

2019 Community Health Needs Assessment

Kaiser Foundation Hospital: Panorama City

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

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Kaiser Permanente Southern California Region Community Benefit CHNA Report for KFH-Panorama City

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I. Introduction/background

A. About Kaiser Permanente (KP)

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

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

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

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

B. About Kaiser Permanente Community Health

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

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

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

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

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

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

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

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

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

Kaiser Permanente's innovative approach to CHNAs includes the development of a free, web-based CHNA data platform that is available to the public. The data platform provides access to a core set of approximately 120 publicly available indicators to understand health through a framework that includes social and economic factors, health behaviors, physical environment, clinical care, and health outcomes. In addition, hospitals operating in the Southern California Region utilize 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 Panorama City 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. Maps

Figure A. KFH-Panorama City Service Area

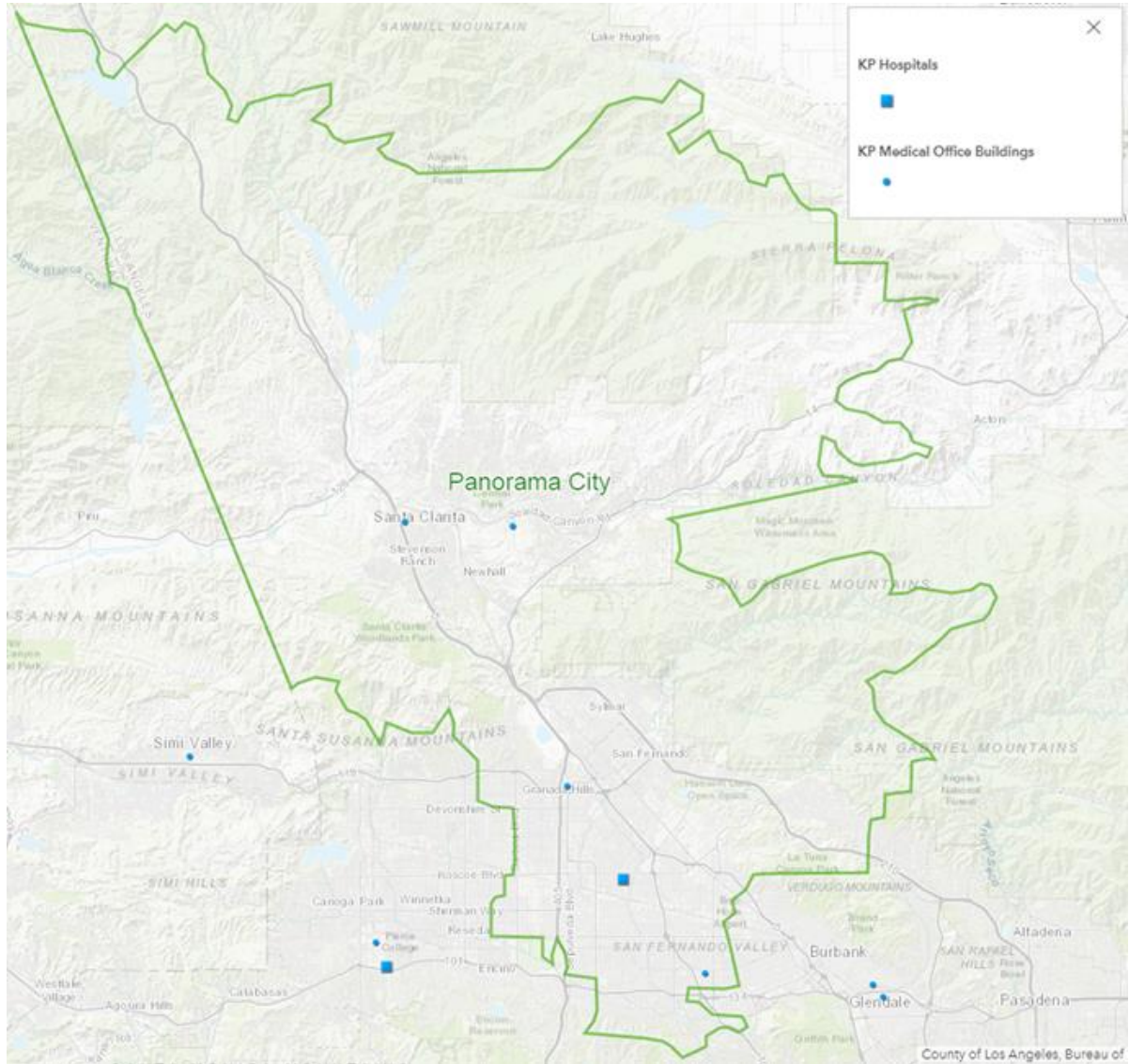
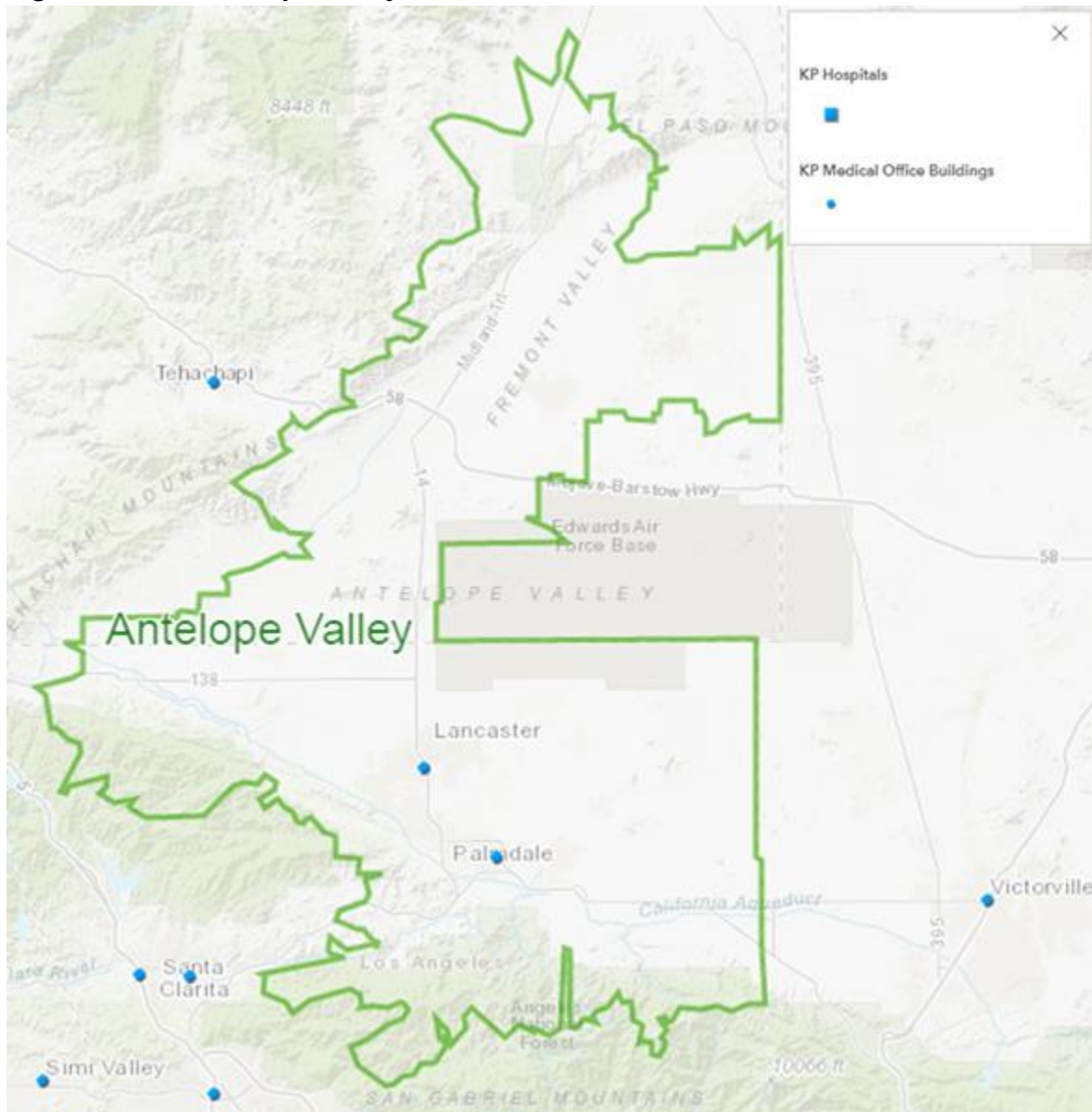


Figure B. KFH-Antelope Valley Service Area



ii. Geographic description of the community served

The communities served by KFH-Panorama City Medical Center Service Area are tremendously diverse with respect to demographic and socio-economic composition, geography and topography. KFH-Panorama City Medical Center Service Area is part of an integrated delivery system that serves the communities of the East San Fernando Valley, Santa Clarita Valley, and Antelope Valley in addition to 4 zip codes in Kern County. For the purposes of this report, the KFH-Panorama City Medical Center Service Area distinguishes between the two sub-service areas of Panorama City Service Area and the Antelope Valley Service Area. The Panorama City Service Area includes Agua Dulce, Arleta, Canyon Country, Castaic, Frazier Park, Granada Hills, Lake View Terrace, Mission Hills, Newhall, North Hills, North Hollywood, Pacoima, Panorama City, San Fernando, Santa Clarita, Saugus, Sherman Oaks, Stevenson Ranch, Sun Valley, Sunland, Sylmar, Tujunga, Universal City, Valencia, and Van Nuys.

The Antelope Valley Service Area includes Acton, California City, Elizabeth Lake, Hi Vista, Juniper Hills, Lake Hughes, Lake Los Angeles, Lancaster, Littlerock, Llano, Mojave, Palmdale, Pearblossom, Quartz Hill, Rosamond, and Valyermo.

iii. Demographic profile of the community served

The following table includes race, ethnicity, and additional socioeconomic data for the KFH-Panorama City service areas. 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 the total population percentage reporting as Hispanic/Latino.

Table 1. Demographic Profile: KFH- Panorama City¹

Panorama City Service Area			
Race/Ethnicity		Socioeconomic	
Total Population	1,232,358	Living in Poverty (<100% Federal Poverty Level)	16.36%
Asian	8.78%	Children in Poverty	22.78%
Black	3.73%	Unemployment	4.1%
Hispanic/Latino	51.47%	Uninsured Population	16.03%
Native American/Alaska Native	0.17%	Adults with No High School Diploma	22.30%
Pacific Islander/Native Hawaiian	0.13%		
Some Other Race	0.26%		
Multiple Races	2.26%		
White	33.19%		

Table 2. Demographic Profile: KFH- Antelope Valley²

Antelope Valley Service Area			
Race/Ethnicity		Socioeconomic	
Total Population	424,496	Living in Poverty (<100% Federal Poverty Level)	21.99%
Asian	3.69%	Children in Poverty	29.93%
Black	14.61%	Unemployment	4.4%
Hispanic/Latino	45.64%	Uninsured Population	12.77%
Native American/Alaska Native	0.31%	Adults with No High School Diploma	21.70%
Pacific Islander/Native Hawaiian	0.15%		
Some Other Race	0.24%		
Multiple Races	2.58%		
White	32.77%		

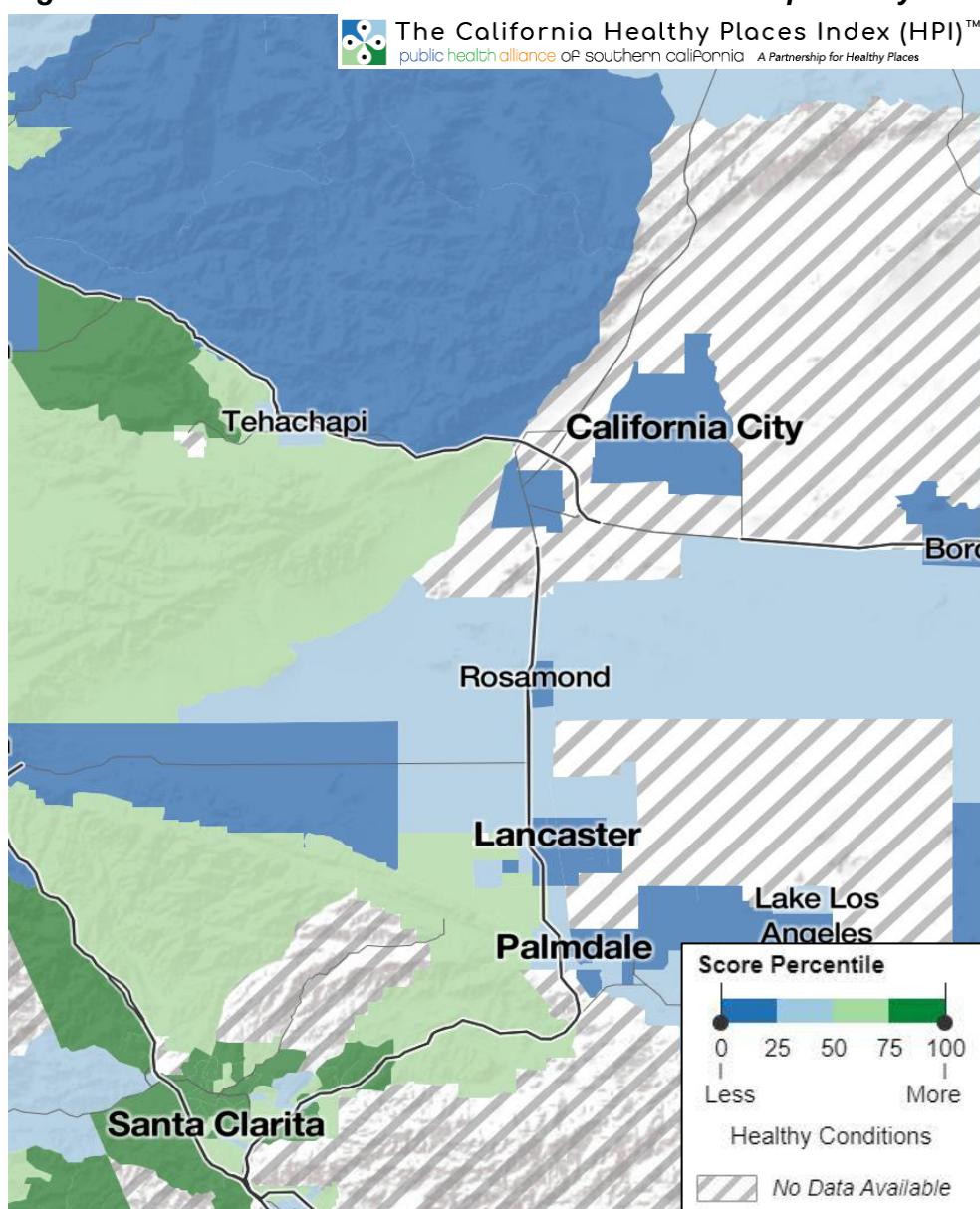
iv. Severely under-resourced communities

¹ American Community Survey (2012-2016).

² Ibid.

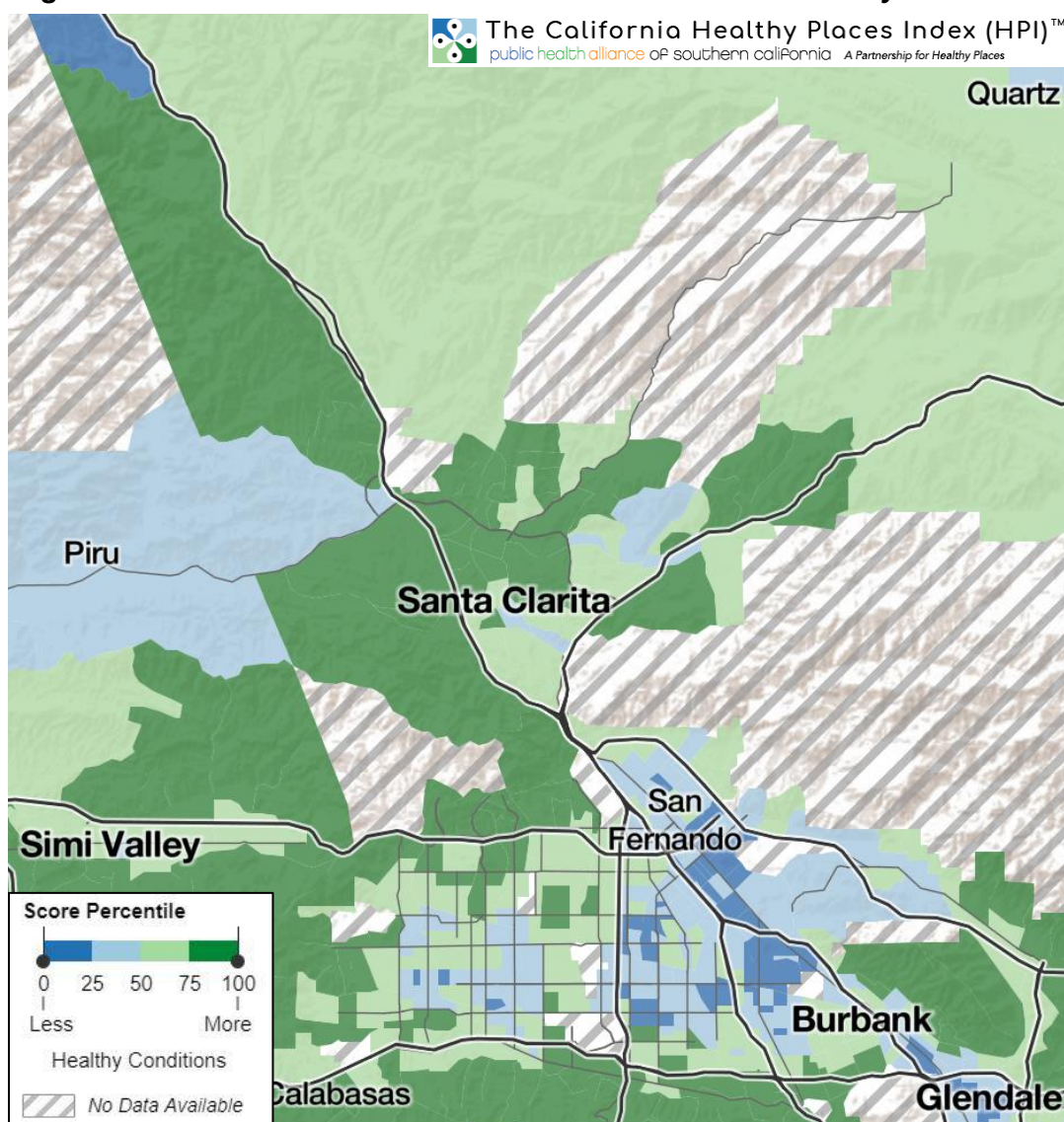
Identifying disparities in the upstream factors that predict negative health outcomes is critical to Kaiser Permanente's community health mission. The map below displays the differences in opportunity for residents in the KFH-Panorama City service area to live a long and healthy life¹. Areas in dark blue represent census tracts in the lowest quartile of health opportunity across California. These areas are severely under-resourced across multiple domains of the social predictors of health (e.g. economics, education, transportation, built environment, etc.).

Figure C. Under-Resourced Communities in KFH-Antelope Valley



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

Figure D. Under-Resourced Communities in KFH-Panorama City



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

Major under-resourced communities in the KFH-Panorama City service area:

Panorama City Service Area: San Fernando, Pacoima, Panorama City, Van Nuys, Sylmar, Sunland/Lake View Terrace and Santa Clarita Valley: Val Verde, Canyon Country, and Newhall.

Antelope Valley Service Area: Lancaster, Palmdale, Littlerock, Lake Los Angeles, California City, and Rosamond.

The data below depicts the differences in opportunity for residents in the KFH-Panorama City and Antelope Valley service areas to live a long and healthy life³. Severely under-resourced areas significantly lack resources across multiple domains of the social predictors of health (e.g. economics, education, transportation, built environment etc.).

In aggregate, residents living in the **KFH- Panorama City service area** are in the **46th percentile** for health opportunity⁴ among all California residents with approximately **317,411** people living in severely under-resourced census tracts. Residents living in the **Antelope Valley service area** are in the **32nd percentile** for health opportunity among all California residents with approximately **202,964** people living in severely under-resourced census tracts.

In effect, this means that nearly 50% to 70% of Californians have a greater opportunity to live a long healthy life than residents living in these service areas⁵.

III. Who was involved in the assessment?

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

Collaborating Hospitals:

- Dignity Health – Northridge Hospital Medical Center
- Providence Holy Cross Medical Center
- Providence St. Joseph Medical Center

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

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

³ 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>.

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

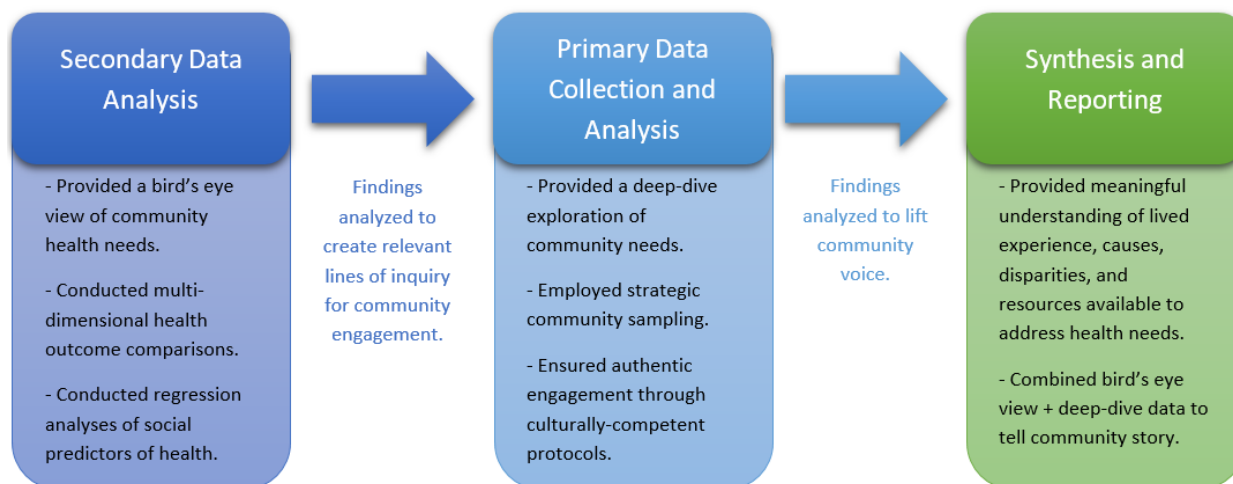
⁵ Calculations are estimates based on population-weighted HPI scores using the most recent US census data.

reputation for gathering the most relevant information, then transforming the information gathered into meaningful and salient “stories” that appropriately convey the lived experiences and perceptions of the community.

IV. Process and methods used to conduct the CHNA

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

Figure E – Mixed-Method Assessment Approach to the CHNA



A. Secondary data

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

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

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

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

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

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

First, the most under-resourced geographic communities were identified utilizing the Public Health Alliance of Southern California's Healthy Places Index (HPI) [mapping function](#). The social predictors of health in this index include 25 indicators related to economic security, education, access to care, clean environment, housing, safety, transportation, and social support (please refer to Figures C & D to see these maps⁶).

Second, social predictors of health were used in multiple linear regression analyses to produce models identifying the social factors most predictive of negative health outcomes in KFH-Panorama City service area census tracts. The results of these analyses found multiple social factors with statistically significant ($p < .05$) predictive relationships with important population health outcomes (please refer to Tables 3 & 4 to see results).

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

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

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

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

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

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

Table 3. Social Factors Linked to KFH-Antelope Valley Health Outcomes

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

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

Table 4. Social Factors Linked to KFH-Panorama City 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	Number of Outcomes Affected
More Crowded Housing	X	X	X	X	X	X			X	7
Less Employment	X	X	X	X		X				5
Fewer Bachelor's Degrees	X		X	X	X				X	5
Lower Income				X	X	X	X			4
Less Homeownership	X	X	X						X	4
Less Health Insurance	X			X					X	3
More Homeownership					X	X	X			3
Worse Air Quality		X	X							2
Less Park Access		X								1
Less Crowded Housing							X			1
Less Supermarket Access				X						1
More Bachelor's Degrees							X			1
More Health Insurance							X			1
More Racial Segregation								X		1

How do service area health needs compare based on Kaiser Permanente Community Health values? The following table ranks health needs based on several principle values: The [prevalence](#) of the health outcome compared to the California state average, the impact of the health outcome on [length](#) and [quality of life](#), the [disparity](#) of disease prevalence across racial/ethnic groups, and the [alignment with county rankings](#) of top causes of mortality.⁷

Table 5. Health Outcome Comparison Table for KFH-Antelope Valley

Health Outcome Category Name	Prevalence in Service Area	Difference From State Average	Reduction in Life Expectancy	Worst Performing Race/Ethnicity vs. Average	Listen in Partner County Top 5 Cause of Death
Substance/Tobacco Use	9.3%	2.25% (Worse than CA)	69.7% Reduction	48% Worse than Average	No
Mental Health*	12.3%	0.17% (Worse than CA)	61.3% Reduction	69% Worse than Average	No
Asthma	16.6%	1.8% (Worse than CA)	13.3% Reduction	67% Worse than Average	No
Stroke*	4.0%	0.3% (Worse than CA)	57% Reduction	40% Worse than Average	Yes
HIV/AIDS/STD	0.5%	0.16% (Worse than CA)	58.2% Reduction	211% Worse than Average	No
Obesity	28.9%	-0.7% (Better than CA)	37% Reduction	31% Worse than Average	No
Maternal/Infant Health	7.1%	0.3% (Worse than CA)	17.9% Reduction	35% Worse than Average	No
Cancer*	3.1%	-0.21% (Better than CA)	51% Reduction	31% Worse than Average	Yes
Oral Health	11.9%	0.6% (Worse than CA)	2.8% Reduction	17% Worse than Average	No
Diabetes*	8.7%	0.3% (Worse than CA)	24.1% Reduction	8% Worse than Average	No
CVD*	5.8%	-1.15% (Better than CA)	30% Reduction	28% Worse than Average	Yes
Violence/Injury	0.0%	-0.0003% (Better than CA)	13.2% Reduction	25% Worse than Average	No

⁷Indicators for prevalence and racial disparities are publicly available. Technical documentation and data dictionary for this table available upon request. Health need category names provided by Kaiser Permanente Program Office. Reduction in life expectancy estimated based on disability-adjusted life years research. "Mental Health" indicators refer to "poor mental health". "Violence/Injury" prevalence is rounded down, but not technically zero. "Yes" indicates health outcome is listed in the top five causes of death for the county covering the majority of this service area. If asthma is listed as "Yes", then chronic lower respiratory disease was listed in the county rankings. Asterisks are outcomes measured by Kaiser Permanente's Program Office.

How do service area health needs compare based on Kaiser Permanente community health values? The following table ranks health needs based on several principle values: The [prevalence](#) of the health outcome compared to the California state average, the impact of the health outcome on [length](#) and [quality of life](#), the [disparity](#) of disease prevalence across racial/ethnic groups, and the [alignment with county rankings](#) of top causes of mortality.⁸

Table 6. Health Outcome Comparison Table for KFH-Panorama City

Health Outcome Category Name	Prevalence in Service area	Difference From State Average	Reduction in Life Expectancy	Worst Performing Race/Ethnicity vs. Average	Listed in Partner County Top 5 Cause of Death
Mental Health*	12.3%	0.17% (Worse than CA)	61.3% Reduction	68% Worse than Average	No
Cancer*	4.6%	1.3% (Worse than CA)	51% Reduction	32% Worse than Average	Yes
Stroke*	4.0%	0.3% (Worse than CA)	57% Reduction	42% Worse than Average	Yes
HIV/AIDS/STD	0.6%	0.18% (Worse than CA)	58.2% Reduction	211% Worse than Average	No
Asthma	13.7%	-1.1% (Better than CA)	13.3% Reduction	101% Worse than Average	No
Obesity	25.3%	-4.3% (Better than CA)	37% Reduction	39% Worse than Average	No
Substance/Tobacco Use	4.5%	-2.46% (Better than CA)	69.7% Reduction	48% Worse than Average	No
Maternal/Infant Health	7.1%	0.3% (Worse than CA)	17.9% Reduction	32% Worse than Average	No
Oral Health	11.6%	0.3% (Worse than CA)	2.8% Reduction	17% Worse than Average	No
CVD*	5.0%	-1.95% (Better than CA)	30% Reduction	30% Worse than Average	Yes
Diabetes*	8.5%	0.1% (Worse than CA)	24.1% Reduction	6% Worse than Average	No
Violence/Injury	0.0%	-0.01% (Better than CA)	13.2% Reduction	30% Worse than Average	No

⁸Indicators for prevalence and racial disparities are publicly available. Technical documentation and data dictionary for this table available upon request. Health need category names provided by Kaiser Permanente Program Office. Reduction in life expectancy estimated based on disability-adjusted life years research. "Mental Health" indicators refer to "poor mental health". "Violence/Injury" prevalence is rounded down, but not technically zero. "Yes" indicates health outcome is listed in the top five causes of death for the county covering the majority of this service area. If asthma is listed as "Yes", then chronic lower respiratory disease was listed in the county rankings. Asterisks are outcomes measured by Kaiser Permanente's Program Office.

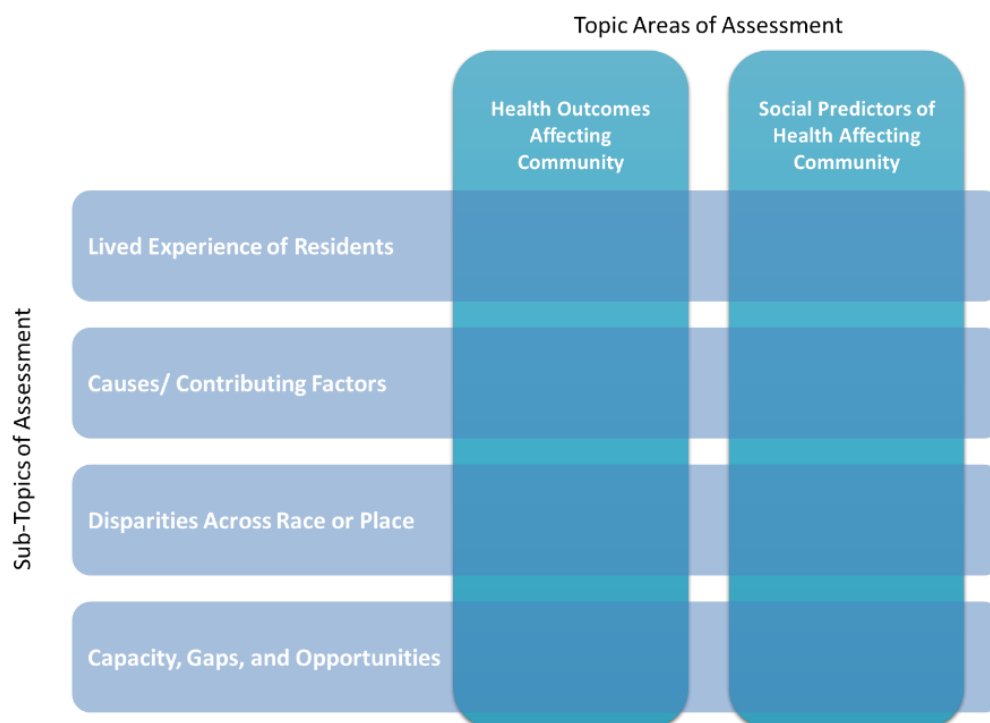
B. Community input

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

1. What social and/or economic factors in the area are driving/contributing to crowded housing?
2. What aspects of crowded housing are driving/contributing to poor health outcomes? Lay out each question using language just like you would in your engagement plans.
3. What type of educational information and resources are available to community residents, that address the areas of poor mental health days, higher prevalence of obesity among adults, and cancer?
4. To what extent are residents aware of the educational information and resources available within their communities?
5. What are the barriers to achieving higher education?
6. How does low income impact the daily lives of community members and what factors contribute to keeping income low?
7. What factors are contributing to the negative health outcomes among black residents?
8. What is driving the high suicide rate among Whites?
9. What is contributing to the above average HIV rate compared to the state and Southern California?
10. What factors are contributing to the above average infant death rate among minorities?

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

Figure F. Community Engagement Framework



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

ii. Methodology for collection and interpretation

In seeking information to help answer strategic lines of inquiry, primary data was collected through the following methods: key informant interviews, focus groups, and/or surveys. Kaiser Permanente and EVALCORP engaged 578 individuals from October 2018 through January 2019, gathering primary data through seven surveys, five focus groups, and 15 key stakeholder interviews.

Primary data was designed to ensure a comprehensive portrait of the health needs at multiple levels. The purpose of the key stakeholder interviews was to identify health outcomes and health drivers, as well as assets and barriers to accessing resources for addressing health issues across the region. The purpose of the surveys and focus groups was to provide opportunities to community members to share health concerns in addition to their lived experiences.

Qualitative data analysis was designed to identify emergent themes in answer to strategic lines of questioning about specific community health needs, as well as open-ended questions about health needs more broadly. Data from community engagement was coded and organized within the SCAL CHNA Learning Framework to generate themes useful for answering strategic learning questions and ultimately informing an implementation strategy plan (see Figure F).

The list of individuals that provided input via community engagement may be found in Appendix B. Community input methodology is described in detail in Appendix E.

C. Written comments

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

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

D. Data limitations and information gaps

As with any community needs assessment process, the data available for use is limited. For example, some data in the Kaiser Permanente CHNA data platform were only available at a county level, making an accurate translation to neighborhood-level health needs challenging. In the Healthy Places Index platform, census tracts with very low populations were represented as missing data (to reduce unreliability of measurement). This caused under-sampling of rural areas. In both platforms, disaggregated data around age, ethnicity, race, and gender were not available for many indicators, which limited the ability to examine disparities of health within the community. Additionally, data in both platforms were not often collected on a yearly basis and therefore may not represent 2018 values.

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

A. Identifying community health needs

i. Definition of "health need"

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

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

To identify community health needs, EVALCORP reviewed secondary data reports prepared by Kaiser Permanente Regional analysts. These reports drew from over 200 indicators and presented analyses specific to the census tracts and zip codes within the service area. These reports acted as a starting point for identification by revealing a bird's eye view of the many health needs in the service area. EVALCORP also undertook an extensive community engagement process (see Appendix B) which provided community stakeholders and residents the opportunity to surface additional health needs.

B. Process and criteria used for prioritization of health needs

The prioritization of health needs in KFH-Panorama City and Antelope Valley occurred through a multi-phased process that relied on several fundamental weighted criteria in addition to community input. Initially, we examined secondary data representing the social predictors of health. Those upstream factors predictive of the most health outcomes moved forward in the prioritization process. We then assessed health outcomes based on several criteria, with the severity, magnitude, and scale of the need receiving the highest weights. Clear disparities/inequities among demographic subgroups for each need were also weighted. Health outcomes that did not score highly across the severity, magnitude, scale, and impact disparity criteria were removed from consideration as a priority health need.

In the next phase of prioritization, we went into the community to gather input about the identified health needs through interviews, surveys, and focus groups. The social predictors of health and health outcomes identified as high priority by community members moved into the final stage of prioritization. The final criteria applied to the list of health needs was the extent to which attention or assets were currently dedicated to the issue (both at Kaiser Permanente and among collaborative community partners).

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

Access to Health Care. Access to comprehensive quality health care is important for the achievement of health equity and for increasing the quality of life for everyone. Limited access to health care can dramatically impact people's health outcomes. Through the community engagement process, health insurance, transportation, childcare, and awareness of available

resources were identified by community members as some of the many mechanisms that enable people to access necessary care.

Economic Security. Economic insecurity exists in both the Panorama City and Antelope Valley service areas. The experience of economic insecurity impacts health needs locally, including asthma, poor mental health, obesity, diabetes, stroke, and cancer. In the Antelope Valley service area for example, on average, 22% of the population lives below the poverty level and some subgroups in the service area, such as Latinos, experience higher levels of poverty (24%) than others. Additionally, the community engagement process revealed that social and economic conditions greatly impact service area residents' ability to maintain a healthful lifestyle and prevent and manage chronic health conditions. For example, many residents have to commute multiple hours a day in and out of the region to make a livable wage. This prevents many residents from being able to exercise and cook meals at home.

Heart Disease and Stroke. Both heart disease and stroke are listed as top 5 causes of death in Los Angeles County and result in up to a 57% reduction in life expectancy. Available data suggests that Black residents are disproportionately affected by these chronic conditions. In the Antelope Valley Service area, Black residents experience rates of cardiovascular disease at 28% above average and stroke at 40% above average when compared to other residents. Similarly, Black residents in the Panorama City Service area experience rates of cardiovascular disease at 30% above average and stroke at 42% above average when compared to other residents. Through the community engagement process, subject matter experts from the community corroborated that black service area residents tend to have higher rates of heart disease and stroke and that these conditions often co-occur with related chronic conditions such as obesity and diabetes.

HIV/AIDS/STIs. Sexual health can be easily maintained through safe sex practices and access to reproductive health care services, but in the Panorama City and Antelope Valley service areas, the prevalence of HIV is much greater than in both the state overall and the Southern California region. The prevalence of HIV is 556 per 100,000 among Panorama City service area residents and is 531 per 100,000 among Antelope Valley service area residents. Other STIs, like congenital syphilis, are also increasing in prevalence and, though easily curable, can mortally impact infant health if left untreated. Through interviews conducted with local subject matter experts, concern among local physicians in the area was high regarding what they considered an epidemic because many patients, especially those in their early twenties, were underinformed about the risks associated with unsafe sex practices.

Maternal and Infant Health. Access to adequate prenatal, obstetric, and postpartum care are important components to ensuring a good start in life, but accessing these services is quite challenging in the Antelope Valley service area and results in stark health outcomes for minority infants and their mothers. In fact, care for minority mothers and their infants is so inadequate that infant mortality is listed as a top 5 cause of death in Los Angeles County. Additionally, minority infants experience mortality at 35% above average. Furthermore, the community

engagement process revealed resident concern regarding the poor quality of care provided in the region and the inadequate number of service providers that accept high risk patients.

Mental Health and Behavioral Health. Mental health is an important component of a person's overall health and well-being. In fact, mental health issues can result in a 61% reduction in life expectancy. In the Panorama City and Antelope Valley service areas, 12% of residents report experiencing a mental health problem. Available data suggests White residents in the service areas are disproportionately impacted and die by suicide nearly 70% above the service area average. In focus groups conducted during the community engagement process, community members emphasized the lack of available services, especially for children in the Antelope Valley service area.

Obesity/HEAL/Diabetes. Access to supermarkets that carry affordable and healthful food options, safe outdoor recreational spaces, and preventative health care are important factors for preventing and managing chronic diseases like diabetes and obesity. Through the community engagement process, it was gleaned that many Panorama City and Antelope Valley service area residents do not have easy access to these resources, especially those in minority communities, which contributes to higher rates of obesity. Furthermore, secondary data indicate that Black and Latino residents in the Antelope Valley service area are disproportionately impacted, as they are obese at above average rates (31% and 12%, respectively) when compared to other ethnic and racial groups. Black and Latino residents in the Panorama City service area are similarly impacted (39% and 25%, respectively).

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

The service area for KFH-Panorama City 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.

VI. KFH-Panorama City 2016 Implementation Strategy evaluation of impact

A. Purpose of 2016 Implementation Strategy evaluation of impact

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

<https://about.kaiserpermanente.org/content/dam/internet/kp/comms/import/uploads/2013/10/KFH-Panorama-City-IS-Report.pdf>.

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

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

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

The impacts detailed below are part of a comprehensive measurement strategy for Community Health. Kaiser Permanente's measurement framework provides a way to 1) represent our collective work, 2) monitor the health status of our communities and track the impact of our work, and 3) facilitate shared accountability. We seek to empirically understand two questions: 1) how healthy are Kaiser Permanente communities and 2) how does Kaiser Permanente contribute to community health? The Community Health Needs Assessment can help inform our comprehensive community health strategy and can help highlight areas where a particular focus is needed and support discussions about strategies aimed at addressing those health needs. As of the documentation of this CHNA Report in March 2019, KFH-Panorama City 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-Panorama City will continue to monitor the impact of strategies implemented in 2019.

B. 2016 Implementation Strategy evaluation of impact overview

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

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

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

Grantmaking: For 70 years, Kaiser Permanente has shown its commitment to improving community health through a variety of grants for charitable and community-based organizations. Successful grant applicants fit within funding priorities with work that examines social predictors of health and/or addresses the elimination of health disparities and inequities. From 2017-2018, Kaiser Permanente paid 147 grants amounting to a total of \$5,469,497 in service of KFH-Panorama 2016 health needs. Additionally, KFH-Panorama City has funded significant contributions to the California Community Foundation in the interest of funding effective long-term, strategic community benefit initiatives within Panorama City. During 2017-2018, a portion of money managed by this foundation was used to pay 25 grants totaling \$4,428,889 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-Panorama City leveraged significant organizational assets in service of 2016 Implementation Strategies and health needs. See table below for illustrative examples.

Collaborations and partnerships: Kaiser Permanente has a long legacy of sharing its most valuable resources: its knowledge and talented professionals. By working together with partners (including nonprofit organizations, government entities, and academic institutions), these collaborations and partnerships can make a difference in promoting thriving communities that

produce healthier, happier, and more productive people. From 2017-2018, KFH-Panorama City 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-Panorama City Priority Health Needs		
Need	Summary of impact	Examples of most impactful efforts
Access to Care	<p><i>During 2017 and 2018, Kaiser Permanente paid 31 grants, totaling \$1,159,107 addressing the priority health need in the KFH-Panorama City service area. In addition, a portion of money managed by a donor advised fund at California Community Foundation was used to pay 9 grants, totaling \$1,856,667 that address this need.</i></p>	<p><u>Providing Affordable Healthcare</u></p> <p>Over two years (2017-2018), KFH-Panorama City and Antelope Valley provided \$54,398,454 in medical care services to 95,479 Medi-Cal recipients (both health plan members and non-members) and \$11,644,093 in medical financial assistance (MFA) for 20,792 beneficiaries.</p>
		<p><u>Building Primary Care Capacity~</u></p> <p>The California Primary Care Association (CPCA) provides education, training, and advocacy to their member community health centers to best serve their low-income, underserved, and diverse patients. In 2018, Kaiser Permanente paid \$126,666 to CPCA to:</p> <ul style="list-style-type: none"> • Hold statewide convenings and conferences and topic-specific peer networks to support over 1,200 California community health centers. • Provide 90 in-person and web-based trainings to over 4,400 attendees and 2,890 individual instances of technical assistance.
		<p><u>Preserving and Expanding California Coverage Gains~</u></p> <p>Insure the Uninsured Project (ITUP) works to preserve and expand access to health care and coverage in California and to reduce access barriers for uninsured and underinsured populations. Over two years (2017-2018), Kaiser Permanente paid \$150,000 to ITUP to:</p> <ul style="list-style-type: none"> • Conduct and disseminate health policy research. • Convene 13 regional statewide work groups • Provide technical assistance to safety net providers and other stakeholders navigating health reform challenges. • Serve as a bridge between health policy and the health care sector to reach 19 million Californians.
		<p><u>Increasing Access to Services in SPA 1 and 2</u></p> <p>Los Angeles Family Housing is the largest affordable housing and supportive services provider in SPA 2. In 2018, Kaiser Permanente paid \$10,000 to support LAFH's efforts to:</p> <ul style="list-style-type: none"> • Facilitate access to care by referral and transportation for 100% of enrolled participants according to their assessed needs, with at least 1,500 participating in the VI-SPDAT needs assessment, working with a Housing Navigator to create an Individualized Housing Plan, connecting to supportive services, and moving into permanent homes. • To provide 500 participants with a face-to-face health care treatment appointment, initial exam, evaluation and enrollment in mainstream benefits and referral to receive specialized care as needed.

		<ul style="list-style-type: none"> To conduct field-based medical support with the provision of diagnoses and initial care to program participants on the street and to engage approximately 25% of the 7,459 and 4,559 homeless residents in SPA 2 and SPA 1 through outreach and started on the path to improved health, permanent homes, and long-term stability.
		<p><u>Increasing Access to Care via KP Assets:</u> Our core functions across KP are using their assets to drive Access to Care in the KFH Panorama City service area. For example:</p> <ul style="list-style-type: none"> KFH-Panorama City continued its Board Placement Program to engage providers in serving on nonprofit organization or university boards of directors where they share best practices, expert knowledge, and provide governance support. In 2018, 6 senior leaders held Board positions at 2 FQHC's, 1 mental health provider, 1 community clinic poverty relief organization, 1 community collaborative organization, and 1 university focused on workforce development. The senior leaders shared clinical practice guidelines and led their Quality Improvement or strategic planning committees. KFH-Panorama City partnered with Maclay Middle School in the San Fernando Valley and Gifford C Cole Middle School in the Antelope Valley to provide the Hippocrates Circle physician mentoring program to over 95 under-represented, diverse students. KFH-Panorama City also provided the Medical Exploring 8-month health career exploration program to 89 underserved, diverse high school students from over 50 High Schools in the San Fernando and Antelope Valleys
Economic Security	<p><i>During 2017 and 2018, Kaiser Permanente paid 18 grants, totaling \$355,000 addressing the priority health need in the KFH-Panorama City service area. In addition, a portion of money managed by a donor advised fund at California Community Foundation was used to pay 2 grants, totaling \$400,000 that address this need.</i></p>	<p><u>Building the Capacity of Small Businesses</u> Kaiser Permanente promotes local economic development and enhances economic opportunity by helping to strengthen small business capacity. The Inner-City Capital Connections (ICCC) Program is an initiative that builds the capacity of local business located in economically underserved areas to access capital (financing) and grow their business. Over two years (2017-2018), KFH-Panorama City joined this initiative to:</p> <ul style="list-style-type: none"> Collectively enroll 299 businesses across the LA County initiative; 65% of participants are minority owned and 52% of participants are women owned. <p><u>Contracting Social Enterprises</u> Social enterprises are competitive, revenue-generating businesses with a clear social mission to hire and provide training to people who are striving to overcome employment barriers including homelessness, incarceration, substance abuse, mental illness, and limited education. Social enterprises provide a real paying job and often provide wraparound services that help employees build skills and stabilize their lives. Kaiser Permanente supports these businesses by identifying and creating contractual relationships. Over two years (2017-2018), KFH-Panorama City contracted with the following social enterprise:</p> <ul style="list-style-type: none"> Goodwill Industry for printing services.

Building Safety Net Provider Capacity~*

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

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

Developing Workforce Pipeline for the Safety Net~*

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

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

Training Leaders in Service of Community Health~

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

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

		<p><u>Increasing Latino Medical School Applicants in California~</u></p> <p>The Latino Physicians of California (LPOC)/MiMentor Partnership supports current and future Latino physicians through education, advocacy, and health policy. This is a culturally responsive mentoring program to increase underrepresented in medicine (UIM) applicants in California. LPOC will expand the Medical School Ready Program to increase the medical school readiness of UIM students through a year-long mentorship workshop series, supporting applicants through the entire medical school application process. In 2018, Kaiser Permanente paid \$25,000 to LPOC to:</p> <ul style="list-style-type: none"> • Enroll 45 UIM undergraduate and post-graduate students from Southern California into the Medical School Ready Series. • Enroll and train 45 physician mentors/coaches/advisors to mentor UIM medical school applicants.
		<p><u>Raising Awareness of the California Earned Income Tax Credit~</u></p> <p>Golden State Opportunity (GSO) leads and supports efforts related to economic security such as job creation, community development, and distribution of benefits. In 2018, Kaiser Permanente paid \$75,000 to GSO to:</p> <ul style="list-style-type: none"> • Support GSO's efforts to expand its innovative California Earned Income Tax Credit (Cal EITC) outreach and education. • Inform 250,000 low-income workers on Cal EITC eligibility and benefits through digital advertising, peer-to-peer text messaging, and grassroots outreach. • Train 25 community partners on smart digital targeting, community messaging, and peer-to-peer text messaging to outreach and engage in the Cal EITC campaign.
Mental and Behavioral Health	<p><i>During 2017 and 2018, Kaiser Permanente paid 33 grants, totaling \$1,025,626 addressing the priority health need in the KFH-Panorama City service area. In addition, a portion of money managed by a donor advised fund at California Community Foundation was used to pay 2 grants, totaling \$80,000 that address this need.</i></p>	<p><u>Strengthening Mental Health Policies and Practices in Schools~</u></p> <p>Children Now educates policymakers, school district leaders, and other key stakeholders about best practices and policy solutions to address suspension and expulsion policies that disproportionately impact students of color, improve school climate, and increase students' access to mental health services. Over two years (2017-2018), Kaiser Permanente paid \$150,000 to Children Now to:</p> <ul style="list-style-type: none"> • Inform over 200 key legislators and stakeholders. • Support the California Department of Education in the development of the Whole Child Resource Map. • Lead committees for both the State School Attendance Review Board and the Superintendent's Mental Health Policy Workgroup.
		<p><u>Improving Services for Human Trafficking Survivors~</u></p> <p>The Coalition to Abolish Slavery and Trafficking (CAST) expands services to improve health outcomes for trafficking victims in Los Angeles County. CAST coordinates a continuum of care for trafficking victims by combining social, medical, and legal services with leadership and advocacy. In 2018, Kaiser Permanente paid \$75,000 to CAST to:</p>

		<ul style="list-style-type: none"> • Coordinate Whole Person Care services, including housing, food, medical, mental health, legal, education, and employment for 100 human trafficking survivors. • Educate and advocate with policymakers, county officials, and community leaders on how to expand or improve access to emergency and permanent housing for victims. <p><u>Building Mental Health First Aid Skills in Service Providers*</u> Mental Health America of Los Angeles (Antelope Valley) Mental Health First Aid project reduces mental health stigma by conducting trainings with 240 diverse providers serving the homeless populations. In 2018, Kaiser Permanente paid \$40,000 to MHALA to:</p> <ul style="list-style-type: none"> • Provide 24 Mental Health First Aid trainings addressing types and signs of mental illness and substance abuse disorders. • Train and certify up to 240 participants in Mental Health First Aid. <p><u>Improving Maternal Mental Health in the Antelope Valley</u> The Children's Center of Antelope Valley received funding on behalf of the LA County Department of Mental Health Antelope Valley Health Neighborhood which is a coalition of health and mental health providers; public health and substance use disorder treatment providers, along with a variety of social service and community support agencies who joined together to improve the health and wellness of the Antelope Valley. In 2018, Kaiser Permanente paid \$15,000 to the Children's Center of Antelope Valley to create the Antelope Valley Maternal Mental Health Network to:</p> <ul style="list-style-type: none"> • Conduct maternal health analysis in the AV consisting of identification and outreach to at least 10 agencies Provide training, outreach and awareness presentations to at least 40 trainees including medical and mental health providers • Provide training, outreach and awareness presentations to at least 5 non-clinical groups • Implement group intervention and create at least 4 community-based groups
Obesity/ HEAL/ Diabetes	<p><i>During 2017 and 2018, Kaiser Permanente paid 55 grants, totaling \$2,694,765 addressing the priority health need in the KFH-Panorama City service area. In addition, a portion of money managed by a donor advised fund at California Community Foundation was used to pay 12 grants, totaling \$2,092,222 that address this need.</i></p>	<p><u>Improving Access to Nutritious Foods~*</u> California Food Policy Advocates (CFPA) is a statewide policy and advocacy organization that aims to improve the health and well-being of low-income Californians by increasing their access to nutritious, affordable food and reducing food insecurity. In 2018, Kaiser Permanente paid \$212,500 to CFPA to:</p> <ul style="list-style-type: none"> • Lead the implementation workgroup for the Supplemental Drinking Water EBT benefit for approximately 40,000 Cal-Fresh households in Kern County. • Lead the implementation workgroup for the Cal-Fresh Fruit and Vegetable EBT pilot project for Southern California retailers.

	<p><u>Fighting Food Insecurity~</u> California Association of Food Banks' (CAFB) Farm to Family program's goal is to improve health food access by providing fresh produce to food banks, CalFresh outreach and enrollment, advocacy to support anti-hunger policies, and technical assistance to members. In 2018, Kaiser Permanente paid \$95,000 to CAFB to:</p> <ul style="list-style-type: none"> • Distribute 250,000 pounds of subsidized fresh fruits and vegetables to 11-member food banks. • Maintain the State Emergency Food Assistance Program to provide food and funding of emergency food to food banks.
	<p><u>Creating Healthier School Environments</u> As part of Southern California Community Benefit's Thriving School Partnership Grants (TSPG) which focuses on improving healthy eating, physical activity, and school climate of K-12 schools including many policy, systems, and environment changes, over two years (2017-2018), Kaiser Permanente paid \$90,000 to the Palmdale School District to:</p> <ul style="list-style-type: none"> • Develop and adopt district-wide healthy eating and active living (HEAL) strategies targeting students and staff including Smarter Lunchroom strategies at all 27 school sites. • Align School Wellness Policy with Local Control and Accountability Plan (LCAP). • Have four schools adopt and implement physical activity and healthy eating strategies targeting students, staff and teachers including brain breaks, healthy fundraisers, Active Recess program, and parent nutrition classes.
	<p><u>Increasing Healthy Eating and Active Living</u> Our core functions across KP are using their assets to drive Healthy Eating Active Living. For example:</p> <ul style="list-style-type: none"> • In 2018, KFH-Panorama City hosted a weekly farmer's market that was open to the public providing access to largely locally-grown fruits and vegetables, accepting WIC and CalFresh electronic benefit transfers as well as educating the public on the benefits of healthy eating and active living. • As part of the Thriving Schools Initiative, a community based effort to improve healthy eating, physical activity and school climate in K-12 schools in Kaiser Permanente's service areas, primarily through a focus on policy, systems and environmental changes that support healthy choices and a positive school climate, KFH-Panorama City Environmental Services and Facilities teams volunteered to clear land, trim trees, plant drought tolerant plants, lay down ground cover, and donate seating with shade to create a Staff Wellness Garden at San Fernando Middle School for over 40 school staff and several nurses and employees volunteered to help clear soil and put together planter boxes for a student teaching garden to be used for their horticulture program for over 760 students.
	<p><u>Promoting Food Recovery and Redistribution</u> Kaiser Permanente envisions foodservices not only as the source of nutritious meals for their patients, staff and guests, but as a resource for local communities. Over two years (2017-2018), Kaiser Permanente partnered with Food Finders to:</p>

		<ul style="list-style-type: none"> Recover 29,247.68 lbs. of food and distribute to organizations serving individuals in the KFH-Panorama City region who face food insecurity.
Oral Health	<p><i>During 2017 and 2018, Kaiser Permanente paid 10 grants, totaling \$235,000 addressing the priority health need in the KFH-Panorama City service area.</i></p>	<p><u>Improving Access to Oral Health</u> Kids Community Dental Clinic provides education, prevention, detection, early intervention and restoration of tooth decay in low income and homeless children in Panorama City, Santa Clarita Valley and Antelope Valley. In 2018, Kaiser Permanente paid \$10,000 to Kids Community Dental Clinic to:</p> <ul style="list-style-type: none"> Provide education, free services, and access to dental care for 1,000 children Provide oral health education to 6-20 case managers from various homeless outreach agencies to refer cases for dental care Provide dental treatment to 20 new children patients establishing a dental home Complete treatment (fillings, extractions, pulpotomy, etc.) for 80% of the new patients <p><u>Improving Access to Oral Health</u> San Fernando Community Health Center is a Federally Qualified Health Center in the San Fernando Valley providing primary care, pediatrics, ob/gyn, behavioral health, dental services, and health education for low income, underinsured and uninsured individuals and families. In 2018, Kaiser Permanente paid \$10,000 to SFCHC to:</p> <ul style="list-style-type: none"> Provide dental services to 1400 unduplicated patients; 291 of these were children and 39 of these were homeless and temporarily residing in Harbor Recuperative Care Center. Provide oral health education at 10 parent centers, schools and other CBO's as well as the adoption of an elementary school under LAUSD's L.A. Trust program, providing oral health screenings and fluoride treatments to approximately 300 students. To expand dental service hours to include bi-monthly Saturday hours, internship opportunities for UCLA School of Dentistry for 2 dental interns four days/week thus providing 3960 patient visits in 2018. <p><u>Supporting Oral Health Programs and Policies</u> KFH – Panorama City participates and supports the Valley Care Community Consortium Oral Health Committee which leads a collaboration of public and private community partners to advocate, plan, assess needs and facilitate development of effective programs and policies to increase access to oral health services for the residents of the San Fernando and Santa Clarita Valleys. Coalition accomplishments include:</p> <ul style="list-style-type: none"> Organizing a luncheon for 45 individuals representing more than 20 agencies/organizations with the CA Department of Public Health Dental Director to review the CA State Dental Plan and opportunities to partner. Working with the LA County Department of Public Health Oral Health Program to conduct a survey of patients attending the Care Harbor event to better understand why they were seeking services there and connecting them to dental homes. Helping bring together partners to organize dental and vision screening events Helping organize a Southern CA Oral Health Summit bringing together over 190 partners from LA, Orange, Santa

Barbara, San Bernardino, and San Diego counties to review and collaborate on the CA State Dental Plan.

- Kaiser Permanente SCAL Oral Health leaders providing technical assistance and collaborating with the LA County Department of Public Health Oral Health Program

VII. Appendices

Appendix A. Secondary Data Sources and Dates

i. Secondary sources from the KP CHNA Data Platform

Source	Dates
1. American Community Survey	2012-2016
2. American Housing Survey	2011-2013
3. Area Health Resource File	2006-2016
4. Behavioral Risk Factor Surveillance System	2006-2015
5. Bureau of Labor Statistics	2016
6. California Department of Education	2014-2017
7. California EpiCenter	2013-2014
8. California Health Interview Survey	2014-2016
9. Center for Applied Research and Environmental System	2012-2015
10. Centers for Medicare and Medicaid Services	2015
11. Climate Impact Lab	2016
12. County Business Patterns	2015
13. County Health Rankings	2012-2014
14. Dartmouth Atlas of Health Care	2012-2014
15. Decennial Census	2010
16. EPA National Air Toxics Assessment	2011
17. EPA Smart Location Database	2011-2013
18. Fatality Analysis Reporting System	2011-2015
19. FBI Uniform Crime Reports	2012-2014
20. FCC Fixed Broadband Deployment Data	2016
21. Feeding America	2014
22. FITNESSGRAM® Physical Fitness Testing	2016-2017
23. Food Environment Atlas (USDA) & Map the Meal Gap (Feeding America)	2014
24. Health Resources and Services Administration	2016
25. Institute for Health Metrics and Evaluation	2014
26. Interactive Atlas of Heart Disease and Stroke	2012-2014
27. Mapping Medicare Disparities Tool	2015
28. National Center for Chronic Disease Prevention and Health Promotion	2013
29. National Center for Education Statistics-Common Core of Data	2015-2016
30. National Center for Education Statistics-EDFacts	2014-2015
31. National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention	2013-2014

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

ii. Additional sources

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

Appendix B. Community Input Tracking Form

	Data collection method	Title/name	Number	Target group(s) represented	Role in target group	Date input was gathered
Organizations						
1	Interview	Manager of Coordinated Entry System; Los Angeles Homeless Services Authority	1	Medically underserved and low income	Content Expert	12/14/18
2	Interview	President and CEO; Valley Economic Alliance	1	Minority, medically underserved, low income	Content Expert	11/13/18
3	Interview	Community Outreach Liaison; Children's Bureau, Black Infant Health Program	1	Minority, medically underserved, low income	Content Expert	12/18/18
4	Interview	Chief of Infectious Disease; Kaiser Permanente	1	Minority, medically underserved, low income	Content Expert	11/14/18
5	Interview	Supervisor of Programs; Catalyst Foundation	1	Minority, medically underserved, low income	Content Expert	11/26/18
6	Interview	Area Health Officer (and staff); Los Angeles County Department of Public Health	5	Health department representative	Content Expert	11/20/18
7	Interview	Executive Director and Regional Breastfeeding Liaison; Breastfeed LA	2	Minority, medically underserved, low income	Content Expert	12/3/18
8	Interview	Executive Director; Los Angeles Economic Development Corporation	1	Minority, medically underserved, low income	Content Expert	10/31/18
9	Interview	Executive Director; Greater Antelope Valley Economic Alliance	1	Minority, medically underserved, low income	Content Expert	10/19/18
10	Interview	President; Valley Industry & Commerce Association	1	Minority, medically underserved, low income	Content Expert	10/19/18

11	Interview	Chief of Behavioral Health; Kaiser Permanente	1	Minority, medically underserved, low income	Content Expert	11/12/18
12	Interview	Manager; Youth Policy Institute	1	Minority, medically underserved, low income	Content Expert	11/26/18
13	Interview	Coordinator of Guidance Services; Antelope Valley Union High School District	1	Minority, medically underserved, low income	Content Expert	11/27/18
14	Interview	OBGYN; Bartz-Altadonna Community Health Center	1	Minority, medically underserved, low income	Content Expert	12/7/18
15	Interview	Chief Advancement Officer; Mental Health America of Los Angeles	1	Medically underserved	Content Expert	11/7/18
16	Survey	Counselor Survey; Antelope Valley Union High School District; Los Angeles Unified School District; and William S. Hart Union High School District	6	Minority, medically underserved, low income	Content Expert	Close date: 1/8/19
17	Survey	Physician Survey; Kaiser Permanente	11	Health department representative	Content Expert	Close date: 1/8/19
18	Survey	Los Angeles County Department of Mental Health; Health Neighborhood (Northeast San Fernando Valley) Survey	12	Health department representative	Content Expert	Close date: 12/13/18
19	Survey	Los Angeles County Department of Mental Health; Health Neighborhood (Antelope Valley) Survey	35	Health department representative	Content Expert	Close date: 12/13/18
20	Survey	San Fernando Valley and Santa Clarita Valley Homelessness Coalition Survey	32	Minority, medically underserved, low income	Content Expert	Close date: 12/13/18

Community residents

21	Focus Group	Valley Care Community Consortium Focus Group	10	Minority, medically underserved, low income	Representative Member	11/30/18
22	Focus Group	NAMI Antelope Valley Focus Group	5	Minority, medically underserved, low income	Representative Member	1/9/19

23	Focus Group	NAMI San Fernando Valley Focus Group	8	Minority, medically underserved, low income	Representative Member	12/15/18
24	Focus Group	Minority Infant Mortality Focus Group	11	Minority, medically underserved, low income	Representative Member	1/30/19
25	Focus Group	Antelope Valley Partners for Health Wellness Coalition Focus Group	11	Minority, medically underserved, low income	Content Experts	12/10/18
26	Survey	College Student Survey	300	Minority, medically underserved, low income	Representative Member	Close date: 12/7/18
27	Survey	Resident Survey	116	Minority, medically underserved, low income	Representative Member	Close date: 1/8/19

Appendix C. Health Need Profiles

I. Health Need Profile: Access to Health Care

Panorama City Medical Center Service Area

Local Issue: Access to Health Care

Residents Struggle to Access Health Care

Belinda's Story As a resident of Mojave, Belinda and her family live so far away from doctor's offices that it can be difficult to attend appointments. When they do attend, they take a 2-hour long bus ride to get to the facility and must plan to arrive early in case of delayed busses, meaning that attending an appointment can take up the entire day. While her family has dental insurance through Medi-Cal, there are few local dentists who both accept Denti-Cal and treat children. Belinda's 5-year old daughter has only seen a dentist once in her life. Belinda's father doesn't take all of his prescribed medications because of high copays. What he does take, he pays for with his retirement savings. Her family knows they need help, but aren't sure what to do. Belinda's story contains themes shared by residents in community focus groups and by local subject matter experts who were interviewed. [This document shares the lived experience of residents living within the Panorama City Medical Center Service Area.](#)

“

"I had to have an MRI and the copay was \$250. I went to the financial office and I asked if they could loan me the money. It turns out that Kaiser helped me out by giving me 6 months of services. But I had to pay for the first \$1,500 of expenses. The people who run Medi-Cal need to have a better system."

-Focus Group Member, Lancaster

“

"When patients...have to travel 2 to 2 and a half hours to get to [a tertiary] center...this results in higher mortality rates because they don't have a provider to go to and they don't see anyone until something catastrophic happens."

-Subject Matter Expert, OB/GYN Physician

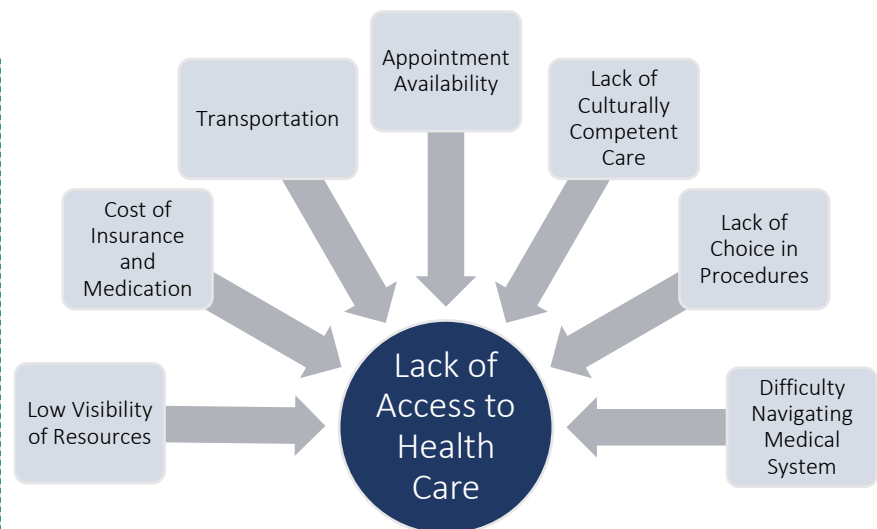
Identified Causes & Contributing Factors

Shortage of Medical Professionals and Resources Impedes Access to Health Care

Several local doctors and subject matter experts interviewed spoke about lack of access to healthcare. They cited a shortage of medical professionals and resources as contributing factors:

- "There is a critical need for more healthcare practitioners...MLK hospital needs 400 more physicians in their service area." - **Local Subject Matter Expert**
- "The public mental health care system only focuses on people with severe and persistent mental illnesses. It's like waiting until a cancer goes to Stage 4 before people can get care." - **Local Subject Matter Expert**
- "WIC does employ [lactation specialists] but when you serve 60,000 to 70,000 people and you only have 5 lactation specialists, you're unlikely to meet their need." - **Local Subject Matter Expert**

Barriers and Factors Driving Lack of Access to Health Care



Kaiser Permanente doctors in the region and **local residents** were invited to share their perspectives on accessing health resources via survey.

- **20% of doctors** who responded said that services are not at all available to patients without insurance.
- **47% of resident** respondents did not know how to access health care resources.

People and Places Affected by Lack of Access to Health Care

ESL Residents (English as a Second Language)

"There are 10 million people in Los Angeles County. 1.5 million don't speak English well or at all. This creates a barrier in terms of communication and for understanding available information."
- Subject Matter Expert

Residents needing Crisis Support

- "Local access to emergency care is our second biggest challenge, with AV patients being sent to LA or farther. There is a very long waiting list for intensive treatment outside hospitalization. I was told 6-12 months as there is only one place Kaiser contracts with." - Community Member
- "We have one psychiatric response team for the entire county to service more than 60,000 students." - Subject Matter Expert

High-Risk Patients

- "The problem is when these patients are labeled as high-risk, they cannot get care in the region and have to go elsewhere." - Subject Matter Expert
- "Many women are labeled high-risk because they've had a c-section or multiple miscarriages. Only one [OB/GYN] will take Medi-Cal and high-risk pregnancies." - Subject Matter Expert

Spotlight on Oral Health Care

Barriers to Accessing Dental Care include:

- Lack of parent or caregiver knowledge about the importance of oral health
- Lack of dentist confidence in providing children's oral health care
- Lack of integration between dental and primary care



Distance



Time



Cost

Limited acceptance of Medicaid dental coverage by dentists drives down accessibility to care and disproportionately affects low income and minority people. In Los Angeles county, nearly 60% of children under 6 are covered by Denti-Cal, but aren't always able to receive care.



Poor oral health is linked to heart health (including cardiovascular disease)



63% of dental Emergency Room visits are by children aged 3-5 years old



Tooth decay is the single most common chronic condition among children

Resources to Address the Issue

Sample of Current Resources

Community stakeholders identified the following existing resources and agencies that address lack of access to health care:

- Children's health clinics
- In-home specialists/home visitations
- Nurse Family Partnership (provides services for low-income expecting or new mothers)
- El Nido Family Centers
- Milk depots for breastmilk provision in NICU

"Antelope Valley...has a very unique geographic layout. Public transit options available in SPA 1 are very limited compared to the rest of Los Angeles."
- Subject Matter Expert

Gaps and Needs

Community stakeholders made the following recommendations for addressing lack of access to health care:

1. More locations of primary and specialty care
2. Add staff to locations of primary and specialty care
3. Offer home visits and extend other child services to adults
4. Train medical professionals in culturally sensitive care
5. Increase patient education, especially with new mothers

"One approach in whole person care is hiring staff with life experience in the population they're trying to address such as substance abuse or reentry so...they feel a connection."
- Subject Matter Expert

II. Health Need Profile: Economic Security

Panorama City Medical Center Service Area

Local Issue: Economic Security

Cycle of Economic Insecurity Holds Local Residents Back

Adriana's Story... A resident of Lancaster, Adriana is barely getting by financially. The monthly bus passes she and her partner need to get to their jobs in Los Angeles each cost over \$300. Adriana had been paying \$1,200 per month in rent, but was recently forced to move to a more expensive apartment when her complex was sold. Both Adriana and her partner are working hard to someday have enough for a down payment on a house, but their expenses make it difficult to save money. Julio, her son, is a junior in high school and has recently started working to help with the bills. He knows he should be thinking about going to college, but can't envision himself doing so and he feels bad about the idea of leaving his family when he could be helping them. Adriana's story reflects the experiences of community residents, gathered through focus groups and surveys, as well as interviews conducted with local subject matter experts. [This document shares the lived experience of residents of the Panorama City Medical Center Service Area.](#)

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"If you're aware of our valley, the have and have-not regions are separated by 10 miles. Gated housing is 10 miles from Section 8 housing."

-Subject Matter Expert, Antelope Valley Union High School District

“

"They're putting these high-rise apartments that no one can afford in the neighborhood. It's pushing everybody out..."

-Focus Group Member, North Hills

“

"How are you supposed to take public transportation if you don't have money?"

-Focus Group Member, Lancaster

Identified Causes & Contributing Factors

Spotlight on Lack of Affordable Housing

Residents of the Panorama City and Antelope Valley Service areas voiced their concerns about local health and safety issues through surveys. Residents surveyed include the San Fernando and Santa Clarita Valley Homeless Coalition, who provided additional perspectives on resources, trends, and factors affecting homelessness.



96% of Homeless Coalition members surveyed identified affordable and safe housing as a resource lacking in the community.



Additionally, resident respondents identified **affordable housing as the primary resource that is lacking** in their community.



7 in 10 resident respondents reported they did not know how to access housing resources.



Homeless coalition members named **unemployment, poverty and food insecurity** among the top three challenges faced by individuals in crowded housing.



50% of Homeless Coalition members surveyed identified affordable and healthy food as a resource lacking in the community.

High Cost of Living Drives Economic Insecurity

Economic Insecurity

- High cost of housing
- High cost of food
- Low educational attainment

Economic Insecurity Impedes Educational Attainment and Impairs Mental Health



Poverty, cost of living, and immigration status were identified as the top contributors to mental illness in the community by mental health providers.



Students reported **cost (48%) and other financial reasons (54%)** among the top 3 barriers to educational attainment.

"Being homeless itself exacerbates existing medical issues and creates new ones." -Subject Matter Expert

People and Places Affected by Economic Insecurity

Homeless Individuals

- “Without an address, one is unable to apply for a job.” – Community Member
- “Salvation Army supports homeless, but its location requires access to a car or transportation. Also, times open and closed are not flexible or accommodating.” – Community Member
- “A lot of shelters, they say safety, but you’ve got drugs around children.” – Community Member

Low Socioeconomic Status Residents

- “When you're educated, you're more likely to have a 9-5 and have weekends off. These low-income families work nights, weekends, 24-hour shifts, and look for the easiest, fastest, cheapest ways to feed their kids, and it isn't always the healthiest way.” – Subject Matter Expert
- “Poor and working poor [are] most impacted [by food prices.]” – Subject Matter Expert

Hispanic/Latino Families

- “I think there are cultural barriers, a lot with our Latino cultures. The culture is to stay, [delay college], and contribute to the family. They place a lot of importance on contribution and responsibilities.” – Subject Matter Expert

Youth in Low Socioeconomic Status Families

- “When of working age, you start working and when your family doesn't have money, you can't delay that. You can't take four years and say ‘I'll give be back in five with more.’” – Subject Matter Expert
- “Sometimes it means taking care of younger siblings or grandparents.” – Subject Matter Expert

Mothers with Infants

- “Currently, lactation specialists cost about \$150 an hour, which is really challenging for a low-income family to afford.” – Subject Matter Expert
- “There are so many women that aren't in a financially stable place to afford these resources.” – Subject Matter Expert
- “Breastfeeding rates are declining. Breastfeeding offsets other socioeconomic disparities families may be facing and helps give babies a better start in life.” – Subject Matter Expert

Resources to Address the Issue

Sample of Current Resources

Community members and local subject matter experts identified the following existing resources and agencies that address economic insecurity:

- Rescue Mission
- Churches
- Foodbanks
- Breast milk banks
- Job placement programs
- California State University (food pantries, clothing distribution centers, resources for students)

“Information about hours, accessibility, and other services for the different shelters is not always clear or known to the homeless or those who seek housing.” – Subject Matter Expert

Gaps and Needs

Community residents and local subject matter experts had the following recommendations for addressing economic insecurity:

1. Open more shelters specifically for women and children
2. Implement supportive housing programs with additional scaffolding for specific populations (such as single parents, homeless)
3. Provide free services at medical clinics
4. Improve the affordability of college and provide free access to computers

“Section 8 is a bandage, not a solution. Housing assistance is critical.” – Subject Matter Expert

III. Health Need Profile: Heart Disease and Stroke

Panorama City Medical Center Service Area

Local Issue: Heart Disease and Stroke

How Heart Disease and Stroke Impact the Lives of Residents

Stanley's Story... Raised by a single mom, Stanley grew up in Antelope Valley facing adversity and financial hardship. Over the years, he has worked hard to help his mother and now supports his own family. Stanley sees a doctor about his cardiovascular disease, but doesn't feel able to follow her advice, in regards to healthy habits, due to a lack of time and money. He commutes for over an hour to and from his job and doesn't always have the time to prioritize his health or to exercise. Stanley has been increasingly stressed due to rent increases and his family recently moved in with extended family to save money. The new house is overcrowded and Stanley knows his family is unhappy, but he doesn't know how they could afford to live elsewhere. Stanley's story reflects themes that emerged from a series of community member focus groups and interviews with local subject matter experts. [This document shares the lived experience of residents within the Panorama City Medical Center Service Area.](#)

“Nationally, the current recommendation is an hour a week for physical activity. 75% of the population isn't meeting it at all. Add to that figure higher housing costs, longer working hours, lower socioeconomic status, they're already doing so much to keep up. The idea that they meet those recommendations when even people in higher socioeconomic areas are having trouble to meet them...this leads to the associated difference in health outcomes.”
-Subject Matter Expert, Public Health

“I went to the doctor one time, I went to the emergency room and told them there was something wrong with me and they didn't believe me.”
-Focus Group Member, North Hills

Identified Causes & Contributing Factors

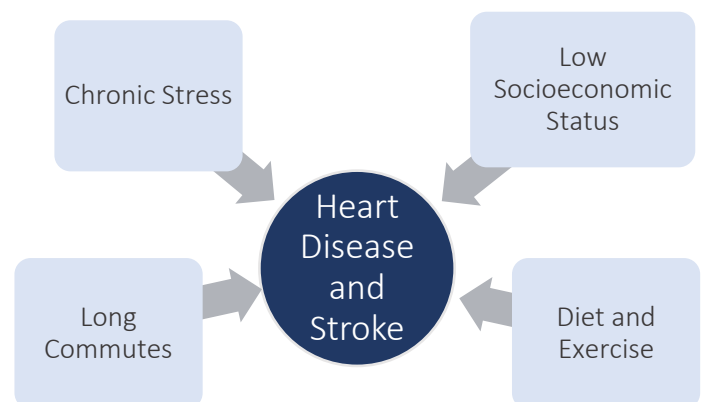
Community Members Express High Levels of Concern about Heart Disease and Stroke

Members of the San Fernando and Santa Clarita Valley Homeless Coalition, voiced their concerns about local health and safety issues through surveys.



85% of homelessness coalition community members said they were concerned or very concerned about heart disease in their community

Lifestyle Factors Impact Heart Disease and Stroke Outcomes



Drivers of Heart Disease and Stroke

Housing Insecurity

Employment and
Low Income

Poor Air Quality

Access to
Health Insurance

Spotlight on the Black Community

40%

Black residents in Panorama City and Antelope Valley die from strokes at a rate 40% above average. They are disproportionately affected compared to other races in the area, who have below average rates.



Black residents experience cardiovascular disease at a higher rate than other races in Panorama City and Antelope Valley.



Medical and public health experts described **the role of race as a contributor to heart disease and stroke**, noting that the cumulative effects of negative race-based experiences, and the resulting chronic stress, compound poor health outcomes.

“Stress isn't in a vacuum, there are underlying effects of institutional racism, discrimination, and implicit bias of practitioners that may be exhibited.” -Subject Matter Expert

“A lot of it comes down to socioeconomic status. Our perspective is with an equity lens, which acknowledges dramatic differences in life experiences based on race.” -Subject Matter Expert

“We know that stress can be generational and that it continues to accumulate over time. This is something we see disproportionately in African American communities.” -Subject Matter Expert

“Even when you level the playing field, [health outcomes are] still lower with women of color...I think it is more an issue of systemic racism and bias that is creating these issues.” -Subject Matter Expert

Resources to Address the Issue

Sample of Current Resources

Interviewees and participants identified the following existing resources and agencies that address the needs of those at risk of stroke and heart disease:

- Direct programs for: education on healthy choices, healthier corner markets, and healthy beverage availability in schools
- Faith-based organization education programs
- One Degree (resource linkage website)
- Nutrition and physical activity classes

“We have a community member that volunteers to teach the [exercise] class and they come in once a week for an hour. I wish there were more programs in the community available and I mean programs that can come to certain communities.” - Subject Matter Expert

Gaps and Needs

Participants and interviewees provided the following recommendations for addressing stroke and heart disease outcomes:

1. Increase patient education about managing these conditions and available resources in the community
2. Disaggregate existing health-related data by race to better understand the specific health conditions of subpopulations in the area
3. Provide cultural training for existing staff and hire staff with an understanding of the experiences of residents

“We offer a class for nutrition and physical activity and community partners would highly advertise, but the challenge is with the languages they're provided in, primarily in Spanish and English. There are other areas with other languages, like Farsi, that our staff don't have the background in, so it is harder to reach that population.” - Subject Matter Expert

IV. Health Need Profile: HIV, AIDS, and STIs

Panorama City Medical Center Service Area

Local Issue: HIV, AIDS, and STIs

Sexual Health has Far Reaching Effects

Ava's Story... A high school sophomore, Ava recently started dating her first boyfriend, Mason, who is a senior. She has a good relationship with her parents, but they have never talked about sex and she received little sex education in school. Mason is unaware that he is HIV positive and when he incorrectly uses a condom with Ava, she becomes both pregnant and HIV positive. She is embarrassed and ashamed, and the stress has taken a toll on her school work and her relationships with her parents. Ava and Mason ultimately decide to break up, but now must face telling all their future partners about their HIV positive status. Ava is working closely with her doctor, whose support has helped her immensely. Ava's story reflects themes that emerged from a series of focus groups with community residents and interviews conducted with local subject matter experts. [This document shares the lived experience of residents within the Panorama City Medical Center Service Area.](#)

“People don't have a fear of HIV like they did back in the 80's...they are not using condoms like they should be..”

-Subject Matter Expert, Infectious Disease

“You have to go out and pass out condoms and pamphlets and get people to come in and get tested regularly.”

-Subject Matter Expert, Infectious Disease

Identified Causes & Contributing Factors

Local Doctors & Residents are Concerned

Kaiser Permanente doctors and local residents in the Panorama City and Antelope Valley Service areas were invited to share their perspectives on sexual health via survey. Residents surveyed include the San Fernando and Santa Clarita Valley Homeless Coalition.

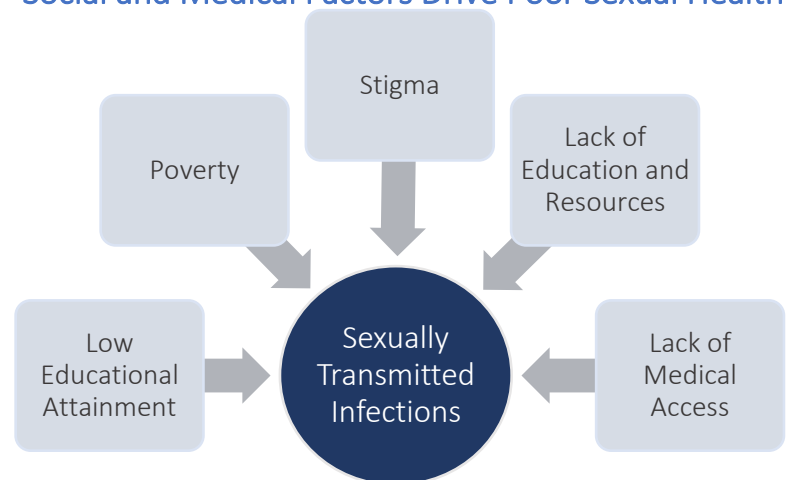
- **64% of physicians** reported that they are concerned about sexually transmitted infections.
- **58% of Homelessness Coalition members** reported being moderately concerned or very concerned about HIV, AIDS, and sexually transmitted infections.
- **HPV and HIV/AIDS** were noted by residents as concerns. Physicians also named **chlamydia, gonorrhea, and syphilis** as concerns.

“We participate in health events and other events and sometimes people want to stay clear of our table, they feel like they don't fall in the category of putting themselves at risk.”

– Subject Matter Expert

“If I treat a young man with syphilis and he is cured, but has sex with the same partner, he will be re-infected. Say he has Kaiser Permanente [insurance], but his partner doesn't, I can't treat his partner.” – Subject Matter Expert

Social and Medical Factors Drive Poor Sexual Health



Reported Barriers to Accessing Sexual Health Care

Embarrassment



Stigma



Quick Fact: Residents of the Antelope Valley and Panorama City service areas experience HIV and AIDS at **above average rates** compared to residents of the State and Southern California.

People and Places Affected by HIV, AIDS, and STIs

Youth

- "In Antelope Valley, the high STI rates are in younger populations: 18-24-year-olds." - Subject Matter Expert
- Subject Matter Expert
- "A lot of 20-year-olds are exposed to HIV." - Subject Matter Expert
- "Syphilis is climbing in young people who are sexually active (16-30)." - Subject Matter Expert
- "Situation have arisen in which young children are experimenting with sexual activity, and it has resulted in medical issues among the children." - Subject Matter Expert
- "Chlamydia is also high in young people." - Subject Matter Expert

High School Students

- "[It's] really important that high-schoolers be provided better information, at least a flyer, just for self-knowledge. Let their parents know and they can decide if it's something they want them to have." - Subject Matter Expert
- "With high schoolers the importance of having protected sex should be emphasized more." - Subject Matter Expert

Hispanic/Latino Residents

- "In the Latino population, there is an element of stigma and shame when talking about STIs and that can affect the number of congenital syphilis cases because they don't want to talk to a doctor and will then pass it onto their baby, which will lead to poor delivery outcomes, including death." - Subject Matter Expert

Seniors

- "Seniors are having issues spreading STDs." - Subject Matter Expert
- "Maybe because they came from a different era, they think there is lower risk and don't think about who the person's last partner is." - Subject Matter Expert

Resources to Address the Issue

Sample of Current Resources

Community members and subject matter experts listed a number of existing resources and agencies that address sexually transmitted infections:

- Tarzana Treatment Center
- Planned Parenthood in Palmdale
- Women's Clinic in Lancaster
- Los Angeles County Department of Public Health
- Catalyst Foundation (provides free, rapid HIV testing, education, condoms, referrals to other resources, and linkage to care)

"We can't go into the schools. We can't even pass out information in front of the schools to let them know how to protect themselves." – Community Expert

Gaps and Needs

To address sexually transmitted infections, community residents and local subject matter experts made the following recommendations:

1. Open clinics that provide free or low-cost services and direct HIV-positive patients to medical care
2. Increase community outreach through education and address misinformation through county tabling, community presentations, and school presentations
3. Have community centers provide free condoms, testing, and educational resources

"[Doctors] see these STDs and report them to the Los Angeles County Department of Public Health. They see these trends and go out into the community to table and do educational presentations, but I don't see a targeted campaign regarding STIs." -Subject Matter Expert

V. Health Need Profile: Maternal and Infant Health

Panorama City Medical Center Service Area

Local Issue: Maternal and Infant Health

Inadequate Access to Quality Maternal and Infant Health Care

Ann's Story... A mother on her second pregnancy, Ann is taking trips from her home in Palmdale to UCLA every two weeks for prenatal appointments. At 4 months pregnant, the trips are becoming more and more difficult to manage. Ann was initially seeing her primary OB/GYN, who is located in Palmdale, but when she was 2 months pregnant, she was designated as high-risk and was referred out of area. She can't recall any health issues from her first pregnancy and doesn't understand why she needs to see specialists at UCLA. When Ann shares her concerns with her doctor, he disregards her. As a woman of color, Ann wonders if she is being overlooked because of her race, or if her doctor has valid reasons to label her pregnancy high-risk. Ann's story reflects themes that emerged from a series of focus groups with community residents and interviews conducted with local subject matter experts. [This document shares the lived experience of residents within the Panorama City Medical Center Service Area.](#)

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“It really starts at the provider level...Not every patient is high-risk, and if we label them all as high-risk, they end up with nowhere to go.”

-Subject Matter Expert, OB/GYN Physician

“

“Many facilities have downsized their offerings and cut hours. Not a single hospital in LA meets the census recommendations. We've probably cut 70-80% of our time [offering lactation specialists] since June and continue to decrease offerings in the hospital...”

-Subject Matter Expert, Policy Advocate

Identified Causes & Contributing Factors

Providers and Patients Express Concern

Subject matter experts and community members shared concerns about maternal and infant health through interviews and focus groups.

- **Women who do not breastfeed** are more likely to become obese and have diabetes.
- **Women repeatedly reported feeling unheard by their OB/GYNs** in terms of maternal care, particularly in regards to choices involving childbirth.
- **Providers need more education and cultural sensitivity training** to provide quality care to high-risk patients and/or women of color, who often suffer from more stressors during pregnancy.

Top Reported Barriers to Accessing Care for Maternal and Infant Health



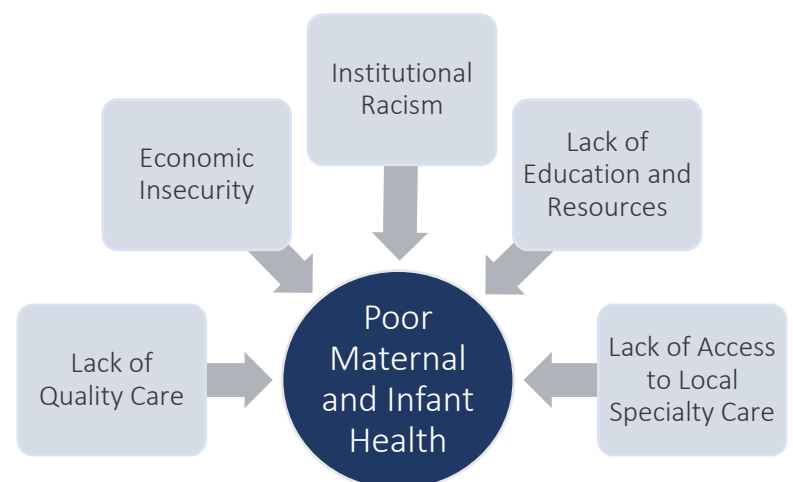
Lack of Local Resources and Providers



Racism and Discrimination

“Even when you level the playing field, [health outcomes are] still lower with women of color...I think it is more an issue of systemic racism and bias that is creating these issues.”- Subject Matter Expert

Factors Impacting Maternal and Infant Health



“There needs to be adequate assessment, addressing the concerns of a mom and meeting the needs of the baby.”

- Subject Matter Expert

Quick Fact: Infant mortality among minority residents is over 30% higher than the average infant mortality rate for both the Antelope Valley and Panorama City Service Areas.

People and Places Affected by Maternal and Infant Health

Women of Color

- "I think for African American moms, because the rate [of infant mortality] is highest, we have to address the daily stress they live under and the stress of racism." - Subject Matter Expert
- "Implicit discrimination contributes to high infant mortality rate among black women...a medical approach to black women needs to be [established]." - Community Member
- "There is bias many women encounter from doctors, latent racism..." - Subject Matter Expert

ESL Mothers (English as a Second Language)

- "I've heard stories from SPA 2 that the mom will only speak Spanish and even though the hospitals have translation services, they won't use it." - Subject Matter Expert
- "We found that less than 3% of lactation specialists spoke an Asian language, yet 16% of...LA does. How are they supposed to access this service?" - Subject Matter Expert

Geographically Isolated Residents

- "We are very spread out, so transportation to get resources is also an issue. If you don't have a vehicle, it is very difficult to get to resources in the outlying areas." - Subject Matter Expert
- "[Increasingly isolated mothers during pregnancy]...they don't know resources are available to them." - Subject Matter Expert

High-Risk Patients

- "The problem is when these patients are labeled as high-risk, they cannot get care in the region and have to go elsewhere." - Subject Matter Expert
- "The providers consider almost all things high-risk [which means they end up] referring patients unnecessarily [outside of the service area]." - Subject Matter Expert

Low Socioeconomic Status Residents

- "There are certain pockets where [a family] may not qualify for WIC, but they don't make enough to be able to pay \$150 for a lactation specialist." - Subject Matter Expert
- "There are so many women that aren't in a financially stable place to afford these resources." - Subject Matter Expert

Women planning Vaginal Births

- "Women who do not want a c-section go to Los Angeles or another medical facility out of the area to successfully have vaginal births. These women...had to go clear outside of the area--outside of Antelope Valley." - Community Member
- "The doctors pushed back and said [they] 'were not able to do this'. [The patients] went to other hospitals and successfully had vaginal births." -- Community Member

Resources to Address the Issue

Sample of Current Resources

Community members and subject matter experts identified the following existing resources and agencies that address maternal and infant health issues:

- Nurse Family Partnership
- El Nido Family Centers
- Breastfeed LA
- Women, Infants, and Children (WIC) Programs
- Children's Bureau, Black Infant Health Program
- Milk Depots within NICUs

"Antelope Valley has some of the best providers, and trauma surgeons are available on staff to consult!"
- Subject Matter Expert

Gaps and Needs

To address maternal and infant health issues, community residents and local subject matter experts made the following recommendations:

1. Continue educational outreach to mothers, using appropriate languages and with cultural sensitivity
2. Provide physician education and cultural competency trainings
3. Expand the number of providers and OB/GYNs within Antelope Valley that are willing and able to see high-risk patients
4. Provide standardized criteria for classification of high-risk pregnancies to limit the number of patients diagnosed as such
5. Increase the number of low-cost lactation specialists in the region
6. Enhance billing and reimbursement and encourage increased collaboration between agencies, the County, and hospitals

"There is no way we can [address high premature birth rates and NICU admissions] without the support of the County and hospital administrators. I hope this would also be a call to action for the area or we will have increased adverse outcomes."
- Subject Matter Expert

VI. Health Need Profile: Mental and Behavioral Health

Panorama City Medical Center Service Area

Local Issue: Mental and Behavioral Health

How Mental Health Impacts the Lives of Residents

John and Beth's Story... While both John and Beth enjoy living in Panorama City, they have been considering moving closer to Los Angeles to ensure Beth can get the mental health services she needs. They are frustrated with the lack of local resources and care options available to them. At times they have had to wait 3 months for Beth to see a mental health specialist. After screenings, Beth was referred to facilities outside of Panorama City or given the option of local County services. John and Beth don't qualify for County services due to their current insurance, but also can't afford to take days off to travel to and from LA. They just wish there was someone to help them navigate the system and find local services. John and Beth's story reflects the experiences of community residents, gathered through a series of focus groups and surveys, as well as interviews conducted with local subject matter experts. [This document shares the lived experience of residents within the Panorama City Medical Center Service Area.](#)

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"It's so difficult when you are mentally ill. They don't have a sophisticated understanding in terms of how to get resources they need and there is a lack of advocacy and social systems to guide patients to appropriate resources."

-Subject Matter Expert, Psychiatry

“

"I think we are taking mental health more seriously, but I do feel that people are still uncomfortable talking about it as if it is something that can be changed, unlike other physical illnesses."

-Focus Group Member, Lancaster

Identified Causes & Contributing Factors

Concern About Mental Health

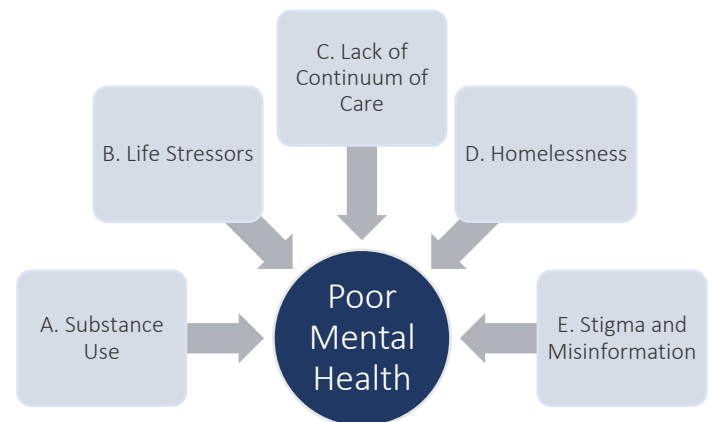
Doctors, mental health professionals, and local residents in the Panorama City and Antelope Valley Service areas were invited to share their perspectives on mental health via survey. Residents surveyed include the San Fernando and Santa Clarita Valley Homeless Coalition.

- **9 in 10 physicians** reported that they are very concerned about mental health.
- **All Homelessness Coalition members (100%)** reported being moderately concerned or very concerned with mental health.
- **Over 5 in 10 residents** reported that they did not know how to access mental health resources (58%) and indicated that mental health services are lacking in their community (52%).
- **Community residents and stakeholders reported that access to mental health services was their greatest concern.**

"The biggest and massive concern is mental health. Access to mental health support outside and inside the schools." – Subject Matter Expert

"[To] help those with mental health issues...assign someone to advocate for them and help them navigate through the system." – Community Member

Factors Impacting Mental Health



- "We're seeing more people that are impaired. It's not just marijuana, we see it with meth, alcohol. People are reaching for escape tools." – Subject Matter Expert
- "There is a lot of [pressure] about financial situations and this adds to emotional and mental stress." – Community Member
- "Public healthcare only addresses those with serious and persistent mental illness, which is necessary, but there is a continuum of mental health that needs to be addressed." – Subject Matter Expert
- "This lack of stability [when homeless] is a huge cause of mental illness. The lack of social safety nets prevents us from moving forward." – Subject Matter Expert
- "[Stigma] is pretty significant in all communities, we have been battling that with education." – Subject Matter Expert

Reported Barriers to Accessing Mental Health Care

Top 5 Barriers include:

1. Navigating the system (lack of health care navigators)
2. Severe staff and provider shortages
3. Lack of an integrated system of care
4. Lack of resources and services in local communities
5. Poor quality of care

Additional barriers include: social stigma, long wait times to see a mental health professional (upwards of 3-hours), cost and insurance coverage concerns, lack of education and visibility of services, lack of transportation, and lack of sensitivity training for local police, therapists, and other professionals.

People and Places Affected by Mental Health

Homeless Individuals

- “With the homeless, it is not only the [issues of] poverty, housing, resources...[that need to be addressed], but also working with their mental health challenges.” – Community Member
- “Homeless people need phones to access resources, schedule appointments, etc.” – Community Member
- “Mental health resources for the homeless are needed.” – Community Member

Foster Youth and Former Foster Youth

- “[For] foster youth, a vast majority are dealing with trauma. As a mental health provider we use an evidence-based practice called trauma-informed care.” – Subject Matter Expert

Transition Age Youth (TAY- 16-25 years old)

- “Some schools invest in developing character, attend to students who experience trouble...provide counselors for students who need counseling.” – Community Member
- Establish support groups...especially at the universities. Mental health breakdowns often occur during college and/or after graduation.” – Community Member

Specific Ethnic Groups (e.g., Blacks, Hispanic/Latinos)

- “African Americans and Hispanic groups in particular, they are often the most challenging to provide [mental health] resources to—there’s a lack of a comprehensive understanding of the types of mental illness issues that come up.” – Subject Matter Expert
- “Social stigma associated with [mental health] in the Hispanic community...prevents individuals from seeking treatment.” – Community Member

Veterans

- “Take care of our veterans who have problems, they should be able to get any kind of care that is necessary for them.” – Community Member

Resources to Address the Issue

Sample of Current Resources

Community members and subject matter experts listed a number of existing resources and agencies that address mental health issues:

- Lucien (home visits)
- National Alliance on Mental Illness
- Mental Health America
- USC School Social Work Program (virtual therapy)
- Primary, preventative, and specialty care via:
 - UCLA, County Department of Mental Health, and Kaiser
 - Vista Del Mar, Olive View, and Hathaway’s Sycamore

Gaps and Needs

To address mental health issues, community residents and subject matter experts recommended the following:

1. Provide health care navigators or advocates for mental health services
2. Seek opportunities to hire additional staff or partner with other mental health professionals locally
3. Coordinate an integrated system of care with local departments and agencies
4. Provide more education and awareness around mental health to address ingrained stigma

“There are a handful of agencies that try to address mental health in the community, but they do not have the capacity to serve the community’s needs.” – Subject Matter Expert

VII. Health Need Profile: Obesity and Diabetes

Panorama City Medical Center Service Area

Local Issue: Obesity and Diabetes

Food Insecurity Contributes to Obesity and Diabetes

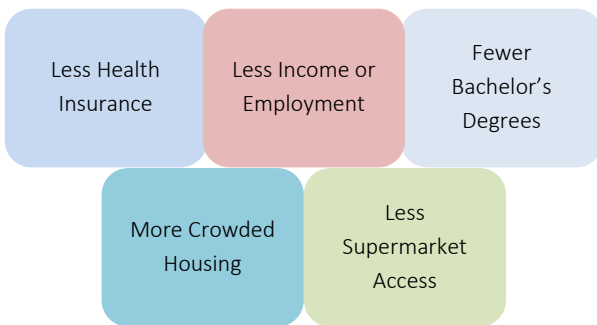
Sofia's Story... Sofia often works 12-hour shifts and doesn't return home until it is after dark. She wants to take walks during her time off, but the neighborhood and local parks are unsafe. To save money, Sofia tries to shop at the 99-cent store that is on her way to work, but she can't keep perishable groceries cold during her workday. When fresh produce is available, it's often in bad condition and doesn't taste as good as packaged food. Sofia's partner helps her make dinner, but he insists on only cooking boxed macaroni and cheese. While she tries to shop at Food 4 Less using coupons and discounts as much as possible, she typically serves her family vegetables only a couple times a week. Sofia worries that her children are gaining weight, but feels more optimistic now that local efforts have brought healthier beverages to their schools. Sofia's story reflects the experiences of residents, gathered through community focus groups, as well as interviews conducted with local subject matter experts. [This document shares the lived experience of residents within the Panorama City Medical Center Service Area.](#)

“Studies have shown [chronic stress] accumulates over time and puts more chronic pressure on the person. It turns into a physiological process by raising cortisone levels, leading to higher blood pressure, and so on.”
-Subject Matter Expert, Public Health

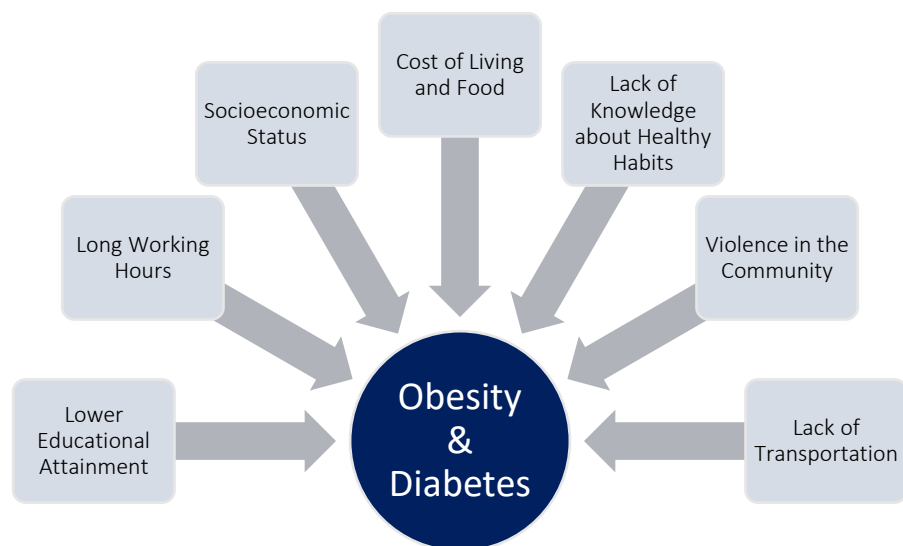
“...If you look at a family who is well educated and they have more access to better, healthier foods, that is a huge one.”
-Subject Matter Expert, Antelope Valley Union High School District

Identified Causes & Contributing Factors

Social Predictors of Obesity and Diabetes



Factors Impacting Obesity and Diabetes



Doctors and Residents Express Concern

Kaiser Permanente doctors in the region and **local residents** were invited to share their perspectives on accessing health resources via survey.

- **9 in 10 local physicians** reported being concerned or very concerned about diabetes (90%) or obesity (91%).
- **Diabetes and obesity** were reported by residents as the **top two health concerns** facing the community.

“People don't know [that resources in the community] exist and resources have difficulty finding the communities that need them.” - Subject Matter Expert

People Affected by Obesity and Diabetes

Specific Ethnic Groups (e.g., Asians, Blacks, Hispanic/Latinos)

- "In the African American community, there is an added factor that causes many health issues and that is the chronic stress that is experienced by this community." - Subject Matter Expert
- "We see lots of research that shows that even if you hold all else equal, many conditions are exacerbated due to race and their experiences." - Subject Matter Expert
- "The information we have about different racial/ethnic groups, such as Asians and Latinos, is in aggregate, but it needs to be disaggregated to understand the various health outcomes that may differ across subpopulations." - Subject Matter Expert

Low Socioeconomic Status Residents

- "A lot of it comes down to socioeconomic status." - Subject Matter Expert
- "Poor and working poor [are] most impacted. [If you go to]...Food for Less and bought food and veggies, it's pretty slim pickings, not what is at Gelson's." - Subject Matter Expert

ESL Residents (English as a Second Language)

- "We have 16 [threshold languages] in Los Angeles County. The amount of materials, supplies, and outreach in all languages is very, very small." - Subject Matter Expert
- "[We provide programming]...primarily in Spanish and English. There are other areas with other languages, like Farsi, that our staff don't have the background in, so it is harder to reach that population." - Subject Matter Expert

Undocumented Individuals

- "There is also the undocumented population...if they see us coming, they may be afraid they'll be turned over for deportation. Their ability to discern between immigration and public health is minimal. They're afraid of utilizing our services and don't realize or trust that we are trying to help them. It is difficult to dispel the rumors and we can't make a public statement that they'll believe." - Subject Matter Expert

Barriers to Care for Obesity and Diabetes

Cost of Healthy Food and Gyms



Availability of Fresh Food



Transportation



"Even if we planned an event or class in an area they go, there are always challenges, like some residents may have a hard time getting there."
- Subject Matter Expert



Quick Fact: Residents of the Panorama City Medical Center Service Area have **higher rates of obesity and diabetes** compared to residents of the State and Southern California.

Resources to Address the Issue

Sample of Current Resources

Community stakeholders identified the following existing resources and agencies that address obesity and diabetes:

- Kaiser Permanente (classes, educational activities)
- Churches (nutrition classes)
- Farmers' markets and community parks
- Foodbanks

"It is sometimes difficult to match resources available in communities with the people who need them."
- Subject Matter Expert

Gaps and Needs

Community stakeholders made the following recommendations for addressing obesity and diabetes:

1. Provide community education on healthy living habits
2. Offer community gymnasiums and/or recreation centers to support the needs of children and families

"There are many foodbanks, [but] most of the products distributed are not fresh or healthy."
- Community Member

2 "There are a number of parks available...many are not used by the general public because of the homeless population." - Community Member

Appendix D. Community Resources

Identified need	Resource provider name	Summary description
Access to Health Care	Community Clinic Association of Los Angeles County	CCALAC helps its Membership serve their patients in an efficient and cost-effective manner while providing quality care. They deliver a variety of member services including policy advocacy, education, technical assistance and peer support. As the local clinic consortium for Los Angeles County, they connect clinics, share and leverage resources, and represent a unified voice on behalf of clinics.
	Los Angeles County Department of Health Services	Provides several no-cost and low-cost programs at county medical facilities, including ability to pay, pre-payment plan, mental health services, child delivery plan, discount payment plan, and dialysis, post-polio and tuberculosis plans
	Northeast Valley Health Corporation	The mission of Northeast Valley Health Corporation is to provide quality, safe and comprehensive primary health care to medically underserved residents of Los Angeles County, particularly in the San Fernando and Santa Clarita valleys, in a manner that is sensitive to the economic, social, cultural and linguistic needs of the community.
Economic Security	Los Angeles Family Housing	LA Family Housing helps people transition out of homelessness and poverty through a continuum of housing enriched with supportive services.
	San Fernando Santa Clarita Valley Homeless Coalition	Coalition of agencies that provide homeless services in San Fernando and Santa Clarita Valleys come together to share resources and services they provide addressing housing, mental health and homeless services. Updates and coordination by the Los Angeles Homeless Services Agency, as well as the local Coordinated Entry System lead agency, Los Angeles Family Housing, are provided here.

	Food Finders	Food Finders links donated food to pantries and shelters in order to bridge the hunger gap in our communities throughout Southern California.
HIV / AIDS / STD	Project Angel Food	Project Angel Food prepares and delivers healthy meals to feed people impacted by serious illness, bringing comfort and hope every day. Clients receive a meal for each day of the week and meals are tailored to their nutritional needs. Their drivers are often the only human interaction a client may have from day to day.
	Bienestar Human Services	Bienestar is a community-based social services organization based in the Greater Los Angeles area focused on identifying and addressing emerging health issues faced by the Latino and LGBTQ populations. Bienestar's education and support programs encompass areas such as: HIV/AIDS treatment and prevention, STIs, mental health services, substance use and harm reduction. All of their services are offered to the community for free
	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 made up of three areas: health services, education, and advocacy.
Mental and Behavioral Health	Mental Health America Los Angeles	Offers a broad spectrum of services for adults and young adults with mental illness, including those who are homeless such as Outreach and Engagement, Mental Health Care, Psychiatry and Medication Management, Housing Services, Benefits and Income Services, Health Care Services, Linkage to Substance Abuse Services, Wellness and Life Skills Programs, Employment and Vocational Services, including Social Enterprise Opportunities, Transition Age Youth and Foster Youth Services, and Specialized Veterans' Service.

	Tarzana Treatment Center	Tarzana Treatment Centers, Inc. is dedicated to providing professional health care that treats each person with compassion and according to their assessed individual needs for improved physical and mental wellbeing. They provide whole-person healthcare through their integrated programs of primary medical and behavioral healthcare including inpatient medical detoxification and psychiatric stabilization, residential and outpatient substance use disorder treatment, outpatient mental health, and residential rehab for teens / youth and adults, primary care clinics, and HIV/AIDS services including specialty medical care.
	Child and Family Center	Changing lives and healing relationships by helping people thrive through education, treatment, prevention & advocacy the agency has grown into a provider of comprehensive prevention, early intervention, diagnostic evaluation and therapeutic services for children, teens, adults and families who live in the Santa Clarita Valley.
Obesity / Healthy Eating & Active Living (HEAL) / Diabetes	International Pre-Diabetes Center	IPDC is a 501(c)3 non-profit organization that is committed to increasing Diabetes Self-Management Education/ Training (DSME/T) and National Diabetes Prevention Program (NDPP) in local communities. IPDC's programs and services are structured around the principles and realization that prevalence and risks for diabetes and Pre-Diabetes are driven by a complex array of social, economic, cultural and educational factors: collectively referred to as the Determinants of Health (DOH).
	Alliance for a Healthier Generation	The Alliance for a Healthier Generation's mission is to reduce the prevalence of childhood obesity and to empower kids to develop lifelong, healthy habits. The Alliance partners with schools and communities to improve environments that foster healthy eating and active living; supports the development and sustainability of healthier marketplaces; informs public policy; and pursues strategic partnerships with youth-serving organizations.

Mid Valley, East Valley, and Antelope Valley Family YMCA's	The YMCA of Los Angeles has been making a positive impact in communities for over 130 years. 26 branches stretch across over 100 miles of Los Angeles County, from Antelope Valley to San Pedro. Membership community is 264,500 strong, open to all, with financial assistance available to those who cannot afford it. This year, the LA Y helped 1 out of 3-member families with financial assistance.
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Appendix E. Strategic Lines of Inquiry for Community Engagement

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

Overview of Question Design Process

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