2019 Community Health Needs Assessment

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Kaiser Permanente Southern California Region Community Benefit CHNA Report for KFH Riverside

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I. Introduction/background

A. About Kaiser Permanente (KP)

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

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

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

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

B. About Kaiser Permanente Community Health

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

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

- Ensuring health access by providing individuals served at KP or by our safety net partners with integrated clinical and social services;
- Improving conditions for health and equity by engaging members, communities, and Kaiser Permanente's workforce and assets; and
- Advancing the future of community health by innovating with technology and social solutions.

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

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

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

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

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

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

In addition to reviewing and analyzing secondary data, each KFH facility, individually or with a collaborative, collected primary data through key informant interviews, focus groups, and surveys. Primary data collection consisted of reaching out to local public health experts, community leaders, and residents to identify issues that most impacted the health of the community. The CHNA process also included an identification of existing community assets and resources to address the health needs.

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

In conjunction with this report, KFH-Riverside will develop an implementation strategy for the priority health needs the hospital will address. These strategies will build on Kaiser Permanente's assets and resources, as well as evidence-based strategies, wherever possible. The Implementation Strategy will be filed with the Internal Revenue Service using Form 990 Schedule H. Both the CHNA and the Implementation Strategy, once they are finalized, will be posted publicly on our website, https://www.kp.org/chna

II. Community served

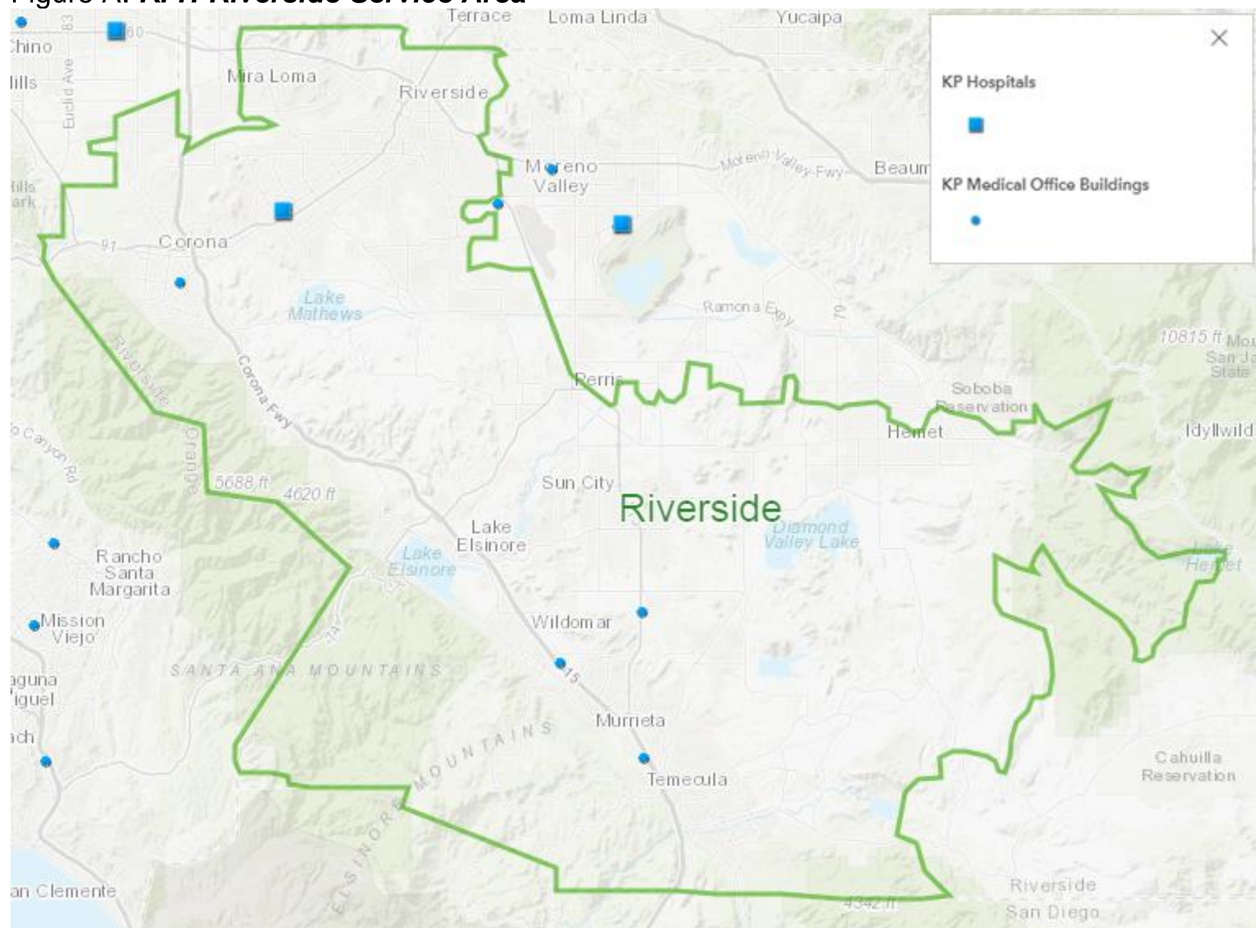
A. Kaiser Permanente's definition of community served

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

B. Map and description of community served

i. Map

Figure A. ***KFH-Riverside Service Area***



ii. Geographic description of the community served

The KFH-Riverside community is located in Western Riverside County, and encompasses the cities of Corona, Eastvale, Jurupa Valley, Lake Elsinore, Menifee, Murrieta, Norco, Riverside, Sun City, Temecula, Temescal Valley, Wildomar, and Winchester.

iii. Demographic profile of the community served

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

Table 1. Demographic profile: KFH-Riverside Service Area[1]

Race/Ethnicity		Socioeconomic	
Total Population	1,401,966	Living in Poverty (<100% Federal Poverty Level)	14.43%
Asian	7.30%	Children in Poverty	18.91%
Black	5.17%	Unemployment	4.3%
Hispanic/Latino	43.60%	Uninsured Population	13.38%
Native American/Alaska Native	0.39%	Adults with no High School Diploma	17.50%
Pacific Islander/Native Hawaiian	0.28%		
Some Other Race	0.18%		
Multiple Races	3.10%		
White	39.98%		

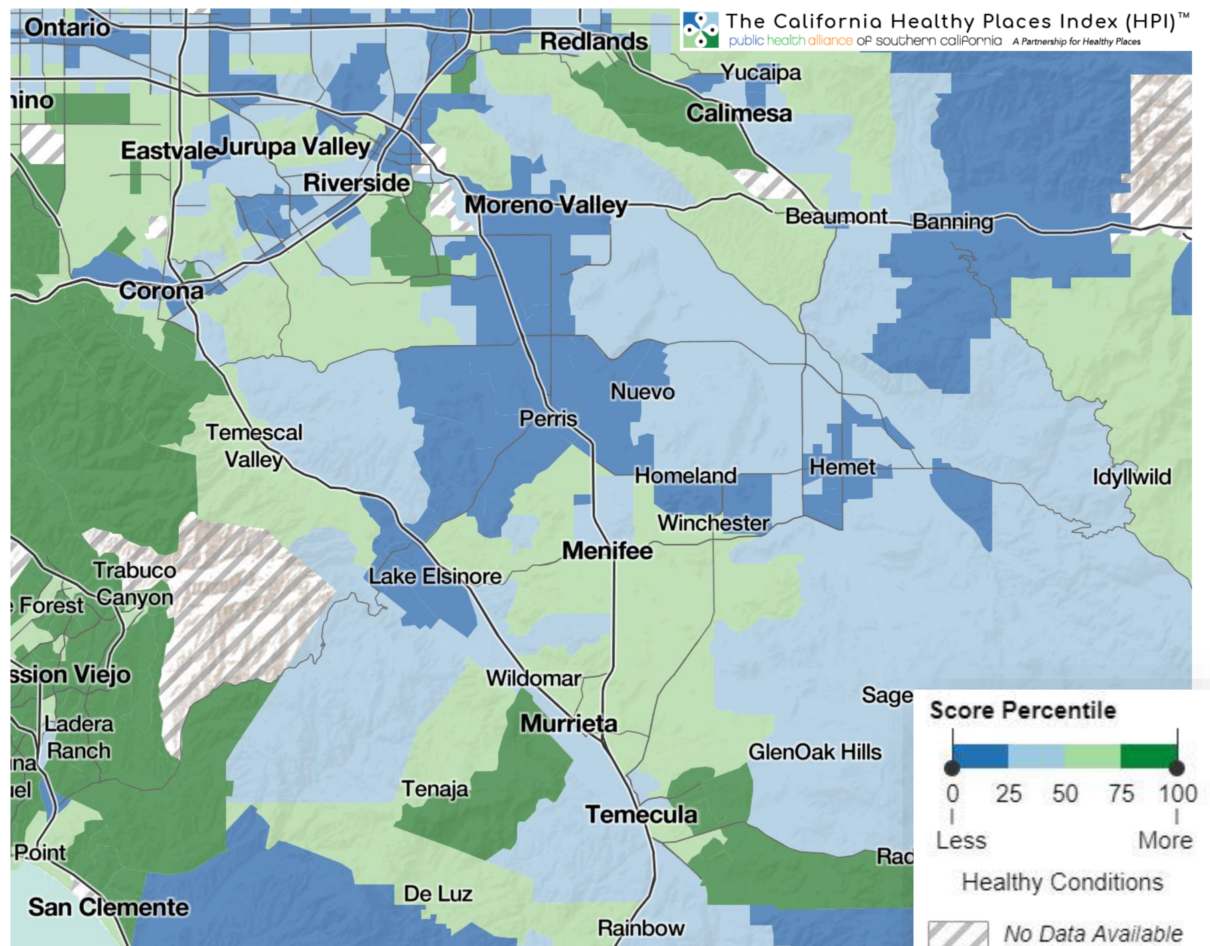
Under-resourced communities

The map below displays the differences in opportunity for residents in the KFH-Riverside service area to live a long and healthy life[2]. Areas in dark blue represent census tracts in the lowest quartile of health opportunity across California. These areas are severely under-resourced across multiple domains of the social predictors of health (e.g. economics, education, transportation, built environment etc.). Note: this map displays an area slightly larger than KFH – Riverside service area boundaries. The map below depicts the under-resourced communities are located in parts of Corona, Lake Elsinore, Riverside proper, and parts of the Jurupa Valley.

[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 of this service area and additional information about HPI methodology, please visit http://healthyplacesindex.org

Figure B. ***Under-Resourced Communities in KFH-Riverside***



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

The opportunity to live a long and healthy life is powerfully influenced by a wide range of social factors including economics, education, transportation, built environment, and access to care[3]. In aggregate, residents living in the KFH-Riverside service area are in the 40th percentile for health opportunity[4] among all California residents with approximately 400,059 people living in severely under-resourced census tracts. In effect, this means that 6 out of 10 Californians have a greater opportunity to live a long healthy life than residents living in this service area.

III. Who was involved in the assessment?

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

There are two Kaiser hospitals in Riverside County: KFH-Riverside and KFH-Moreno Valley. Expertise from both hospitals was used to create this CHNA, although each hospital has its own unique CHNA.

[3] Please read more about the strong scientific evidence for these relationships here.
[4] As described by the California Healthy Places Index.

A few local organizations helped us to gather community input during the engagement process. These include: Borrego Health, Riverside Community Health Foundation, and University of California, Riverside – School of Medicine.

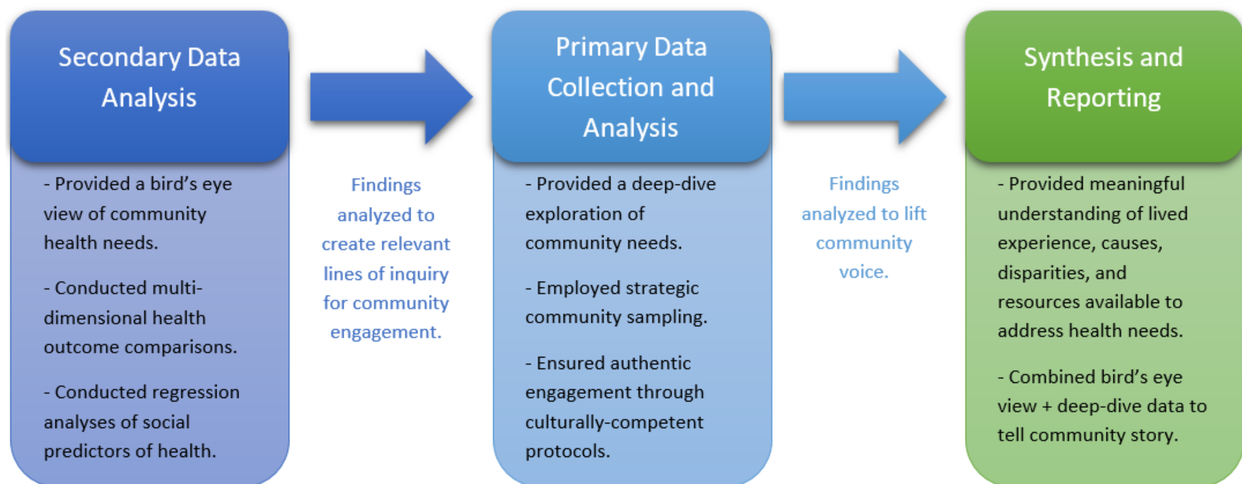
B. Identity and qualifications of consultants used to conduct the assessment

HARC, Inc. (Health Assessment and Research for Communities), a nonprofit research and evaluation firm located in Riverside County, was utilized for this assessment. HARC has been conducting community health needs assessments in Riverside County for more than 12 years and has extensive community connections. HARC's expertise lies in the social predictors of health; that is, the idea that where you live, work, learn, and play has a strong impact on your well-being and quality of life. The social predictors of health encompass things like economic security, education, safety, community cohesion, neighborhoods and the built environment, and of course, healthcare. In the past year, HARC has conducted numerous community health needs assessments in Riverside County, including one for Betty Ford Center relating to substance use and mental health, as well as one for Eisenhower Health relating to lesbian, gay, bisexual, transgender, intersex, and asexual health needs.

IV. Process and methods used to conduct the CHNA

KFH-Riverside 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***



A. Secondary data

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

KFH-Riverside 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 predictor of health indicators were used in multiple linear regression analyses to produce models identifying the social factors most predictive of negative health outcomes in KFH-Riverside 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/.

Table 2. Social Factors Linked to KFH-Riverside Health Outcomes

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*").

	More Poor Mental Health Days	More Heart Attack ER Visits	Higher Asthma Prevalence	Higher Obesity Prevalence	Higher Diabetes Prevalence	Higher Stroke Prevalence	Higher Cancer Prevalence	Higher Percentage of Babies Born with Low Birth Weight	Higher Smoking Prevalence	More Pedestrian Injuries	Number of Outcomes Affected
Lower Income	X	X	X	X	X	X	X			X	8
Less Health Insurance	X	X		X				X	X		5
Fewer Bachelor's Degrees	X	X	X	X					X		5
More Racial Segregation	X		X	X		X		X			5
More Crowded Housing	X		X	X	X				X		5
Worse Air Quality		X	X								2
More Homeownership					X	X	X				3
Less Employment						X					1
More Bachelor's Degrees							X				1
Less Crowded Housing							X				1
Less Homeownership									X		1

Table 3. Health Outcome Comparison Table

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]

Health Outcome Category Name	Prevalence	Difference From State Average	Reduction in Length of Life Per Year	Worst Performing Race/Ethnicity vs. Average	Listed in Partner County Top 5 Cause of Death
Mental Health*	13.0%	0.83% (Worse than CA)	61.3% Reduction	65% Worse than Average	No
Cancer*	4.0%	0.66% (Worse than CA)	51% Reduction	17% Worse than Average	Yes
Substance/Tobacco Use	6.4%	-0.63% (Better than CA)	69.7% Reduction	48% Worse than Average	No
HIV/AIDS/STD	0.3%	-0.12% (Better than CA)	58.2% Reduction	211% Worse than Average	No
Stroke*	3.6%	-0.1% (Better than CA)	57% Reduction	34% Worse than Average	Yes
Asthma	12.9%	-1.9% (Better than CA)	13.3% Reduction	58% Worse than Average	Yes
Obesity	25.7%	-3.9% (Better than CA)	37% Reduction	39% Worse than Average	No
Maternal/Infant Health	6.5%	-0.3% (Better than CA)	17.9% Reduction	40% Worse than Average	No
Oral Health	11.9%	0.6% (Worse than CA)	2.8% Reduction	17% Worse than Average	No
CVD*	5.4%	-1.55% (Better than CA)	30% Reduction	14% Worse than Average	Yes
Violence/Injury	0.0%	-0.01% (Better than CA)	13.2% Reduction	10% Worse than Average	Yes
Diabetes*	6.9%	-1.5% (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.

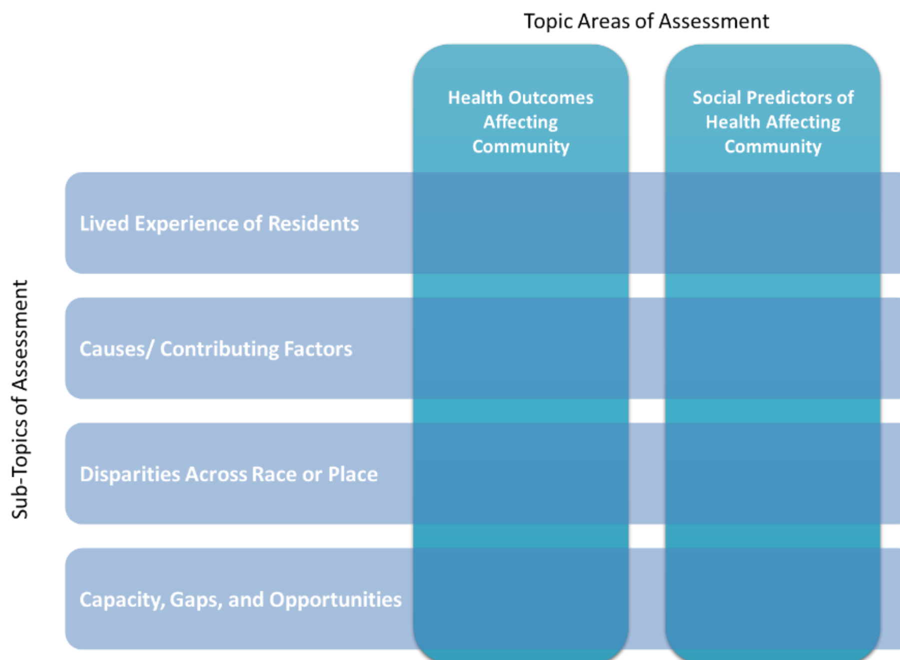
B. Community Input

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 F for more details about how these questions were developed):

1. What are the drivers of poverty in our under-resourced communities?
2. How does the local job mix/landscape influence poverty in our community?
3. What factors inhibit or support the health insurance enrollment process?
4. What are the barriers to accessing mental health services?
5. What are the barriers to higher educational attainment in our under-resourced communities?
6. How is higher education linked to health outcomes?
7. Are students obtaining degrees that have value in the current job market?
8. Do racially segregated communities feel that this segregation has an impact on their health? If so, how?
9. How does crowded housing relate to poor mental health, asthma, obesity, diabetes, and smoking?
10. What factors are contributing to/causing crowded housing situations?
11. How do the top social predictors of health (poverty, access to care, education, race, and housing) relate to each other?

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

Figure D. ***Community Engagement Framework***



i. Description of who was consulted
Residents, community leaders, and government and public health department representatives were selected for the CHNA sample. Selection criteria across these groups included (a) those best able to respond in rich detail to the strategic learning questions, (b) those who had expertise in local health needs, (c) those who resided and/or provided services in an under-resourced or medically underserved community, and (d) those able to represent the health needs of a given racial or ethnic minority group. Given the large size of the KFH-Riverside service area, community engagement efforts set out to target those geographies most under-resourced and where health outcomes were the poorest (see Figure B for a map referencing the most underserved areas of KFH-Riverside). 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:

HARC conducted key informant interviews with 26 community leaders and 18 community members. See Appendix B: Community Input Tracking Form for a complete list. Community members and local leaders were interviewed to provide insight into the strategic learning questions and core learning questions. All interviews were audio recorded and then transcribed. Those that were conducted in Spanish were then translated into English. Transcriptions were then loaded into a qualitative data analysis software, NVivo 12, and analyzed based on strategic learning questions.

The community input was used to provide information on the strategic learning questions and to provide context and a deeper understanding of the correlations found in the secondary data. These stories were used to provide background in the health need profiles; see Appendix C. The stories demonstrated the lived experience of community members who experience the identified health needs. Finally, the community input (especially the input from community leaders) also helped to identify existing resources; for more information, see Appendix D.

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 C).

C. Written Comments

KP provided the public an opportunity to submit written comments on the facility's previous CHNA Report through CHNA-communications@kp.org. This email will continue to allow for written community input on the facility's most recently conducted CHNA Report. As of the time of this CHNA report development, KFH-Riverside had not received written comments about previous CHNA Reports. Kaiser Permanente will continue to track any submitted written comments and ensure that relevant submissions will be considered and addressed by the appropriate Facility staff.

D. Data Limitations and Information Gaps

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

V. Identification and Prioritization of the Community's Health Needs

A. Identifying Community Health Needs

i. Definition of "health need"

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

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

To identify community health needs, HARC 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 prioritization by revealing a bird's eye view of the many health needs in the service area. HARC also undertook an extensive community engagement process which provided community stakeholders and residents the opportunity to surface additional health needs.

B. Process and criteria used for prioritization of health needs

Selection of the eight priority health needs was conducted collaboratively between HARC staff and Kaiser Permanente staff (namely Community Benefit Manager Cecilia Arias). The prioritization of health needs was accomplished by considering a variety of factors collectively. Specifically, our prioritization included an examination of secondary data, consideration of health issues deemed important by the community, consideration of the severity of need, consideration of the magnitude/scale of the need, consideration of disparities or inequities, and consideration of social predictors of health. After considering these factors, the strongest themes that emerged were selected as main health as the community needs.

The aforementioned criteria are defined as follows:

- Severity of need: a health need's potential to cause death or disability and its degree of poor performance against the relevant benchmark.
- Magnitude/scale of the need: The number of people affected by the health need.
- Clear disparities or inequities: Differences in health outcomes by subgroups. Subgroups may be based on geography, languages, ethnicity, culture, citizenship status, economic status, sexual orientation, age, gender, or others.

Other criteria given some consideration in the prioritization process included:

- Issue is getting worse over time/not improving
- Community prioritizes the issue over other issues
- Existing attention/resources dedicated to the issue

- Effective and feasible interventions exist
- A successful solution has the potential to solve multiple problems

Some health needs which were grouped separately in the secondary data were combined based on how other professionals grouped needs (e.g., combining "mental health" and "substance abuse" into a single category called "behavioral health" mirrors the move of re-naming the Riverside County "mental health" office into "behavioral health" to address both fields). Others were grouped together because they are a tightly-knit cause and effect (e.g., putting "obesity" with "healthy eating active living" because HEAL activities can prevent/treat obesity).

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

- ***Access to Care:*** Access to adequate health care and mental health care are certainly important issues, including the importance of access to services available in the community (e.g., nonprofits, free resources, etc.). According to 2016 data, roughly 16.0% are uninsured in Riverside in contrast to 12.6% who are uninsured in California. Our community outreach efforts often targeted free health clinics to obtain participant input, and it became evident that a high number of people rely on free events/resources for primary health care because they serve as the most affordable source of care available.
- ***Asthma:*** The prevalence of asthma is quite high in the Riverside region, affecting roughly 12.9% of the population. Moreover, asthma has an equity component given that blacks experience asthma discharge rates at a rate 58% worse than the average. Asthma and the quality of air in the region is also an important concern of the community.
- ***Cancer:*** Cancer is the second leading cause of death in the United States, and a diagnosis of cancer results in a 51% reduction in length of life per year. The prevalence of cancer is 4% in Riverside, which is 0.66% worse than the state of California as a whole. The need for local cancer resources is increasingly a concern of the community. For example, a cancer treatment task force was recently formed in southwest Riverside county to assess local cancer resources and strategize ways to improve. Information about the task force is hosted on the City of Temecula's website: https://temeculaca.gov/1149/Regional-Cancer-Treatment-Task-Force
- ***Economic Opportunity:*** Economic opportunity (education, jobs, homelessness, poverty, housing) is largely considered an upstream factor as it is considered a social predictor of health. Proper education, income, and access to gainful employment equate to better health care, better quality of life, and a longer more vibrant life. The concept of economic opportunity was consistently identified as a priority issue throughout community engagement, in that community members discussed the difficulties obtaining gainful employment. Data supports community claims: the median household income for Riverside is $58,972 while the median for the state of California is $64,500.
- ***HIV/AIDS:*** This issue has been deemed a priority for a few reasons. One main reason for addressing HIV/AIDS is that this diagnosis results in a 58.2% reduction in length of life per one year. HIV/AIDS is also an equity issue and there are clear inequities in the types of groups who are impacted. Blacks generally experience HIV/AIDS/STDs at a high rate compared to other races/ethnicities (211% worse in the state of California).
- ***Behavioral Health (Mental Health and Substance Abuse):*** Mental health has grown immensely as a high priority for the local community, and even the nation. Our engagement with community leaders reiterated that there are many more people who need mental health treatment than are actually seeking and obtaining treatment. Data

shows that residents in the KFH-Riverside service area report having 3.9 poor mental health days per month. In comparison, California residents report 3.7 poor mental health days per month. There are also significant disparities in impact. Whites in Riverside experience suicide at a rate that is 63% higher than average for the service area.

- ***Obesity/Healthy Eating Active Living (HEAL):*** Obesity/HEAL have been a long-standing priority in the community. Additionally, Obesity/HEAL are largely considered upstream health issues that lead to other health ailments such as heart disease and diabetes. The obesity prevalence rate in the Riverside region is exceedingly high -- approximately 25.7% of the population is obese.
- ***Stroke:*** Stroke is also an important cause of disability. In addition, stroke results in a 57% reduction in length of life per one year. Stroke issues also present an equity issue in that blacks die from stroke at a rate that is 34% higher than the average for the area.

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

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

VI. KFH Riverside 2016 Implementation Strategy Evaluation of Impact

A. Purpose of 2016 Implementation Strategy evaluation of impact

KFH-Riverside's 2016 Implementation Strategy Report was developed to identify activities to address health needs identified in the 2016 CHNA. This section of the CHNA Report describes and assesses the impact of these activities. For more information on KFH-Riverside's Implementation Strategy Report, including the health needs identified in the facility's 2016 service area, the health needs the facility chose to address, and the process and criteria used for developing Implementation Strategies, please visit:
https://about.kaiserpermanente.org/content/dam/internet/kp/comms/import/uploads/2013/10/KFH-Riverside-IS-Report.pdf

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

1. Access to Care
2. Mental and Behavioral Health
3. Obesity/Diabetes

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

The impacts detailed below are part of a comprehensive measurement strategy for Community Health. KP's measurement framework provides a way to 1) represent our collective work, 2) monitor the health status of our communities and track the impact of our work, and 3) facilitate shared accountability. We seek to empirically understand two questions 1) how healthy are Kaiser Permanente communities, and 2) how does Kaiser Permanente contribute to community health? The Community Health Needs Assessment can help inform our comprehensive

community health strategy and can help highlight areas where a particular focus is needed and support discussions about strategies aimed at addressing those health needs.

As of the documentation of this CHNA Report in March 2019, KFH-Riverside had evaluation of impact information on activities from 2017 and 2018. These data help us monitor progress toward improving the health of the communities we serve. While not reflected in this report, KFH-Riverside will continue to monitor impact for strategies implemented in 2019.

B. 2016 Implementation Strategy evaluation of impact overview

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

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

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

Grantmaking: For 70 years, Kaiser Permanente has shown its commitment to improving community health through a variety of grants for charitable and community-based organizations. Successful grant applicants fit within funding priorities with work that examines social determinants of health and/or addresses the elimination of health disparities and inequities. From 2017-2018, Kaiser Permanente paid 54 grants amounting to a total of $3,211,208 in service of the health needs identified in the 2016 CHNA. Additionally, KFH-Riverside has funded significant contributions to California Community Foundation in the interest of funding effective long-term, strategic community benefit initiatives within KFH-Riverside. During 2017-2018, a

portion of money managed by this foundation was used to pay 24 grants totaling $3,923,047 in service of the health needs identified in the 2016 CHNA.

In-kind resources: In addition to our significant community health investments, Kaiser Permanente is aware of the significant impact that our organization has on the economic vitality of our communities as a consequence of our business practices including hiring, purchasing, building or improving facilities and environmental stewardship. We will continue to explore opportunities to align our hiring practices, our purchasing, our building design and services and our environmental stewardship efforts with the goal of improving the conditions that contribute to health in our communities. From 2017-2018, KFH-Riverside leveraged significant organizational assets in service of 2016 Implementation Strategies and health needs. See table below for illustrative examples.

Collaborations and partnerships: Kaiser Permanente has a long legacy of sharing its most valuable resources: its knowledge and talented professionals. By working together with partners (including nonprofit organizations, government entities, and academic institutions), these collaborations and partnerships can make a difference in promoting thriving communities that produce healthier, happier, more productive people. From 2017-2018, KFH-Riverside engaged in several partnerships and collaborations in service of 2016 Implementation Strategies and health needs. See table below for illustrative examples.

C. 2016 Implementation Strategy evaluation of impact by health need

KFH-Riverside Priority Health Needs

Need	**Summary of impact**	**Examples of most impactful efforts**
Access to Care	*During 2017 and 2018, Kaiser Permanente paid 16 grants, totaling $1,262,667 addressing the priority health need in the KFH-Riverside service area. In addition, a portion of money managed by a donor advised fund at California Community Foundation was used to pay 6 grants, totaling $941,667 that address this need.*	**Providing Affordable Healthcare** Over two years (2017-2018), KFH-Riverside provided $37,377,900 in medical care services to 67,455 Medi-Cal recipients (both health plan members and non-members) and $13,008,076 in medical financial assistance (MFA) for 16,513 beneficiaries.
		Building Primary Care Capacity~ The California Primary Care Association (CPCA) provides education, training, and advocacy to their member community health centers to best serve their low-income, underserved, and diverse patients. In 2018, Kaiser Permanente paid $126,666 to CPCA to: • Hold statewide convenings and conferences and topic-specific peer networks to support over 1,200 California community health centers. • Provide 90 in-person and web-based trainings to over 4,400 attendees and 2,890 individual instances of technical assistance.
		Preserving and Expanding California Coverage Gains~ Insure the Uninsured Project (ITUP) works to preserve and expand access to health care and coverage in California and to reduce access barriers for uninsured and underinsured populations. 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.
		Integrating Health Care Riverside Free Clinic provides primary care, oral health and mental health for the uninsured, working poor, and homeless through aspiring physicians, dentists, and mental health professionals. In 2018, Kaiser Permanente paid $10,000 to Riverside Free Clinic to: • Coordinate medical, dental, and mental health services to 300 patients. • Identify social service needs and provide resources. • Provide opportunities for student interns to develop patient care skills, health education teaching and gain practical clinical experiences.
		Increasing Access to Care via KP Asset Our core functions across KP are using their assets to drive Access to Care in the KFH-Riverside service area. For example: • Expertise: Eighteen Family Medicine Residents at KFH-Riverside provided clinical support at two local community clinics. They also supported our Thriving Schools by presenting at 11 school educational events on healthy eating, active living and diabetes prevention and career day events.

Mental and Behavioral Health	*During 2017 and 2018, Kaiser Permanente paid 24 grants, totaling $1,064,541 addressing the priority health need in the KFH-Riverside service area.*	**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.
		Supporting Social and Emotional Wellness in Schools Kaiser Permanente Thriving Schools initiative supports and strengthen strategies that promote the social and emotional wellness among students, teachers, and staff. Over two years (2017-2018), Kaiser Permanente paid Jurupa Unified School District $90,000 to: • Train staff at Ina Arbuckle Elementary school on the Strengthening Families framework and the 5 protective factors, as well as the centralized referral process and supports available to students, families, and school communities. • Train staff at Jurupa Valley High on trauma informed care. • Place 21 master level interns at the school district to provide social emotional wellness support. This resulted in over 500 mental health referrals, a 100% increase from the previous school year.
		Expanding Behavioral Health Consultations North County Health Services provides behavioral health consultation along with medical and dental care services to underserved individuals at the Perris Health Center. In 2018, Kaiser Permanente paid $25,000 to North County Health Services to: • Provide behavioral health services to 700 patients. • Increase access to behavioral health services through a same-day direct warm hand off referral from a primary care provider. • Improve operational process to screen and identify behavioral health conditions, including substance abuse.
		Advancing Trauma Informed Care Delivery KFH-Riverside's Community Health Manager has participated in the Riverside Resilience Initiative, a collaborative which began in 2016. The collaborative has hosted educational training webinars, town hall meetings, and learning workshops. Community leaders formed two workgroups to work on: • strategies around innovative approaches to collecting ACEs data • activate policy and practice change to advance trauma informed care delivery
		Supporting Mental and Behavioral Health via KP Assets Our core functions across KP are using their assets to drive Mental & Behavioral Health. For example: • Facilities: KFH-Riverside conference room space was made available to the National Alliance for Mental Illness (NAMI) who provide the 10-week series Family to Family and Peer

		to Peer sessions at no cost to the community. During 2017-18, a total of 623 individuals participated in the weekly series.
Obesity/ Diabetes	*During 2017 and 2018, Kaiser Permanente paid 14 grants, totaling $884,000 addressing the priority health need in the KFH-Riverside service area. In addition, a portion of money managed by a donor advised fund at California Community Foundation was used to pay 18 grants, totaling $2,981,380 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. • Collaborate with health centers to share WIC staff for nutrition and breastfeeding counseling (Watts Health Care and clinics in San Diego). • Work to strengthen ties with CPCA and present at CPCA's annual conference. • Visit all CA legislators with 44 appointments and drop-in visits. • Provide extensive information to legislators on nutrition and breastfeeding counseling, food benefits, local economic impacts to grocers, health outcomes, access to Farmers markets, and updates on immigration threats. • Participate in Capitol WIC Education Day in Sacramento with 50 attendees from 30 WIC agencies from all over the state.
		Supporting Healthy Eating and Active Living* The Riverside Community Health Foundation HEAL Zone site focuses on school and community strategies that address healthy eating and physical activity opportunities through policy, environmental, and system (PSE) changes. In 2018, Kaiser Permanente paid $333,333 to the Riverside Community Health Foundation to: • Use HEAL Rx (in EMR) and provide or refer patients to additional support and education. They also give patients food vouchers that can be redeemed at local markets/stands. • Conduct four 8-week diabetes management workshops at one clinic. • Train 13 people from four churches on Body & Soul Framework. • Assist resident efforts to pave an alleyway, add safety features at one intersection, paint a mural at Eastside Health Center, and complete the Eastside Art Corridor Safe Routes Survey.
		Fighting Food Insecurity~ California Association of Food Banks' (CAFB) Farm to Family program's goal is to improve health food access by providing fresh produce to food banks, CalFresh outreach and enrollment, advocacy to support anti-hunger policies, and technical assistance to members. In 2018, Kaiser Permanente paid $95,000 to CAFB to: • Distribute 250,000 pounds of subsidized fresh fruits and vegetables to 11-member food banks.

		• Maintain the State Emergency Food Assistance Program to provide food and funding of emergency food to food banks.
		Increasing Access to Healthy Local Foods KFH-Riverside's Community Health Manager serves on the Riverside Food Systems Alliance Advisory Committee. Accomplishments in 2017-2018 includes: • NextGen Farmer training program • Riverside Food Rescue and Waste Ambassador Program • partnership with the Farmworker Institute of Education and Leadership Development (FIELD) to expand their charter school in the Eastside Riverside neighborhood These projects aim to create a food system that makes healthy local foods available for all, especially the most under-resourced in our region.
		Preventing Obesity and Diabetes Our core functions across KP are using their assets to drive the prevention of Obesity and Diabetes. For example: • Facilities: The partnership with 100 Mile Club and KHF-Riverside continues to reach local students and families using the Thrive Path to walk or run. The monthly meet-ups reach over 100 participants from 7 area school districts and private schools. In 2017-2018 an estimated 2,300 walkers have benefited from this safe environment to be physically active. • Facilities: The community garden club at Murrieta Medical Office Building has been a year-round project for staff and community members. In collaboration with UC Cooperative Extension's Master Gardener Program, volunteer sessions are educational including tips for planting, harvesting, and soil management including healthy eating demonstrations.
		Practicing Food Recovery and Redistribution Kaiser Permanente envisions foodservices not only as the source of nutritious meals for their patients, staff and guests, but as a resource for local communities. Over two years (2017-2018), Kaiser Permanente partnered with Food Finders to: • Recover 20,214 lbs. of food and distribute to organizations serving individuals in the KFH-Riverside region who face food insecurity.

VII. Appendices

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

Appendix A. Secondary Data Sources and Dates

i. Secondary sources from the KP CHNA Data Platform

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

ii. Additional Sources

	Source	Dates
1.	Asthma and Allergy Foundation	2018
2.	California Department of Public Health	2016
3.	Center for Disease Control	2017
4.	California Healthy Places Index	2018
5.	California HIV Surveillance Report	2015
6.	Department of Health and Human Services	2016
7.	National Vital Statistics System	2011-2015
8.	Office of Environmental Health Hazard Assessment	2011-2013
9.	Riverside University Health System- Public Health HIV/STD Data	2017
10.	Southwest Riverside County Cancer Care Needs Assessment	2018
11.	State Cancer Profiles	2011-2015

Appendix B. Community Input Tracking Form

	Data collection method	Title/name	Number	Target group(s) represented	Role in target group	Date input was gathered
Organizations						
1	*Key Informant Interviews*	*American Heart Association; Catholic Charities; Desert AIDS Project; Family Service Association; Latino Health Riverside; MFI Recovery; Michelle's Place; Oak Grove Center; Operation SafeHouse; Path of Life Ministries*	*10*	*Community based organizations and nonprofits; mental health*	*Leaders & representative members*	*10/12/18, 10/18/18, 10/19/18, 10/24/18, 10/25/18, 12/10/18, 12/18/18, 12/19/18*
2	*Key Informant Interviews*	*City of Lake Elsinore; First 5 Riverside; Office on Aging; Riverside Community Health Foundation; Riverside County Housing Authority; Riverside County Office on Education; RUHS- Behavioral Health; RUHS- Public Health;*	*8*	*Government organizations/resources; housing*	*Leaders & representative members*	*10/16/18, 10/18/18, 10/25/18, 10/31/18, 11/30/18, 12/4/18, 12/11/18, 12/18/18*
3	*Key Informant Interviews*	*Riverside City College; UC Riverside School of Medicine*	*3*	*Educational institutions*	*Leaders & representative members*	*10/3/18, 10/18/18, 11/19/18*
4	*Key Informant Interviews*	*Borrego Health; IEHP*	*2*	*Health department representatives; low income*	*Leaders & representative members*	*10/4/18, 10/5/18*
5	*Key Informant Interviews*	*Inland Empire Economic Partnership*	*1*	*Economic development organizations*	*Leaders & representative members*	*11/26/18*
Community residents						
6	*Community Event*	*Jurupa Health Fair*	*4*	*Medically underserved; low-income; minorities*	*Member*	*10/27/18*
7	*Community Event*	*UCR Community Health Clinic*	*2*	*Medically underserved, low-income; mental health; homeless*	*Member*	*11/7/18*
8	*Community Event*	*Borrego Flu Vaccine Event*	*8*	*Medically underserved; low-income; minorities*	*Member*	*11/17/18*
9	*Interviews*	*Phone interviews*	*3*	*Medically underserved; low-income*	*Member*	*10/30/18, 11/8/18, 12/5/18*

Riverside
Access to Care

"There are a number of [residents] who are eligible for Medi-Cal, but simply haven't signed up. We think they just don't know."

Community health leader serving Riverside

Local Prevalence

Health insurance is the primary means for accessing and obtaining needed medical care. Those who are uninsured receive less preventative health treatments, less are for major health conditions, and less and less care for chronic illnesses.

According to census data from 2015, 16.0% of Riverside County residents were uninsured. This uninsured rate is higher than it is for the state of California.

16.0%
are uninsured in Riverside

12.6%
are uninsured in California

Lived Experience of Residents

"My employer asked me if I want insurance, but I was forced to say no because I need the money for bills. I drove to this clinic because I don't know any place to go."

52-year-old male from Riverside

"I don't have insurane at the moment. When I seem to check rates and everything, there is no available coverage in my area sometimes. Then the other thing is that I just can't afford it."

23-year-old male from Riverside

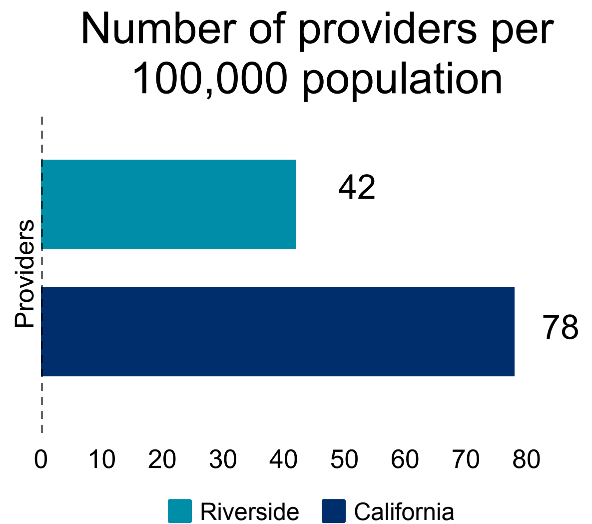
Barriers to Care

"Finding folks that are bilingual, sometimes that presents a little bit of a barrier for physicians."

Community health leader serving Riverside

"It's upsetting that you've got potentially undocumented children that would be eligible for Medi-Cal but don't sign up because they're concerned about the immigration impact."

Community health leader serving Riverside



Existing Community Resources

Community Health Systems

A non-profit organization who seeks to extend the safety net of health services who can't afford health services.

Borrego Health

Provides high quality health care regardless of their ability to pay.

RUHS - Community Health Center

Offers primary and specialty care locations throughout Riverside County, regardless of one's ability to pay.

Solutions

"Billboards, radio, [our marketing campaigns are] all about that there's an option. There's a free option for you. We're hoping that we can get increased enrollment to those marketing campaigns."

Public health leader serving Riverside

This infographic was prepared for Kaiser Permanente by HARC Inc. Visit www.HARCdata.org for more information.

Riverside

Asthma

"In the Inland Empire, air quality is a big issue."

Community health educator serving Riverside

Local Prevalence

It is not known what causes asthma or how it can be cured. However, it is important for people with asthma to know what triggers their asthma so it can be avoided. It is also important to know when and how to treat asthma with proper medication.

Approximately 12.9% of Riverside residents have been diagnosed with asthma. This rate of asthma is higher in Riverside than it is for the United States.

12.9%
of people living in Riverside have asthma

7.8%
of people living in the United States have asthma

Lived Experience of Residents

"Around springtime I try to stay inside more, especially when the weather changes from winter to spring. That's hard for me."

"There are a lot of orange trees behind my house. If it's a windy day you can see particles of pollen floating around the air. I can just look outside and know that it's not a good day to go outside or exercise. I know it's not going to make me feel well."

34-year-old male from Riverside

Barriers to Care

"Many people struggle with medication adherence. Many of them do not understand the difference beween controller medications and rescue medications. We see that many participants do not take this condition seriously until they end up in the hospital or emergency room. "

"Many times participants tell us their doctor never told them about rescue/controller meds or an action plan. It is important that providers have these conversations with their patients."

Community health educator serving Riverside

Community Resources

IEHP Asthma Classes

Offers free asthma education classes for families. Health navigators are also available.

RUHS Public Health Asthma Program

Offers free asthma treatment for children up to age five.

Solutions

"There need to be more concerted efforts between primary care physicians and asthma educators to connect the continuum of care. "

Health educator serving Riverside

"Right now, we are exploring different modes of education. We have our traditional face-to-face asthma classes, but we also developed a podcast of our asthma classes. We will potentially experiment with webinars, YouTube videos, and Facebook Live. "

Community health leader serving Riverside

This infographic was prepared for Kaiser Permanente by HARC Inc. Visit www.HARCdata.org for more information.

Riverside
Behavioral Health:
Mental Health & Substance Abuse

"A lot of people need [mental health treatment] but they associate it with the word 'crazy'. We need to educate people that it's okay to seek these services."

Nonprofit mental health leader serving Riverside

Local Prevalence

Mental health has been deemed a high priority area by the local community, as well as much of the nation. Poor mental health not only damages quality of life, but can be fatal when it leads to suicide, which is one of the top 10 leading causes of death in America. Locally, our population has more poor mental health days and higher suicide rates than state averages.

3.9
poor mental health days per month

10.6
suicide deaths per 100,000

Main Issues in Mental Health

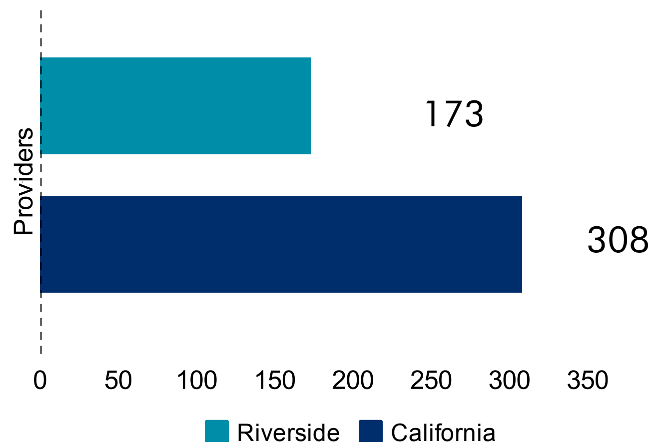
"The three biggest things that we're seeing right now is depression, anxiety, and PTSD. For depression and anxiety, it just goes back to poverty and dealing with everyday stressors."

Mental health leader serving Riverside

"We're seeing increases in the number of suicide attempts and deaths by suicide. There are drug overdoses -- particularly the opiod epidemic, alcohol-related health issues. All of those are tied to mental wellness ."

Mental health leader serving Riverside

Number of Mental Health Providers per 100,000



Barriers to Care

"[When I couldn't get therapy, I just] melted down. Medicated. You know, all that."

51-year-old homeless male from Riverside

"Trust and insurance [are the reasons I haven't sought treatment]. I don't know, it's my personal private life. That's not really easy for me to express that to some stranger."

30-year-old male from Riverside

Existing Community Resources

MFI Recovery

Committed to providing affordable mental health and substance abuse treatment.

Operation Safehouse

Provides preventative mental health classes for youth, and serves as a safe shelter for those who need it.

Latino Health Riverside

Engages the community in honest conversations about mental health.

Solutions

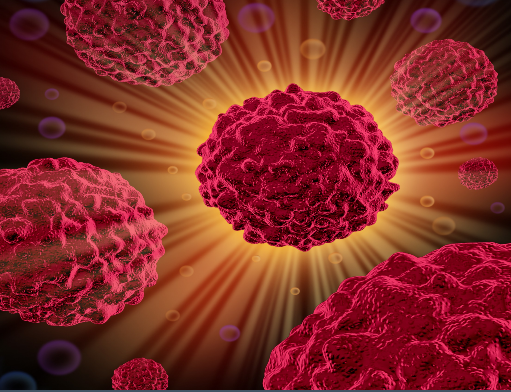
"We try to be innovative in the way we provide services, so we've embraced telepsychiatry, a primarily in [remote] places where we've struggled to provide staffing."

Public health leader serving Riverside

"Education and health services are available. I think education is a big thing with these different types of populations, it's just that no one knows it's there. We need to get it in front of people that these are available and it's okay to seek these services."

Mental health leader serving Riverside

This infographic was prepared for Kaiser Permanente by HARC Inc.
Visit www.HARCdata.org for more information.



Riverside Cancer

"There's a very, very limited amount of PCTs [patient care technician], oncologists, and then specialty, forget about it. There's only one breast surgeon in our entire region, one breast surgeon."

Community Health Leader serving Cancer Patients in Riverside

Local Prevalence

Cancer is the second leading cause of death, after heart disease.

Roughly 4.0% of residents in Riverside have been diagnosed with cancer, while 3.3% have been diagnosed with cancer in the United States.

On average, over

9,500

people die each year from cancer in Riverside County

According to State Cancer Profiles (2011-2015)

What Residents Experience

"They [lack of local providers] can't meet the need of the patient. That's really frustrating for a lot of them. They have really long wait times to get in to see their doctors. They're frustrated because there's really no specialist. Anything specialty, they have to be referred out."

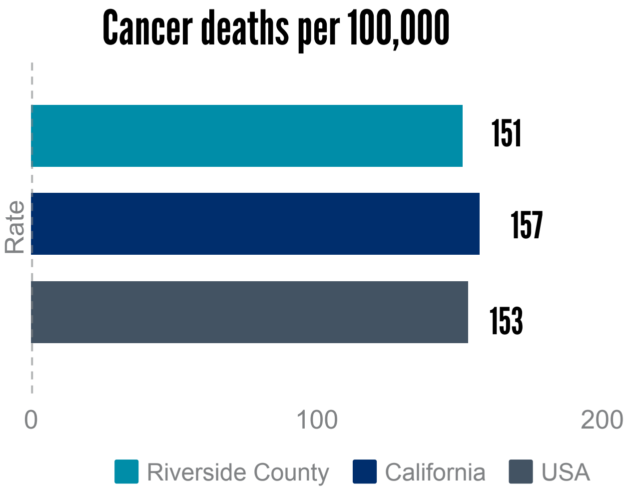
Community health leader serving cancer patients in Riverside

Barriers and Issues

"We need a transportation program [for people undergoing cancer treatment]. Fuel is really expensive and they're just tired. It's exhausting to sit in traffic all day all the time like that."

"Some of our patients, clients don't have the resources available to them like counseling. We can refer them to someone to talk to but it's not covered under their insurance."

Community health leader serving cancer patients in Riverside



Existing Community Resources

Michelle's Place

Works to empower individuals and families impacted by cancer through education and support services.

The Pink Ribbon Place

Serves families impacted by cancers throughout the Inland Empire by offering services and resources at no-cost

RUHS - Community Health Center - Cancer Screening

Offering a variety of services to the community, including cancer screenings.

Solutions

"Mental health would be huge. More support in terms of support groups or access to more support groups would be great."

"There should just be more conversation about early detection and getting screenings. The top ones, the prostate screening, the colon screening, breast screenings."

"Collaboration with the hospitals. Like I said, they give us free certificates to give to our clients. On a bigger push, having a screening day where you can have all these screenings done at one stop would be huge, and providing transportation to get to that."

Cancer Health Community leader serving Riverside County

**This infographic was prepared for Kaiser Permanente by HARC Inc.
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Riverside
Economic Opportunity
Education, jobs, homelessness, poverty, and housing

Local Prevalence

There are a variety of barriers that can hold a person back from reaching their intellectual and econonmic potential. For example, lack of education and/or job skills, scarcity of jobs, and jobs with low wages all limit a person's economic opportunity. The median income is lower in Riverside than it is for California.

The median income for Riverside is
$58,972

The median income for California is
$64,500

The Lived Experience of Residents

"The rent sometimes is hard, but at the same time the pay is not high enough. More money coming in is what I need. I need a better job. It's harder to find a good job at this time."

48-year-old male from Riverside

"The main core I think is budgeting with everybody. People were never really taught how to manage their money when they were younger. That's one of the hardest things."

36-year-old male from Riverside

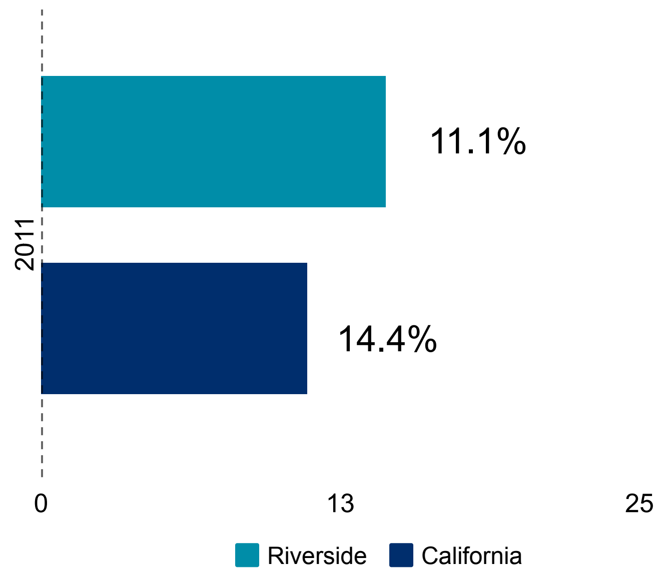
Barriers and Issues

"If they're employed, they're often relying on the paycheck advances which then rack up debt. It's this never-ending cycle of not being able to get ahead. "

Community leader serving Riverside

"Anything that doesn't make a living wage in our region-- which is around $20 an hour -- is at risk of becoming housing insecure."

Community leader serving Riverside



Existing Community Resources

Catholic Charities

Helping people struggling with poverty and other complex issues.

Operation Safehouse

Works to improve the social, economic and spiritual health of the impoverished, homeless, and at-risk individuals.

Riverside County DPSS

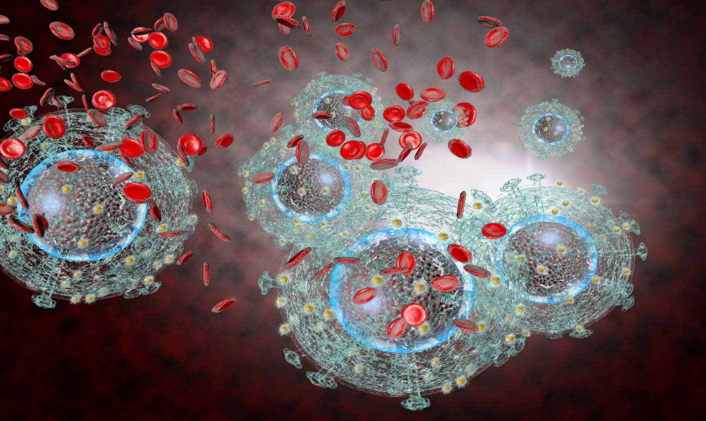
Provides services and assistance to protect and empower volunerable people in the community.

Solutions

"Strong collaborations exist... and are critical to being able to address some of these things. At the end of the day, we'll never have enough resources to make a dent in these working alone."

Public heallth leader serving Riverside County

This infographic was prepared for Kaiser Permanente by HARC Inc. Visit www.HARCdata.org for more information.



Riverside HIV/AIDS

"For people living with HIV/AIDS, you're going to be dealing with mental health, depression, anxiety, loneliness, and isolation"

Nonprofit leader of sexual health serving Riverside

Local Prevalence

This issue has been deemed a priority. One main reason for addressing HIV/AIDS is that it is an equity issue and there are clear disproportionate impacts among various racial minorities. While no cure exists, HIV can be controlled if provided with proper medical care.

Number of people living with HIV or AIDS per 100,000 people

192

people in Riverside

According to Riverside University Health System - Public Health (2017)

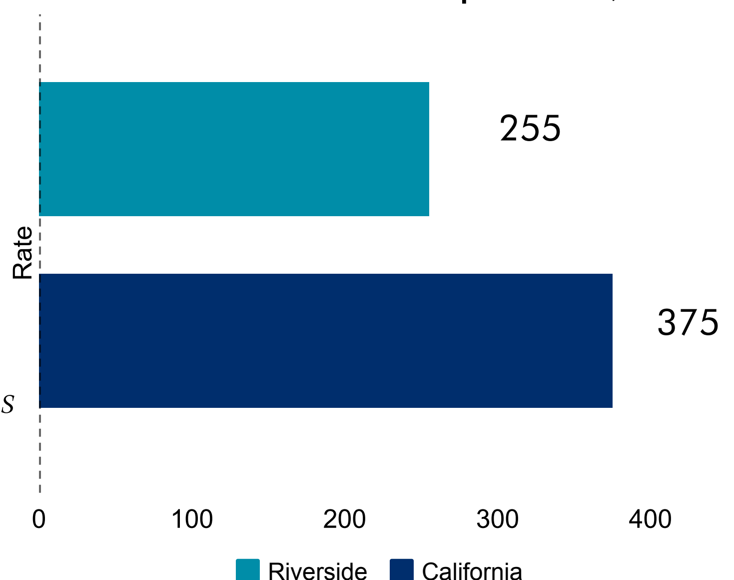
Main Issues with HIV/AIDS

"Lack of access to continual health care [is a priority health issue], along with a positive interaction with healthcare providers."

Community health leader serving Riverside

"Many insurance programs today have extremely high annual out-of-pocket costs, in addition to copays for appointments and for treatments. If we want to effectively get in front of the STD epidemics in this region of California, we need to remove financial barriers for that."

Community health leader serving Riverside



Barriers to Care

"We have stigma associated with the virus. If you're living in isolation and fear because of stigma, then it's really hampering your ability to be successfully in treatment."

"Some of the other challenges that folks face that we've not gone over besides stigma, aging. Aging, aging, aging. As they age, and they're at that point where they would need what you and I would know as assisted living, there's nothing for them."

Community health leader serving Riverside

Existing Community Resources

Desert AIDS Project

Providing primary care and preventative services including specialty care for HIV/AIDS and Hepatitis.

Foothill AIDS Project

Providing a variety of programs and services for those living with HIV/AIDS including case management, housing, and outreach.

TruEvolution

Focuses on advocacy efforts and direct social services such as support groups and HIV testing.

Solutions

"We need to continue to do awareness and education campaigns to fight stigma, so people can find support that they need within their support system, and within the healthcare system as well."

Community health leader serving Riverside

"Looking at adult day care programs such as PACE, P-A-C-E. It's a well-known adult day care program. It's looking to other communities to see how they're addressing the aging of people with HIV, but we know that any solution we find is going to need financial support-- and significant, because that's where the big gaps are, is the financing of it."

Community health leader serving Riverside

This infographic was prepared for Kaiser Permanente by HARC Inc. Visit www.HARCdata.org for more information.

Riverside
Obesity & Healthy Eating Active Living

"It seems to me that the only way to ensure you get a healthy meal is to prepare the food yourself."

34-year-old female resident from Riverside

Local Prevalence

Adults are considered obese when they have a Body Mass Index (BMI) that is greater than 30.0, and this can have a negative affect on health. Healthy Eating Active Living (HEAL) initiatives encourage the community to eat fruits, vegetables, small portions, and increase physical activity.

More than a quarter of Riverside residents are considered obese, according to the California Health Interview Survey (2014).

1 out of 4 are obese

in Riverside

Lived Experience of Residents

"Schedule of life, work, and kids makes it hard to find time to cook a healthy meal. Sometimes cooking a meal is far down on the list of priorities. That leaves fast food as the only option."

"Time management [is also a problem for me]." If I could manage my time a little better, then I would be able to exercise every day."

35-year-old male resident from Riverside

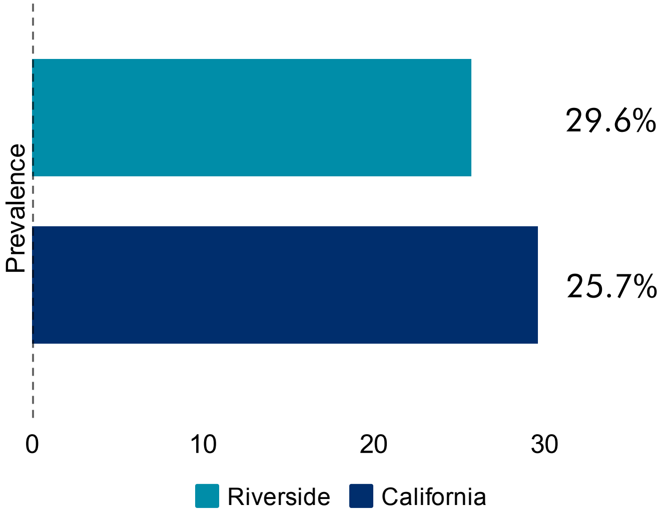
Barriers and Issues

"In Riverside there should be a lot of access to food grown by farmers in the area, just because --that's Riverside. But low-income individuals for some reason don't have the greatest access to that. There's not a food shortage, there's an accessibility challenge"

Community leader serving Riverside County

"There is a safety issue in Riverside, which is why people don't walk. We need to make sure that there are sidewalks and that there's lighting, "

Community leader serving Riverside County



Existing Community Resources

Office on Aging - Fit After 50

Exercise program with an emphasis on improving strength and mobility to promote independence and protect against falls.

Riverside Community Health Foundation

Certified instructors conduct classes such as aerobics, Zumba and more

RUHS Public Health - Nutrition and Health Promotion

Ten programs are offered to promote good nutrition and physical activity.

Solutions

"I'd love to see more parks in the community. There's one big park but it's not close to my house. You basicallly have to get in your car to go there."

33-year-old male resident from Riverside

"The HEAL Zone initiative has given an opportunity for community members to be advocates for what they need around healthy eating and active living. We also offer physical activity classes and grocery store tours so people can learn how to shop for healthy food."

Community leader serving Riverside County

This infographic was prepared for Kaiser Permanente by HARC Inc. Visit www.HARCdata.com for more information.

HARC

Riverside

Stroke

"I think that education and prevention is key and early intervention is key. Learning and knowing the signs and symptoms of a stroke are very important so whoever is suffering a stroke can take action immediately."

Nonprofit Community Health Leader Serving Riverside

Local Prevalence

Stroke is the fifth leading cause of death in the United States. Having a stroke can lead to lifelong disabilities. Stroke issues also present an equity concern in that African Americans die from stroke at a rate that is 34% higher than average in the area.

Roughly 3.6% of residents in Riverside have suffered a stroke.

3.6%

of residents in Riverside
have suffered a stroke

A Message for Residents

"There's the misconception that "This is never going to happen to me," and things like that, and thinking like, "It's only happening to older people." I think that the more we share the message, the better, so they understand that it's not only happening with older people, everybody is at risk."

Community health leader serving Riverside

Barriers and Issues

"I would say rehabilitation [is a barrier to accessing resources], access to that might be not only transportation, but also understanding the importance of that step in the recovery process."

"I know that in the past, several health insurance used to provide that, but I think that stopped. Getting access to their doctor's appointments and their activities, transportation is a big issue."

Community leader serving Riverside County

Existing Community Resources

Riverside Medical Clinic

The brain injury and support group includes meetings that encourage education, support and discussion of related topics.

Kaiser Permanente Riverside Medical Center

Certified as an Advanced Primary Stroke Center by The Joint Commission since 2012

Riverside Community Hospital

The Certified Primary Stroke Center offers 24-hour diagnostic and treatment services for patients presenting with acute stroke.

Solutions

"Learning and knowing the signs and symptoms of a stroke are very important so whoever is suffering a stroke can take action immediately. The sooner, the better. I think that a lot of people in our community still don't know about that. That's why we emphasize so much on education and awareness of stroke symptoms and signs."

Community leader serving Riverside

This infographic was prepared for Kaiser Permanente by HARC Inc. Visit www.HARCdata.org for more information.

Appendix D. Community Resources

Identified need	Resource provider name	Summary description
Access to Care	Community Health Systems	Community Health Systems, Inc. is a non-profit healthcare organization serving the Tri-County area (San Bernardino, Riverside & San Diego Counties) of Southern California. CHSI participates in a nationwide effort to extend a safety net of health services to those who lack access to health services, especially the low-income, underinsured (or uninsured) individuals with limited means to pay for quality health services.
	Borrego Health	Borrego Health provides high quality, comprehensive, compassionate primary health care to the people in our communities, regardless of their ability to pay. We serve these communities and adjoining regions with respect, dignity and cultural sensitivity as a medical home and safety net for essential health care and social services. Borrego Health is a non-profit 501(c)(3) Federally Qualified Health Center (FQHC) and a Federal Tort Claims Act Deemed (FTCA) facility.
	Riverside University Health System – Community Health Center	Riverside University Health System – Community Health Centers include primary and specialty care at 10 Federally Qualified Health Centers (FQHCs) throughout Riverside County. The FQHCs provide comprehensive outpatient primary care services to all – regardless of your ability to pay. Cancer screenings, immunizations, flu shots, nutrition management, pregnancy care and counseling, and child health services are a few of the many services available to you.
Asthma	Riverside University Health System – Public Health – Asthma Program	The County of Riverside Department of Public Health Asthma Program offers free services to children up to the age of five who suffer from asthma.
	American Lung Association	The American Lung Association is the leading organization working to save lives by improving lung health and preventing lung disease, through research, education and advocacy. Our work is focused on four strategic imperatives: to defeat lung cancer; to improve the air we breathe; to reduce the burden of lung disease on individuals and their families; and to eliminate tobacco use and tobacco-related diseases.
Behavioral Health (Mental Health and Substance Abuse)	Riverside University Health System – Behavioral Health	Provides community-based services for adults and children with mental health and substance use challenges that are delivered in settings that are friendly, accessible and sensitive to different cultural and language needs.
	MFI Recovery Center	Nonprofit corporation dedicated to providing quality, affordable mental health and substance abuse treatment programs for men, women, women with children, and adolescents.
	Riverside County Residential Treatment	Residential treatment programs are available to Riverside County Residents. Individuals may call a toll-free number (800) 499-3008 for an assessment by a substance use certified counselor.
Cancer	Riverside University Health System – Community Health Centers – Cancer Screening	Cancer screenings, immunizations, flu shots, nutrition management, pregnancy care and counseling, and child health services are a few of the many services available to you.

	The Pink Ribbon Place	The Pink Ribbon Place was established in 2006 and adopted by Riverside Community Health Foundation in 2013. Since its inception, the program has served families impacted by cancers throughout the Inland Empire by offering services and resources at no-cost.
	Michelle's Place	Michelle's Place works to empower individuals and families impacted by cancer through education and support services. Michelle's Place provides over 10,000 free services a year to individuals and families impacted by cancer.
Economic opportunity (education, jobs, homelessness, poverty, housing)	Path of Life Ministries	Path of Life provides a holistic system of care offered in an integrated, seamless manner to individuals and families, leading them from a place of crisis to a life of stability and self-sufficiency. Our commitment to partner with community organizations and agencies contributes to a holistic, community-based solution that improves the social, economic and spiritual health and vitality of the impoverished, homeless, and at-risk individuals and families in Riverside County.
	Riverside County – Department of Public Social Services	The Riverside County Department of Public Social Services (DPSS) provides services and assistance to protect and empower vulnerable people in our community. Provides temporary financial assistance and employment services for families and individuals, programs and services to protect children and adults from abuse and/or neglect, and access to health care coverage to low income individuals and families.
	Catholic Charities	At Catholic Charities we help people, regardless of their faith, who are struggling with poverty and other complex issues. The national office, through its advocacy and disaster relief programs — and its support of member agencies in our network — is making tangible progress toward better serving and loving our neighbors across the country.
HIV/STD's/AIDS	TruEvolution	Over the last ten years, TruEvolution has expanded its reach and focused its programs on advocacy efforts and direct social services. TruEvolution engages in policy advocacy initiatives as a regional response to the deficits in local and state investments on sexual health services in rural-suburban regions and engages in national advocacy efforts through community-based public policy trainings and leadership development of LGBTQ youth working in community-based settings.
	Foothill AIDS Project	Offers a full spectrum of programs and services that empower clients in three counties to manage their own long-term health goals. Integrated treatment and chronic care management, paired with stable housing planning and outreach, provide many tools for people living with HIV/AIDS to live longer, healthier, and more stable lives.
	Desert AIDS Project	A Federally Qualified Health Center (FQHC) with the goal of improving the overall health of the entire community, especially the disenfranchised. D.A.P. provides comprehensive, culturally competent, quality primary and preventative health care services including; primary medical care, HIV and Hepatitis specialty care, dentistry, behavioral health and social services all-under-one-roof.

Obesity/HEAL	Riverside Community Health Foundation	The Riverside Community Health Foundation (RCHF) hosts classes at community centers throughout the City. RCHF certified instructors conduct classes such as aerobics, Zumba and more. In addition, the RCHF instructors give participants simple and easy steps to better living on a variety of topics, like diabetes, family nutrition, heart disease, and more.
	Riverside County Office on Aging – Fit After 50	The Fit after 50 evidence-based exercise program emphasis is on improving strength, balance and mobility using stretching, upper and lower body resistance and core exercises to prolong independence, prevent falls, and prevent or decrease the effects of chronic illnesses.
	Riverside University Health System – Public Health – Nutrition Services Branch and Health Promotion Branch	The Nutrition Services Branch and Health Promotion Branch are dedicated to building healthier and more physically active communities throughout Riverside County. The branch serves more than 100,000 people each month through ten programs, each designed to promote good nutrition and physical activity. Additionally, staff work on coalitions and task forces to ensure extensive reach to all county residents.
Stroke	Kaiser Permanente Riverside Medical Center	Kaiser Permanente Riverside Medical Center has been certified as an Advanced Primary Stroke Center by The Joint Commission since 2012. They are recognized by the American Heart Association/American Stroke Association as a Get with the Guidelines Gold Plus with Target Stroke Honor Roll Elite Plus Awardee for providing efficient, rapid and reliable stroke care to our patients.
	Riverside Community Hospital Certified Primary Stroke Center	The Primary Stroke Center at Riverside Community Hospital offers 24-hour emergent diagnostic and treatment services for patients presenting with acute stroke. Through the program, the dedicated Stroke Team comprised of trained physicians and nurses, work together to identify stroke symptoms as quickly as possible beginning with emergency medical service workers in the field. By the time a patient arrives at the hospital, the stroke team is ready.
	Riverside Medical Clinic – Brain Injury and Support Group	Meetings encourage education, support and discussion about various related topics, including available treatments and the benefits of diet, exercise and other lifestyle modifications. Members have time to interact with other patients and caregivers to share their experiences and receive mutual support.

Appendix E. Methods of Qualitative Analysis

Qualitative data was analyzed using NVivo 12, a coding software platform. Each of the main research questions were analyzed separately to ensure there that there was complete immersion in each topic as it was being analyzed. Following the analysis of the research questions, it was then that a type of “axial coding” was used to identify relationships between separate variables and pervasive themes throughout all of the data. In other words, all of the themes in the data were examined in relation to one another so that the individual questions were not considered in isolation, but connections could be made between findings.

A similar method of analysis was used to analyze each of the research questions. For each question, all relevant transcripts were read closely to become familiarized with the data. Next, a primary cycle of coding was conducted which involved assigning brief words or phrases to the concepts being described in the transcripts. The primary cycle of coding was less devoted to interpretation and analysis, but rather was aimed at simplifying the complex ideas of participants into very simple words or phrases. Next, all similar codes were grouped together and the initial codes were refined to best capture the essence of what was being stated in the original code. The codes with numerous comments were deemed as dominant themes, though codes with few comments were retained.

Appendix F. 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 process.

Overview of Question Design Process

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