



# 2019 Implementation Strategy Report

Kaiser Foundation Hospital: Redwood City

License number: 220000021

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

March 18, 2020

Kaiser Permanente Northern California Region Community Health  
IS Report for KFH-Redwood City

Contents

- I. General information..... 3
- II. About Kaiser Permanente (KP) ..... 4
- III. About Kaiser Permanente Community Health ..... 4
- IV. Kaiser Foundation Hospitals—Redwood City Service Area ..... 5
  - A. Map of facility service area ..... 5
  - B. Geographic description of the community served (towns, counties, and/or zip codes) .... 5
  - C. Demographic profile of community served..... 6
- V. Purpose of Implementation Strategy ..... 6
  - List of Community Health Needs Identified in 2019 CHNA Report..... 6
- VI. Who was involved in the Implementation Strategy development..... 7
  - A. Partner organizations..... 7
  - B. Community engagement strategy ..... 7
  - C. Consultant(s) used ..... 9
- VII. Health needs that KFH-Redwood City plans to address..... 10
  - A. Process and criteria used ..... 10
  - B. Health needs that KFH-Redwood City plans to address..... 11
- VIII. KFH-Redwood City's Implementation Strategies..... 12
  - A. About Kaiser Permanente's Implementation Strategies ..... 12
  - B. 2019 Implementation Strategies by selected health need ..... 13
  - C. Our commitment to Community Health ..... 17
- IX. Evaluation plans ..... 18
- X. Health needs KFH-Redwood City does not intend to address..... 18

## I. General information

Contact Person:	Stacey Wagner, Director of Public Affairs
Date of written plan:	December 19, 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 15 <sup>th</sup> day of the fifth month after the end of the taxable year the CHNA was completed?	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
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:

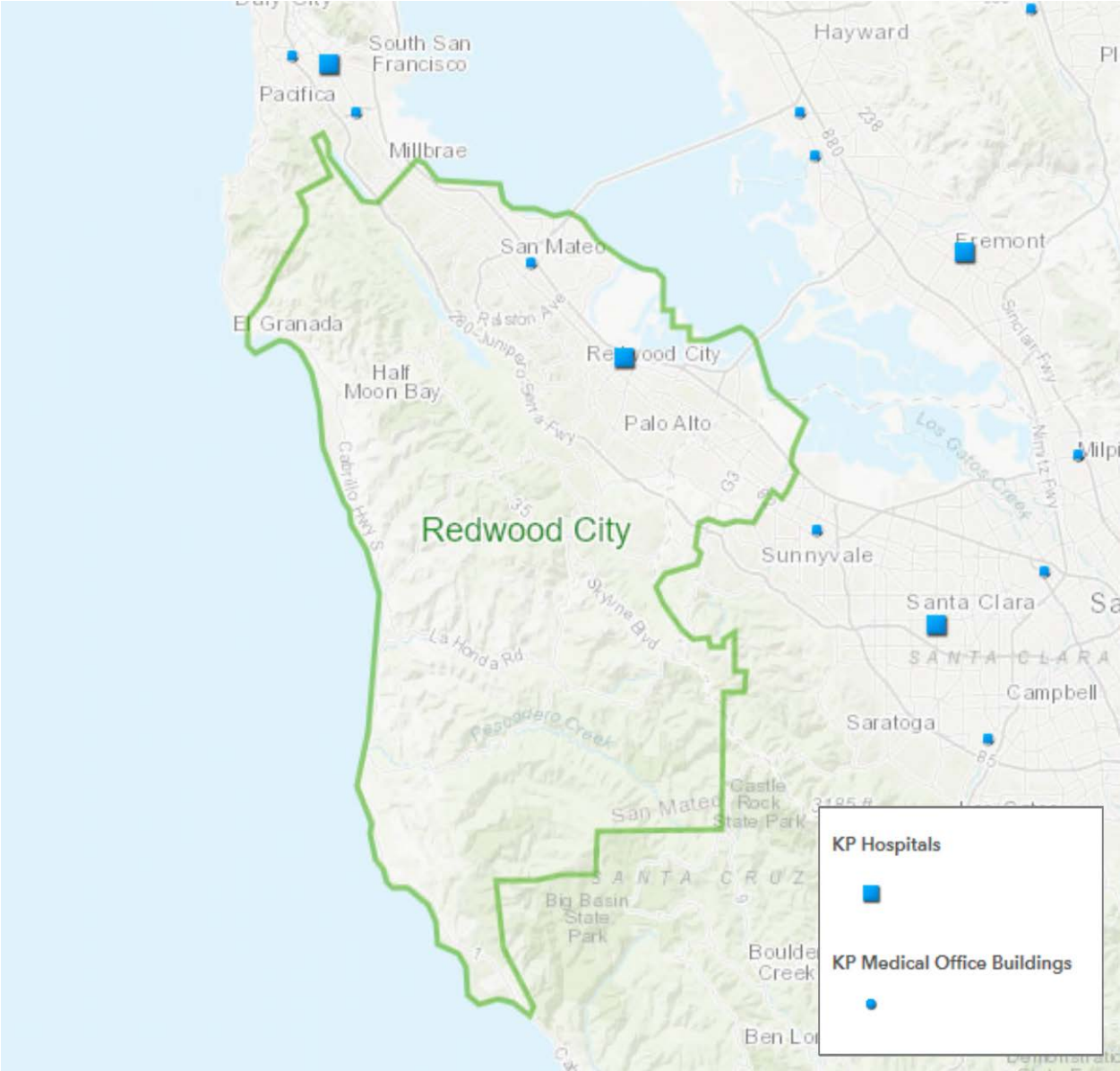
- Ensuring health access by providing individuals served at Kaiser Permanente or by our safety net partners with integrated clinical and social services;
- Improving conditions for health and equity by engaging members, communities, and Kaiser Permanente's workforce and assets; and
- Advancing the future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

A. Map of facility service area



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

The KFH-Redwood City service area covers the central, south, and Coastside sub-area portions of San Mateo County. Cities include but are not limited to Belmont, East Palo Alto, El Granada, Foster City, San Mateo, Half Moon Bay, Menlo Park (some portions), North Fair Oaks, Pescadero, Redwood City, and San Carlos. With the addition of a medical office building in San Mateo in 2011, the service

area has been able to offer health care services to members that reside closer to the City of San Mateo.

**C. Demographic profile of community served.**

The KFH-Redwood City service area is slightly less diverse than the state, with 63% of the population identifying as White; however, nearly 23% of the population identifies as Hispanic or Latinx and nearly 20% as Asian. Across the larger county, over a third (35%) of residents are foreign-born.<sup>1</sup>

<b>Race/ethnicity</b>		<b>Socioeconomic Data</b>	
Total Population	539,501	Living in poverty (<100% federal poverty level)	7.8%
Asian	19.6%	Children in poverty	9.5%
Black	2.4%	Unemployment	2.2%
Hispanic/Latino	22.6%	Uninsured population	6.5%
Native American/Alaska Native	0.3%	Adults with no high school diploma	9.7%
Pacific Islander/Native Hawaiian	1.2%		
Some other race	8.5%		
Multiple races	5.0%		
White	62.9%		

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-Redwood City’s planned response to the needs identified through the 2019 CHNA process. For information about KFH-Redwood City’s 2019 CHNA process and for a copy of the report please visit [www.kp.org/chna](http://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-Redwood City service area through the 2019 CHNA process.

**Highest Priority:**

- Mental Health and Well-being
- Economic Security (Including Housing & Homelessness)
- Health Care Access & Delivery

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<sup>1</sup> U.S. Census Bureau. American Community Survey, 5-Year Estimates, 2012-16.

**Medium Priority:**

Health Eating/Active Living

**Lower Priority:**

Cancer

Environment

Oral/Dental Health

## VI. Who was involved in the Implementation Strategy development

### A. Partner organizations

No other partner organizations were involved in the implementation strategy development process for KFH-Redwood City.

### 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 Kaiser Permanente's unique structure and resources to effectively foster meaningful partnerships.

In August 2019, ten KFH-Redwood City non-profit agency partners gathered to provide feedback on proposed priority health needs and implementation strategies. Organizations reflected different age groups, geographic areas, and health needs, including Access to Care, Mental and Behavioral Health, Healthy Eating / Active Living, Economic Security, and Housing and Homelessness.

Participants received a brief overview of the CHNA process and how the health needs had been selected, as well as highlights from the community concerns that had emerged from focus groups and interviews conducted in 2018. They also learned about specific implementation strategies to achieve outcomes related to each health need, drawn from an outcomes menu developed by Kaiser Permanente's Northern California Region Community Benefit team to guide investments and strategies from 2020-22. The health needs, outcomes, and strategies helped to provide a framework and focus for the partner input discussions.

For each priority health need, participants were asked to reflect on four questions:

1. **What** work is already happening in Redwood City 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?
4. How will **we know we've made progress?** What are the indicators and metrics to track as we move forward?

### **Health Care Access & Delivery**

- Successful collaborations currently underway to expand access to care include providing transportation support for seniors and their caregivers to reach appointments, referrals for those seeking behavioral health care, onsite nursing care at transitional housing sites to attend to routine health needs as well as referrals for more acute needs, and vision and oral health assessments in schools.
- Gaps and needs include strengthening capacity to share data and using technology to help them track and refer clients more effectively, so that fewer would fall through the cracks.

### **Mental Health & Well-being**

- Some partners would like to offer more training on behavioral health issues to both service providers and families. Many partners mentioned the need to support caregivers as well.
- Partners would like to see more safe spaces such as a women's only shelter, as well as more bilingual/bicultural staff with behavioral health expertise.
- Partners see potential in expanding subsidized rides to appointments (for behavioral health and other health care appointments).
- Warm handoffs (that start before a client's departure from a shelter or other services) would be helpful, but a lack of information and staffing hampers these efforts.
- Partners are concerned about suicide rates (and ideation) and wonder what more they could do together to support suicide prevention initiatives.
- Symposiums about how to navigate the mental health system would be helpful, bringing together agencies involved in crisis support, treatment, housing, and other services.

### **Healthy Eating/Active Living**

- Current Healthy Eating/Active Living efforts include health fairs, family fitness nights, walking groups, cooking classes, and a youth nutrition club.
- Many programs combine nutrition and activity programming.
- High housing costs affect many families' budgets, preventing them from following through on intentions to prepare healthier meals.
- Youth sports have become expensive and out of reach for area families.
- Partners would like to see more healthy lifestyle coaching for the whole family and more programming that combines movement and nutrition (instead of addressing them separately).
- Some partners also would like to see a "farm to table" approach to school cafeterias, with students eating what they've grown.



- In addition to transporting people to medical appointments, rides could take people to food providers and Farmer’s Markets.
- Through chair yoga and other movement programs, elders could improve their balance and mobility and possibly stay at home longer; access to physical and occupational therapy may be particularly helpful for isolated seniors (e.g., stroke survivors).
- Partners would like to know more about their impact on entire families, and how various services impact food security (e.g., CalFresh, food pantries, community gardens). For school-based programs, they would like to know how physical activity and nutrition affect school achievement, sleep patterns, and avoidance of chronic disease (particularly diabetes).

### Economic Security (Including Housing & Homelessness)

- The demand for housing and supportive services far exceeds the supply—especially for transitional housing, supportive housing and housing for very low-income individuals (e.g., studios). The number of people living in their cars has skyrocketed, so more safe parking sites are needed.
- Partners noted the role of domestic/intimate partner violence driving homelessness for women; if they get to a point where they decide to leave an abusive partner, women in abusive relationships are left with few options.
- Partners also noted the role of financial literacy programs in preventing homelessness.
- Partners would like to see more community-based housing programs, shared housing initiatives (e.g., helping seniors find roommates so they can stay in their homes), and advocacy with landlords.

	Data collection method	Title/name	Number	Notes (e.g., input gained or role in IS process)
Organizations				
1	Group Discussion	Partner Input Session	10	<p>Community organizations focused on these health needs (some on more than one):</p> <ul style="list-style-type: none"> <li>• Behavioral Health (3)</li> <li>• Healthy Eating / Active Living (4)</li> <li>• Youth (4)</li> <li>• Seniors (2)</li> <li>• Health Care (3)</li> <li>• Housing/Homelessness (2)</li> <li>• Education/Literacy (1)</li> </ul>

### C. Consultant(s) used

The Implementation Strategy process and report were prepared with support from Nicole Lezin of Cole Communications, Inc. and Jane Conklin of Jane Conklin Consulting.

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.

Jane Conklin brings 20 years of experience in public health grants and program management, including program planning and implementation, grants administration, training and capacity development, and program monitoring and evaluation. As key staff for nonprofit organizations, a foundation, and a state health department, Conklin has worked with a diverse set of community groups, non-profit organizations, and public health agencies. Since launching her consulting practice, she has continued to support the implementation of high-quality programming at local, national, and international levels.

## VII. Health needs that KFH-Redwood City plans to address

### A. Process and criteria used

In May 2019, members of the KFH-Redwood City Community Health Investment Committee (CHIC) met to review results of the 2019 CHNA.

Committee members included KFH-Redwood City staff in the following roles:

- Area Finance Officer
- Medical Group Administrator
- Physician in Chief
- Public Affairs Director for KFH-Redwood City Medical Center
- Senior Vice President and Area Manager
- Social Services Manager

The CHNA process had identified priority health needs according to the severity of the need, magnitude/scale of need, presence of clear disparities or inequities, and alignment with community priorities. Applying these criteria, the needs identified included:

- **Highest** priority needs: mental health and well-being, economic security (including housing and homelessness), and health care access and delivery
- **Medium priority need:** health eating/active living
- **Lower priority needs:** cancer, environment, and oral/dental health.

CHIC members applied a simple scoring scale (assigning scores of low=1, medium=2, or high=3) for each criterion to each health need. The criteria included:

- **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 KFH-Redwood City could make a meaningful contribution to addressing the need), and
- **Feasibility** (whether KFH-Redwood City has the ability to make an impact, given the resources available).

When the scores were tallied, access to care received the highest total score, followed closely by behavioral health and healthy eating / active living. Housing and homelessness and cancer were tied with the same number of points. Oral health and the environment received the lowest number of points. In both cases, oral health and the environment received relatively low scores in terms of leveraging community assets, leveraging Kaiser Permanente assets, and the feasibility of Kaiser Permanente being able to make an impact.

Housing and homelessness also received a lower feasibility score than the other options but emerged as a priority in the initial ranking of priority health needs. For this reason, and because it appears among the priorities of other Northern California areas and regions, the CHIC members agreed to make housing and homelessness a fourth priority, along with health care access and delivery, behavioral health, and healthy eating / active living.

#### **B. Health needs that KFH-Redwood City plans to address**

The four health needs that emerged from this scoring process (in order from highest ranking to lowest) are listed below. All four also emerged as top priorities in the CHNA process. Because of the potential to make an impact and leverage both Kaiser Permanente and community assets, the Committee members agreed to focus Implementation Strategies on these four health needs.

#### **Health Care Access and Delivery**

Health care access and delivery were prioritized by the KFH-Redwood City community. As reflected in statistical and qualitative data, barriers to receiving quality care include lack of availability, high cost, lack of insurance coverage, and lack of cultural competence among providers. While the service area has high rates of available primary care, dental, and mental health providers overall, community input suggests that health care is often unaffordable. Latinxs (16% uninsured), Pacific Islanders (13%), and those of "Other" ethnicities (16%) have higher percentages of uninsured individuals in the service area compared to their White peers. The community indicated that undocumented immigrants are accessing health care less often in recent years due to the political climate that has resulted in a fear of being identified and deported. In addition to receiving the highest score overall, health Care Access and Delivery received the highest ranking for the potential to leverage community assets and feasibility of making an impact, and was ranked second in terms of the availability of evidence-based programs and ability to leverage Kaiser Permanente expertise and assets.

#### **Mental Health and Well-being**

KFH-Redwood City residents and representatives of various vulnerable groups (e.g., LGBTQI, Pacific Islanders, individuals experiencing homelessness) expressed a greater need for behavioral health care. Economic insecurity (including housing instability) was discussed as a driver of poor mental health and substance use, perhaps due to increased stress associated with financial instability. A common theme in community input was the co-occurrence of poor mental health and substance use. Community members frequently identified stigma as a barrier to both mental health care and substance use treatment, both in acknowledging the need for care (i.e., facing negative cultural perceptions/taboo, either internalized or imposed by family and/or friends) and in seeking and receiving care (i.e., experiencing stigma from providers delivering care). This health need received the second-highest overall ranking and received high scores for the availability of evidence-based programs and potential to leverage community and Kaiser Permanente assets.

### **Healthy Eating/Active Living**

Healthy eating, together with active living, is a need in the KFH-Redwood City service area that was prioritized by the community. This need includes concerns about diabetes, obesity, fitness, diet, and nutrition, and access to food and recreation. The KFH-Redwood City community expressed concern about the rising number of children and youth being diagnosed with diabetes. They also identified diabetes as an issue among individuals experiencing homelessness. Diabetes management among the service area's Medicare patients (80%) is significantly worse than the state (82%). Community input included notions about cultural differences in diet and formal exercise, lack of time (or, in some cases, space) for cooking or recreation, and issues of access to healthy food in schools, senior centers, and other institutions. This health need received the highest ranking for leveraging Kaiser Permanente expertise and assets, and was also highly ranked in terms of leveraging community assets.

### **Economic Security (Including Housing and Homelessness)**

Economic security, as well as housing and homelessness, were of chief concern to the KFH-Redwood City community. The community emphasized the relative lack of affordable housing and the poor quality of the affordable housing that is available in the county. The community also described stress about the high costs of housing and lack of affordable rent as another major priority; the community linked housing instability with mental health. Moreover, the community shared how economic instability and stress were increasing for those with middle incomes; community members described the growing call for help with basic needs among those with middle incomes for whom services are lacking as they do not qualify for most assistance programs. This health need was not initially highly ranked, but Committee members agreed that the urgency and impact of the issue warranted attempting to address it, especially in terms of lessening the impacts of homelessness or helping those affected access supportive services.

## **VIII. KFH-Redwood City's Implementation Strategies**

### **A. About Kaiser Permanente's Implementation Strategies**

As part of the Kaiser Permanente integrated health system, KFH-Redwood City 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-Redwood City 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-Redwood City welcomes future opportunities to enhance its strategic plans by relying on and building upon the strong community partnerships it currently has in place.

KFH-Redwood City 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: Health Care Access & Delivery*

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)	<ul style="list-style-type: none"> <li>• Increase access to comprehensive health care coverage for low-income individuals</li> <li>• Increase access to subsidized care for those facing financial barriers to health care</li> <li>• Increase access to social non-medical services for low income and vulnerable populations</li> <li>• Increase access to a diverse, culturally competent health care workforce</li> <li>• Improve the capacity of health care systems to provide quality health care services</li> </ul>
Strategies	<ul style="list-style-type: none"> <li>• Increase capacity of organizations to conduct effective outreach and navigation to vulnerable populations to connect them to care</li> <li>• Promote systems for resource-sharing among providers to enhance and integrate referral networks</li> <li>• Support partnerships with food banks for CalFresh enrollment and food pharmacy programs</li> <li>• Support outreach and enrollment campaigns to increase CalFresh enrollment for eligible community members (Food for Life)</li> <li>• Support screening for social non-medical service needs and connect low-income individuals and families to community and government resources (Thrive Local)</li> <li>• Support population health management approaches that improve health outcomes for safety net patients with diabetes and hypertension (PHASE)</li> <li>• Support community clinic consortia to develop programs and advocate for policies that improve access to quality health care for low income individuals</li> <li>• Participate in Medi-Cal Managed care</li> </ul>

	<ul style="list-style-type: none"> <li>• Provide Charitable Health Coverage</li> <li>• Provide Medical Financial Assistance</li> <li>• 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</li> <li>• Implement health care workforce pipeline programs to introduce diverse, underrepresented school age youth and college students to health careers (KP LAUNCH)</li> <li>• School for Allied Health expanding access to training and certificate programs for underrepresented individuals</li> </ul>
Expected outcomes	<ul style="list-style-type: none"> <li>• Increased outreach to vulnerable populations that helps them access comprehensive health care coverage</li> <li>• Increased outreach to vulnerable populations that helps them navigate and connect to subsidized care</li> <li>• Increased enrollment in CalFresh</li> <li>• Reduced financial barriers to care by increasing access to Medical Financial Assistance</li> <li>• Increased access to trained navigators and community health workers that connect low-income and vulnerable populations to social non-medical services</li> <li>• Increased opportunities for diverse, culturally competent workers to enter the health care workforce</li> </ul>

*Health need #2: Mental Health and Well-being*

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)	<ul style="list-style-type: none"> <li>• Increase capacity of organizations and institutions to provide trauma-informed services and programs</li> <li>• Increase support for caregivers of individuals with behavioral health and/or substance use issues</li> <li>• Increase access to behavioral health care services for low-income and vulnerable populations</li> <li>• Develop a diverse, well trained behavioral health care workforce that provides culturally competent care</li> <li>• Prevent and reduce misuse of drugs and alcohol</li> </ul>

Strategies	<ul style="list-style-type: none"> <li>• Provide training in culturally appropriate trauma-informed care, especially for bilingual/bicultural staff</li> <li>• Provide training and support to family members (especially caregivers) whose family members are struggling with behavioral health and/or substance use issues</li> <li>• Support programs that screen for behavioral health/substance use issues</li> <li>• Support programs that address adolescent suicide and suicide ideation</li> <li>• Support efforts to share information (for agency staff and patients) on how to navigate the mental health system</li> <li>• Support programs/initiatives that reduce stigma associated with seeking help for behavioral health/substance use problems</li> <li>• Support the capacity of clinics, schools or other community-based organizations to provide trauma-informed care to youth</li> <li>• 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</li> <li>• Provide KP's Education Theater program, Resilience Squad</li> <li>• Participate in Medi-Cal Managed care</li> <li>• Provide Charitable Health Coverage</li> <li>• Provide workforce training programs to train current and future mental health practitioners with the skills and linguistic and cultural competence to meet the health care needs of diverse communities</li> </ul>
Expected outcomes	<ul style="list-style-type: none"> <li>• Increased scope and availability of trauma-informed services and programs available through programs serving vulnerable populations</li> <li>• Increased screening and referrals to behavioral health care services for low-income and vulnerable populations, especially youth (in settings such as FQHCs and schools)</li> <li>• Reduced adolescent suicide/ideation</li> <li>• Increased access for vulnerable populations to a diverse, well-trained behavioral health care workforce that provides culturally competent care</li> <li>• Increased help-seeking for behavioral health issues and misuse of drugs and alcohol prompted by stigma reduction campaigns</li> </ul>

*Health need #3: Healthy Eating/Active Living*

Long term goal	All community members eat better and move more as part of daily life
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Intermediate goal(s)	<ul style="list-style-type: none"> <li>• Reduce food insecurity among low-income families and individuals</li> <li>• Increase variety of physical activity programming to meet needs of specific populations (e.g., seniors)</li> </ul>
Strategies	<ul style="list-style-type: none"> <li>• Increase access to healthy foods</li> <li>• Support partnerships between food security agencies and other services (e.g., housing, employment)</li> <li>• Promote variety of physical activity among specific populations (e.g., seniors or others with disabilities who are chair-bound)</li> </ul>
Expected outcomes	<ul style="list-style-type: none"> <li>• Reduced food insecurity among low-income clients of community agencies in new partnerships food security agencies</li> <li>• Increased access for seniors and people with disabilities to physical activity programming</li> </ul>

*Health need #4: Economic Security (Including Housing and Homelessness)*

Long term goal	All community members have access to quality, affordable, and stable housing
Intermediate goal(s)	<ul style="list-style-type: none"> <li>• Prevent individuals and families from falling into homelessness</li> <li>• Increase connections to supportive services for individuals experiencing homelessness</li> <li>• Increase and enhance transitional housing and shelter availability</li> </ul>
Strategies	<ul style="list-style-type: none"> <li>• Support programs that aim to keep people in their homes (e.g., frail elderly)</li> <li>• Support individualized case management and advocacy for people experiencing homelessness</li> <li>• Support programs that decrease indignities of living rough (on streets, in cars) — e.g., shower access, safe parking for people living in cars/vans</li> <li>• Funding to strengthen local homeless system of care through the Housing and Health Initiative</li> <li>• Partnership with KP Division of Research to develop a predictive model for housing instability</li> </ul>
Expected outcomes	<ul style="list-style-type: none"> <li>• Reduced homelessness among vulnerable populations (e.g., frail elderly)</li> <li>• Increased access to individualized case management to connect people experiencing homelessness to supportive services</li> <li>• Increased access to services for unhoused populations (e.g., people living in cars/vans)</li> </ul>



## 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 CHNAs, to improve the effectiveness of our work and demonstrate our impact. The CHNAs 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-Redwood City 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-Redwood City tracks outcomes, including behavior and health outcomes, as appropriate and where available.

## X. Health needs KFH-Redwood City does not intend to address

Three health needs were identified through the CHNA process that were not selected as priorities for implementation strategies: cancer, oral/dental health, and the environment. All three were lower priorities than those selected by KFH-Redwood City.

- **Oral/dental health.** Oral health was determined to be a lower priority from the CHNA process and could be partially addressed through overall Access to Care strategies (e.g., strengthening referral networks and navigation support; diversifying the health care workforce).
- **Cancer.** Cancer also was a lower priority health need in the CHNA process. As a result, it was not selected as one of the priority health needs by KFH-Redwood City. Some risk factors that are correlated with many cancers—particularly unhealthy diets and lack of physical activity—are the focus of the Healthy Eating / Active Living priority health need. In addition, the Access to Care health need supports access to ongoing care that could lead to regular screening, which in turn supports early detection of common cancers.

- **Environment.** Environmental interventions—another lower priority from the CHNA process—were viewed as less feasible than others, requiring resources and a scale of intervention beyond the scope of community grant-making.