2019 Community Health Needs Assessment

Kaiser Permanente: Kern County

License number:

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

September 16, 2019

KAISER PERMANENTE®

Kaiser Permanente Southern California Region Community Benefit CHNA Report for KP-Kern County

Contents

I. Introduction/background

A. About Kaiser Permanente (KP)

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

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

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

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

B. About Kaiser Permanente Community Health

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

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

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

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

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

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

The Patient Protection and Affordable Care Act (ACA), enacted on March 23rd, 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, KP-Kern County 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 as those individuals residing within its service area. A service area includes all residents in a defined geographic area surrounding its medical facilities and does not exclude low-income or underserved populations.

B. Map and description of community served
i. Map –

Figure A. KP-Kern County Medical Care Service Area
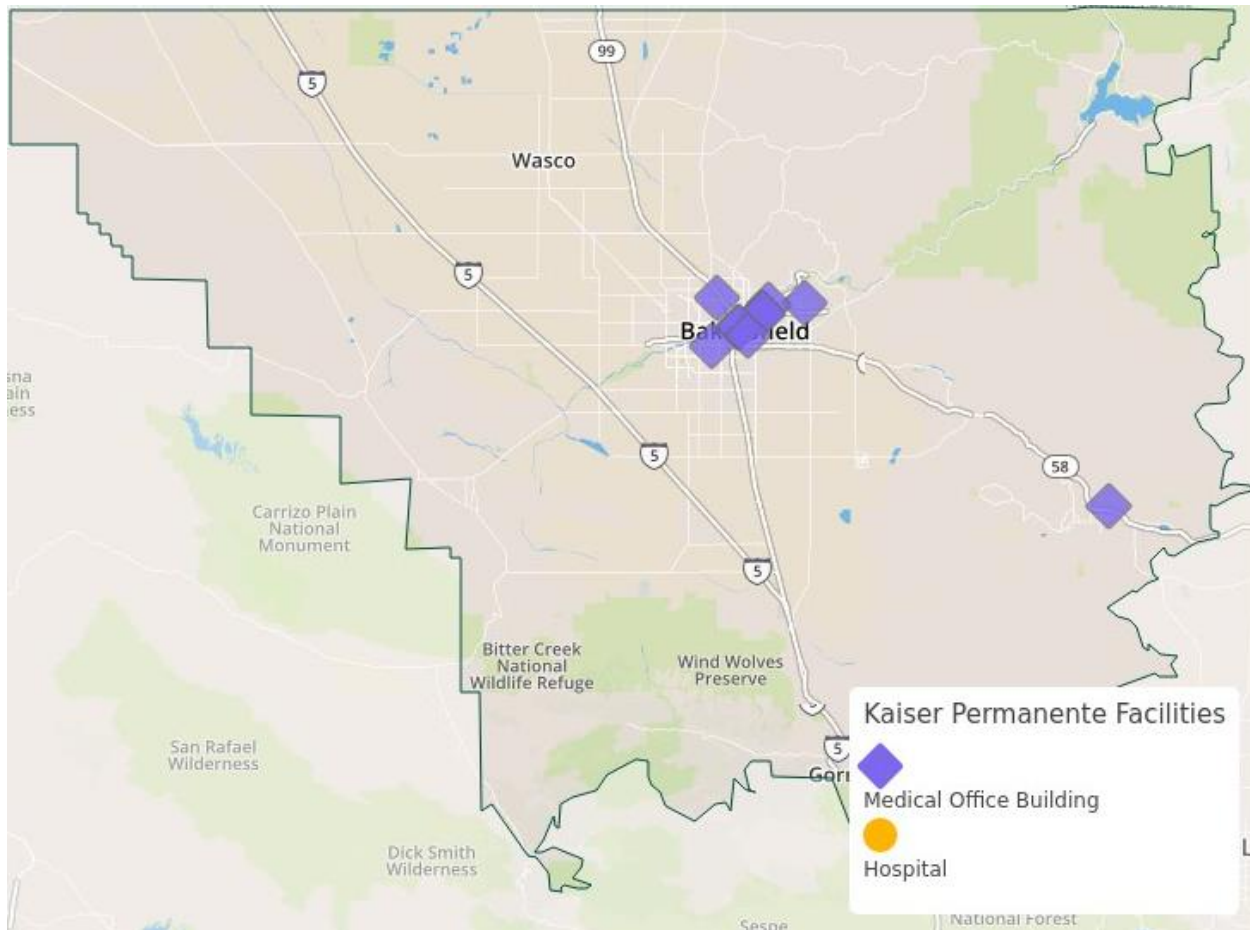
ii. Geographic description of the community served

The KP-Kern County medical care service area includes Arvin, Bakersfield, Bodfish, Buttonwillow, Caliente, Delano, Fellows, Glenville, Keene, Kernville, Lake Isabella, Lamont, Lebec, Lost Hills, Maricopa, McKittrick, McFarland, Shafter, Taft, Tehachapi, Wasco, and Wofford Heights.

iii. Demographic profile of the community served

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

Table 1. Demographic profile: KP-Kern County[1]

Race/ethnicity		Socioeconomic Data	
Total Population	788,068	Living in poverty (<100% federal poverty level)	23.47%
Asian	4.56%	Children in poverty	32.63%
Black	4.73%	Unemployment	7.4%
Hispanic/Latino	54.51%	Uninsured population	13.81%
Native American/Alaska Native	0.49%	Adults with no high school diploma	27.70%
Pacific Islander/Native Hawaiian	0.11%		
Some other race	0.10%		
Multiple races	1.71%		
White	33.80%		

iv. Severely under-resourced communities

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

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

---

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

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

Figure B. Under-Resourced Communities in KP-Kern County
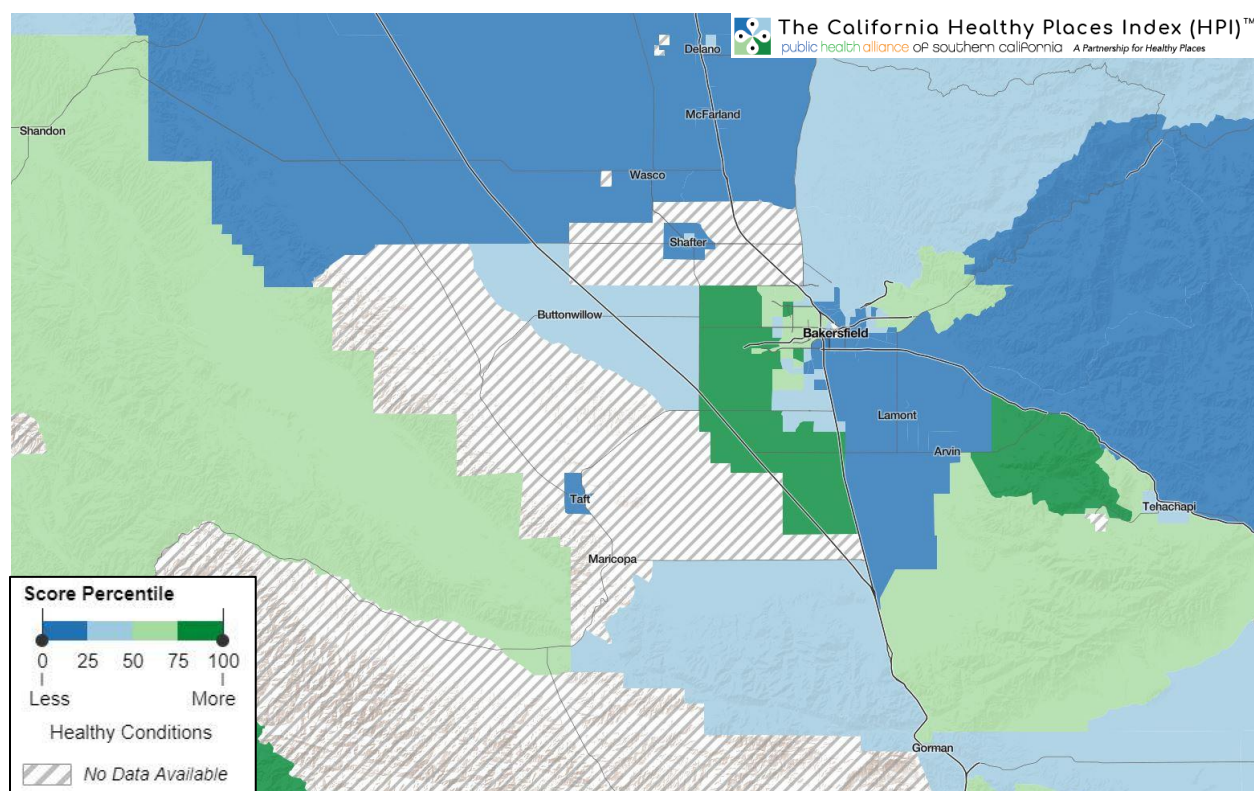
Source: The California Healthy Places Index, © 2018 Public Health Alliance of Southern California, http://healthyplacesindex.org/

Major under-resourced communities in the KP-Kern County service area:

- Oildale, East Bakersfield, & Southeast Bakersfield
- Arvin, Lamont, & Greenfield
- Wasco, McFarland, Delano, & Shafter
- Taft & Buttonwillow

The opportunity to live a long and healthy life is influenced by a wide range of social factors, including economics, education, transportation, built environment, and access to care[3]. In aggregate, the KP-Kern County service area is in the **27th percentile** for health opportunity among California residents. In effect, this means that 7 out of 10 Californians have a greater opportunity to live a long healthy life than residents living in the KP-Kern County service area.

Approximately **2 out of every 3 people** in the Kern County service area (well over **519,000**) are living in a severely under-resourced area[4].

---

[3] Please read more about the strong scientific evidence for these relationships here.
[4] Calculations are estimates based on population-weighted HPI scores using the most recent US census data.

III. Who was involved in the assessment?

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

Collaborating Hospitals:
- Delano Regional Medical Center
- Valley Children's Hospital
- Adventist Health Hospital
- Dignity Health
- Kern Medical

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

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

IV. Process and methods used to conduct the CHNA

KP-Kern County 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 C below).

Figure C – Mixed-Method Assessment Approach to the CHNA

Secondary Data Analysis

- Provided a bird's eye view of community health needs.

- Conducted multi-dimensional health outcome comparisons.

- Conducted regression analyses of social predictors of health.

Findings analyzed to create relevant lines of inquiry for community engagement.

Primary Data Collection and Analysis

- Provided a deep-dive exploration of community needs.

- Employed strategic community sampling.

- Ensured authentic engagement through culturally-competent protocols.

Findings analyzed to lift community voice.

Synthesis and Reporting

- Provided meaningful understanding of lived experience, causes, disparities, and resources available to address health needs.

- Combined bird's eye view + deep-dive data to tell community story.

A. Secondary data

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

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

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

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

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

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

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

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

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

social predictors of health in this index include 25 indicators related to economic security, education, access to care, clean environment, housing, safety, transportation, and social support (please refer to Figure B to see this map[5]).

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 KP-Kern County service area census tracts. The results of these analyses found multiple social factors with statistically significant ($p < .05$) predictive relationships with important population health outcomes (please refer to Table 2 to see results).

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

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

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

---

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

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

Table 2. Social Factors Linked to KP-Kern County Health Outcomes

	More Poor Mental Health Days	More Heart Attack ER Visits	Higher Asthma Prevalence	Higher Obesity Prevalence	Higher Diabetes Prevalence	Higher Stroke Prevalence	Higher Cancer Prevalence	Higher Percentage of Babies Born with Low Birth Weight	Higher Smoking Prevalence	More Pedestrian Injuries	Number of Outcomes Affected
Lower Income		X	X	X	X	X	X	X			7
Fewer Bachelor's Degrees	X			X	X			X	X		5
More Homeownership				X	X	X	X				4
More Crowded Housing	X			X					X	X	4
More Bachelor's Degrees						X	X				2
Less Homeownership		X	X								2
Less Health Insurance				X							1
Worse Air Quality		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.[6]

Table 3. Health Outcome Comparison Table for KP-Kern County

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*	13.7%	1.5% (Worse than CA)	61.3% Reduction	60% Worse than Average	No
Obesity	36.8%	7.2% (Worse than CA)	37% Reduction	25% Worse than Average	No
Stroke*	3.9%	0.2% (Worse than CA)	57% Reduction	24% Worse than Average	Yes
Maternal/Infant Health	7.1%	0.3% (Worse than CA)	17.9% Reduction	55% Worse than Average	No
HIV/AIDS/STD	0.3%	-0.11% (Better than CA)	58.2% Reduction	211% Worse than Average	No
Asthma	13.4%	-1.4% (Better than CA)	13.3% Reduction	89% Worse than Average	Yes
Substance/Tobacco Use	6.2%	-0.85% (Better than CA)	69.7% Reduction	48% Worse than Average	No
Oral Health	14.8%	3.5% (Worse than CA)	2.8% Reduction	17% Worse than Average	No
Cancer*	3.2%	-0.07% (Better than CA)	51% Reduction	15% Worse than Average	Yes
CVD*	6.8%	-0.15% (Better than CA)	30% Reduction	10% Worse than Average	Yes
Violence/Injury	0.0%	0.05% (Worse than CA)	13.2% Reduction	21% Worse than Average	Yes
Diabetes*	8.2%	-0.2% (Better than CA)	24.1% Reduction	5% Worse than Average	No

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

B. Community input

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

1. What types of resources are needed among the low-income population to better address health outcomes?
2. What is contributing to the number of negative health outcomes among those with no college degree?
3. What factors are negatively impacting mental health days in Kern?
4. What is driving the suicide rate among White residents?
5. Why is the obesity prevalence high/above average among Black and Latino residents?
6. What is the lived experience among Black and Latino residents that could be contributing to high obesity rates?
7. What local efforts or resources could be contributing to the lower cancer prevalence rates in Kern compared to the state and southern California region?
8. What is driving the high cancer rate among White and Black residents within Kern?
9. What is contributing to the high chlamydia rate in Kern County?
10. What is driving the higher than average domestic violence hospitalization rate Kern County?

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

Figure D. Community Engagement Framework
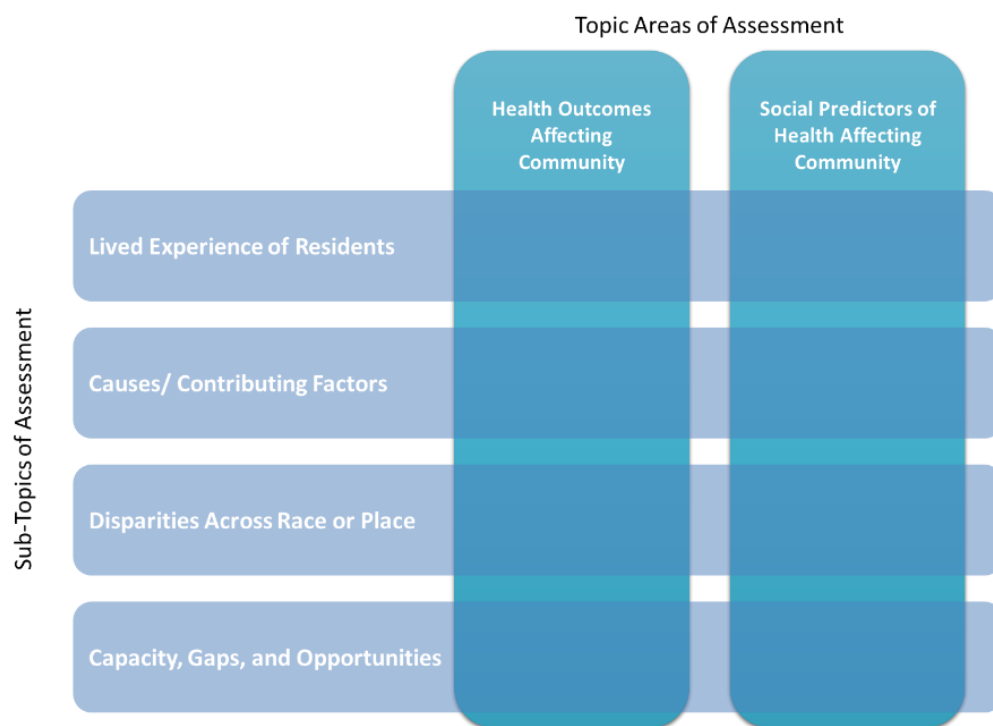
i. Description of who was consulted

Residents, community leaders, and government and public health department representatives were selected for the CHNA sample. Selection criteria across these groups included (a) those best able to respond in rich detail to the strategic learning questions, (b) those who had expertise in local health needs, (c) those who resided and/or provided services in an under-resourced or medically underserved community, and (d) those able to represent the health needs of a given racial or ethnic minority group. Given the large size of the KP-Kern County service area, community engagement efforts set out to target those geographies most under-resourced and where health outcomes were the poorest (see Figure B for a map referencing the most underserved areas of KP-Kern County). 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 surveys. Kaiser Permanente and EVALCORP engaged 1,669 individuals from October 2018 through January 2019, gathering primary data through two surveys, five focus groups, and 14 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 D).

The list of individuals and groups 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, KP-Kern County had not received written comments about previous CHNA Reports. Kaiser Permanente will continue to track any submitted written comments and ensure that relevant submissions will be considered and addressed by the appropriate facility staff.

D. Data limitations and information gaps

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

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 KP-Kern County 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 Healthcare. Access to comprehensive quality health care is important for the achievement of health equity and for increasing the quality of life. Limited access can dramatically impact health outcomes. Through the community engagement process, the following barriers and challenges were identified by community residents: lack and high cost of

health insurance, transportation limitations in being able to access health care, constraints in obtaining childcare to be able seek medical attention, and lack of awareness of available resources.

HIV/AIDS/STD. Sexual health can be easily maintained through safe sex practices and access to reproductive health care services, but in the Kern service area, the prevalence of an easily treatable STI, chlamydia, has burgeoned. Chlamydia prevalence among service area residents (734 per 100,000) is roughly 50% higher than both state (460 per 100,000) and regional (483 per 100,000) rates. Other STIs, like congenital syphilis, are also increasing in prevalence and, though easily curable, can and do mortally impact infant health if left untreated. Through the community engagement process, residents indicated that the dearth in preventative education, both in schools and the general population, is partially to blame for rising STI rates.

Mental Health. Mental health is an important component of a person's overall health and well-being. In fact, poor mental health can result in a 61% reduction in life expectancy when left untreated. In Kern County, 14% of residents report experiencing a mental health problem. White residents in the Kern service area are disproportionately impacted, as they die by suicide at rates 60% above the service area average, when compared to other ethnic and racial groups. Additionally, through the community engagement process, community residents and subject matter experts noted that mental health needs for youth and young adults, especially those from minority and LGBTQ+ communities, are not being met, but that school-based services could be a solution.

Obesity and 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. Many Kern residents do not have easy access to these resources and thus experience a high rate of obesity (37%); higher than both the state and southern California region. Black and Latino residents in the Kern service area are disproportionately impacted, as they are obese at above average rates (25% and 14%, respectively) when compared to other ethnic and racial groups. During the community engagement process, residents shared how the hot summers, unsafe pedestrian spaces, and little access to affordable fresh produce severely impact their ability to make healthful choices.

Violence. Violence, both accidental and non-accidental, is listed as a top 5 cause of death in Kern County. Experiences with violence can have a drastic impact on both a person's physical and mental well-being. For non-accidental injury, motor vehicle incidents are almost twice as prevalent (14.2 per 100,000) in the Kern service area as the southern California region overall (7.7 per 100,000). Domestic violence also has a serious impact on resident lives. Kern service area residents are hospitalized for domestic violence (9.8 per 100,000) twice as often as state residents (4.9 per 100,000) and at an even higher rate than other southern Californian residents (4 per 100,000). Additionally, survivors of domestic violence, who participated in the community engagement process, expressed their concern about the lack of shelter beds and adequate legal and financial aid for those seeking assistance.

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

The service area for KP-Kern County 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. KP Kern County 2016 Implementation Strategy evaluation of impact

A. Purpose of 2016 Implementation Strategy evaluation of impact

KP-Kern County'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 KP-Kern County'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/Kern-County-IS-Report.pdf.

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

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

KP-Kern County 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, KP-Kern County 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, KP-Kern County 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, KP-Kern County 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,

KP-Kern County paid 51 grants amounting to a total of $2,783,535 in service of 2016 health needs. Additionally, KP-Kern County has funded significant contributions to the California Community Foundation in the interest of funding effective long-term, strategic community benefit initiatives within KP-Kern County. During 2017-2018, a portion of money managed by this foundation was used to pay 20 grants totaling $3,308,939 in service of 2016 health needs.

In-kind resources: In addition to our extensive 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, KP-Kern County leveraged significant organizational assets in service of 2016 Implementation Strategies and health needs, including:
- Hippocrates Circle Program
- Plant Based Diet seminars
- Durable Medical Equipment Storage
- Physician speaker for World Aids Day
- Flu shots during the Dia De Los Muertos

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, KP-Kern County engaged in several partnerships and collaborations in service of 2016 Implementation Strategies and health needs, including:
- STD Task Force
- Kern High School District and Educational Theatre
- Covenant Coffee Pilot at 16th Street facility

C. 2016 Implementation Strategy evaluation of impact by health need

KP-Kern County Priority Health Needs

Need	Summary of impact	Examples of most impactful efforts
Access to Care	*During 2017 and 2018, Kaiser Permanente paid 15 grants, totaling $981,167 addressing the priority health need in the KP-Kern County service area. In addition, a portion of money managed by a donor advised fund at California Community Foundation was used to pay 5 grants, totaling $930,667 that address this need.*	**Providing Affordable Healthcare** Over two years (2017-2018), KFH-Kern provided $10,852,433 in medical care services to 15,047 Medi-Cal recipients (both health plan members and non-members) and $162,362 in medical financial assistance (MFA).
		Building Primary Care Capacity~ The California Primary Care Association (CPCA) provides education, training, and advocacy to their member community health centers to best serve their low-income, underserved, and diverse patients. In 2018, Kaiser Permanente paid $126,666 to CPCA to: • Hold statewide convenings and conferences and topic-specific peer networks to support over 1,200 California community health centers. • Provide 90 in-person and web-based trainings to over 4,400 attendees and 2,890 individual instances of technical assistance.
		Preserving and Expanding California Coverage Gains~ Insure the Uninsured Project (ITUP) works to preserve and expand access to health care and coverage in California and to reduce access barriers for uninsured and underinsured populations Over two years (2017-2018), Kaiser Permanente paid $150,000 to ITUP to: • Conduct and disseminate health policy research. • Convene 13 regional statewide work groups. • Provide technical assistance to safety net providers and other stakeholders navigating health reform challenges. • Serve as a bridge between health policy and the health care sector to reach 19 million Californians.
		Providing Flu Shots: The Kern County Flu team has provided over 400 flu shots to nonmembers. In November 2018, they specifically targeted the Hispanic community and were able to provide 180 flu shots during the Dia De Los Muertos event hosted by the Hispanic Chamber of Commerce.
		Increasing Senior Support The Alzheimer's Disease Association of Kern County aims to improve the lives of Kern County Residents affected by Alzheimer's disease and related disorders. In 2018, Kaiser Permanente paid $30,000 to The Alzheimer's Disease Association of Kern County to: • Provide increased access to comprehensive quality care services to low-income seniors with dementia, while providing concurrent respite to caregivers and alleviating the transportation barrier.

		Hospice Funding Support The Optimal Hospice Foundation commits its resources to activities which are intended to ensure hospice care and other compassionate programs are available for families facing a life-limiting illness with particular emphasis on the underinsured or uninsured population. In 2018, Kaiser Permanente paid $18,000 to The Optimal Hospice Foundation to: • Provide funding for patients who qualify for and desire hospice but who are uninsured, underinsured or whose coverage benefits have run out.
		Developing Future Workforce through Partnerships Kaiser Permanente physicians and staff work in partnership with Adventist Health, CSU Bakersfield's nursing program and Ross University to deliver the Hippocrates Circle Program which aims to provide a robust program with the intention of building the pipeline for future physicians and healthcare workers by providing 30 junior high students from Sierra Middle School with a 5-day medical career experience.
Behavioral & Mental Health	*During 2017 and 2018, Kaiser Permanente paid 18 grants, totaling $734,368 addressing the priority health need in the KP-Kern County service area. In addition, a portion of money managed by a donor advised fund at California Community Foundation was used to pay 1 grant, totaling $40,000 that address this need.*	**Strengthening Mental Health Policies and Practices in Schools~** Children Now educates policymakers, school district leaders, and other key stakeholders about best practices and policy solutions to address suspension and expulsion policies that disproportionately impact students of color, improve school climate, and increase students' access to mental health services. Over two years (2017-2018), Kaiser Permanente paid $150,000 to Children Now to: • Inform over 200 key legislators and stakeholders. • Support the California Department of Education in the development of the Whole Child Resource Map. • Lead committees for both the State School Attendance Review Board and the Superintendent's Mental Health Policy Workgroup.
		Building the Mental Health Workforce* Cal State Bakersfield Foundation (CSBF) builds the emerging mental health workforce by introducing underserved high school students to counseling or therapy careers through its Counseling Training Pathways Program (CTPP). In 2018, Kaiser Permanente paid $40,000 to CSBF to: • Partner with five Kern County high schools to develop the CTPP program. • Engage at least 40 high school students in monthly CTPP activities that support understanding of mental health careers. • Recruit at least 40 Cal State University, Bakersfield (CSUB) students for the Pre-Counseling program at the CSUB. • Provide mentorship for past CTPP participants who enter CSUB as Psychology majors to increase application and admission rates into the Master of Science Program in Counseling Psychology.
		Hosting Mental Health and Wellness Convening: Kaiser Permanente hosted a second mental health and wellness convening bringing together organizations involved in improving the mental health of the community. This convening

allowed for networking and partnership building between nontraditional and traditional mental health organizations.

Supporting Courts for Child Development Issues
Court Appointed Special Advocates supports and promotes court-appointed volunteer advocacy so every abused or neglected child in the United States can be safe, have a permanent home, and have the opportunity to thrive. In 2018, Kaiser Permanente paid $30,000 to Court Appointed Special Advocates (CASA) of Kern County to:

- Train and supervise CASA volunteers. Each CASA will inform the court and all providers of the trauma and child developmental issues affecting children they are representing in the system. As a result of this work the local juvenile justices have created a standing order for all foster children on psychotropic medication to be assigned a CASA to ensure appropriate and comprehensive quality mental health care.

Expanding Trauma Informed Care Training
In 2018, Kaiser Permanente paid $30,000 to Kern County Medically Vulnerable Care Coordination Project to:

- Expand the programs coordination services with a Trauma Informed Care training program for parents, providers, case managers and nurses to improve lifelong outcomes for at risk infants and children in Kern County. The long-term goal of the program includes creating a Trauma Informed Kern County. The work was successful in its first year and in its second year will include top county leaders and elected officials.

Partnering with Companies that Employ Foster Youth

Kaiser Permanente's Kern 16th Street location (Engineering, IT, Materials Management, Medical Records etc...) hosted a pilot where they switched coffee vendors to Covenant Coffee. Covenant Coffee Roasting Company employs foster youth and former foster youth. It was successful and the employees really enjoyed the coffee, so now the pilot has been extended to our administrative offices. We are waiting for the organizations to build its capacity a little bit larger in order to extend into additional medical office buildings.

STI	*During 2017 and 2018, Kaiser Permanente paid 4 grants, totaling $285,000 addressing the priority health need in the KP-Kern County service area.*	**Improving Schools Wellness Centers** In 2018, Kaiser Permanente paid $30,000 to Bakersfield City School District to: - Improve the capacity of the district's on-site wellness centers, nurses and social workers to focus on students who are in junior high school and middle school who are sexually active but unable to access care for diagnosis/treatment of STIs & pregnancy.

		Spreading Knowledge through Educational Theatre
		Educational Theatre, Performs What Goes Around to all high schools in the KHSD
		Partnering to Reduce STIs in Kern County Kaiser Permanente is an active member in the Kern County STD taskforce. The taskforce is led by the Kern County Department of Public Health (KCDPH). In addition to KCDPH, organizations such as Kern High School District, CSU Bakersfield, Planned Parenthood, Clinica Sierra Vista, Omni Health, Komono Pharmacy, Bakersfield College, & the Bakersfield Pregnancy Center work together on community awareness campaigns and coordinated programs to decrease the occurrence of STD's in Kern County.
Diabetes & Obesity	*During 2017 and 2018, Kaiser Permanente paid 14 grants, totaling $783,000 addressing the priority health need in the KP-Kern County service area. In addition, a portion of money managed by a donor advised fund at California Community Foundation was used to pay 14 grants, totaling $2,338,272 that address this need.*	**Advocating for Maternal, Infant, and Child Health~** The California WIC Association (CWA) supports efforts to increase local WIC agencies' capacity, increase state and federal decision makers' understanding of WIC services, and increase the capacity of community health centers to build a breastfeeding continuum of care in low-income communities. Over two years (2017-2018), Kaiser Permanente paid $100,000 to CWA to: • Pilot two video conferencing projects increasing awareness and consideration within the CA WIC community. • Work to strengthen ties with CPCA and present at CPCA's annual conference. • Visit all CA legislators with 44 appointments and drop-in visits. • Provide extensive information to legislators on nutrition and breastfeeding counseling, food benefits, local economic impacts to grocers, health outcomes, access to Farmers markets, and updates on immigration threats. • Participate in Capitol WIC Education Day in Sacramento with 50 attendees from 30 WIC agencies from all over the state.
		Fighting Food Insecurity~ California Association of Food Banks' (CAFB) Farm to Family program's goal is to improve health food access by providing fresh produce to food banks, CalFresh outreach and enrollment, advocacy to support anti-hunger policies, and technical assistance to members. In 2018, Kaiser Permanente paid $95,000 to CAFB to: • Distribute 250,000 pounds of subsidized fresh fruits and vegetables to 11member food banks. • Maintain the State Emergency Food Assistance Program to provide food and funding of emergency food to food banks.
		Collection and Redistribution of Food In 2018, Kaiser Permanente paid $30,000 to Kern County Public Health Services Department to: • Support their "Waste Hunger Not Food Kern County" initiative. Since program implementation began in September 2018 the initiative has rescued and redistributed nearly 100,000 pounds of healthy and fresh food to residents in the community who are food insecure.

Educating around Eating Healthy

Kaiser Permanente physician Dr. Benjamin Ha and the Center for Healthy Living Manager Cheryl Leighter, RD hosted monthly free community seminars on plant-based diet strategies during the Sunday Farmers market at the Ming Medical Office Building. They averaged over **100** participants each seminar and provided guidance on how to shop local and healthy at our KP farmers market.

Partnering around Obesity and Diabetes

Community Benefit Manager, Kristin Weber, serves on the Kern Food Policy Council. Other organizations involved include the Apple Core Project, Community Action Partnership of Kern, Edible School Yard Bakersfield, CSU Bakersfield, Grimm Family Foundation, The Wonderful Company, & United Way of Kern County. This group works to create a stronger local food system economy through policy advocacy and program coordination.

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
5.	Kern County Coroner	2013-2017
6.	Kern County Sheriff's Office	2015-2017
7.	Review of STD Literature	2007-2017
8.	Kern County Department of Public Health	2017

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	Case Manager; Alliance Against Family Violence	1	Minority, medically underserved, low income	Content Expert	11/2/18
2	Interview	Chief of Emergency Medicine; Kern Medical	1	Minority, medically underserved, low income	Content Expert	11/6/18
3	Interview	Director of Student Health and Wellness Services; Bakersfield College	1	Minority, medically underserved, low income	Content Expert	1/11/19
4	Interview	Executive Director; Center for Sexuality and Gender Diversity	1	Minority, medically underserved, low income	Content Expert	10/25/18
5	Interview	Senior Health Educator; Planned Parenthood	1	Minority, medically underserved, low income	Content Expert	11/16/18
6	Interview	Epidemiology Manager; Department of Public Health	1	Health Department Representative	Content Expert	11/16/18
7	Interview	President; Kern Food Policy Council	1	Minority, medically underserved, low income	Content Expert	12/18/18
8	Interview	Director of Community Wellness Programs; Dignity Health	1	Minority, medically underserved, low income	Content Expert	11/28/18
9	Interview	Epidemiology Manager and Public Relations Officer; Department of Public Health	2	Health department representative	Content Expert	10/28/18
10	Interview	Director of Operations; Adventist Health Hospital	1	Minority, medically underserved, low income	Content Expert	10/25/18
11	Interview	Executive Director; Links for Life	1	Minority, medically underserved, low income	Content Expert	10/31/18
12	Interview	Chief of Oncology; Kern Medical	1	Minority, medically underserved, low income	Content Expert	11/19/18
13	Interview	President/CEO; Wendale Davis Foundation	1	Minority, medically underserved, low income	Representative Member	11/29/18
14	Interview	Project Manager; Kern Behavioral Health and Recovery Services	1	Minority, medically underserved, low income	Content Expert	1/7/19
Community residents						
15	Focus Group	Dream Center Focus Group	8	Minority, medically underserved, low income	Representative Member	11/14/18

	Data collection method	Title/name	Number	Target group(s) represented	Role in target group	Date input was gathered
16	Focus Group	Center for Sexuality and Gender Diversity Focus Group	6	Minority and medically underserved	Representative Member	11/13/18
17	Focus Group	Lamont Resource Center Focus Group	9	Minority, medically underserved, low income	Representative Member	11/27/18
18	Focus Group	Alliance Against Family Violence Focus Group	11	Medically Underserved	Representative Member	11/27/18
19	Focus Group	Wendale Davis Foundation Focus Group	10	Minority, medically underserved, low income	Representative Member	11/29/18
20	Survey	Community Resident Survey	1006	Minority, medically underserved, low income	Representative Member	Close date: 1/3/19
21	Survey	Bakersfield College Student Survey	601	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

Kern County Medical Care Service Area
Local Issue: Access to Health Care

Many Residents Struggle with Lack of Access to Health Care

Punit's Story…He has been diagnosed with a chronic illness. To make ends meet, Punit works 3 part-time jobs and therefore is not eligible for employer insurance. He can apply for Medi-Cal, but he does not have internet access and is not sure where to start. By the time Punit gets home from work, he has only a few hours to sleep before starting his next job, so there is no time to fill out paperwork. The last time he called to make a doctor appointment, there were no openings in the early morning or late evening when he is available and Punit cannot afford to take time off work to see a doctor. When his health takes a turn for the worse, he ends up in the ER, resulting in a large ambulance and ER bill. Punit still can't make it in to get regular care and his health continues to suffer. He is overwhelmed by his medical bills and is only one missed paycheck away from being evicted. Punit'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 Kern County Medical Care Service Area.**

"
"We have a lot of people that come in through the emergency room…who have had difficulty accessing the system. So increase access to care. People aren't going in and when they finally do, it is at later stages."

- Subject Matter Expert, Cancer

"
"The challenge is getting the undocumented in to primary care because they are scared of deportation."

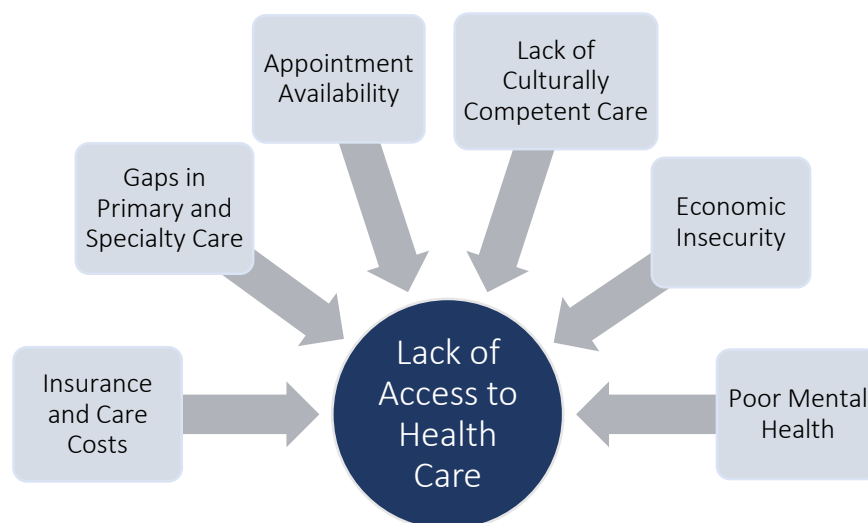- Subject Matter Expert, Internal Medicine

---

Causes & Contributing Factors

Residents are Concerned about Accessing Health Care

Community members in Kern County were invited to share their concerns about local health issues via surveys, interviews, and focus groups.

- **45% of community residents** were **concerned or very concerned** with being able to get health care services.

- **Appointment availability** and **cost** were the top two barriers when trying to access medical and mental health care.

- **Mental health resources** and **health education/awareness** were selected as the two biggest needs in the community.

- **Access to affordable care and coverage** was selected as the second biggest need for children and families.

Many Factors Lead to Lack of Access to Health

Appointment Availability

Lack of Culturally Competent Care

Gaps in Primary and Specialty Care

Economic Insecurity

Insurance and Care Costs

Lack of Access to Health Care

Poor Mental Health

"We need a Community Patient Navigator. If someone was having difficulty accessing medical care, they'd tell them where to go. It seems like patients don't know how to access the system." –Subject Matter Expert

People and Places Affected by Lack of Access to Health Care

Cultural and Linguistic Minorities	• "I do see a growing Sikh population. Having a more culturally aware [clinical] workforce is important." –Subject Matter Expert • "We really need [cancer] prehabilitation and survivorship programs available in other languages: Tagalog, Spanish, Punjabi." –Subject Matter Expert
Low Socioeconomic Status Communities	• "They aren't getting HPV vaccine or pap smears. Many are undocumented, many are field workers that are underinsured. These are people who could never access Kaiser." –Subject Matter Expert • "There is no option for those with no insurance." –Communiy Resident
Rural Communities	• "The lack of frequent public transportation is a challenge for lower SES... in the outlying communities." –Subject Matter Expert • "Another issue for discharged patients is basic transportation needs for their treatments. Sometimes these patients are labeled as noncompliant, but they just don't have the resources." –Subject Matter Expert
LGBTQ+ Residents	• "There are no well-trained low-income mental health resources in Bakersfield for LGBTQ folks." –Community Member • "We need more LGBTQ friendly doctors. Some people are not out to their doctors and that will affect their health." –Subject Matter Expert
College-Aged Individuals	• "College age population are among those who are most impacted by access to medical care: Can I get an appointment? Can I get there?" –Subject Matter Expert
Medi-Cal Patients	• "Doctors are discriminatory. This is my first time on Medi-Cal and I see I'm being treated differently." –Community Member • "With Medi-Cal you still pay out of pocket. I have asthma and most of my medications aren't covered." –Community Member

Why Residents Cannot Access Care

Cost of Insurance and Health Care

$

Appointment Availability

Transportation

Additional barriers to care include: language barriers, getting time off work, mental health concerns not taken seriously, lack of awareness and low visibility of resources, and lack of primary and specialist care providers.

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:

- Kern County Cancer Fund (help with co-pays)
- Links for Life (screenings and education)
- Lamont Resource Center (help navigate care)
- Clinica Sierra Vista
- OMNI
- 211

Quick Fact: Lower income and fewer bachelor's degrees are linked to **worse health outcomes** in Kern, including more asthma, obesity, diabetes, stroke, cancer, low birth weight, poor mental health days, and heart attack ER visits.

Gaps and Needs

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

1. Increase access to screenings by providing transportation and routine screenings in workplaces and outlying communities
2. Employ more general practitioners, mental health providers, pediatricians, and specialists
3. Increase community awareness about available resources and common health problems through education and outreach
4. Improve cultural competency of healthcare providers through education and improve health care access in minority groups by providing resources in multiple languages
5. Improve coordination of care from initial diagnosis to follow-up.
6. Introduce community health navigators to assist with enrollment into insurance and to help patients seek appropriate care early and often

II. Health Need Profile: Mental Health

Kern County Medical Care Service Area
Local Issue: Mental Health

Mental Health is an Urgent Issue on the Hearts and Minds of Kern Residents

Antar's Story… As a 19-year-old, gay student attending Bakersfield College, Antar has been experiencing increasingly poor mental health. He is suffering from stress, anxiety, and depression. He has tried going to counseling, but feels like staff at his local counseling center are homophobic and don't take his complaints seriously. Antar struggles to pay for housing and his education and feels more isolated by the day. He can't ask his family for support and the nearest counseling center with LGBTQ+ friendly programs is over an hour away. Antar has contemplated suicide, but the Kern 24-hour Suicide Prevention Hotline has given him support when he needed it most. He hopes he can find an affordable counselor that can help him cope and refer him to other services. Antar'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 Kern County Medical Care Service Area.

From 2013-2017, **21% of suicide deaths** in Kern County were among residents between 18-29 years old and **19% of suicide deaths** were among residents 50-59 years old.

↓ The Coroner reported a lower percentage of 18-29-year-old suicide deaths in 2017 **(17%)** than in 2013 **(25%)**

↑ However, a higher percentage **of 50-59-year-old suicide deaths** was observed in 2017 **(21%)** than in 2013 **(17%)**

"

"We find that persons with mental health problems often have problems accessing the array of healthcare providers that they require as their complaints are dismissed."

-Subject Matter Expert, Behavioral Health

Causes & Contributing Factors

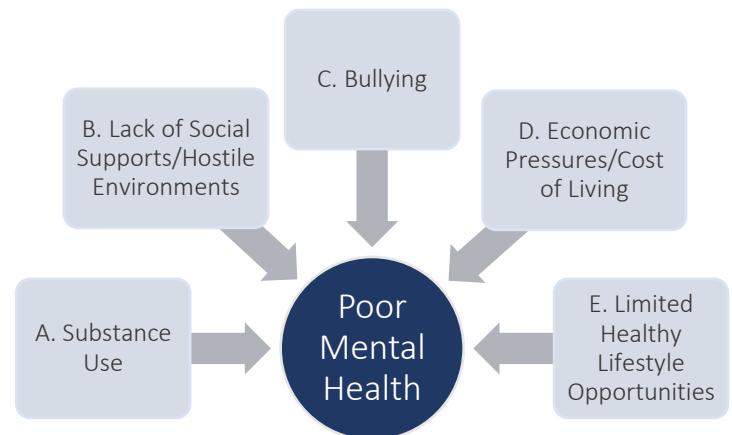### Residents & College Students Express Concern About Mental Health

Through surveys, interviews, and focus groups, community residents highlighted **four major mental health concerns** they experience:

57% of college student survey respondents reported that they felt **sad, stressed, or depressed** on a **daily or weekly basis** in the past 12 months.

Depression

Stress

Poor Mental Health

Trauma

Anxiety

2 in 3 resident survey respondents reported they are **concerned or very concerned** about **mental health**

Many Issues Exacerbate Poor Mental Health

C. Bullying

B. Lack of Social Supports/Hostile Environments

D. Economic Pressures/Cost of Living

A. Substance Use

Poor Mental Health

E. Limited Healthy Lifestyle Opportunities

A. "The ongoing epidemic of addiction is challenging many neighborhoods… [there are] frequently high levels of substance use." —Subject Matter Expert

B. "We still have teenagers who call us…threatened with being thrown out of their homes when they come out [to their families]." —Subject Matter Expert

C. "I was bullied before and I used to cut myself." —Community Member

D. "The inability to get books [due to cost] and high amounts of stress…leads to depressive states that make accomplishing assignments difficult." —Bakersfield College Student

E. "I think that skipping meals is what causes me to be fatigued often, plus it takes a toll on my mental health. I'm often depressed." —Bakersfield College Student

Barriers that Prevent Residents from Accessing Mental Health Care

KAISER PERMANENTE

Cost	Location	Appointment Availability
$	⦿	📅

Additional barriers include: staff shortages and low staff retention rates, poor staff cultural competencies and poor quality of care, lack of insurance or poor coverage, lack of therapy support and diagnostic testing, social stigma, long wait times to see a mental health professional, lack of work accommodations, and lack of education and visibility of services.

People and Places Affected by Mental Health

College-Aged Individuals	• "They are parents, they are employed, and they are students, so time is divided very tightly... what we have identified as having the [most] impact [on college students] are mental health concerns." –Subject Matter Expert
LGBTQ+ Residents	• "LGBTQ+ people who are from the Sikh religion... in that culture there seems to be a very negative view of someone who identifies as LGBTQ+." –Subject Matter Expert • "School bullying is still an issue for young LGBTQ+ youth." –Subject Matter Expert
Rural Communities	• "Transportation is an issue in this spread out community." –Subject Matter Expert • "...Rural populations have fewer resources and service options closer to the county border." –Subject Matter Expert
Spanish-speaking Communities	• "Specific efforts are made in outreach and the hiring of Spanish bilingual staff, which is the county's one threshold language." –Subject Matter Expert
Low Socioeconomic Status Communities	• "The lack of frequent public transportation is a challenge for lower SES." –Subject Matter Expert • "Common to lower SES neighborhoods...lack of resources are a challenge." –Subject Matter Expert
Transition Age Youth (TAY- 16-25 years old)	• "Addictions of all sorts are a challenge for the TAY population." –Subject Matter Expert • "...Teachers and subs have to do something for child physical abuse, but it would be great if there was something for mental health." –Community Member

⚠ **Quick Fact**: In 2017, the Coroner reported that 10% of deaths by suicide in Kern County were among female residents between 18-29 years old, as compared to 23% in 2013. This is a **57% decrease in deaths by suicide** among 18-29-year-old females.

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:

- Kern Behavioral Health Recovery Services (In-jail services, 24-hour suicide prevention/crisis hotline, mobile evaluations)
- National Alliance on Mental Illness
- Psychiatric residency program (UCLA)
- Dream Center (LGBTQ+ resources, counseling)
- Primary, preventative, and specialty care via:
  - Kaiser and OMNI
  - School counseling centers, clinics (Clinica Sierra Vista)
  - Private care

Gaps and Needs

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

1. Seek opportunities to hire additional staff or partner with mental health providers
2. Provide more education and awareness around mental health to address ingrained stigma and increase visibility of existing services/resources
3. Consider expanding alternative care options for rural, socially isolated communities (i.e., mobile units, telepsychiatry/tele-therapy, crisis hotlines)

48% of resident survey respondents reported that mental health services and supports are lacking in their community.

III. Health Need Profile: Obesity and Diabetes

Kern County Medical Care Service Area
Local Issue: Obesity and Diabetes

Daily Obstacles Drive Obesity and Diabetes Rates in Residents

Maria's Story... She works two jobs in order to support her family and Maria often picks up fast food after her long work day. She wants to serve healthier foods to her family and to try to lose weight, but she doesn't know how to start. The few fruits and vegetables in the corner store are expensive and don't look very fresh, and she doesn't have any time to cook. The only park nearby doesn't seem safe for exercising. As a woman of color, the discrimination Maria experiences on a daily basis only adds to her stress, which she copes with by eating comfort foods. She has noticed her health is declining, but she has no time to take the hour and a half drive to get care. When she finally is able to see a doctor, she is diagnosed with Type 2 diabetes. Maria'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 Kern County Medical Care Service Area.

> "Everyone is working so much. The convenience of unhealthy food is why people continue to do so. It takes work to eat right. We don't know how to live a healthy lifestyle."
>
> - Focus Group Member, Bakersfield

> "There is a higher adjusted death rate for diabetes in Kern County than the rest of the state. People are dying younger from diabetes."
>
> -Subject Matter Expert, Public Health

Causes & Contributing Factors

Obesity and Diabetes are Serious Issues in the Eyes of Residents

Community members in Kern County were invited to share their concerns about local health issues via surveys, interviews, and focus groups.

- **Over 6 in 10 residents** reported being concerned or very concerned about diabetes (69%) and obesity (67%).

- **Obesity** was selected by residents as the **#1 issue affecting children** in the community.

- **Diabetes** and **obesity** were reported as the two biggest health issues facing the community, according to residents.

- Diabetes and/or obesity were brought up in **5 of 5 community focus groups** and by **12 of 16 local subject matter experts.**

Many Social Factors are Contributing to Obesity and Diabetes

Cost of Living and Food

Lack of Knowledge about Healthy Habits

Easy Access to Fast Foods

Lack of Primary and Specialty Care

Stress

Lower Educational Attainment

Obesity & Diabetes

Geographic Isolation

People and Places Affected by Obesity and Diabetes

| Black and Hispanic/Latino Residents | • "It's sometimes cheaper to eat unhealthy and it is fulfilling." –Community Member
• "A lot of the population is uneducated about what they should and should not eat." –Subject Matter Expert |

| Low Socioeconomic Status Communities | • "Many [stores with fresh fruits and vegetables] are only in higher SES areas. Certain areas don't have them." –Subject Matter Expert
• "The biggest health concern is poverty because it just seems to be at the core of so much illness." –Subject Matter Expert |

| Rural Communities | • "There are [rural] communities like Kern Canyon when there are times of the year where it is very difficult to get to or to get anything up there. Also, a third of the area is still without internet access...to connect source to need is really difficult." –Subject Matter Expert |

| Survivors of Domestic Violence, LGBTQ+, and People with Mental Illness | • "I've gained 50 pounds. I can't sleep. I have PTSD and emotionally eat." –Community Member
• "There is an obesity epidemic in the LGBTQ community because they fill a void by eating." –Community Member
• "Our target population [those struggling with mental illness] are not adherent to primary care, nor to treatment regimens, which results in uncontrolled chronic illnesses." –Subject Matter Expert |

Barriers That Prevent Residents from Accessing Health Resources

Cost of Healthy Food

$

Appointment Availability

Transportation

Additional barriers include: cost of care and insurance, lack of appointment times outside of work hours, homeless and gangs in parks, extreme heat, poor air quality, pedestrian unfriendly streets, food insecurity, low wages, lack of time, and cultural diet norms.

Sample of Current Resources

Gaps and

Resources to Address the Issue

Needs

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

- The Center for Race, Poverty, and Environment
- Community Wellness at Dignity Health
- Kern Food Policy Council
- Kern Public Health
- Bike Bakersfield (restores and distributes bikes)

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

1. Increase access to screening and preventative care
2. Employ more specialists such as endocrinologists and registered dieticians
3. Provide community education on healthy living habits
4. Increase access to healthy foods and exercise spaces

"Communities with lower educational attainment have a higher prevalence of chronic illness and decreased lifespan."
–Subject Matter Expert

Quick Fact: In Kern County, the prevalence of obesity is 37%, **with Black and Latino residents at even higher rates** than the county average.

IV. Health Need Profile: Sexually Transmitted Infections

Kern County Medical Care Service Area
Local Issue: Sexually Transmitted Infections

The Silent Cycle of Sexually Transmitted Infections

Why We Care... Rates of sexually transmitted infections in Kern County are increasing, despite education and stigma reduction efforts at the national level. In many cultural communities and school health classes in Kern County, talking about sex and sexually transmitted infections is taboo. Education on prevention and treatment is lacking, which contributes to the spread of misinformation. A lack of proactive preventative efforts, combined with the "silent" nature of infections that do not produce symptoms, has led to increased rates of infection. To understand how sexually transmitted infections impact the lives of residents in the Kern Medical Care Service area, a series of community member focus groups and interviews with local subject matter experts were conducted. This document shares the lived experience of residents within the Kern County Medical Care Service Area.

> "There is a lack of messaging that sexual health is part of our overall well-being."
>
> -Subject Matter Expert, Local Health Educator

> "Schools didn't really have good sex education...In high school they tell you if you have sex then you'll get pregnant. You have to go searching for this information on your own."
>
> -Focus Group Member, Bakersfield

> "We can't get a good handle on the medical issue without handling the social issues."
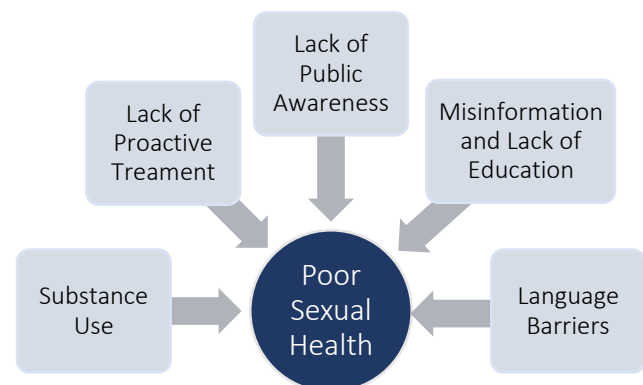>
> -Subject Matter Expert, Public Health

Causes & Contributing Factors

Residents Are Concerned About STIs

Residents in Kern County were invited to share their concerns about local health and safety issues via survey. Of those who responded, approximately **half of community residents** reported feeling **concerned or very concerned** about sexually transmitted infections.

Diverse Factors Contribute to Poor Sexual Health

- Lack of Public Awareness
- Lack of Proactive Treament
- Misinformation and Lack of Education
- Substance Use
- Language Barriers

→ **Poor Sexual Health**

Barriers that Prevent Access to Sexual Health Care

- Long Wait Times
- Insensitive Care
- Stigma

Additional barriers include: lack of visible symptoms, lack of child care, homelessness, and embarrassment or shame.

![Kaiser Permanente]

People and Places Affected by STIs

Youth
- "Being in a conservative community means that there is a history of not talking about STDs…so encouraging adults to talk to their own kids about health and relationships is important." –Subject Matter Expert
- "Syphilis has gotten younger, it used to be diagnosed in people in their 30's." –Subject Matter Expert

Adults
- "With older folks, we are seeing that substance use issues are contributing to STI cases." –Subject Matter Expert
- "There are some concerns about STI awareness and HPV immunizations, as we have a very high rate of cervical cancer in our county." –Subject Matter Expert

Infants
- "Syphilis is a crisis at the moment…it is particularly an issue with pregnant women, as it is passed on to the infant and can be fatal." –Subject Matter Expert
- "[There has been a] significant rise in congenital syphilis, where babies are born with treatable and preventable STIs." –Subject Matter Expert

Individuals with Co-occuring Disorders
- "If we're in a certain area of town, [people] with high substance use issues or mental health issues aren't able to receive the information we're aiming to provide." –Subject Matter Expert

Rural Communities
- "The wide range of rural areas, the cities outside of Bakersfield…with migrant workers, who are impacted by the political climate. They may be afraid to access care, they don't want to get pulled over on their way to the doctor." –Community Expert
- "Many are undocumented, many are field workers that are underinsured. They aren't getting the HPV vaccine or pap smears." –Subject Matter Expert

Quick Fact: Residents of Kern County experience chlamydia at **above average rates** compared to residents of the State and Southern California.

Resources to Address the Issue

Sample of Current Resources

Interviewees and participants identified the following existing resources and agencies that address sexual health:

- Kaiser Permanente
- Planned Parenthood (provides testing)
- OMNI Resource Center
- Sierra Vista
- Kern County Health Center (offers walk-in services)

"I keep returning to the idea that routine screening is needed because people are not showing symptoms." –Subject Matter Expert

Gaps and Needs

Participants and interviewees made the following recommendations for addressing sexually transmitted infections and sexual health:

1. Greater medical attention, including routine screening for STIs and cervical cancer
2. Increase public education and awareness through social media, dating apps, billboard campaigns, and community health forums
3. Increase the availability of resources such as condom dispensers
4. Include comprehensive information on sexual wellness in school education programs

V. Health Need Profile: Violence

KAISER PERMANENTE®

Kern County Medical Care Service Area
Local Issue: Violence

Violence is Hard to Escape

Emily's Story… After another violent incident with her partner, Emily sees her primary care physician for pain in her arm. Her doctor asks her discreetly whether she is experiencing domestic violence and provides pamphlets about local resources including a women and children's shelter. Emily is relieved that her doctor believed her, but is worried about what to do next. She calls all the shelters in Kern County and learns that they are all full. She would have to move to another county to get emergency housing support. She doesn't know how she can get out of this unsafe situation. Emily'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 within the Kern County Medical Care Service Area.

"

"I get panic attacks now which I didn't get much before. I'll hear a slamming door and when I was in court I kept hearing a door and almost had a panic attack in court. [Others] don't understand how sensitive [having experienced violence] makes people and how much it affects us."

- Domestic Violence Survivor

Within Kern County, **more than half (52%)** of domestic violence charges between 2015 and 2017 were **a misdemeanor battery charge against a spouse or roommate**.

Causes & Contributing Factors

Violence and Safety are Major Concerns

Community members in Kern County were invited to share their concerns about local health issues via surveys, interviews, and focus groups.

- Over **7 in 10 residents** were concerned or very concerned about **violence** (72%) and more than **half** (58%) were concerned or very concerned about **traffic accidents**.

- Over **1 in 3 residents** reported **family violence** (36%) and **gun violence** (36%) as safety concerns in their community.

- More than **6 in 10 residents** reported safety concerns regarding **burglary/theft** (63%) and **crime** (60%).

- Almost **2 in 5 students** reported being moderately or very concerned with traffic accidents/fatalities (39%).

Social Factors Drive Violence

Violence ↑

- Low Socioeconomic Status
- Lack of Social Support
- Low Educational Attainment
- Substance Abuse

Domestic Violence Survivors Suffer from Additional Health Problems

Post-Traumatic Stress Disorder	Trouble Sleeping (e.g. nightmares, anxiety)	Emotional Eating and Weight Gain
	Poor Mental Health Days	

Survivors Face Barriers to Seeking and Receiving Services After Experiencing Violence

Lack of Court Advocacy	Shelter Capacity	Stigma and Misinformation

Additional barriers include: slow response times to emergencies, lack of sensitivity among police, language barriers between individuals experiencing violence, case managers, and first responders, immigration concerns and fear of reporting, and lack of education and promotion of available support services and shelters.

"A lot of people believe that domestic violence has to be physical."
—Community Resident

People and Places Affected by Violence

Women
- "These women need to know that if they want to leave, there's somewhere for them to go."
  —Community Resident
- "It's mostly [considered] the female's fault because she chooses to stay..."
  —Community Resident

Low Socioeconomic Status Communities
- "[Rent increases are]...why I still live in a dangerous neighborhood." —Community Resident
- "...You can't get access to services with 'homeless' status if you have a car considered suitable enough to live in." —Community Resident

Spanish- and Indigenous-speaking Communities
- "There's not enough case managers that are able to speak both [Spanish and English]."
  —Subject Matter Expert
- "I had a client that was indigenous so there was a language barrier..." —Community Resident

Immigrant and Undocumented Communities
- "Fear of being deported...fear of having their children removed [results in underreporting of incidents of violence]." —Subject Matter Expert
- "Undocumented people are scared of being reported." —Community Resident

Quick Fact: Emergency department visits for domestic violence in Kern County are nearly **twice as high** compared to the State of California and the Southern California region.

Resources to Address the Issue

Sample of Current Resources

Community members and subject matter experts listed a number of existing resources and agencies available to address violence in their communities:
- Alliance
- Kaiser Permanente
- Homeless shelters
- Domestic violence shelters
- Local police
- Urgent Care
- Greater Bakersfield Legal Assistance

"Police...can get involved with knowledge and...talk to victims. [They shouldn't] have preconceived ideas when they arrive on scene."
—Community Member

Gaps and Needs

To address violence in Kern County, community residents and subject matter experts recommended the following:

1. Seek opportunities to hire additional court advocates, case managers, and attorneys to assist survivors of domestic violence
2. Provide more education and awareness around domestic violence to address ingrained stigma and increase visibility of existing services and resources
3. Provide sensitivity training for police, medical care professionals, and counselors to better respond and provide care for individuals experiencing violence

Appendix D. Community Resources

Identified need	Resource provider name	Summary description
Access to care	Community Health Initiative	Linking community residents to insurance and/or clinical care providers who provide low cost health care & resources. Website: http://www.coveredkerncounty.org/
	Clinica Sierra Vista	Clinica Sierra Vista provides quality health care and support to the inner city, the rural and isolated, those of low, moderate and fixed incomes, and families from an array of cultural backgrounds who speak several languages. Website: https://www.clinicasierravista.org/
	Omni Health	Omni Family Health is a network of state-of-the-art health centers located in the communities of Buttonwillow, Lost Hills, Wasco, Taft, Delano, Shafter, Ridgecrest, Tehachapi, and Bakersfield. Omni Family Health operates in sixteen medical sites, ten dental sites, five behavioral health sites and three full pharmacies. Website: http://omnifamilyhealth.org/
Diabetes & Obesity	Kern County Department of Public Health	Waste Hunger Not Food Program rescues healthy fresh food from local restaurants, caterers and schools and redistributes to those in the community who are food insecure. Website: http://wastehungerkerncounty.com/
	City of Bakersfield Parks & Recreation	Operates two large scale community centers with recreational and education programs aimed at reducing obesity and living and active and healthy life.
Mental Health	Kern Behavioral Health & Recovery Services	The countywide service provider for mental health services in the county of Kern. Website: https://www.kernbhrs.org/
	Garden Pathways	Garden Pathways is a community-based nonprofit founded in 1997 that mentors children, youth, and adults to build productive lives. Diverse mentoring and education programs lead families to educational advancement, employment, family stability, self-sufficiency, healthy living, and improved quality of life. Website: https://www.gardenpathways.org/
	Medically Vulnerable Care Coordination Program	Working towards a trauma informed Kern County by providing yearlong training to service providers and community leaders to ensure that we are addressing the mental health needs of all individuals in Kern.
STD's	Kern County Department of Public Health	Leader of the Kern County STD task force. Additionally, they offer free STD testing at their Mt. Vernon clinic and their Mobile Health Vehicle which visits communities throughout Kern County. Website: https://kernpublichealth.com/std/

	Planned Parenthood Mar Monte	Planned Parenthood is one of the nation's leading providers of high-quality, affordable health care and the nation's largest provider of sex education. With or without insurance, you can always go to them for health care. Most birth control, annual exams, HIV testing, and STD testing will be covered for free, with no copay. Website: https://www.plannedparenthood.org/planned-parenthood-mar-monte
Violence	Bakersfield Police Department	The Bakersfield Police Department is committed to achieving excellence in public safety by conducting themselves with honor, providing selfless service, exhibiting physical and moral courage, and vigilantly safeguarding their community. Website: https://bakersfieldcity.us/gov/depts/police/
	Alliance Against Violence & Sexual Assault	The mission of the Alliance Against Family Violence & Sexual Assault is to stop domestic violence and sexual assault in Kern County and assist survivors in reclaiming their lives. Their purpose as an agency is to make a difference in our community by providing expertise in dealing with domestic violence and sexual assault and ensuring the safety and well-being of victims and their children by providing services that address their individual needs and prepare them for self-sufficiency. Website: https://kernalliance.org/
	Family Justice Center	The Kern County Family Justice Center (FJC) is a unique and safe place where victims of domestic violence and their children are their highest priority. Through collaboration and coordinated services, the FJC and its partners are committed to providing the help needed to break the cycle of violence that so often damages and destroys families. Website: https://www.kerncounty.com/da/FamilyJustice.aspx

Appendix E. Strategic Lines of Inquiry for Community Engagement

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

Overview of Question Design Process

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

KAISER PERMANENTE.