






2019 Implementation Strategy Report

Kaiser Foundation Hospital: Fremont

License number: 140000053

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

March 18, 2020

KAISER PERMANENTE®

Kaiser Permanente Northern California Region Community Health

IS Report for KFH-Fremont

Contents

I. General information

Contact Person:	Debra Lambert Director, Public Affairs, Greater Southern Alameda Area
Date of written plan:	December 16, 2019
Date written plan was adopted by authorized governing body:	March 18, 2020
Date written plan was required to be adopted:	May 15, 2020
Authorized governing body that adopted the written plan:	Kaiser Foundation Hospitals Board of Directors' Community Health Committee
Was the written plan adopted by the authorized governing body on or before the 15th day of the fifth month after the end of the taxable year the CHNA was completed?	Yes ☒ No ☐
Date facility's prior written plan was adopted by organization's governing body:	March 16, 2017
Name and EIN of hospital organization operating hospital facility:	Kaiser Foundation Hospitals, 94-1105628
Address of hospital organization:	One Kaiser Plaza, Oakland, CA 94612

II. About Kaiser Permanente (KP)

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

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

Kaiser Permanente is an integrated health care delivery system comprised of Kaiser Foundation Hospitals (KFH), Kaiser Foundation Health Plan (KFHP), and physicians in the Permanente Medical Groups. Today we serve more than 12 million members in eight 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.

III. 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 grant making to pair financial resources with medical research, physician expertise, and clinical practices. Our community health strategy focuses on three areas:

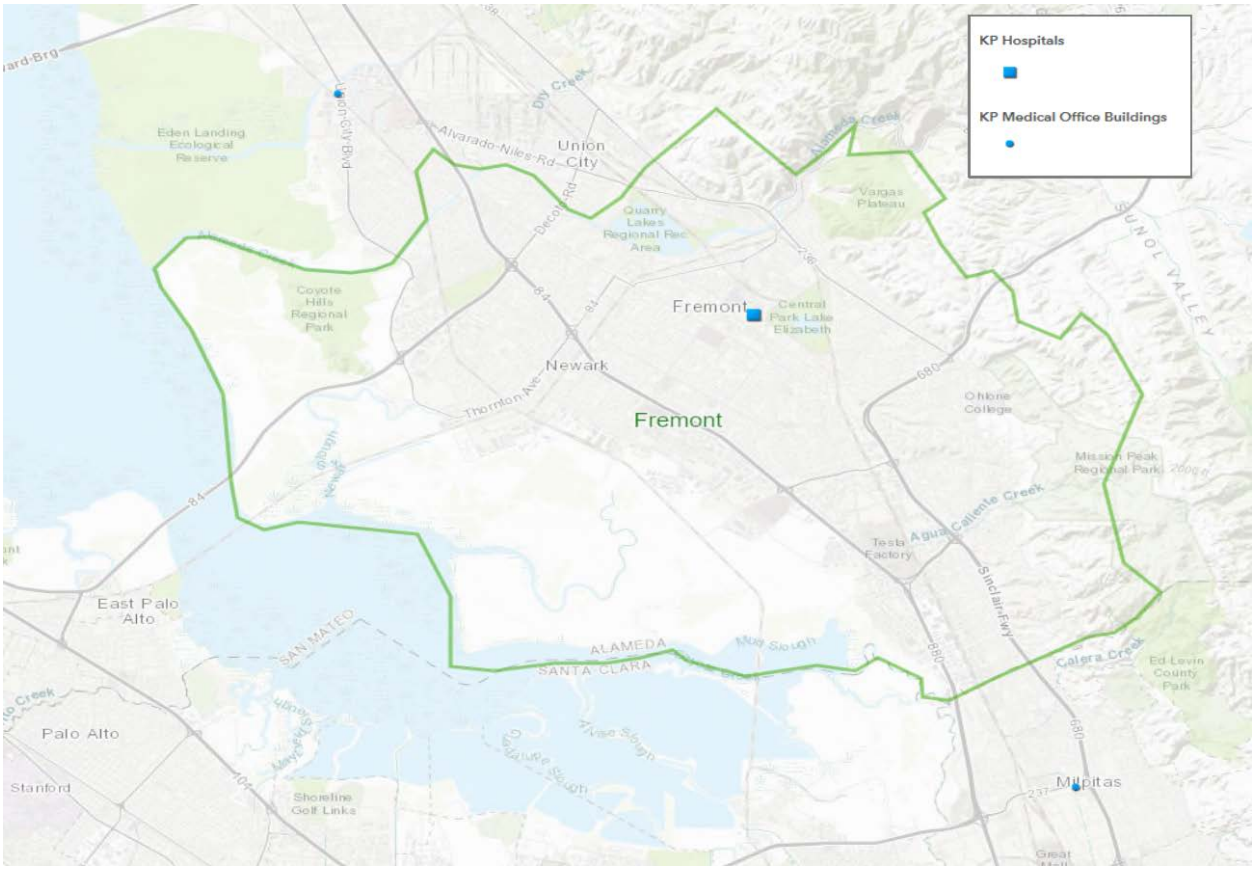
- Ensuring health access by providing individuals served at Kaiser Permanente or by our safety net partners with integrated clinical and social services;
- Improving conditions for health and equity by engaging members, communities, and Kaiser Permanente's workforce and assets; and
- Advancing the future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

IV. Kaiser Foundation Hospitals—Fremont Service Area

A. Map of facility service area



B. Geographic description of the community served (towns, counties, and/or zip codes)

The KFH-Fremont service area covers the southern part of the Alameda County. The cities served include Fremont, Newark, and the southern part of Union City. The map above shows the service area which also includes unincorporated areas.

C. Demographic profile of community served

The KFH-Fremont service area is racially and ethnically diverse, with over half of residents (52%) identifying as Asian and nearly 17% identifying as Hispanic or Latinx. Overall, the service area reports lower rates of people living in poverty and uninsured than the state average (6% versus 16%; and 6% versus 13%, respectively).

Race/ethnicity		Socioeconomic Data	
Total Population	273,040	Living in poverty (<100% federal poverty level)	5.6%
Asian	51.7%	Children in poverty	5.7%
Black	3.5%	Unemployment	2.9%
Hispanic/Latino	16.7%	Uninsured population	5.5%
Native American/Alaska Native	0.5%	Adults with no high school diploma	7.8%
Pacific Islander/Native Hawaiian	0.9%		
Some other race	9.6%		
Multiple races	6.1%		
White	27.7%		

Source: American Community Survey, 2012-2016

V. Purpose of Implementation Strategy

This Implementation Strategy has been prepared in order to comply with federal tax law requirements set forth in Internal Revenue Code section 501(r) requiring hospital facilities owned and operated by an organization described in Code section 501(c)(3) to conduct a community health needs assessment at least once every three years and adopt an implementation strategy to meet the community health needs identified through the community health needs assessment.

This Implementation Strategy is intended to satisfy each of the applicable requirements set forth in final regulations released in December 2014. This implementation strategy describes KFH-Fremont's planned response to the needs identified through the 2019 Community Health Needs Assessment (CHNA) process. For information about KFH-Fremont's 2019 CHNA process and for a copy of the report please visit www.kp.org/chna.

List of Community Health Needs Identified in 2019 CHNA Report

The list below summarizes the health needs identified for the KFH-Fremont service area through the 2019 Community Health Needs Assessment process.

1. Behavioral Health
2. Housing and Homelessness
3. Economic Security
4. Health Care Access and Delivery
5. Education and Literacy
6. Health Eating/Active Living
7. Community and Family Safety
8. Transportation and Traffic
9. Climate/Natural Environment

VI. Who was involved in the Implementation Strategy development

A. Partner organizations

KFH-Fremont collaborated with partners on both the CHNA and Implementation Strategy processes. Partners include John Muir Health, Sutter Health, Stanford Health Care—Valley Care, Washington Hospital Healthcare System, and the Alameda County Public Health Department.

B. Community engagement strategy

While not required by Federal CHNA regulations, Kaiser Permanente requires all KFH facilities developing Implementation Strategy plans to elicit community input throughout the plan development process. Community member and stakeholder engagement in the implementation strategy development process is intended to enable:

- KFH facilities to develop a deeper understanding of community perspective in developing Implementation Strategies, allowing opportunities for increased collaboration, potential impact, and sustainability
- Opportunities to engage community members beyond organizations and leaders with whom facilities may typically collaborate
- Transparency throughout the implementation strategy development process
- Opportunities to inform community leaders about the health system partners' structures and resources to effectively foster meaningful partnerships

The Alameda County hospital and health system partners jointly sponsored a large community and partner input session in San Leandro that drew 110 participants active in a range of health need topic areas across Alameda County. Kaiser Permanente and the Alameda County Public Health Department also held an additional session in Fremont (attended by 23 participants) to provide opportunities for in-depth conversations and input specifically about the Tri-City area (which includes the cities of Fremont, Newark, and Union City). For those who could not attend in person or wished to provide additional input, four online interactive webinars were scheduled in September 2019. However, these were sparsely attended, with only six individuals registered and participating.

During both in-person meetings, participants received a brief overview of the CHNA process and priority health needs that emerged, as well as highlights from the community concerns raised in focus groups and interviews conducted in 2018. They also learned about specific implementation strategies to achieve outcomes related to each health need, drawn in part from an outcomes menu developed by Kaiser Permanente's Northern California Region Community Benefit team to guide investments and strategies from 2020-22. The proposed strategies were informed by the hospital partners, based on those considered most likely to achieve intended outcomes. In the smaller session in Fremont, participants chose from a combined set of health need topics, because the number of participants was too small to generate multiple break-out discussions for individual topic areas.

In both partner input sessions, participants were asked to reflect on three questions for the priority health need they selected:

1. **What work is** already happening in Alameda County overall (and in subregions, where applicable) to achieve the intended outcomes?
2. **How's it going?** What's working well (e.g., Best practices and approaches? What could be improved)?

3. **What's possible to achieve together?** What are emerging opportunities, collaborative strategies, collection action, etc. that could contribute to these outcomes in the future?

In the smaller break-out groups, a hospital/health system table leader/facilitator and notetaker staffed each group to guide the discussion and capture key points.

At the countywide session on August 29, 2019, 110 participants divided into 10 groups, including:

- Health Care Access and Delivery (2 groups)
- Behavioral Health (2 groups)
- Economic Security (2 groups)
- Healthy Eating / Active Living
- Housing and Homelessness
- Education and Literacy
- Community and Family Safety.

At the Tri-City partner input session in Fremont on August 14, 2019, the 23 attendees broke into four smaller discussion groups:

- Health Care Access and Delivery—Medi-Cal, the uninsured, community clinics, navigating services, health homes, social services.
- Behavioral Health—ACEs, trauma, resilience, well-being, substance use, access
- Economic Security—Food security, financial education, workforce development, job training, career coaching; combined with Housing and Homelessness
- Healthy Eating / Active Living.

The summaries below share feedback from both groups.

Health Care Access and Delivery. Participants are concerned about many subpopulations within Alameda County who are particularly vulnerable and lack access to care, including Latinx, South Asians (e.g., Afghans, Sikhs, especially in the Tri-City area), new immigrants, homeless, women, seniors, and youth aging out of their parents' health insurance plans. Many programs are responding to these needs with targeted outreach and bilingual/bicultural staff but recognize that more is needed. Suggestions to improve access to care include sharing data about different services (especially non-medical services) to better coordinate care, increasing the social work and case management workforce (e.g., with loan forgiveness, stipends, and pipeline programs), strengthening existing partnerships and identifying opportunities for more interaction among local partners, and monitoring policy opportunities (such as support for Medi-Cal integration). Several local strategies reflect these concerns and suggestions: increasing organizations' capacity to conduct effective outreach and supporting navigation to connect vulnerable populations to care; supporting the training and recruitment of community health workers trusted by community members; and strengthening capacity for screening and referring clients to social, non-medical services.

Behavioral Health. Trauma-informed approaches have extended to many systems and agencies, but additional training (both for initial awareness of these approaches and deeper practice topics) is needed. Community partners and groups see great potential in initiatives such as screening for ACEs in pediatric settings and increased funding for home visiting programs, as well as behavioral health

partnerships with school systems. Partners also are interested in how technology could advance both practice (via online training) and access (via telehealth options).

In the Tri-City session, partners noted how Kaiser Permanente's educational theater program has helped reduce stigma and also helped adolescents and young adults learn about where and how to seek help. They also saw more opportunities to collaborate with school systems to identify needs and refer patients to care and support, such as supporting formal coordinator roles on school campuses (to help navigate school and health care systems).

Strategies that address gaps and concerns raised during the partner input sessions include providing more support to caregivers, providing training on trauma-informed care for those working closely with vulnerable populations, and supporting telehealth options to increase access to behavioral health services.

Economic Security (including food security and housing/homelessness). In the Tri-City partner input session, participants noted the "ripple effects" of the lack of affordable housing: reduced safety and security, a negative impact on the local economy for businesses and developers, and economic insecurity for families. Participants are encouraged by workforce development and job training initiatives, but fear these advances are quickly outpaced by high housing costs that make it difficult to maintain livable wages in the Bay Area and contribute to the risk of homelessness. Participants see potential for stronger connections to community colleges, providing more wraparound services for students and their families, focusing on literacy, collaborating across counties (because youth and families move across county lines), and incorporating more workforce development into school curricula.

To prevent homelessness and/or support those living in their cars or on the streets, participants in the Tri-City area recommended supporting non-profit partners (such as churches) to open their parking lots as safe places to park overnight and providing services such as mobile showers. Working with specific populations at risk—such as frail seniors—could help them remain in their homes while providing housing for roommates. Participants noted the role of domestic violence in placing women at risk for homelessness; this is particularly acute for recent immigrants who are isolated by language and culture. In addition, while Coordinated Entry programs have helped identify those at greatest risk, participants were concerned about those still at risk who did not meet the Coordinated Entry thresholds; they recommended particular attention to this group with supportive services and flexible funding.

Connecting food security to economic security, participants recommended closer partnerships between agencies that offer support and services (such as clothing, immigration, legal aid, and more) to food pantries, food banks, and farmers' markets, noting that many at risk for food insecurity may not see themselves in that category (e.g., eligible for CalFresh).

Several of these ideas are reflected in the selected local strategies, including linking food security services more closely to other types of support (such as immigration, clothing, or job training), and supporting outreach and case management that connects the most vulnerable who are experiencing homelessness to Coordinated Entry services.

	Data collection method	Title/name	Number	Notes (e.g., input gained or role in IS process)
Organizations				
1	*Group Discussion*	*Partner Input Session for Alameda County partners*	*110*	*Community organizations focused on these health needs (some on more than one):* • *Behavioral Health (19)* • *Healthy Eating / Active Living (18)* • *Health Care (23)* • *Housing/Homelessness (9)* • *Economic/Food Security (6)* • *Education/Literacy (20)* • *Community/Family Safety (12)*
1	*Group Discussion*	*Partner Input Session for Tri-City partners*	*23*	*Community organizations focused on these health needs/populations (some on more than one):* • *Behavioral Health (4)* • *Health Care (5)* • *Education/Literacy (3)* • *Healthy Eating / Active Living (2)* • *Economic Security/ Housing/ Homelessness (5)* • *Youth (3)* • *Seniors (1)* • *Immigrants (1)*
4	*Webinars*	*Partner Input via online Webinar*	*6*	*Representatives of Economic/Food Security, Education/Literacy, Behavioral Health, Healthy Eating / Active Living, Housing/Homelessness, and Community/Family Safety organizations*

C. Consultant(s) used

Cole Communications, Inc. is a public health planning and communications consulting practice founded by Nicole Lezin in 1999. Cole Communications' consulting services include qualitative evaluation, strategic planning, writing and editing, and facilitation for public and nonprofit agencies. Over the past 20 years, consulting assignments have covered a wide range of public health topics, including arthritis, Alzheimer's disease, children's health and development, reproductive health, immunizations, diabetes, obesity, injury and violence prevention, and oral health, among many others.

Mesu Strategies, LLC is a research and strategy firm committed to realizing a just and inclusive society. The firm envisions a strong ecosystem of leaders across industries working to create healthy, equitable and sustainable communities for current and future generations. Mesu Strategies provides strategic guidance and analytical support, as well as coaching, training, and facilitation to community and organizational leaders looking to create and scale up social impacts through policies, systems and organizational change. The firm's specialties include health equity, racial justice, and resilient equitable development. Located in Oakland, California, Mesu Strategies is a woman- and minority-

owned business partnering with community organizations; health services providers; local and regional public agencies; and state, national and international foundations nationwide.

VII. Health needs that KFH-Fremont plans to address

A. Process and criteria used

The Greater Southern Alameda Area (GSAA) Community Health Investment Committee (CHIC), with representation from both KFH-Fremont and KFH-San Leandro, met in July 2019 to select priority health needs from those that had emerged through the CHNA process.

Attendees included:

- Area Finance Officer
- Assistant Medical Group Administrator
- Health Education Director
- NCAL Medi-Cal Service Director
- Public Affairs Director

During the July 2019 meeting, the group reviewed the results of the CHNA, demographic data, and indicators and community concerns (especially those related to health disparities). The group then used individual worksheets to apply a rating scale (with a score of 3 for high priority, 2 for medium, and 1 for low) to assess each health need in terms of the following criteria:

- **Priority health need from CHNA process** (low, medium, or high)
- **Individual rating of health need** (low, medium, or high)
- **Leveraging community assets** (i.e., whether there are opportunities to collaborate with existing community-wide partnerships, build on current programs or emerging opportunities, or partner with other community assets)
- **Evidence-based or promising approaches** (i.e., whether there are effective, evidence-based or promising strategies to be applied to address the health need)
- **Leveraging Kaiser Permanente expertise and/or assets** (i.e., whether GSAA hospitals could make a meaningful contribution to addressing the need), and
- **Feasibility** (whether GSAA hospitals have the ability to make an impact, given the resources available)

In the scoring process, the priorities emerging from the CHNA for both hospital areas (KFH-Fremont and KFH-San Leandro) were pre-scored. The option for CHIC members to rank the health needs (in addition to the ranking that emerged from the CHNA process) was intended to give those with specific expertise or insight an opportunity to add to the CHNA rankings, but in practice their responses were similar and did not affect the outcome. The “leveraging Kaiser Permanente expertise and/or assets” rating was given double weight compared to the others. Members discussed where Kaiser Permanente could reasonably expect to have an impact based on the degree to which community and/or Kaiser Permanente assets could be leveraged, how feasible it would be to have an impact, and how (and even whether) feasibility could be determined.

The highest scores from this process (summing the low, medium, or high rating for each, and doubling “leveraging Kaiser Permanente expertise and/or assets”) yielded Behavioral Health as the top priority,

followed by a tie between Housing and Homelessness and Healthy Eating / Active Living. Health Care Access and Delivery had the next highest score, closely followed by Economic Security. These were the highest-scoring health needs overall and specifically in terms of leveraging community assets, applying evidence-based or promising approaches, and the feasibility of making an impact, given available resources.

B. Health needs that KFH-Fremont plans to address

The CHIC members agreed to focus on **Behavioral Health** as their top priority health need. Because of the close scores (including a tie between Housing and Homelessness and Healthy Eating / Active Living) and the alignment with priorities emerging from the CHNA process, the group chose to elevate **Health Care Access and Delivery** as its second priority. This health need also received one of the three highest scores for feasibility, leveraging Kaiser Permanente expertise and organizational assets, and applying evidence-based or promising approaches. To address multiple aspects of related health needs, the group then chose **Economic Security** as its third priority but expanded it to include aspects of Housing and Homelessness, Education and Literacy (particularly related to job readiness and training), and Healthy Eating / Active Living (particularly food security).

Behavioral Health

Behavioral health, including mental health and substance use, is one of the strongest priorities of the KFH-Fremont service area. Community members from the service area emphasized depression and stress, as well as the co-occurrence of mental health and substance use. KFH-Fremont community members also identified trauma and adverse childhood experiences (ACEs) as other drivers of behavioral health problems. In addition to individual trauma, community members called for culturally reflective support while discussing generational trauma, the impact of discrimination and institutionalized racism, and how these factors contribute to inequitable health outcomes. The CHIC members agreed that Behavioral Health is a top priority health need for both KFH-Fremont and KFH-San Leandro. Committee members gave this health need the highest scores for leveraging Kaiser Permanente and community assets, applying evidence-based or promising approaches, and the feasibility of making an impact.

Health Care Access and Delivery

Quantitative data indicate challenges to health care access for residents in the KFH-Fremont service area. Community members discussed issues related to health insurance access, affordability of care (including deductibles), and the lack of access to specialists, especially for Medi-Cal patients. Many community members in the KFH-Fremont service area expressed alarm about health care access barriers faced by immigrants who are either ineligible for Medi-Cal due to their immigration status. The community often identified the need for greater language support, culturally appropriate health care services, and whole-person care. In addition to immigrants, the community discussed how this need for sensitive, whole-person care also applied to LGBTQ community members; experts described the difficulty LGBTQ community members, especially transgender individuals, experience in finding medical professionals sensitive to their needs. Health Care Access and Delivery received among the highest scores for leveraging Kaiser Permanente expertise and organizational assets, the ability to apply evidence-based or promising approaches, and for the feasibility of making an impact.

Economic Security

Community members discussed food insecurity, risk of homelessness, and employment. Residents emphasized that while there may be plenty of jobs in the service area, they do not pay enough considering the high cost of living. Community members observed that individuals working low-wage jobs are among those who can least afford to miss work in order to attend to their health and cited the stress of economic instability as one of the most pressing drivers of poor mental health. Ethnic disparities in economic security also exist among service area residents. CHNA participants in the service area specifically mentioned food insecurity, and often expressed the perception that healthy food is more expensive than fast food and packaged foods.

Economic Security was highly ranked in both the CHNA process and individual rankings among CHIC members. In contrast to prior years, it also received high scores for leveraging Kaiser Permanente expertise and organizational assets, as well as feasibility of making an impact. Because economic security is so closely linked to other health needs, CHIC members elevated this health need and incorporated aspects of Housing and Homelessness and Healthy Eating / Active Living.

VIII. KFH-Fremont's Implementation Strategies

A. About Kaiser Permanente's Implementation Strategies

As part of the Kaiser Permanente integrated health system, KFH-Fremont has a long history of working internally with Kaiser Foundation Health Plan, The Permanente Medical Group, and other Kaiser Foundation Hospitals, as well as externally with multiple stakeholders, to identify, develop and implement strategies to address the health needs in the community. These strategies are developed so that they:

- Are available broadly to the public and serve low-income individuals
- Are informed by evidence
- Reduce geographic, financial, or cultural barriers to accessing health services, and if they ceased would result in access problems
- Address federal, state, or local public health priorities
- Leverage or enhance public health department activities
- Advance increased general knowledge through education or research that benefits the public
- Otherwise would *not* become the responsibility of government or another tax-exempt organization

KFH-Fremont is committed to enhancing its understanding about how best to develop and implement effective strategies to address community health needs and recognizes that good health outcomes cannot be achieved without joint planning and partnerships with community stakeholders and leaders. As such, KFH-Fremont welcomes future opportunities to enhance its strategic plans by relying on and building upon the strong community partnerships it currently has in place.

KFH-Fremont will draw on a broad array of strategies and organizational resources to improve the health of vulnerable populations within our communities, such as grant making, leveraged assets, collaborations and partnerships, as well as several internal KFH programs. The goals, outcomes, strategies, and examples of resources planned are described below for each selected health need.

B. 2019 Implementation Strategies by selected health need

Health need #1: Behavioral Health

Long term goal	All community members experience social emotional health and wellbeing and have access to high quality behavioral health care services when needed
Intermediate goal(s)	• Increase capacity of organizations and institutions to provide trauma-informed services and programs • Increase access to behavioral health care services for low-income and vulnerable populations • Develop a diverse, well trained behavioral health care workforce that provides culturally competent care
Strategies	• Support trauma-informed services and training for organizations serving vulnerable populations (re-entry, immigrant, foster care, transition age youth, domestic violence survivors, homeless) • Support programs providing direct mental health services in schools (MOU required) • Implement the Public Good Projects' Action Minded campaign, a digital community health intervention using education, social engagement and multi-media tools to engage the general public, issue-advocates and community partners, and KP employees as partners in reducing stigma towards mental health conditions • Support programs providing trauma and ACEs training for school staff and/or self-care for teachers • Support FQHC capacity to screen and connect patients to mental health services • Support organizations that support caregivers by connecting them to navigators and services for themselves and the people for whom they are caring ("Support the supporters") • Support telehealth options to increase access to behavioral health services by reducing transportation and stigma barriers • Support the capacity of clinics, schools or other community-based organizations to provide trauma-informed care to youth • Build student and staff resilience to address trauma and adverse childhood experiences (RISE) • Provide KP's Education Theater program, Resilience Squad • KP Behavioral Health Training program
Expected outcomes	• Increased scope and availability of trauma-informed services and programs available through programs serving vulnerable populations • Increased screening and referrals to behavioral health care services for low-income and vulnerable populations, especially youth (in settings such as FQHCs and schools)

	• Increased access for vulnerable populations to a diverse, well-trained behavioral health care workforce that provides culturally competent care • Increased help-seeking for behavioral health issues prompted by stigma reduction campaigns

Health need #2: Access to care

Long term goal	All community members have access to high quality, culturally and linguistically appropriate health care services in coordinated delivery systems
Intermediate goal(s)	• Increase access to comprehensive health care coverage for low-income individuals • Increase access to subsidized care for those facing financial barriers to health care • Increase access to social non-medical services for low income and vulnerable populations • Increase access to a diverse, culturally competent health care workforce • Improve the capacity of health care systems to provide quality health care services
Strategies	• Increase capacity of organizations to conduct effective outreach and navigation to vulnerable populations to connect them to care • Increase FQHC and health system capacity to screen and refer clients to social, non-medical services (e.g., food, housing, employment) • Support partnerships with food banks for CalFresh enrollment and food pharmacy programs • Support training/ recruitment of community health workers (e.g., *promotoras*); Parent Ambassadors • Support training/ recruitment of health and social system navigators • Support screening for social non-medical service needs and connect low-income individuals and families to community and government resources (Thrive Local) • Support population health management approaches that improve health outcomes for safety net patients with diabetes and hypertension (PHASE) • Support community clinic consortia to develop programs and advocate for policies that improve access to quality health care for low income individuals Participate in Medi-Cal Managed Care • Provide Charitable Health Coverage • Provide Medical Financial Assistance • Provide workforce training programs to train current and future health care providers, including physicians, mental health practitioners, physical therapy,

	pharmacy, nurses, and allied health professionals, with the skills and linguistic and cultural competence to meet the health care needs of diverse communities • Implement health care workforce pipeline programs to introduce diverse, underrepresented school age youth and college students to health careers (KP LAUNCH) • School for Allied Health expanding access to training and certificate programs for underrepresented individuals
Expected outcomes	• Increased outreach to vulnerable populations that helps them access comprehensive health care coverage • Increased outreach to vulnerable populations that helps them navigate and connect to subsidized care • Reduced financial barriers to care by increasing access to Medical Financial Assistance • Increased access to trained navigators and community health workers that connect low-income and vulnerable populations to social non-medical services • Increased opportunities for diverse, culturally competent workers to enter the health care workforce

Health need #3: Economic Security

Long term goal	All community members are economically secure in order to thrive
Intermediate goal(s)	• Improve economic vitality of local and diverse businesses • Increase in enrollment and participation in public benefit programs • Improve job readiness for people with barriers to employment • Increase connections to supportive services for individuals experiencing homelessness or at-risk of homelessness • Reduce food insecurity among low-income families and individuals
Strategies	• Support outreach efforts to increase enrollment in CalFresh • Support food distribution programs that partner with school districts, health systems and community partners to provide nutritious foods • Provide support for programs that offer training and employment assistance to vulnerable populations (re-entry, immigrant, domestic violence survivors, homeless population) • Support outreach, navigation, and case management that connects individuals to coordinated entry services • Support outreach and enrollment campaigns to increase CalFresh enrollment for eligible community members (Food For Life)

	• Funding to strengthen local homeless system of care through the Housing and Health Initiative • Increase baseline spend for local and diverse businesses
Expected outcomes	• Increased use of local and diverse businesses as suppliers • Increased enrollment and participation in public benefit programs (e.g., CalFresh) • Improved job readiness for people with barriers to employment (especially due to re-entry, domestic violence, immigration status, homelessness) • Increased connections to supportive services (e.g., Coordinated Entry) for individuals experiencing homelessness • Reduced food insecurity among low-income families and individuals through access to nutritious foods via school, health, and community partner settings

C. Our commitment to Community Health

At Kaiser Permanente, our scale and permanence in communities mean we have the resources and relationships to make a real impact, and wherever possible, our regions and facilities collaborate with each other and with key institutions in our communities, such as schools, health departments, and city/county governments to create greater impact. The CHNA/IS process also presents the opportunity to reinforce and scale national strategies to address health needs that impact all of our communities, even if those health needs are not prioritized locally. The following strategies illustrate the types of organizational business practices we implement to address health needs and contribute to community health and well-being:

- **Reduce our negative environmental impacts and contribute to health at every opportunity.** We have optimized the ways in which we manage our buildings; purchase food, medical supplies and equipment; serve our members; consume energy; and process waste. The following strategies illustrate several of our practices that enable us to operate effectively while creating a healthier environment for everyone. Our Environmentally Preferable Purchasing Standard prioritizes the procurement of products with fewer chemicals of concern and less resource intensity, thus encouraging suppliers to increase the availability of healthier products. We are building renewable energy programs into our operations, with plans to be carbon neutral in 2020. We recognize that mitigating the impacts of climate change and pollution is a collective effort, and we are therefore proud to work with like-minded organizations and individuals, including the United Nations, Health Care Without Harm, government entities, as well as other influencers that advocate for environmental stewardship in the healthcare industry and beyond.
- **Deploy research expertise to conduct, publish, and disseminate epidemiological and health services research.** 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

in diverse populations disproportionately impacted by health disparities. Research projects encompass epidemiologic and health services studies as well as clinical trials and program evaluations. They cover a wide range of topics including cardiovascular disease, cancer, diabetes, substance abuse, mental health, maternal and child health, women's health, health care delivery, health care disparities, pharmaco-epidemiology, and studies of the impact of changing health care policy and practice.

- **Implement healthy food policies to address obesity/overweight**, such as purchasing sustainable, locally produced fruits and vegetables; supporting local restaurants and caterers that meet KP's Healthy Picks and to make more available healthier food options in our communities; and supporting vendors that hire under/unemployed residents (with living wages and benefits) in the food production/distribution process. We also partner with school districts and city governments to support them in adopting and implementing healthy food procurement policies.
- **Contribute toward workforce development, supplier diversity, and affordable housing to address economic security.** We support supplier diversity by implementing policies and standards to procure supplies and services from a diverse set of providers; working with vendors to support sub-contracting with diverse suppliers; partnering with community-based workforce development programs to support a pipeline for diverse suppliers; and building the capacity of local small businesses through training on business fundamentals. We also seek to reduce homelessness and increase the supply of affordable housing by strengthening systems to end homelessness and shaping policies to preserve and stimulate the supply of affordable housing.

IX. Evaluation plans

Kaiser Permanente has a comprehensive measurement strategy for Community Health. Our vision at Kaiser Permanente is for our communities to be the healthiest in the nation. To that end, we are committed to pursuing a deep and rigorous understanding of the impact of our community health efforts. We monitor the health status of our communities and track the impact of our many initiatives on an ongoing basis. And we use our measurement and evaluation data, and information gathered through our Community Health Needs Assessments, to improve the effectiveness of our work and demonstrate our impact. The Community Health Needs Assessments 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.

In addition, KFH-Fremont will monitor and evaluate the strategies listed above 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 metrics specific to KFH leveraged assets. In addition, KFH-Fremont tracks outcomes, including behavior and health outcomes, as appropriate and where available.

X. Health needs KFH-Fremont does not intend to address

Three health needs identified through the CHNA process are partially addressed in the strategies listed above.

The Healthy Eating / Active Living health need received scores in the middle of the total rankings from CHIC members and was a lower priority in the CHNA process. The group agreed to incorporate one element of this health need—food security—into the Economic Security emphasis.

Housing and Homelessness was ranked second among health needs by the CHIC members, in a tie with Economic Security. Recognizing the link between Economic Security and Housing and Homelessness, this health need was incorporated into the Economic Security priority health need.

The Education and Literacy health need was rated as a medium priority in the CHNA and received similar rankings in the CHIC process. Relative to other health needs, it received lower rankings for the ability to leverage Kaiser Permanente expertise or organizational assets, and for the feasibility of making an impact. However, the CHIC members selected elements of Education and Literacy—notably job training and workforce development—in the higher-ranked Economic Security health need, as well as mental health and wellness for school-aged children under Behavioral Health.

Three health needs were among the priorities that emerged from the CHNA process but are not addressed among the implementation strategies.

Community and Family Safety received lower scores from the CHIC in terms of evidence-based or promising approaches, leveraging Kaiser Permanente expertise or organizational assets, and feasibility of making an impact. Some elements of Community and Family Safety are specifically addressed by strategies included in the priority health needs—particularly addressing trauma through the education and behavioral health systems, helping people navigate and access health and non-medical social services (including survivors of human trafficking and domestic violence), and supporting interventions that increase economic security and reduce homelessness.

Climate/Natural Environment—particularly poor air quality—was recognized as a factor in health outcomes but received low scores in terms of leveraging community assets, applying evidence-based or promising approaches, leveraging Kaiser Permanente expertise and organizational assets, and feasibility of making an impact. Instead, some of the improvements in health care access and delivery (such as connecting low-income children and families to care for asthma) were considered more accessible ways to address the effects of climate issues within the service area.

Transportation and traffic create barriers to health by lengthening commutes (making it more difficult for people to spend time being physically active or preparing healthy meals), increasing stress, and affecting access to care. However, CHIC members did not identify specific ways for Kaiser Permanente to address this structural issue. Of all the health needs considered, transportation and traffic received the lowest scores overall and for opportunities to leverage community and/or Kaiser Permanente assets, apply evidence-based approaches, and the feasibility of making an impact.