Permanente's assets and resources, as well as evidence-based strategies, wherever possible. The Implementation Strategy will be filed with the Internal Revenue Service using Form 990 Schedule H. 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-Los Angeles Service Area
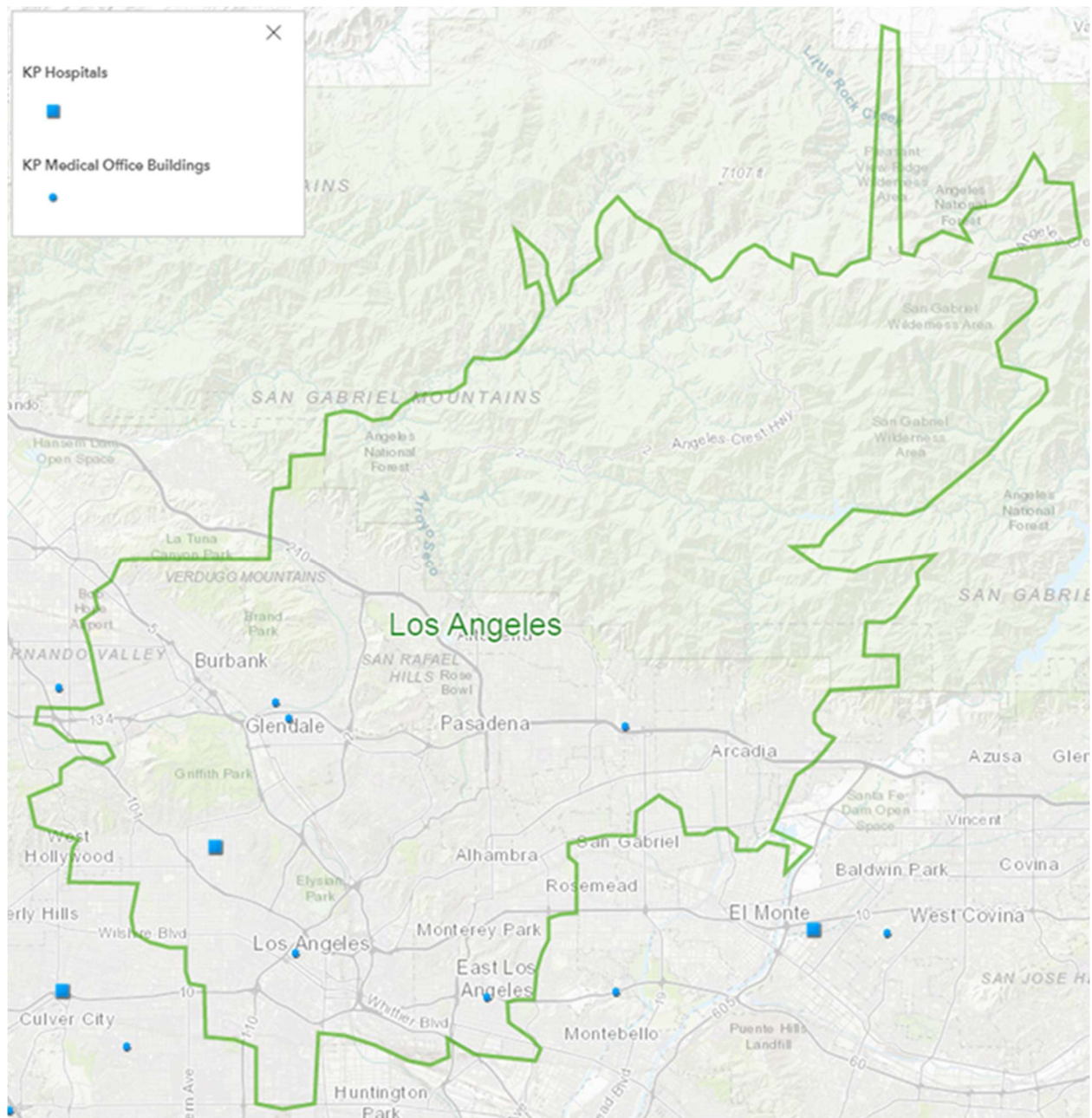
ii. Geographic description of the community served

The KFH-Los Angeles service area includes Alhambra, Altadena, Arcadia, Burbank, Glendale, La Cañada Flintridge, La Crescenta, Los Angeles, Monrovia, Monterey Park, Montrose, Pasadena, San Gabriel, San Marino, Sierra Madre, South Pasadena, and West Hollywood (East). Communities include Atwater, Boyle Heights, Chinatown, City Terrace, Downtown, Eagle Rock, East Hollywood, East Los Angeles, Echo Park, El Sereno, Glassell Park, Hancock Park,

Highland Park, Hollywood, Hollywood Hills, Koreatown, Laurel Canyon, Los Feliz, Montecito Heights, South Park, Silverlake, and Westlake.

iii. Demographic profile of the community served

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

TABLE 1 KFH-Los Angeles Service Area[1]

Race/Ethnicity		*Socioeconomic Data*	
Total Population	2,119,206	Living in Poverty (<100% Federal Poverty Level)	21.12%
Asian	18.95%	Children in Poverty	29.86%
Black	4.26%	Unemployment	4.1%
Hispanic/Latino	46.53%	Uninsured Population	18.65%
Native American/Alaska Native	0.14%	Adults with No High School Diploma	24.10%
Pacific Islander/Native Hawaiian	0.14%		
Some Other Race	0.31%		
Multiple Races	2.03%		
White	27.64%		

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-Los Angeles service area to live a long and healthy life[2]. Areas in dark blue represent census tracts in the lowest quartile of health opportunity across California. These areas are severely under-resourced across multiple domains of the social predictors of health (e.g. economics, education, transportation, built environment etc.).

Note: this map displays an area slightly larger than KFH-Los Angeles service area boundaries and is taken directly from the Southern California Public Health Alliance's Healthy Places Index.

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1 American Community Survey (2012-2016)

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

FIGURE B Under-Resourced Communities in KFH-Los Angeles
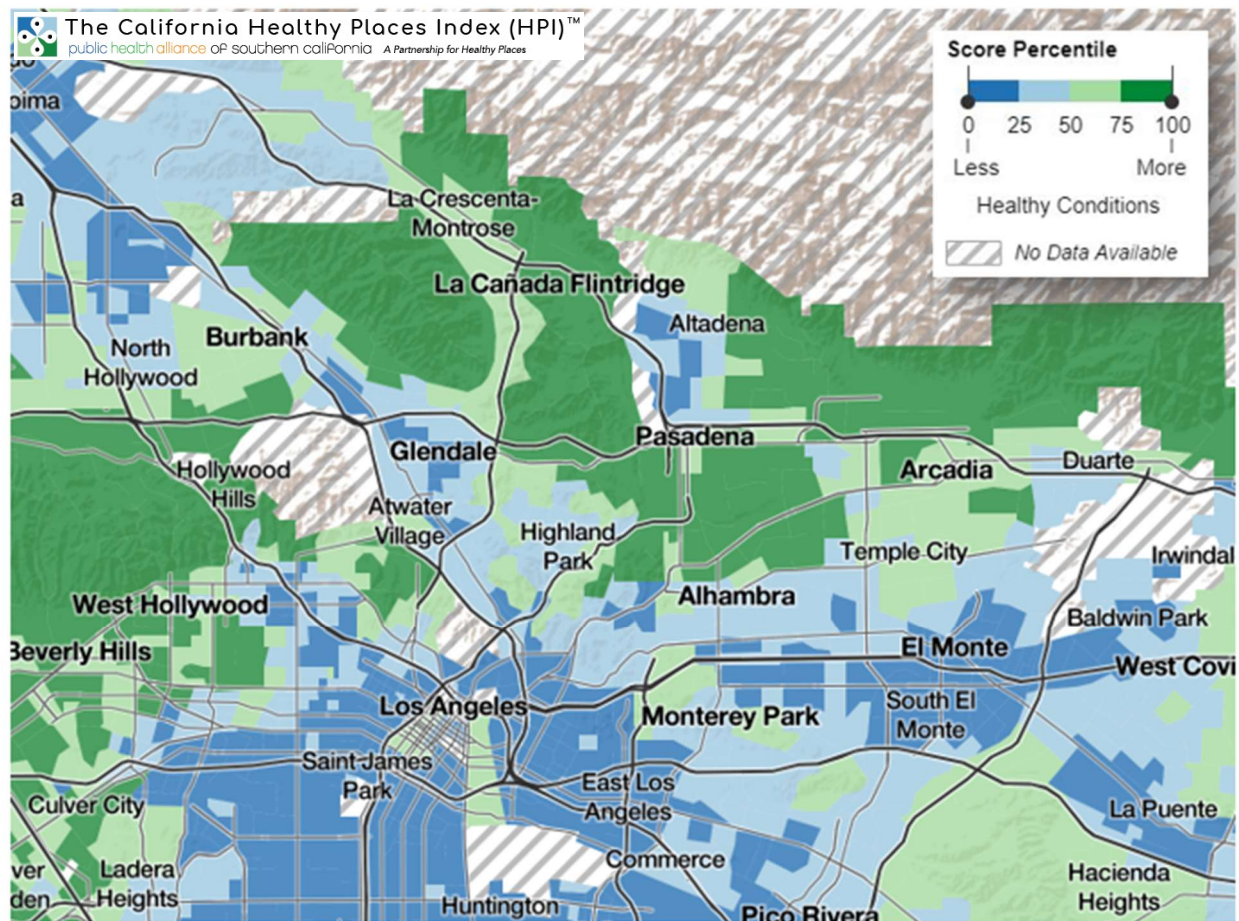
Source: The California Healthy Places Index, © 2018 Public Health Alliance of Southern California, http://healthyplacesindex.org/

The opportunity to live a long and healthy life is powerfully influenced by a wide range of social factors including economics, education, transportation, built environment, and access to care[3]. In aggregate, residents living in the **KFH-Los Angeles service area** are in the **40th percentile** for health opportunity[4] among all California residents with approximately **879,530** people living in severely under-resourced census tracts (more than any other KFH service area in southern California). In effect, this means that 6 out of 10 Californians have a greater opportunity to live a long healthy life than residents living in this service area[5].

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[3] Please read more about the strong scientific evidence for these relationships here.

[4] As described by the California Healthy Places Index.

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

III. Who was involved in the assessment?

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

Hospitals that collaborated with KFH-Los Angeles on this assessment:

- KFH-West Los Angeles

Partner organizations who collaborated with consultants in conducting the assessment:

- A Place Called Home
- Asian Pacific AIDS Intervention Team
- Bienestar
- Bravo Medical Magnet High School
- Brotherhood Crusade
- California Community Foundation
- CHIRLA
- Esperanza Community Housing Corporation
- Foothill Family Services
- Heart of Los Angeles
- Hollywood Community Housing Corporation
- Hollywood DMH
- JWCH Institute
- LA Care
- LA Conservation Corps Sheila Kuehl
- LA Promise Fund
- Los Angeles Christian Health Services
- Los Angeles Neighborhood Legal Services
- LURN
- Mayor's Office of Resident Engagement
- Mi Centro/Latino Equality Alliance
- My Friends Place
- Office of Councilmember Mitch O'Farrell
- Office of Councilmember Riu
- Office of Deputy Supervisor Sheila Kuehl
- Office of State Senator Maria Elena Durazo
- Pasadena Black Infant Health Program
- Pasadena Public Health Department
- Pasadena Public Health Department, Tobacco Control
- Pasadena Unified School District
- PATH
- RootDownLA
- South Central Family Health Services
- SPA 4 Health Office

- St. Barnabas
- St. Francis Center
- STEM Academy
- StepUp on 2nd
- TEACH Public Schools
- The Center at Blessed Sacrament
- The Los Angeles LGBT Center
- To Help Everyone Health and Wellness Centers
- TransLatin@ Coalition
- Youth Policy Institute

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

The Center for Nonprofit Management (CNM) was established in 1979 by the corporate and foundation community as the Southern California source for management education, training, and consulting within the nonprofit community. From core management fundamentals to executive coaching, in-depth consulting and analyses, CNM enables individuals to become better leaders of more effective organizations. CNM's research and networking efforts distribute knowledge and thought to nonprofit organizations so they are prepared to face today's known tasks and tomorrow's unknown challenges. CNM seeks to shape how nonprofit leaders approach problems so they can more effectively pursue their missions. CNM helps individuals and their organizations evolve, adapt and thrive.

CNM has extensive experience conducting Community Health Needs Assessments (CHNAs) to meet Affordable Care Act and SB 697 requirements, as well as other community-based needs assessments, in health, early education, social services, and other areas. The CNM team has been involved in and conducted CHNAs for hospitals throughout Los Angeles County and throughout Southern California for over fifteen years. The CNM team conducted the 2004, 2007 and 2010, 2013 and 2016 assessments for the Metro Hospital Collaborative (California Hospital Medical Center, Children's Hospital Los Angeles, Good Samaritan Hospital, Kaiser Foundation Hospital Los Angeles, Queens Care, and St. Vincent Medical Center). Key members of the CNM team also worked on the 2007 CHNAs for St. Francis Medical Center and the Franciscan Clinics. CNM conducted the 2013 CHNAs for three and two in 2016 Kaiser Foundation hospitals and one non-Kaiser Foundation hospital in the greater Los Angeles area, three Glendale hospitals and the and assisted an additional two Kaiser Foundation Hospitals (Panorama City and San Diego) in community benefit planning based on the needs assessments. More recently, the CNM team conducted the 2014 CHNA for a specialty hospital, Casa Colina Hospital and Centers for Health Care, where the team modified a process to capture the specialized needs of its service area and population.

IV. Process and methods used to conduct the CHNA

KFH-Los Angeles conducted the CHNA in a mixed-methods sequential explanatory assessment intended to produce the most accurate, vivid, and meaningful story of community health possible. Secondary data was analyzed to provide a bird's eye view of the most pressing health issues across the service area and raise strategic lines of inquiry for community engagement.

Findings from both the secondary and primary data collection processes were then combined to produce a robust story of community health needs (see figure A below).

Figure C Mixed-Method Assessment Approach to the CHNA
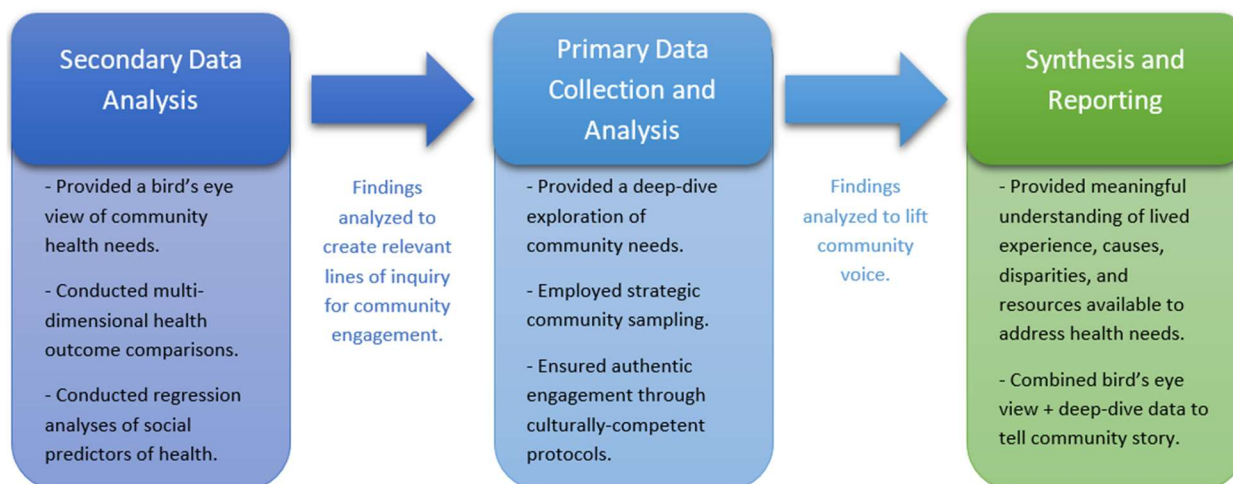
A. Secondary data

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

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

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

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

> 1. Determine the geographic footprint of the most under-resourced communities in the KFH-Los Angeles service area.
> 2. Identify the top social predictors of health (upstream factors) linked to community health outcomes in the KFH-Los Angeles 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-Los Angeles service area.
> 4. Provide descriptive information about the demographic profile of the KFH-Los Angeles service area and support understanding of key CHNA findings.

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

education, access to care, clean environment, housing, safety, transportation, and social support. (Please refer to FIGURE B to see this map[6]).

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-Los Angeles service area census tracts. The results of these analyses found multiple social factors with statistically significant (p<.05) predictive relationships with important population health outcomes. (Please refer to Table 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 – Los Angeles 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-Los Angeles service area needs and (b) provided a closer look at the impact of social factors that influence the opportunity of community residents in the service area to live long and healthy lives.

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

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

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		6
More Crowded Housing	X		X	X	X	X			X		6
Fewer Bachelor's Degrees	X	X		X	X			X	X		6
Less Health Insurance	X		X	X					X		4
More Racial Segregation			X	X	X						3
More Homeownership					X	X	X				3
Less Park/Beach Access	X		X								2
Less Crowded Housing							X				1
More Bachelor's Degrees							X				1
Less Supermarket Access		X									1
Less Employment							X				1
Fewer Two Parent Households		X									1
Less Homeownership										X	1

Table 3 Ranked Health Outcome Comparison Table

Health Outcome Category Name	Prevalence	Difference From State Average	Reduction in Length of Life Per Year	Worst Performing Race/Ethnicity vs. Average	Listed in Partner County Top 5 Cause of Death
Mental Health*	12.3%	0.17% (Worse than CA)	61.3% Reduction	68% Worse than Average	No
Stroke*	4.0%	0.3% (Worse than CA)	57% Reduction	42% Worse than Average	Yes
Cancer*	3.7%	0.37% (Worse than CA)	51% Reduction	32% Worse than Average	Yes
HIV/AIDS/STD	0.6%	0.18% (Worse than CA)	58.2% Reduction	211% Worse than verage	No
Obesity	22.1%	-7.5% (Better than CA)	37% Reduction	49% Worse than Average	No
Asthma	12.5%	-2.3% (Better than CA)	13.3% Reduction	93% Worse than Average	No
Diabetes*	9.2%	0.8% (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	2.8%	-4.2% (Better than CA)	69.7% Reduction	48% Worse than Average	No
CVD*	5.2%	-1.76% (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

B. Community input

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

1. In what ways do housing and other neighborhood factors affect the lived experience and health of Black residents?

2. What factors inhibit or promote attaining or maintaining comfortable, healthy and/or improved housing among Black residents?

3. In what ways do housing and other neighborhood factors impact the lived experience of Latino residents?

4. What factors inhibit or promote attaining or maintaining comfortable, healthy and/or improved housing among Latino residents in the service area?

5. Considering that the Latino population served by KFH-Los Angeles is comparatively low income, has a low level of formal education, and lives in crowded housing, why are the health outcomes for this population better than for similarly situated Black populations? Is there important intra-group variation among Latinos (e.g. 1st vs 2nd generation status/immigrant status) that is overlooked when we average all subgroups of Latinos together? Are there protective factors we can nurture? What is the lived experience of each of these Latino subgroups?

6. How does (lack of) social support and stable housing relate to rising rates of STI incidence among the LGBTQ people of color in the service area?

7. What factors inhibit or promote finding stable, comfortable, healthy and/or improved housing, and stable social networks for LGBTQ people of color in the service area?

8. What factors inhibit or promote secure, consistent access to and use of health care for residents of the service area?

9. What are the strengths and assets of the network of homeless service providers and homeless communities in the Hollywood area that keep temporarily and chronically homeless individuals and families safe, and help them find the resources they need?

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
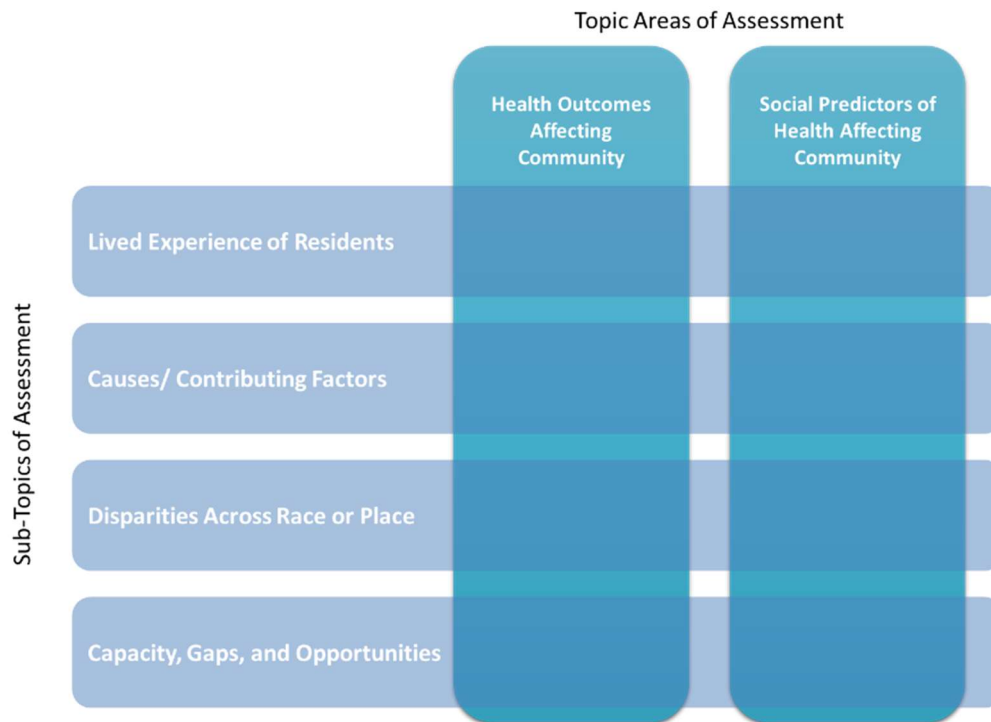
i. Description of who was consulted

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-Los Angeles service area, community engagement efforts set out to target those geographies most under-resourced and where health outcomes were the poorest (see Figure B for a map referencing the most underserved areas of KFH-Los Angeles). Once selected for engagement, participants were provided the opportunity to share their perspective on targeted health needs and raise any additional health needs outside the strategic lines of inquiry. For a complete list of individuals who provided input on this CHNA, see Appendix B.

ii. Methodology for collection and interpretation

In seeking information to help answer strategic lines of inquiry, primary data was collected through the following methods:

- Individual Interviews
- Focus Groups
- Community Voice Workshop with high school youth

In the first round of data analysis, primary data from community engagements were coded according to the SCAL CHNA Community Engagement Framework (Figure D) to facilitate exploring text referring to lived experience with, causes and contributing factors of, disparities within populations per, and opportunities for improvement for each of the health outcomes and social predictors identified in Table 3, as well as additional health outcomes and social predictors identified by community members and service providers.

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-Los Angeles received one written comment related to the previous CHNA Report. These comments were regarding further inquiry about the Implementation Strategy report. Community Benefit Manager Mario Ceballos reached out to the commenter to address the comment.

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

First, the consultant team produced a short list of community health needs from the secondary data using the following methodology: Health outcomes (see Table 3) were ranked independently according to four criteria (prevalence, difference from state average, reduction in length of life per year, and worst performing race/ethnicity vs. average). Health outcomes found to have a highly negative impact on the service area population according to two or more criteria were identified for further analysis. Similarly, social predictors of health (see Table 2) predictive of 3 or more negative health outcomes were identified for further analysis.

Second, the consultant team identified a short list of community health needs from the primary data using the following methodology: All community engagements (focus groups and key

informant interviews) were reviewed and key themes identified. A primary data coding structure was developed by collapsing the lists of key themes from each engagement into health needs categories and subcategories. This coding structure was then applied to the data. Community health needs mentioned most frequently were isolated for further exploration. Through an iterative process, the analysts built conceptual models of these health needs that represented the consensus of community engagement participants.

Finally, the consultant team crosswalked the health needs derived from both the primary and secondary data to build a list of health needs that best reflected the perspectives of the participants engaged in the process and that incorporated the largest possible number of highly prevalent, severe and disproportionately distributed health outcomes.

B. Process and criteria used for prioritization of health needs
Required Criteria

Before beginning the prioritization process, KFH-Los Angeles chose a set of criteria to use in prioritizing the list of health needs. These criteria were:

- Severity of need: This refers to how severe the health need is (such as its potential to cause death or disability) and its degree of poor performance against the relevant benchmark.
- Magnitude/scale of the need: The magnitude refers to the number of people affected by the health need.
- Clear disparities or inequities: This refers to differences in health outcomes by subgroups. Subgroups may be based on geography, languages, ethnicity, culture, citizenship status, economic status, sexual orientation, age, gender, or others. Primary data collection was conducted with an intentional focus on factors related to equity.

Participants in the prioritization process were given access to the secondary data (health outcomes and social predictors of health) ranked according to criteria detailed above. Additionally, participants in the prioritization process were given access to the preliminary findings of the primary data analyzed according to the methodology outlined in section V.A.ii. of this report. Participants were asked to consider these health needs and social predictors of health in light of the following additional criteria:

- Degree to which the community prioritizes the issue over other issues
- Existing attention/resources dedicated to the issue
- Accessibility of effective and feasible interventions
- The degree to which an effective and feasible intervention has the potential to solve multiple problems
- Opportunity to intervene at the prevention level
- History of local contributions and investments

Through this process, participants came to consensus on a list of seven priority health needs, detailed below.

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

Access to care. Accessible health insurance addresses a major obstacle to primary health care utilization, particularly for very low-income residents. Nearly 1 in every 5 service area residents is uninsured. Latinos fare worse than the service area average: nearly 1 in 4 Latino service area residents have no insurance coverage.[7] Our community engagements indicated that insurance access accounts for only one component of health care access: equally important to access to insurance include access to culturally and linguistically relevant providers, access to paid sick leave for doctors visits, and access to health care facilities that provide appointments during the evenings and on the weekends.

Mental and behavioral health. According to the data prepared for the KFH-Los Angeles CHNA, poor mental health is associated with a 61.3% reduction in length of life per year for residents in the service area.[8] Our community engagements revealed that poor mental health is common to the lived experience of service area residents, and particularly for those residents dealing with economic and housing insecurity and structural exclusion. Communities of color are more vulnerable to certain factors underlying poor mental health. For example, in California, 8.1% of African American and Latino Children have experienced a serious emotional disturbance, compared to only 6.9% of White children.[9] Moreover, communities of color and undocumented communities are much less likely to receive necessary mental health services. For example, from 2011-2013, 11.3% of Blacks in California had an unmet mental health need, compared to only 8.2% of Whites.[10]

Economic security. Economic security is a dominant concern for a large proportion of residents of the service area. Without economic security, housing security, food security, good mental and good physical health are difficult to achieve. Over 1 in 5 service area residents are living below the federal poverty line in the KFH-Los Angeles service area;[11] Moreover, poverty disproportionately impacts Blacks and Latinos: they are nearly twice as likely as Whites to be living below the federal poverty line. Our community engagements indicated that economic insecurity underlies all health needs in the service area, and that economic insecurity is growing as housing prices continue to increase against a backdrop of stagnant wages and persistent obstacles to employment for the communities most impacted by this health need.

Housing insecurity. Unstable housing threatens social, physical, mental and emotional wellbeing. Our community engagements indicated that housing insecurity is growing as gentrification and rising real estate values continue to fuel the displacement of long-time Latino and Black communities throughout the service area. Many residents of the service area are vulnerable to housing insecurity because of an imbalance of wages and housing costs: 50.2% of residents spend more than 30% of their income on housing.[12] However, this vulnerability to displacement is exacerbated by the social patterning of home ownership in the region. In Los

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[7] KFH-Los Angeles CHNA data platform.

[8] KFH-Los Angeles CHNA data platform.

[9] California Health Care Foundation, California Health Care Almanac; https://www.chcf.org/wp-content/uploads/2018/03/MentalHealthCalifornia2018.pdf

[10] California Health Interview Survey (CHIS)

[11] KFH-Los Angeles CHNA data platform.

[12] KFH-Los Angeles CHNA data platform.

Angeles County, many more people rent than own, but the pattern of homeownership is disproportionately distributed across races. People of color are more vulnerable to losing their homes than Whites because they are far less likely to be homeowners: 2 out of 3 households headed by a White adult is owned, not rented, compared to only 1 out of 3 homes headed by a Black adult.[13]

Food insecurity. Our community engagements revealed that lack of affordable and accessible healthy food options prevents low-income residents from eating well and taking care of their health. The issue of food insecurity affects a large population in the service area: over 1 in 7 adults experienced food insecurity in the last year.[14] The issue disproportionately impacts people of color. For example, 1 in 6 Latino households in the KFH-Los Angeles service area receive SNAP benefits compared to only 1 in 22 White households.[15]

HIV/AIDS/STIs. STIs greatly reduce life expectancy and are uncommonly prevalent in the LAMC service area.[16] An STD/HIV/AIDS diagnosis is associated with a 58.2% reduction in length of life per year.[17] STIs disproportionately impact people of color. In 2017, in Pasadena, 10-year average death rate due to HIV was twice as high for Black males than for White males.[18] Our community engagements revealed that an HIV/AIDS diagnosis may lead to loss of employment and housing, particularly for people of color, and underlies chronic poor mental and physical health for many service area residents.

Structural exclusion. There is growing recognition that until issues of structural exclusion of and bias against populations of color and LGBTQ identity are addressed, inequities in health outcomes will persist. Our community engagements revealed many opportunities for health care practitioners to adopt practices that counter structural inequities.

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

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

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

A. Purpose of 2016 Implementation Strategy evaluation of impact
KFH-Los Angeles' 2016 Implementation Strategy Report was developed to identify activities to address health needs identified in the 2016 CHNA. This section of the CHNA Report describes and assesses the impact of these activities. For more information on KFH-Los Angeles' Implementation Strategy Report, including the health needs identified in the facility's 2016 service area, the health needs the facility chose to address, and the process and criteria used

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[13] National Equity Atlas; nationalequityatlas.org
[14] KFH-Los Angeles CHNA data platform.
[15] KFH-Los Angeles CHNA data platform.
[16] KFH-Los Angeles CHNA data platform.
[17] KFH-Los Angeles CHNA data platform.
[18] Pasadena 2018 Mortality Report; https://www.cityofpasadena.net/public-health/data/

for developing Implementation Strategies, please visit (https://about.kaiserpermanente.org/content/dam/internet/kp/comms/import/uploads/2013/10/KFH-Los-Angeles-IS-Report.pdf). For reference, the list below includes the 2016 CHNA health needs that were prioritized to be addressed by KFH-Los Angeles in the 2016 Implementation Strategy Report.

1. Access to Care
2. Mental and Behavioral Health
3. Obesity/HEAL/Diabetes
4. HIV/AIDS/STIs

KFH-Los Angeles is monitoring and evaluating progress to date on its 2016 Implementation Strategies for the purpose of tracking the implementation and documenting the impact of those strategies in addressing selected CHNA health needs. Tracking metrics for each prioritized health need include the number of grants made, the number of dollars spent, the number of people reached/served, collaborations and partnerships, and KFH-Los Angeles in-kind resources. In addition, KFH-Los Angeles tracks outcomes, including behavior and health outcomes, as appropriate and where available.

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

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

B. 2016 Implementation Strategy evaluation of impact overview

In the 2016 IS process, all KFH hospital facilities planned for and drew on a broad array of resources and strategies to improve the health of our communities and vulnerable populations, such as grantmaking, in-kind resources, collaborations and partnerships, as well as several internal KFH programs including, charitable health coverage programs, future health professional training programs, and research. 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 determinants of health and/or addresses the elimination of health disparities and inequities. From 2017-2018, KFH-Los Angeles paid 130 grants amounting to a total of $6,548,908 in service of 2016 health needs. Additionally, KFH-Los Angeles has funded significant contributions to California Community Foundation in the interest of funding effective long-term, strategic community benefit initiatives within KFH-Los Angeles. During 2017-2018, a portion of money managed by this foundation was used to pay 28 grants totaling $3,699,389 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-Los Angeles 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-Los Angeles 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-Los Angeles Priority Health Needs

Need	Summary of impact	Examples of most impactful efforts
Access to Care	*During 2017 and 2018, Kaiser Permanente paid 30 grants, totaling $1,337,167 addressing the priority health need in the KFH-Los Angeles 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 $1,456,667 that address this need.*	**Providing Affordable Healthcare** In 2017 and 2018, KFH-Los Angeles provided $42,622,243 in medical care services to 53,543 Medi-Cal recipients (both health plan members and non-members) and $16,915,213 in medical financial assistance (MFA) for 22,973 beneficiaries. **Building Primary Care Capacity~** The California Primary Care Association (CPCA) provides education, training, and advocacy to their member community health centers to best serve their low-income, underserved, and diverse patients. In 2018, Kaiser Permanente paid $126,666 to CPCA to: • Hold statewide convenings and conferences and topic-specific peer networks to support over 1,200 California community health centers. • Provide 90 in-person and web-based trainings to over 4,400 attendees and 2,890 individual instances of technical assistance. **Preserving and Expanding California Coverage Gains~** Insure the Uninsured Project (ITUP) works to preserve and expand access to health care and coverage in California and to reduce access barriers for uninsured and underinsured populations. In 2017 and 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. **Providing Primary and Specialty Care to Underserved Populations** Kheir is a Federally Qualified Health Center that provides health care, human services, adult day health care, and affordable housing for underserved populations. In 2018, Kaiser Permanente's Community Medicine Fellows collaborated with Kheir to: • Provide primary care, diabetes prevention, dermatology consultations, and health education to Kheir patients.

		• Expand healthcare servicing by serving 377 low-income, underserved patients and conducting 505 clinical visits. • Grant over $108,000 in in-kind contributions to the Kheir Center.
		Providing Health and Human Services for Low-Income and Under-Insured Residents The Chinatown Service Center (CSC) helps underserved populations achieve better health by providing preventative care services and supporting patients navigate the healthcare system. CSC is dedicated to educating the community about appropriate vaccinations, diabetes prevention, and AIDS. In 2018, Kaiser Permanente paid $30,000 to CSC to: • Outreach to 2,800 individuals. • Enroll 700 individuals and their families for health care coverage and linkages to a medical home. • Provide 40 health education workshops to its patients.
		Preventing Hospital Readmissions Northeast Community Clinic provides comprehensive, quality healthcare to low-income, underserved and indigent patients. Northeast Community Clinic is dedicated to reducing the number of non-critical emergency room visits by expanding preventive care services and offering robust case management to the most vulnerable populations. In 2018, Kaiser Permanente $30,000 to paid Northeast Community Clinic to: • Pilot a new approach that addresses and reduces the amount of times a patient is admitted to the emergency room facilitated by case managers. • Reduce hospital readmissions among 800 chronically-ill patients. • Establish a monitoring and compliance system to identify targeted patients to monitor their care plan.
Mental and Behavioral Health	*During 2017 and 2018, Kaiser Permanente paid 48 grants, totaling $2,111,149 addressing the priority health need in the KFH-Los Angeles service area. In addition, a portion of money managed by a donor advised fund at California Community Foundation was used to pay 4 grants, totaling $335,000 that address this need.*	**Strengthening Mental Health Policies and Practices in Schools~** Children Now educates policymakers, school district leaders, and other key stakeholders about best practices and policy solutions to address suspension and expulsion policies that disproportionately impact students of color, improve school climate, and increase students' access to mental health services. In 2017 and 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.
		Reducing Mental Health Stigma and Improving Resiliency* The Coalition for Human Immigrant Rights of Los Angeles (CHIRLA) Mental Health & Resilience Project reduces mental health stigma and improves resilience in low-income immigrant communities by

providing culturally-competent mental health training. In 2018, Kaiser Permanente paid CHIRLA $40,000 to:

- Conduct one-on-one consultations with immigrant families to reduce stigma about mental health and improve resiliency.
- Train 83 staff in four culturally-competent trainings.
- Conduct two Mental Health trainings to 300 CHIRLA members including high school and college youth.

Connecting Homeless Individuals to Health Care:

The Center at Blessed Sacrament and its project organization, Hollywood4WRD, outreach to homeless individuals in Hollywood. In 2017 and 2018, Kaiser Permanente paid $50,000 to the Center at Blessed Sacrament and Hollywood4WARD to:

- Serve nearly 1,000 homeless individuals by conducting homeless assessments.
- Connect homeless individuals to primary care and mental health care services.

Providing Mental Health Case Management for Seniors:

St. Barnabas Senior Center of Los Angeles provides comprehensive services to the elderly. In 2018, Kaiser Permanente paid St. Barnabas Senior Center $30,000 to:

- Provide case management to 700 low-income seniors linked to mental and behavioral health, social connection and other health promotion services.

Improving Behavioral Health Services for Transgender Populations

Translatin@ Coalition provides comprehensive behavior health and social services. In 2018, Kaiser Permanente paid Translatin@ Coalition $30,000 to:

- Expand its Behavioral Health Services Department with an added component focusing on Trans violence prevention and wellness.
- Serve over 300 Latina and African-American transgender women in need of behavioral health and violence prevention services.

| Obesity/ HEAL/ Diabetes | *During 2017 and 2018, Kaiser Permanente paid 47 grants, totaling $2,763,092 addressing the priority health need in the KFH-Los Angeles service area. In addition, a portion of money managed by a donor advised fund at California Community Foundation was used to pay 14 grants, totaling $1,907,722 that address this need.* | **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. In 2017 and 2018, Kaiser Permanente paid $100,000 to CWA to:
  • Pilot two video conferencing projects increasing awareness and consideration within the CA WIC community.
  • Collaborate with health centers to share WIC staff for nutrition and breastfeeding counseling (Watts Health Care and clinics in San Diego). |

		• Work to strengthen ties with CPCA and present at CPCA's annual conference. • Visit all CA legislators with 44 appointments and drop-in visits. • Provide extensive information to legislators on nutrition and breastfeeding counseling, food benefits, local economic impacts to grocers, health outcomes, access to Farmers markets, and updates on immigration threats. • Participate in Capitol WIC Education Day in Sacramento with 50 attendees from 30 WIC agencies from all over the state.
		Fighting Food Insecurity~ California Association of Food Banks' (CAFB) Farm to Family program's goal is to improve health food access by providing fresh produce to food banks, CalFresh outreach and enrollment, advocacy to support anti-hunger policies, and technical assistance to members. In 2018, Kaiser Permanente paid $95,000 to CAFB to: • Distribute 250,000 pounds of subsidized fresh fruits and vegetables to 11 member food banks. Maintain the State Emergency Food Assistance Program to provide food and funding of emergency food to food banks.
		Promoting Intergenerational Health Jumpstart uses an intergenerational model to provide language, literacy, and social-emotional programming for low-income preschool children and older adults. This programming includes support for promoting and practicing healthy eating and physical activity. In 2018, Kaiser Permanente paid Jumpstart $30,000 to: • Support 240 pre-school aged children and 75 older adults involved in this unique program.
		Practicing 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. In 2017 and 2018, Kaiser Permanente partnered with Food Finders to: • Recover 1,104 pounds of food and distribute to organizations serving individuals in the KFH-Los Angeles region who face food insecurity.
HIV/ AIDS/ STIs	*During 2017 and 2018, Kaiser Permanente paid 5 grants, totaling $337,500 addressing the priority health need in the KFH-Los Angeles service area.*	**Providing HIV Testing and Treatment to Medically Underserved Populations** Asian Pacific AIDS Intervention Team (APAIT) provides medically underserved communities living with or at risk for HIV/AIDS with culturally competent and linguistically appropriate support programs. In 2018, Kaiser Permanente paid APAIT $30,000 to: • Provide patient navigator services to over 700 high-risk individuals reached during late evening hours (Midnight Stroll) at known homeless gatherings or encampments. • Test 120 individuals and linked 25 homeless individuals with HIV to transition or permanent supportive services.

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

Appendix A. Secondary data sources and dates

i. Secondary sources from the KP CHNA Data Platform

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

ii. Additional sources

Source	Dates
1. California Department of Public Health	2016
2. California Healthy Places Index	2018
3. California HIV Surveillance Report	2015
4. Equity in the Center: Awake to Woke to Work	2019
5. Los Angeles Country Affordable Housing Outcomes Report	2018
6. Office of Environmental Health Hazard Assessment	2011-2013
7. Pasadena Public Health Department	2017
8. National Equity Atlas	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	Individual Interview	President, LA Promise Fund	1	Minority, Low Income, Medically Underserved	Leader	11/13/2018
2	Individual Interview	Founder and Program Manager, RootDown LA	2	Minority, Low Income, Medically Underserved	Leader	11/16/2018
3	Individual Interview	Chief Development & Communications Officer, To Help Everyone Health and Wellness Centers	1	Minority, Low Income, Medically Underserved	Leader	11/16/2018
4	Individual Interview	Director of Mental Health Services, Foothill Family Services	1	Minority, Low Income, Medically Underserved	Leader	11/19/2019
5	Individual Interview	Executive Director, St. Francis Center	1	Minority, Low Income, Medically Underserved	Leader	10/30/2019
6	Individual Interview	Project Manager, Esperanza Community Housing Corporation		Minority, Low Income, Medically Underserved	Leader	10/31/2018
7	Individual Interview	Executive Director, LURN	1	Minority, Low Income, Medically Underserved	Leader	11/13/2018
8	Individual Interview	Visual Arts Director, Heart of Los Angeles	1	Minority, Low Income, Medically Underserved	Leader	12/7/2018
9	Individual Interview	Executive Director, My Friends Place	1	Minority, Low Income, Medically Underserved	Leader	10/29/2018
10	Individual Interview	Director of Social Services, Asian Pacific AIDS Intervention Team (APAIT)	1	Minority, Low Income, Medically Underserved	Leader	12/11/2018
11	Individual Interview	Program Manager, Bienestar	1	Minority, Low Income, Medically Underserved	Leader	10/29/2018
12	Individual Interview	President & CEO, TransLatin@Coalition	1	Minority, Low Income, Medically Underserved	Leader	10/24/2018
13	Individual Interview	Director of Programs, The LGBT Center; Co-Director of Health Services, The LGBT Center	1	Minority, Low Income, Medically Underserved	Leader	10/17/2018

	Data collection method	Title/name	Number	Target group(s) represented	Role in target group	Date input was gathered
14	Individual Interview	Co-Director of Health Services, The LGBT Center	1	Minority, Low Income, Medically Underserved	Leader	10/17/2018
15	Individual Interview	Director of Development and Marketing, Hollywood Community Housing Corporation	1	Minority, Low Income, Medically Underserved	Leader	11/13/2018
16	Individual Interview	Director of Community Engagement, LA Conservation Corps	1	Minority, Low Income, Medically Underserved	Leader	11/12/2018
17	Individual Interview	Support and Transition Services Manager, LA Conservation Corps	1	Minority, Low Income, Medically Underserved	Leader	11/12/2018
18	Individual Interview	Chief Development Officer, Via Care Community Health Center	1	Minority, Low Income, Medically Underserved	Leader	11/01/2018
19	Individual Interview	Chief Executive Officer, ChapCare	1	Minority, Low Income, Medically Underserved	Leader	11/19/2018
20	Individual Interview	Chief Deputy Officer, JWCH/Wesley Health Center	1	Minority, Low Income, Medically Underserved	Leader	11/02/2019
21	Individual Interview	Director of Strategy, Saban Community Clinic	1	Minority, Low Income, Medically Underserved	Leader	01/07/2019
22	Individual Interview	Director of Social Services, Los Angeles Christian Health Centers	1	Minority, Low Income, Medically Underserved	Leader	12/11/2018
23	Individual Interview	Director of Business Operations, St. Barnabas	1	Minority, Low Income, Medically Underserved	Leader	11/05/2018
24	Individual Interview	Program Director, Pasadena Black Infant Health Program	1	Minority, Low Income, Medically Underserved	Leader	2/19/2019
25	Individual Interview	Director of Health Programs, Pasadena Unified School District	1	Minority, Low Income, Medically Underserved	Leader	2/26/2019
26	Individual Interview	Supervising Attorney, Los Angeles Neighborhood Legal Services	1	Minority, Low Income, Medically Underserved	Leader	2/21/2019
27	Individual Interview	Health Officer, Pasadena Public Health Department	1	Minority, Low Income, Medically Underserved	Leader	2/21/2019
28	Focus Group	Associate Director of Counseling Services, A Place Called Home	3	Minority, Low Income, Medically Underserved	Leader	1/16/2019

	Data collection method	Title/name	Number	Target group(s) represented	Role in target group	Date input was gathered
29	Focus Group	VP of Trauma-Informed Youth Development and Social Emotional Learning, Brotherhood Crusade	3	Minority, Low Income, Medically Underserved	Leader	1/16/2019
30	Focus Group	Development Director and CEO, South Central Family Health Center	3	Minority, Low Income, Medically Underserved	Leader	1/16/2019
31	Individual Interview	Information and Referral Specialist, CHIRLA	1	Minority, Low Income, Medically Underserved	Leader	01/30/2019
32	Individual Interview	Director of Development and Marketing, Hollywood DMH	1	Minority, Low Income, Medically Underserved	Leader	01/18/2019
33	Focus Group	Director of Operations, The Center at Blessed Sacrament	5	Minority, Low Income, Medically Underserved	Leader	2/4/2019
34	Focus Group	Program Directors, JWCH Institute, Inc.	5	Minority, Low Income, Medically Underserved	Leader	2/4/2019
35	Focus Group	Sr. Program Officer Health, California Community Foundation	4	Minority, Low Income, Medically Underserved	Leader	1/25/2019
36	Focus Group	Director of Health & Wellness, Youth Policy Institute	4	Minority, Low Income, Medically Underserved	Leader	1/25/2019
37	Focus Group	Health Program Analyst, SPA 4 Health Office	4	Health Department Representative, Minority, Low Income, Medically Underserved	Leader	1/25/2019
38	Focus Group	Sr. Director, Strategic Planning, LA Care	4	Minority, Low Income, Medically Underserved	Leader	1/25/2019
39	Focus Group	Director of Housing Supportive Services, Step Up on 2nd	2	Minority, Low Income, Medically Underserved	Leader	1/18/2019
40	Focus Group	Associate Director, PATH	2	Minority, Low Income, Medically Underserved	Leader	1/18/2019
41	Focus Group	Field Deputy, Councilmember Riu	4	Minority, Low Income, Medically Underserved	Leader	2/19/2019
42	Focus Group	Field Deputy, Mayor's Office of Resident Engagement	4	Minority, Low Income, Medically Underserved	Leader	2/19/2019

	Data collection method	Title/name	Number	Target group(s) represented	Role in target group	Date input was gathered
43	Focus Group	Senior Field Deputy, Supervisor Sheila Kuehl	4	Minority, Low Income, Medically Underserved	Leader	2/19/2019
44	Focus Group	Field Representative, State Senator Maria Elena Durazo	4	Minority, Low Income, Medically Underserved	Leader	2/19/2019
45	Individual Interview	Field Deputy, Councilmember Mitch O'Farrell	1	Minority, Low Income, Medically Underserved	Leader	2/22/2019
Community residents						
1	Focus Group	Latino youth, East LA	120	Minority, Low Income, Medically Underserved	Representative member	11/6/2018
2	Focus Group	Latino LGBTQ youth, East LA	7	Minority, Low Income, Medically Underserved	Representative member	12/10/2018
3	Focus Group	Latino adults, East LA	15	Minority, Low Income, Medically Underserved	Representative member	12/10/2018
4	Focus Group	Latino youth, Hollywood	12	Minority, Low Income, Medically Underserved	Representative member	10/23/2018
5	Focus Group	Latino adults, Hollywood	7	Minority, Low Income, Medically Underserved	Representative member	9/27/2018
6	Focus Group	MSM of color, Hollywood	15	Minority, Low Income, Medically Underserved	Representative member	11/8/2018
7	Focus Group	WSW of color, Hollywood	10	Minority, Low Income, Medically Underserved	Representative member	11/10/2018
8	Focus Group	LGBTQ/homeless youth, Hollywood	15	Minority, Low Income, Medically Underserved	Representative member	11/8/2018
9	Focus Group	LGBTQ aging adults, Hollywood	15	Minority, Low Income, Medically Underserved	Representative member	11/8/2018
10	Focus Group	African American youth, NW Pasadena	15	Minority, Low Income, Medically Underserved	Representative member	11/8/2018
11	Focus Group	African American youth, South Park	10	Minority, Low Income, Medically Underserved	Representative member	*2/20/2019*
12	Focus Group	African American adults, South Park	15	Minority, Low Income, Medically Underserved	Representative member	*In progress*

Appendix C. Health Need Profiles

"Because there is so little money, I sacrifice a lot. I don't buy new clothes for my children, we don't eat or rest well and don't go to the doctor on a regular basis. When you are poor you don't have time or extra money to think about your health or the health of your children until we're really sick." **—Diana***

Diana has been in the US for two years. Having experienced community and domestic violence in El Salvador, she decided to travel to the US with her children in search of a better life. Last year, when Diana went to a resource center to sign up for health insurance, she was told to come back with proof of income, but she didn't have it due to her immigration status: she has to work "under the table." In addition, Diana felt embarrassed when attempting to fill out the necessary paperwork, because she can't easily read Spanish or English well. Diana speaks Nawat. Eventually, an acquaintance connected her to an organization that offered health coverage for undocumented immigrants. This organization helped her feel welcomed and accepted, and helped her with the paperwork. They assured her that applying for coverage would not jeopardize her application for citizenship. Recently, Diana was experiencing severe stomach pain, and was scheduled for an appointment during the workday. She skipped the appointment because she couldn't afford to take the unpaid time off. Soon after, Diana's pain became worst, she went to the emergency department of a local hospital that was sympathetic to undocumented immigrants. She received good care, but is now struggling to pay off the expensive emergency visit.

David has been homeless for 18 years. When he was a kid his dad beat him and his mom. He started doing drugs with his friends to cope with his anger. He ran away when he was 17 and has been homeless since. David doesn't trust people easily, if at all. Perhaps because of early trauma, or because of the extreme stress of living on the streets, David struggles with depression. Recently, David has been experiencing a lot of chest pain that comes and goes. He knows that he shouldn't ignore it, but the thought of seeking help feels very overwhelming. He learns about a mobile medical clinic that some of his friends have visited. They told him this clinic is very welcoming—they are warm and patient and make you feel like a person, not a problem. Still, he's not sure he will visit it. He doesn't know what he will do if he finds out he has a serious problem. It takes all of his energy to live day-to-day, he can't handle any more problems than he already has. He feels very alone and scared.

"I don't want to go to the doctor because I don't want to know what I have. I can't afford it and I can't do anything about it anyways. Sometimes it's better not to know." **—David***

* The characters depicted in these profiles are fictional. They were developed based on research to illustrate some of the health needs facing our local communities.

KAISER PERMANENTE®

Trends and Disparities in Access to Care

18.6% of the Los Angeles Medical Center service area community members are uninsured.

Percent uninsured by race/ethnicity within the LAMC service area. Total population: **18.6%** uninsured.

10.2% 12.1%
15.3%
14.2%
25.9%
26.3%

- ⬜ Native Hawaiian/Pacific Islander
- ⬛ Non Hispanic White
- 🟦 Native American Alaska Native
- 🟦 Hispanic
- 🟦 Black
- ⬜ Asian

1 out of 4 Latino service area residents have no insurance coverage, compared to only **1 out of 10** White service area residents.

Key Upstream and Immediate Factors Influencing Access to Care

Economic Stress, Particularly Related to Housing Costs: 1 in every 2 service area residents spend more than 30% of their income on housing: there is very little money left over to spend on co-pays and prescription medication.

No Paid Time Off for Health Care: Often, service area residents have to make a choice between getting paid and going to the doctor.

Immigration Status: Particularly in the current political environment, undocumented immigrants choose not to seek health care except for in emergencies for fear of jeopardizing their ability to continue living in the U.S..

Mental and Physical Health Comorbidity: A large proportion of chronically homeless service area residents struggle with poor mental health and therefore struggle to address and care for their physical health.

Cultural Norms of Health and Illness: Many groups within the service area community have culturally specific ways of making sense of and treating physical illness, and therefore may seek care only for acute illness or severe physical injury.

Service Area Residents Most Impacted by Difficulties Accessing Care

Chronically Homeless   Undocumented Immigrants   Working Poor

Opportunities for Impact

Co-location and collaboration of physical, mental and behavioral health care services, open outside of normal business hours during the week and on weekends, and available with no-interest, low-cost payment plans.

Partnerships with CBOs to reach community residents and engage them in healthcare services through health screening events.

Legal aid and service navigation services for health care access for low-income and immigrant community residents.

Advocacy for paid sick time off for non-exempt, hourly workers.

Community Resources

- The Wellness Center in Boyle Heights
- Neighborhood Legal Services
- St. Barnabas
- Hollywood 4WD
- JWCH/Wesley Health Center
- Kids Community Dental Clinic of Burbank
- Via Care

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ECONOMIC INSECURITY: Individuals and families struggling to afford the basics don't have the needed resources to prioritize health care and wellness

"You have to work more to make ends meet, but because rent goes up you don't have anything left for all the other things you want or need." —Jon*

Jon and his family have lived in the same apartment for 15 years. In the last few years they have really felt the stress of their financial difficulties. They pay $1200 a month in a deteriorating building near downtown—an area rapidly gentrifying. Jon, his wife, and his kids have all been working as much as possible to be able to absorb each new rent hike. A few months ago, Jon's wife was laid off without notice from one of her cleaning jobs. It was incredibly stressful, and a reminder of how precarious their lives really are. Jon has the contact information for an organization that offers funding to help those who are very close to missing their rent payments and becoming evicted, but it seems like a short-term solution to a very long-term problem: they simply can't get the kind of jobs that would allow them to pay or afford higher rent. Jon and his wife are very interested in a community-based adult education program in their neighborhood, something that might help them make higher salaries – they just need to be able to find the time to go to the program. In the meantime, making money takes priority over everything else, and Jon's high blood pressure and cholesterol are issues he barely has time to think about. He is still working to pay off debt from emergency room visits for his daughter last year.

Tonya is a young, new mother. Her baby girl is five weeks old and Tonya's employer is expecting her to come back to work in a week. After an extensive search for childcare nearby, she has determined that the only childcare immediately available costs about 50% of Tonya's weekly salary. If she got the childcare, she would have no money left to support herself and her baby after paying rent. Another option is to return to work and have a family member care for her baby and get reimbursed by the state—but Tonya doesn't have any family members who can quit their jobs. Tonya has looked for job postings to make a higher salary, but with a new baby, she can't work and go to school at the same time. She fears taking out loans for school because she has family members who have done that and haven't been able to pay them off. For now, it seems like the best option is to stop working and collect government assistance. This will mean struggling to pay bills and eat, but at least she will know she has the dependable means to feed and care for her baby.

"Low wages are a barrier to wellness and a better life for myself and my baby girl. I don't have money for childcare, or any sort of emergencies—much less recreation." —Tonya*

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Trends and Disparities in Economic Insecurity

Federal Poverty Level

21% of the Los Angeles Medical Center service area community members live below the Federal Poverty Level.

$1 vs. $13

In Los Angeles Metro Area, in 2015, the median wage for workers of color was **$13 less** than the median wage for White workers.

Over **1 in 4** Latinos and African Americans in the service area community are living below the Federal Poverty Level, compared to only **1 in 8** Whites.

Key Upstream and Immediate Factors Influencing Economic Insecurity

Lack of Social and Economic Capital: Across communities, individuals and families struggle when they don't have friends and relatives in close proximity with the flexibility or economic resources to provide support when times get tough.

Housing Costs and Gentrification: Rising rents and rising costs of goods and services in gentrifying neighborhoods put a financial strain on working poor families who have been longterm residents and have depended on small neighborhood businesses that have closed.

Low Wages and a Lack of Secure, Low-Skill Jobs: Workers that rely on low-skill, part-time or hourly work are usually not insured through work.

Immigration Status: Undocumented immigrants working in the informal economy are very vulnerable to job loss and very low wages.

Weaknesses in the Educational Pipeline for Low-Income Families: Many communities lack resources that would help them move out of poverty, including quality early childhood.

Service Area Residents Most Impacted by Economic Insecurity

Working Poor

Undocumented Immigrants

Transition Age Youth

Opportunities for Impact

Linguistically and logistically accessible employment and education interventions for community members including the homeless.

Programs supporting new moms by bridging to affordable childcare and providing career and personal development support.

Advocacy for affordable housing, and renters' rights.

Support Efforts to expand availability of affordable healthy food.

Community Resources

- My Friend's Place
- Youth Policy Institute
- Project SEARCH
- Glendale Youth Alliance

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FOOD INSECURITY: Lack of affordable and accessible healthy food options and lack of access to the means for preparing healthy food contribute to chronic illness

"Everything is connected. We work a lot to eat, pay rent, pay doctor bills. We can only afford cheap and eat fast food since we have little money and time from working long hours. When we are hungry, we eat whatever to get full and that is why we also get sick. We rarely eat a healthy meal."
—Anna*
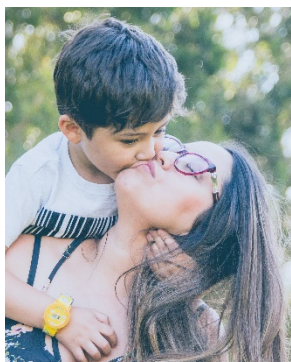
Anna's ideal world is one in which she has a house with a garden to grow food to feed her kids—just like when she was little: it would be more affordable and allow her to control what her family ate. At the same time, it would also require having the time to cook something currently impossible because of her work schedule. Her reality is to stretches her budget of $250 a month to feed a family of four. She shops at stores in her area, and she divides her money between the best of a variety of spoiling produce and unhealthy junk food. When she has the time, she drives with her cousin to a grocery store about 30 minutes away that has affordable quality produce. According to the social services guidelines, she makes just enough money that she doesn't qualify for food aid programs: what doesn't show up in her household income is the debt load she has from her daughter's university expenses. What has been helpful is a class at a local community center that taught her how to make food from the low-cost ingredients she can access – this helped her feel like she had an important role to play in protecting her kids' health, even in the midst of tough circumstances. At the end, quality time and food are rare pleasures for Anna's family.

Kim has been living in her family's van with her parents, two brothers and dog for almost 8 months. Her dad works, but her mom can't work because she takes care of Kim's baby sister during the day. While there is some degree of normalcy in her life, including going to school every day, going to parks, and sometimes to the beach on the weekends, her life is very different from her friends'. At night, Kim doesn't get very much sleep because she is always worried about her family's safety. She takes a shower at a shelter when she can, but her family can't stay long term in a shelter because of their dog. The hardest thing is that she doesn't eat very much, and when she does, it's whatever junk food they can afford. Kim knows that the food contributes to her headaches and stomachaches, making it very hard to concentrate in school. Someone is helping her family get food assistance, but even then it will be a stretch to buy food every month.

"In my family the hardest thing is that we don't eat very much and when we do it's whatever junk food we can get. I get headaches and tummy aches, and I can't have fun in school."
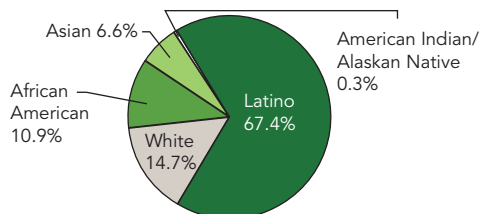**—Kim***

* The characters depicted in these profiles are fictional. They were developed based on research to illustrate some of the health needs facing our local communities.

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Trends and Disparities in Food Insecurity

Asian 6.6%

African American 10.9%

White 14.7%

Latino 67.4%

American Indian/Alaskan Native 0.3%

Over **1 in 7** adults in the service area community experienced food insecurity last year.

Los Angeles County adults with low income households living in food insecure households.

1 in 6 Latino households receives SNAP benefits, compared to only **1 in 22** White households.

Key Upstream and Immediate Factors Influencing Food Insecurity

Lack of Affordable Fresh Produce: Although the density of grocery stores is slightly higher in the service area than the state average, residents explain that the healthy food options in these stores cost too much, and therefore are inaccessible.

Many Residents Lack Complete or Functional Kitchens: Residents who are subject to negligent landlords or live in unpermitted units (like converted garages) do not have access to functioning refrigerators, stoves or microwaves.

Homeless Individuals and Families Lack Food Options: There are very few accessible healthy food resources for families who are not stably housed; many homeless rely on what can be salvaged from the garbage and what they can find at food pantries.

Working Adults Lack Time for Food Preparation: When adults work multiple part-time jobs, there is very little available time to prepare and cook food from scratch.

Service Area Residents Most Impacted by Food Insecurity

Chronically and Temporarily Homeless

Children and their Parents

Residents Living in Food Deserts

Opportunities for Impact

Healthy cooking and eating classes combined with provision of free and affordable healthy ingredients to participants.

Small businesses that make affordable, culturally relevant healthy food.

Advocacy for renters in need of affordable rents, repairs to kitchens and appliances.

Community Resources

- Vida Sana
- Project Angel Food
- St. Barnabas Senior Center
- Seeds of Hope
- RootDown LA

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HOUSING INSECURITY: A stable home is essential to social, physical, mental, and emotional wellbeing

"I feel very alone. No one seems to notice or care that I am still here. I can no longer afford the home or community I've lived in for 25 years, and I don't have any family who can take me. It is a sad time in my life."   —Mark*

Mark lost his husband 8 years ago, and with him, his connections to friends and most of his family. These days, Mark is suffering from neuropathy in his legs which makes it extremely difficult to move around and go out, and he rarely has friends come visit him. In the last couple of years, his landlord has been raising the rent in his apartment to such an extent that Mark has only enough money left to buy food and pay utilities—and even those basics are becoming more and more costly in his neighborhood as wealthier residents move in to is community and drive up costs in stores and for services. Mark is grateful that at least he still has the apartment he shared with his partner, and the things that remind him of their hobbies together. Soon, because he has a fixed income, he will have to choose between keeping his apartment and paying for his health conditions. The thought of losing this space he's lived in for so many years—and with it many of the belongings that give him his sense of identity and joy—brings him to tears. For now, it is helpful that a woman from a social services agency is keeping up with him, asking him about his expenses, and understands his reluctance to pursue other housing options. Mark is holding on to hope, but is is harder to do.

Like two thirds of the homeless population in Los Angeles, Lauro has been living in Los Angeles for over 20 years. He is an undocumented immigrant and for years was able to make ends meet as a cook. Until two months ago, he lived in a small studio apartment. He started having problems about a year ago, when the landlord stopped responding to repair requests. Gradually, as pipes leaked and the air conditioner stopped working, the apartment became less and less habitable. Fearful of disclosing his immigration status and unaware of his renter's rights, Lauro did not voice his concerns. Finally, his landlord raised the rent again, and Lauro couldn't pay. Without another place to go, he started sleeping in his car, which he now does every night. A few years ago he could cope with being separated from his family, but now, with all of this weighing on him, he is feeling increasingly anxious and depressed. He has worked such long days for so many years, paid taxes and has been working on obtaining citizenship. It feels overwhelming and like there are no housing options for someone like Lauro.

"As a human being we have basic needs to meet first. Like shelter, food, and safety, those are very basic needs before we wish for something else."
—Lauro*

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Trends and Disparities in Housing Insecurity

—30%

50.2% of service area community residents spend more than **30%** of their income on housing.
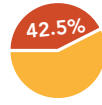
20% **3%**

In LA county, rent increased **20%** and wages decreased **3%** since 2000.

42.5%

In 2018, **42.5%** of the City of LA's homeless population live in the service area.

VS.

In Metro Los Angeles, nearly **2 out of 3** households headed by a White adult age 25 to 54 years is owned, not rented, compared to only **1 out of 3** homes headed by a Black adult.

Key Upstream and Immediate Factors Influencing Housing Insecurity

Lack of Rent Control Policies: Homes built after 1978 are not subject to Los Angeles' rent stabilization ordinance; in gentrifying areas, landlords are motivated to replace long-term tenants paying low rents with new tenants paying much higher market rates.

Shortage of Affordable Housing Stock: Individuals and families who have lost their homes but do not qualify for assistance can't find affordable options in Los Angeles. As a result, many become homeless.

Employment and Housing Discrimination: Many resident groups, including the LGBTQ and HIV positive community, face discrimination from employers and landlords that makes it even more difficult to secure affordable housing.

Systems to Access Affordable Housing are Very Complex and Very Few Applicants Qualify: Residents who are deemed eligible to work and who have a history of income find it very difficult to qualify for rental assistance, even in moments of economic hardship. Housing navigators are key to helping these residents find solutions.

Homeless Who Have Been Housed Need Ongoing Supportive Services: Once housed, individuals and families struggle to stay housed without ongoing social and economic support and health care.

Renters—Including Undocumented Renters—are Unaware of their Rights: Many residents lose their homes as victims of illegal housing practices.

Service Area Residents Most Impacted by Housing Insecurity

$
Renters with Fixed or Low Income

Undocumented Immigrants

Residents in Need of Mental and Behavioral Health Care

Opportunities for Impact

Services to fight illegal eviction and advocate for housing rights.

Case management to support newly homeless and newly housed individuals and families.

Coordination among CBOs that support the legal rights of, and access to resources for, the undocumented and immigrant populations, LGBTQ and HIV positive communities, in addition to residents facing temporary hardship.

Community Resources

- Inqilinos Unidos
- CHIRLA
- Hollywood Community Housing Coalition
- Eviction Defense Network
- Public Counsel

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"The stress. That is how the different health issues come. In my case, there are many reasons why I'm stressed. I don't have health insurance and because of my immigration status, I'm afraid to go to a community clinic." —Laura*

Laura suffered greatly on the journey north to the US with her children. Her life is now is very difficult. She works two jobs every day to pay her rent and utilities. She stays up late to cook what food she can afford for her children and helps them with homework. She sleeps about four hours per night. She rarely has time to relax with her friends or her kids. Even though she talks on the phone to her family in her home country, she misses them and worries about them. Laura and her family share an apartment with her cousins, some of whom drink a lot and can become violent. When they are in the house, everyone tries to stay silent. It can be very stressful. Laura is aware that she feels very anxious and heavy. She cries easily, and often feels very overwhelmed. After a long period of time dealing with her anxiety in the ways she learned to do growing up, she recognizes that she is struggling to keep up at work, and finally agreed to go to a community center and see a counselor. If she feels she can take the time off work without risking losing her job, she will go to the appointment. If not, then she will need to manage on her own.

Jess left her family's house when she was in her late teens. Growing up, her father would lose his temper and hit her. Before leaving home, Jess was bullied at school and mistreated by her family. This made her feel angry and worthless. It continued on the street. Jess has learned quickly that there are no safe places when you're homeless – she has been beaten up in shelters, and has had things stolen from her. She sees the way people look at her and judge her. In order to stay as safe as possible, Jess tries not to sleep too much. She has tried several different drugs in this effort, including meth, which really scares her. An outreach group has been routinely meeting with her, and she has been getting to know them. She likes them because they accept her – they call her by her name, "Jess," and don't ask the same awkward questions that other health care providers have asked her in the past. They have been working with her to make some appointments for a mental health evaluation. The last three times, she has missed these appointments because of other issues that have come up, but they aren't giving up on getting her to see someone who can help.

"You need a therapist who understands where you are coming from and values you, so that you can be open." —Jess*
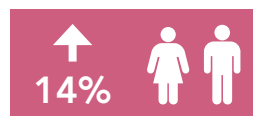
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Trends and Disparities in Mental & Behavioral Health

Poor mental health is associated with a **61.3%** reduction in length of life per year for residents in the service area.

CALIFORNIA STATE RESIDENTS	3.65
SCAL RESIDENTS	3.69
LOS ANGELES SERVICE AREA RESIDENTS	3.70
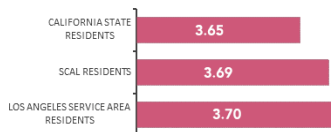
Poor mental health days per month.

14%

Over **14%** of adults in LA County's SPA 4 have been diagnosed with depression.

1 in 10 children living below the poverty level have experienced a serious emotional disturbance.

Key Upstream and Immediate Factors Influencing Mental & Behavioral Health

Chronic Homelessness: The conditions of life on the streets contribute to and exacerbate existing poor mental and behavioral health.

Adverse Childhood Experiences and Trauma: Experiences including growing up in community violence and the foster care system increase vulnerability to poor mental health.

Social Isolation and Disconnection: Across resident communities, individuals are struggling with feelings of disconnection and isolation.

Lack of culturally competent mental health care: Knowledge of the culture and lived experience of specific patient groups, including immigrants of various cultural backgrounds, African Americans, LGBTQ immigrants and seniors, is necessary for accurate assessment and treatment of mental and behavioral health issues.

Service Area Residents Most Impacted by Poor Mental & Behavioral Health

Chronically Homeless

Homeless LGBTQ Youth

Residents with Histories of Trauma

Opportunities for Impact

Housing First and "no wrong door" approaches to supporting the homeless population

Co-location and collaboration of physical, mental and behavioral health care services, open beyond normal business hours during the week, and on weekends

Partner with CBOs and the faith community to provide mental health and social support outreach to communities

Adopt trauma-informed care approaches in health care services, schools, and social services

Community Resources

- The Center at Blessed Sacrament
- LA Child Guidance and Family
- Foothill Family Services
- CHIRLA
- LAC DMH Health Neighborhood

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"When you are in a situation where you might have to have sex with someone to eat and have a safe place to sleep at night, you can't control your exposure to HIV/STDs. You got to do whatever you need to do to survive sometimes."
—George*

George contracted HIV a few years ago, during a period of time he was staying with a friend because he couldn't afford rent. He had grown up in foster care, and in spite of getting jobs here and there, has struggled to maintain enough income to pay for an apartment consistently. Because he is gay, his extended family has always stayed away from him and hasn't stepped up to help him out. At the time he was living with his friend, he knew he was at risk of contracting HIV, but didn't know about things he could do—like PrEP—to protect himself. It took him a few years to come to terms with the diagnosis after he got it. He didn't seek treatment because he couldn't confront the reality of the disease and the shame he felt. In the last year, he has accepted it, and has been trying to advance himself. He is currently in the process of applying for housing support for HIV patients. He hit a road block, though. The program he is eligible for would send housing assistance directly to his landlord via the funding agency. He knows that his landlord would immediately know his HIV status if he received this check. Ryan isn't sure what he wants to do next. He's afraid he will be evicted if he is outed to his landlord.

Araceli is 16 and has been dating the same boy for about 6 months. She doesn't want her parents to find out about her boyfriend because she's afraid they would kick her out of the house. She goes to school in a community that is still fairly conservative, where most of the parents don't talk about sex with their kids. Living in this community, it is hard not to feel ashamed, embarrassed and judged. Araceli doesn't have access to women role models who can help her better understand her body. She hasn't had an opportunity to ask questions about sex and STIs. She doesn't feel empowered. She feels afraid that she will contract an STI or HIV because she doesn't know how to protect herself. If this or anything else happens that requires her to share details about her relationship with a doctor, she knows her parents will find out. For this reason, she avoids going to the doctor. She wishes that talking about sex wasn't a big deal, and that she could be more knowledgeable about sexual health.

"STIs classes would help me understand how to take care of myself. Many of my friends are also having sex and they are also not using protection." **—Araceli***

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Trends and Disparities in STIs/HIV/AIDS
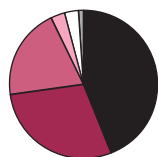
Legend:
- American Indian/Alaskan Native
- Multi-race/Unknown
- Asian/Pacific Islander
- African American
- White
- Latino

An STD/HIV/AIDS diagnosis is associated with a **58.2%** reduction in length of life per year.

Among persons living with HIV in LA county, 44% were Latino, 29% were white, 20% were African American, 3% were Asian/Pacific Islander, 3% were multi-race/unknown, and 1% were American Indian/Alaskan Native.

In the City of Pasadena, the 10-year average death rate due to HIV was **2x** higher for Black males than for White males.

Key Upstream and Immediate Factors Influencing STIs/HIV/AIDS

Lack of Mental and Behavioral Health Services mean individuals continue to struggle in relationships and with substance use issues that make them vulnerable to STI transmission.

Homelessness and Housing Insecurity lead to vulnerability for STI transmission because survival sometimes means engaging in risky behaviors like drug use.

Lack of Funding for Research and Interventions means there is little money to research the ongoing high STI transmission rates among youth and adults of color and LGBTQ individuals.

Lack of Education Among Clinicians about LGBTQ Communities means that often, LGBTQ at risk youth and individuals are not engaged in conversations about safe sex practices relevant to their lived experience, and are not made aware of effective methods for protecting themselves.

Groups Most Impacted by STIs/HIV/AIDS

Homeless with Substance Use Disorders

African American and Latino Males

Homeless LGBTQ Youth

Youth of Color

Opportunities for Impact

STI/HIV/AIDS education in shelters and youth centers.

Employment, economic, mental health and educational support for targeted groups like trans women of color and homeless LGBTQ teens.

Efforts to build LGBTQ safe spaces on school campuses.

Community Resources

- Mi Centro/Latino Equity Alliance
- Bienestar
- AIDS Project Los Angeles
- Asian Pacific AIDS Intervention Team
- Planned Parenthood Los Angeles

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"When I was little my mom told me I had two counts against me: I was Black and I was male. Now I understand what she meant. I do one thing wrong and I could get shot or locked up. I am proud of who I am. I just wish I had the same opportunities than others do." **—Kevin***

Kevin is 16 and lives in a very crowded apartment with his mom, his aunt and his cousins. His home and environment make him and his family feel very stressed out. A lot of the families in the complex have been there since the 1950s or 60s – they grew up there with their kids, and now their grandkids are growing up there too. The families moved in because it was one of the few places in the area where Black people could live. It is a community of generations of families, but also of cycles of poverty, poor quality education and lack opportunities. Now, people just don't seem to be able to get out. Kevin sees that his older friends and cousins can't find jobs that pay enough to live. Kevin is very aware of how unfairly he is treated because of his skin color. He sees how much harder he, his friends, and his family must work for things that come easily to others. He tries his best but the constant struggle and effort for basic opportunitiers can make him feel discouraged, and sometimes he just wants to give up. He wants to be able to experience a totally different reality, one where he can get an education, a job and a better life without fear and stress.
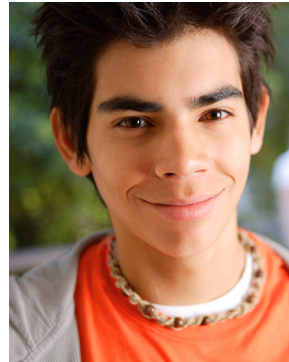
Alex grew up in foster care. He was physically abused as a young kidby his family. He thinks this was because of his gender identity. In his hometown, trans people were stigmatized and stoned. He encountered this often. Medical appointments were difficult because nurses and doctors were confused by him and didn't know how to treat him. When he went to get his driver's license, he was publicly ridiculed by an administrator when Alex asked about the rules for changing one's sex in DMV records. Small events like that added up, and compounded the trauma Alex has carried from his youth. Alex took a bus to LA two months ago because he heard that in Hollywood he can get help for his transition and build a life for himself. For now, he's homeless and sleeping at a shelter for LGBTQ youth. He's hoping to find a medical clinic that understands what he's going through and will support his transition. He's looking for a job. Thanks to a program supporting trans homeless youth, he has found other young people who he can relate to. Being trans and without family support means that relationships with friends, LGBTQ mentors and advocates are essential to his survival and dreams of a better future.

"I moved to here to build my life. Where I come from, I couldn't change the sex on my driver's license without getting surgery first–something I can't afford. Without an ID with my gender, I face discrimination and finding a job is very hard." **—Alex***
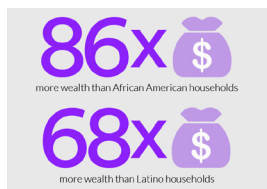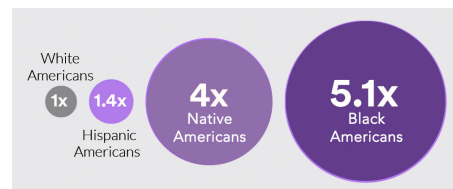
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Outcomes of Structural Exclusion
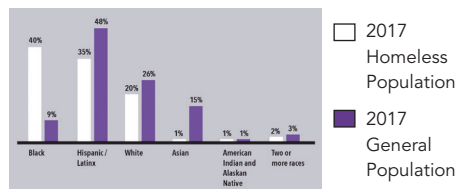
Homeless population vs. General population by race & ethnicity.

Projected wealth of White American households in 2020.

Average U.S. incarceration rates.

Key Downstream Consequences of Exclusionary Policies and Norms

Economic Stress among communities of color, LGBTQ communities, and other marginalized groups is attributable to structural exclusion--policies and practices that created and perpetuate inequality in access to property, loans, education, jobs and health care.

Poor Mental Health and Substance Use Disorders disproportionately impact communities that have experienced structural exclusion.

Community Violence disproportionately impacts communities that have experienced generational poverty resulting from explicit or implicit structural exclusion.

Homelessness disproportionately impacts people of color and LGBTQ individuals because they disproportionately experience acute economic stress, poor mental and behavioral health, community violence, stigma and social marginalization.

Groups for Whom Policies and Practices Limit Access to Opportunity

African Americans   Latinos   LGBTQ   Immigrants

Individuals, men or women, who are identified with marginalized groups

Opportunities for Impact

Include clients in all planning and program evaluation activities to ensure the voices of those often excluded are heard and experience and expertise are incorporated.

Build culture-based programs that teach participants about the meaningful contributions of members of their communities and use cultural touchpoints to build trusting relationships.

Assess how policies, programs and budgetary decisions by organizations or agencies disproportionately burden or systematically exclude specific populations. Include community members impacted in recommending alternatives.

Build and grow leadership to increase representation, participation of and decision-making by people of color and other excluded groups to change cultures, systems and practices. Make equity impact and culture a priority at all levels of organizations, systems and practices.

Community Resources

- Brotherhood Crusade
- Black Infant Health Programs
- LGBT Center
- TransLatin@ Coalition

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Appendix D. Community resources

Identified need	Resource provider name	Summary description
Economic security	Youth Policy Institute	YPI's long-term goal is to eradicate poverty through programs designed to increase academic achievement, elevate income, and improve access to high-quality education, training, and technology services. YPI's programs currently assist more than 115,000 Los Angeles youth and adults throughout Los Angeles, with focuses on Hollywood/East Hollywood, Thai Town, Koreatown, Little Armenia, Pico Union, Westlake, and Pacoima. YPI clients are primarily Latino and other people of color, and approximately 60% are youth. Poverty is a serious concern, with 61% of Promise Zone residents designated as low-income (185% of federal poverty line). 77% of households with children under 18 receive CalFresh (food stamps) and more than 80% of students are eligible for free and reduced lunch.
	Project SEARCH	Project SEARCH is a partnership between business, education and vocational rehabilitation. The goal is to provide on-site internship experiences for youth with disabilities leading to competitive employment. Project SEARCH is a one year, high school transition program which provides training and education leading to employment for individuals with disabilities. The program occurs on-site at a high status community business. Project SEARCH serves as a workforce alternative for students in their last year of high school. The cornerstone of Project SEARCH is total immersion in a large business. Each day, students report to the host business, learn employability skills in the classroom and job skills while participating in 3 – 4 internships/experiences during the year. If available, students utilize public transportation. Students get continual feedback from the internship manager, co-workers and Project SEARCH staff. Students end their day by reflection, problem solving, planning and journaling their key learning's. The ultimate goal upon program completion is competitive employment utilizing the skills learned on the internships and throughout the program.
	Glendale Youth Alliance	The mission of the Glendale Youth Alliance (GYA), as a youth service organization, is to provide, coordinate and/or support youth employment activities, efforts and programs that have a positive impact on the GYA youth. Glendale Youth Alliance provides jobs and employment preparedness training for at-risk youth ages 14 to 24. GYA Programs are designed to build civic values, provide a foundation to learn job skills and increase the likelihood for the participants to become productive members of the workforce. Glendale Youth Alliance currently operates five programs on a spectrum that provide mentored employment to youth. These range from a program that gives subsidized jobs to the youngest youth who have never held a job, to a program for older youth who are ready to secure unsubsidized employment.
Mental and behavioral health	LA Child Guidance and Family	The mission of the Los Angeles Child Guidance Clinic is to provide quality mental health services to a community in great need by ensuring easy access and promoting early intervention. The Clinic enhances the mental health and well-being of children and youth ages 0-25 years, and their caregivers by providing: family-centered, culturally sensitive and clinically sound mental health programs in an atmosphere that fosters emotional and social growth; specialized educational services to seriously emotionally disturbed children and youth who have failed in other settings;

Identified need	Resource provider name	Summary description
		as well as training and advocacy programs for increased access to mental health and related services.
	Latino Equality Alliance	The mission of Latino Equality Alliance (LEA) is to support LGBTQ youth to ensure their overall happiness and success as community members. LEA's goal is to sharply increase safe spaces for LGBTQ youth within their community, schools, and home environments and to create opportunities for them to live a healthy, successful life with the support of their family, peers, and community. Through its educational and outreach efforts, LEA links LGBTQ youth and their families to mental, primary case and other supportive services to ensure the overall well-being of LGBTQ youth in communities such as East Los Angeles and South Los Angeles. LEA has been a key community partner in promoting social support networks and access to counseling and suicide prevention services to this high-risk youth population.
	Foothill Family Services	Foothill Family Service helps the San Gabriel Valley with family centers in Pasadena, El Monte, West Covina, Duarte, and Pomona. Working with more than 22,000 clients and family members a year, Foothill Family Service's 290 staff include social workers, marriage and family therapists, early childhood therapists, parent partners, psychologists and consulting psychiatrists.
Food insecurity	Project Angel Food	Project Angel Food provides free food and nutrition services to low-income individuals of all backgrounds and diagnoses throughout the entire 4,000+ square-mile LA County region. Project Angel goals are to promote healthy outcomes, alleviate hunger and prevent malnutrition among individuals struggling with life threatening diagnoses through the provision of free food and nutrition services. About 80% of Project Angel Food's clients are people of color and 59% are 60 and over. 97% of our clients live below or at the federal poverty line - facing multiple challenges of their medical condition, hunger and isolation.
	St. Barnabas Senior Center	St. Barnabas Senior Services (SBSS) is a nonsectarian, nonprofit organization grounded in the belief that all older adults have the right to age with dignity. As the oldest senior service agency in LA, SBSS has grown from operating a single senior center in Mid-City to a dynamic senior service agency developing new models of care and providing innovative services throughout the Greater Los Angeles Area. SBSS participants are in their mid-70s, live alone, have few relatives or friends to provide assistance, and speak minimal English. These participants roughly match the demographic profile of this geographic area: 35% Asian, 33% Latino, 25% White, 6% African/American, 1% Other. Most depend on Social Security of $800-$900 per month to cover their expenses and rely on Medicare and Medicaid for their health coverage. Living at or below the federal poverty level, they lack the resources to meet their basic food, housing, and healthcare needs.
	Seeds of Hope	Seeds of Hope seeks to help congregations, communities, and schools turn unused land into productive gardens and orchards to provide healthy and fresh food in areas of need across the county. Through garden workshops, nutrition education, and with creative collaboration with communities, we are working to Cultivate Wellness in Los Angeles to create stronger, healthier communities. Seeds of Hope provides gardening and nutrition/cooking education, topics include: food groups and portions,

Identified need	Resource provider name	Summary description
		unit prices, reading a nutrition label and sugar sweetened beverages. All classes and materials will be in English and Spanish.
Access to care	JWCH/Wesley Health Center	As a federally-qualified health center, JWCH/Wesley Health Center's mission is to improve the health and wellness of the homeless and other under-served populations of Los Angeles County through the direct provision or coordination of health care, health education services and research. JWCH/Wesley Health Center offers a variety of programs and activities, such as: medical outreach and referrals for medical care, HIV services and drug treatment; health education; psychosocial assessment and intervention; primary medical care; family planning services; and research.
	Kids Community Dental Clinic of Burbank	The Kids' Community Dental Clinic is dedicated to improving children's oral health through quality dental care and preventive education for low-income families in greater Burbank and surrounding areas. The Kids' Community Dental Clinic was created to fill a crucial need and gap in oral health care services for children of low-income children ages 0-18 years old.
	Via Care	Via Care is a non-profit federally qualified health center formed to provide healthcare to low-income patients in the greater East Los Angeles area. As a community-based organization, Via Care fulfills its mission by delivering quality health care services throughout the entire life cycle, in a manner that is respectful and conscious of the cultural and linguistic needs of its patients and their families.
Housing insecurity	Hollywood Community Housing Corporation	Hollywood Community Housing Corporation (HCHC) provides affordable housing that achieves design excellence and environmental sustainability, while at the same time respecting the history, culture, and architecture of the communities it serves. HCHC strives to transform lives by providing supportive housing services and access to resources that improve the quality of life for its low-income, vulnerable residents. HCHC has developed 29 properties, creating over 951 units of safe, attractive and centrally located affordable housing. HCHC was among the first affordable housing developers to recognize the importance of combining supportive services with housing and developing and operating affordable rental housing and providing on-site supportive services for special needs households, including seniors and formerly chronically homeless households.
	Eviction Defense Network	The Eviction Defense Network (EDN) is a network of trial lawyers, advocates and tenants defending the right to affordable housing. EDN was formed in 2003 to provide affordable representation by experienced tenant attorneys to all tenants facing eviction in Los Angeles County. EDN is a nonprofit organization that is based on a unique model. EDN was formed to fill in the gap between the free services already provided by Legal Aid organizations and the huge number of tenants facing eviction who are either not eligible for Legal Aid or otherwise unable to obtain legal representation. EDN also works to prevent evictions and collaborates with several tenants' rights organizations to provide tenant education, so tenants are in a better position to assert their rights and protect their homes.
	Public Counsel	Public Counsel is the nation's largest not-for-profit law firm specializing in delivering pro bono legal services. Founded in 1970, Public Counsel

Identified need	Resource provider name	Summary description
		strives to achieve three main goals: protecting the legal rights of disadvantaged children; representing immigrants who have been the victims of torture, persecution, domestic violence, trafficking, and other crimes; and fostering economic justice by providing individuals and institutions in underserved communities with access to quality legal representation. Through a pro bono model that leverages the talents and dedication of thousands of attorney and law student volunteers, Public Counsel annually assists more than 30,000 families, children, immigrants, veterans, and nonprofit organizations and addresses systemic poverty and civil rights issues through impact litigation and policy advocacy.
Sexually transmitted infections/Sexually transmitted diseases	AIDS Project Los Angeles	AIDS Project Los Angeles (APLA) provides primary care services (medical, oral and behavioral) to low-income, underserved populations. For People Living with HIV (PLWH) APLA offers direct access/referrals to basic needs including nutrition, linkage-to-care services, and housing support. In addition, we offer culturally appropriate HIV prevention, HIV testing, STD testing/treatment, specialty HIV care, home health and support for other community service providers through its Capacity Building Assistance program.
	Asian Pacific AIDS Intervention Team	The mission of Asian Pacific AIDS Intervention Team (APAIT) is to positively affect the quality of life for Asian and Pacific Islanders living with or at-risk for STD/HIV/AIDS by providing a continuum of prevention, health and social services, community leadership and advocacy to the Southern California region. APAIT provides STD/HIV health education and testing, substance abuse counseling, and case management. APAIT's patient navigators provide consultations and health information, assess clients' eligibility for public health coverage and other benefits programs including housing.
	Planned Parenthood Los Angeles	The mission of Planned Parenthood Los Angeles is to provide convenient and affordable access to a comprehensive range of quality reproductive health care and sexual health information, through patient services, education and advocacy. Planned Parenthood Los Angeles is one of the largest providers of comprehensive, reproductive health care services in Los Angeles County. Planned Parenthood Los Angeles's education and outreach programs deliver sexuality and family planning education to nearly women, men and teens each year. Its outreach programs include middle and high school responsible sexuality courses, parent-child communication programs, Promotoras Comunitarias (Latina community health educators), and teen education programs.
Race and identify	Jovenes Inc	At Jovenes, Inc helps homeless young people ages 18-25 end their cycle of homelessness. Jovenes goes deep with each of its youth, implementing a plan addressing their needs for housing, healthcare, education/employment, and trauma recovery. Jovenes' goal is to place youth into permanent housing with tools to develop pathways for their personal and professional growth. Jovenes provides an innovative program of stable housing options, compassionate care, life skills training, and employment support for young adults seeking a path to life change. Jovenes' Employment, Education, and Youth Leadership Program. Jovenes' Employment and Career Counselor leads this program with support from Jovenes' psychologist, and AmeriCorps VISTA volunteer, and two youth leaders. Our approach is designed to provide our youth with

Identified need	Resource provider name	Summary description
		the support and direction they need to gain employment and develop their personal skills and leadership capacity. Jovenes offers both Employment. Education, & Career Advancement and a Youth Leadership Internship. These programs prepare youth to take on the personal leadership and employment responsibilities that are necessary to become independent adults. Activities such as employment preparation, mental health counseling, field trips, mentoring, advocacy & awareness, and community service teach skills vital for youth to be able to accomplish the core goal of Jovenes: move into permanent housing with the personal tools and support needed to become independent and self-sufficient adults.
	The LGBT Center	The LGBT Center is a pioneer and leader in the LGBTQ community providing essential, critical support services that can take care of any need from social services and housing to health and mental health to culture and advocacy, leadership and education. The LGBT Center provides comprehensive, wraparound approach to responding to the needs of LGBTQ individuals, particularly the most vulnerable in our community like LGBTQ youth of color and LGBTQ seniors. The Center's programs reach throughout Los Angeles County and provide many underserved neighborhoods with opportunities to link to the closest available service site. The Center's programs annually reach over 30,000 youth and adults (80% LGBT; 20% non-LGBT) with 90% at or below the poverty line. With a Federally Qualified Health Center, the Center is committed to serving any community member regardless of income, gender, sexuality, documentation status.
	YWCA Pasadena Foothill	The YWCA Pasadena-Foothill Valley is dedicated to eliminating racism, empowering women, and promoting peace, justice, freedom and dignity for all. YWCA Pasadena-Foothill's mission is carried out through its programs for low-income and minority communities in the area with a special emphasis on low-income, minority youth in the Northwest Pasadena/Altadena area. The YWCA's girls' empowerment programs – TechGyrls, Express Yourself!, Girls' Empowerment Summer Camp, and our community outreach workshops – provide girls with opportunities to participate in interdisciplinary Science, Technology, Engineering, Art and Mathematics activities, giving them the tools they need to excel in school and prepare for higher education and careers.

Appendix E – Strategic Lines of Inquiry for Community Engagement

Southern California Kaiser Permanente's approach to the 2019 CHNA employed a mixed-methods sequential explanatory assessment design intended to produce the most accurate, vivid, and meaningful story of community health possible. This appendix reports an overview of the assessment design and the resulting list of strategic questions that guided community engagement for this report.

Overview of Question Design Process

·   Secondary data from over 200 relevant indicators were analyzed by Kaiser Permanente Regional analysts to provide a bird's eye view of the most pressing health issues across the service area.

·   These analyses were reviewed and discussed by Kaiser Permanente clinicians, experts, and hospital leaders who had knowledge of the local community. These discussions helped provide additional context to findings and identify targeted strategic lines of inquiry that provided the foundation of a relevant community engagement plan. For example, Kaiser Permanente social workers might review the data during this phase and provide their perspective that immigration policies could be influencing Hispanic/Latino resident willingness to access care.

·   Across these internal sensemaking sessions, strategic lines of inquiry were synthesized by consultants and re-framed to work as a driving force behind community engagement planning. These strategic questions were also designed to be answerable by human beings (not more secondary data). Strategic questions targeted the root causes of health needs, racial/ethnic disparities in impact, community lived experience, or the resources available to address a health need (e.g. *to what extent are current immigration policies inhibiting resident willingness to access healthcare and other community resources and how can these obstacles be overcome?*).

·   Strategic questions were not asked *directly* of engagement participants but were instead used to build a sampling frame and culturally competent in-person engagement protocols. For example, a question asking about the impact of immigration policies on resident willingness to access health care would lead to: a) recruitment of community residents and experts who could provide rich answers to the question and b) tailored interview and focus group protocols for engagement participants that would conversationally surface the answer in a manner consistent with best practices in qualitative data collection.

·   By using a series of strategic questions in this way, primary data collection allowed for authentic community engagements with residents and stakeholders that could "dive deep" on issues relevant to the community (and ground truth their relevance).

·   Regardless of the strategic focus of the engagements, however, they also provided the opportunity for the community to raise any other health needs not targeted through the strategic lines of inquiry and these data were also included primary data analysis.