



2019 Implementation Strategy Report

Kaiser Foundation Hospital: Roseville

License number: 550001681

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-Roseville

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I. General information

| | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|
| Contact Person: | Richard J. Robinson |
| Date of written plan: | November 10, 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 th 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.

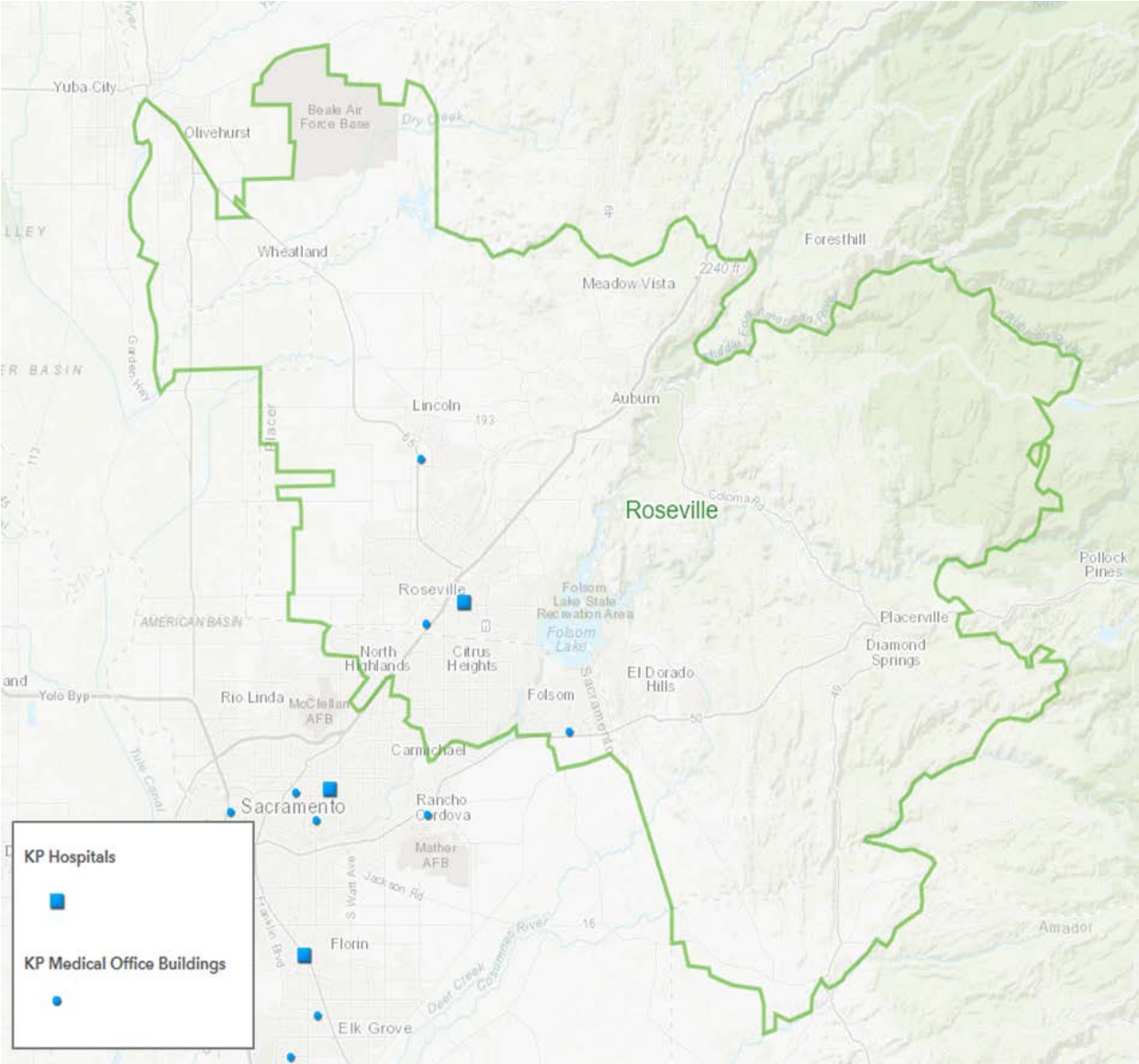
Better health outcomes begin where health starts, in our communities. Like our approach to medicine, our work in the community takes a prevention-focused, evidence-based approach. We go beyond traditional corporate philanthropy or grant making to pair financial resources with medical research, physician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

- Ensuring health access by providing individuals served at 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.

IV. Kaiser Foundation Hospitals – Roseville Service Area/Region

A. Map of facility service area



B. Geographic description of the community served (towns, counties, and/or zip codes)
 The KFH-Roseville service area extends into parts of seven counties: Amador, El Dorado, Nevada, Placer, Sacramento, Sutter, and Yuba. The highest concentration of the population resides in the Sacramento Valley. Geographically, the service area principally includes Placer and El Dorado counties. It has a very diverse geography including urban cities (e.g., North Highlands/Foothill Farms and Citrus Heights), suburban cities (e.g., El Dorado Hills, Roseville, Lincoln, and Auburn) and more rural cities and towns (e.g., Placerville and Olivehurst). The service area also encompasses numerous small communities throughout the Sierra Foothills.

C. Demographic profile of community served

| Race/ethnicity | | Socioeconomic Data | |
|----------------------------------|---------|-------------------------------------------------|-------|
| Total Population | 827,023 | Living in poverty (<100% federal poverty level) | 10.4% |
| Asian | 7.1% | Children in poverty | 12.9% |
| Black | 2.6% | Unemployment | 3.5% |
| Hispanic/Latino | 14.3% | Uninsured population | 8.1% |
| Native American/Alaska Native | 0.7% | Adults with no high school diploma | 7.6% |
| Pacific Islander/Native Hawaiian | 0.3% | | |
| Some other race | 3.6% | | |
| Multiple races | 5.3% | | |
| White | 80.4% | | |

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-Roseville’s planned response to the needs identified through the 2019 Community Health Needs Assessment (CHNA) process. For information about KFH-Roseville’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-Roseville service area through the 2019 Community Health Needs Assessment process.

1. Access to Care
2. Mental and Behavioral Health
3. Economic Security
4. Women and Children’s Wellbeing
5. Healthy Eating and Active Living (HEAL)

VI. Who was involved in the Implementation Strategy development

A. Partner organizations

KFH-Roseville did not collaborate with any other hospitals on this implementation strategy report. Through the community engagement process described below, input from local community stakeholders contributed to the development of the implementation strategy report.

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.

The identification of the implementation strategies included input from a broad range of residents through a community engagement meeting. Individuals with knowledge, information, and expertise relevant to the health needs of the community were consulted (see table below for additional details on attendees). These individuals included representatives from health departments, school districts, local non-profits, and other regional public and private organizations, as well as community leaders, clients of local service providers, and other individuals representing medically underserved, low income, and sub-populations that face unique barriers to health (e.g., communities of color, individuals experiencing homelessness).

In order to identify diverse perspectives and experiences in the community engagement meeting, Harder+Company staff reviewed the participant lists from the interviews and focus groups conducted for the KFH-Roseville service area 2019 CHNA health need identification process, as participants were selected due to their expertise and deep involvement in the community. The Community Benefit Manager for the KFH-Roseville service area provided additional suggestions for key stakeholders to include.

The two-hour community engagement meeting was scheduled at a central location in the service area. One primary goal of the meeting was to elevate the current community efforts underway to address disparate health outcomes and to achieve health equity. The consulting team developed facilitation guides designed to inquire about the following: which community organizations and initiatives were engaging in significant efforts to advance progress in the selected health needs; and which populations or geographic regions within the community would need additional support to reduce disparities in the health needs. Attendees reflected on CHNA data presented during the meeting, and were then asked to provide their expertise related to question prompts.

The participating community stakeholders (n=13) provided rich information on organizations engaged in deep work in the community to address the prioritized health needs for the implementation strategies. Furthermore, as the community stakeholders reflected on the selected impact outcomes, they provided valuable feedback around which seemed to be most achievable. They also shared insights on what outcomes were missing, or where some outcomes overlapped. Collectively this information and feedback refined the outcomes and strategies selected for the KFH-Roseville service area.

The community engagement meeting provided important insight into the KFH-Roseville approach to identifying the implementation strategies for the 2020-2022. In addition to confirming the prioritized health needs and many of the identified intermediate goals and expected outcomes, participants' insight helped to shape the goals and strategies selected. For example, insight shared by community partners helped to prioritize mental and behavioral health needs as an underlying factor associated with many of the other health needs. Further, the community input reinforced the KFH-Roseville commitment to supporting lower income communities of color, youth, and rural communities, as each of these populations' experiences is associated with increased barriers to accessing services. In particular, community engagement participants identified the need for workforce development strategies serving these populations.

| | Data collection method | Title/name | Number | Notes (e.g., input gained or role in IS process) |
|------------------------|-----------------------------------|-----------------------------------------------------------------------------------------------------------------------------------|--------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Community Stakeholders | | | | |
| 1 | <i>Community Engagement Event</i> | Community partners and service providers (e.g., mental and behavioral health, physical health, education, county representatives) | 13 | <i>Community partners reviewed CHNA data and shared insights on existing efforts underway in the service area. Through this process, community members shared the need to create more integrated systems of care especially to meet the mental health needs of the community. Community partners also identified the importance of supporting low income community members of color, youth, and rural populations, with emphasis on workforce development opportunities.</i> |

C. Consultant(s) used

Harder+Company Community Research (Harder+Company) is a social research and planning firm with offices in San Francisco, Sacramento, Los Angeles, and San Diego. Harder+Company works with public sector, nonprofit, and philanthropic clients nationwide to reveal new insights about the nature and impact of their work. Through high-quality, culturally-responsive evaluation, planning, and consulting services, Harder+Company helps organizations translate data into meaningful

action. Since 1986, Harder+Company has worked with health and human service agencies throughout California and the country to plan, evaluate, and improve services for vulnerable populations. The firm’s staff offer deep experience assisting hospitals, health departments, and other health agencies on a variety of efforts including conducting needs assessments, developing and operationalizing strategic plans, engaging and gathering meaningful input from community members, and using data for program development and implementation. Harder+Company offers considerable expertise in broad community participation, which is essential to both health care reform and the CHNA process in particular. Harder+Company is the consultant on several CHNAs throughout the state, including other Kaiser Foundation Hospital service areas in Sacramento, San Bernardino, San Rafael, Santa Rosa, South Sacramento, Vacaville, and Vallejo.

VII. Health needs that KFH-Roseville plans to address

A. Process and criteria used

In order to select health needs that KFH-Roseville will address in the 2020-2022 implementation plans, the KFH-Roseville Community Health Investment Committee (CHIC) convened for discussion and input. KFH-Roseville selected a smaller number of needs from the broader list identified as significant during the CHNA process in order to maximize the hospital’s ability to focus resources and have a meaningful impact on these significant and complex health needs.

Harder+Company staff presented CHIC members with quantitative and qualitative data from the KFH-Roseville CHNA; information related to existing national and regional Kaiser Permanente initiatives, as well as local community efforts related to the 2019 CHNA health needs; and existing Community Benefit projects. CHIC members engaged in a dialogue about the health needs and information presented and ranked the health needs on the criteria described below.

| Criteria | Definition |
|----------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. CHNA prioritization | How the health need ranked in the CHNA (takes into account <u>community prioritization</u> as well as the following three criteria employed at the prioritization event: severity, scale, health disparities/equity, ability to impact change based on community assets) |
| 2. Health disparities/equity | Health need disproportionately impacts the health status of community members |
| 3. Ability to leverage organizational assets | Opportunity to have KP Regional CB funding deployed to address health needs in NSA, as well as opportunity to draw down other KP organizational assets |
| 4. Feasibility | Kaiser Permanente has the ability to have an impact given the local CB budget |
| 5. Ability to leverage community assets | Opportunity to collaborate, partner, or build on existing community efforts |

Participants ranked criteria two through five (i.e., disparities/equity; ability to leverage organizational assets; feasibility; ability to leverage community assets) with a 3-point scale: 3 =

meets criteria well; 2 = *meets criteria somewhat*, and 1 = *doesn't meet criteria*. For the first criteria, the three health needs with the highest scores in the CHNA process received a “3” and the remaining two health needs received a “2”.

Through the ranking process, four health needs emerged: Access to Care, Economic Security, Healthy Eating and Active Living, and Mental and Behavioral Health. Women and Children’s Health was not selected as a priority health need, although through discussion it was agreed upon that the data indicated that women and children should be priority populations within Access to Care.

B. Health needs that KFH-Roseville plans to address

1. **Access to Care:** Access to quality health care includes affordable health insurance and utilization of preventive care, with the ultimate goal of reducing the risk of unnecessary disability and premature death. This is the first year that Economic Security was identified as a priority health need for Roseville. In the KFH-Roseville service area, access to comprehensive care for women and children has specifically risen to the top as a priority. In the 2019 KFH-Roseville CHNA report, Women and Children’s Well-being was a separate health need; however this is integrated in access to care for the implementation strategies. The CHIC prioritized this health need as a result of identifying access to care at the core of Kaiser Permanente’s work and the opportunity to leverage organizational assets to address this need in the community. The CHIC also expressed commitment to addressing existing disparities and inequity related to access to care in the community found in the CHNA data.
2. **Economic Security:** Economic security means having the financial resources, public supports, career and educational opportunities, and housing accommodations necessary to live one’s fullest life. This is the first year that Economic Security was identified as a priority health need for the Roseville service area. This health need was prioritized by the CHIC given the large disparities and inequity in the community related to economic security reflected in the CHNA qualitative and quantitative data. The Committee also felt that there were some clear internal and collaborative strategies that could be leveraged to address this need.
3. **Healthy Eating and Active Living:** Healthy eating and active living (HEAL) relates to the ability of residents to positively shape their health outcomes through a focus on nutrition and exercise. Many factors outside of individuals' control also shape these behaviors, such as access to safe parks and affordable vegetables. HEAL also impacts the rates of many chronic conditions like cardiovascular disease, stroke, and cancer. The CHIC prioritized this health need as a result of barriers to HEAL identified in the qualitative and quantitative CHNA data. The data also reflected striking disparities within the Roseville service area that limit HEAL opportunities for low income community members who may not have access to healthy food and reliable transportation, for example.
4. **Mental and Behavioral Health:** Mental and behavioral health are foundations for healthy living and encompass indicators such as rates of mental illness, access to social and emotional support, and access to providers for services related to preventive care and treatment for mental health and substance abuse. The CHIC expressed concern related to

the mental and behavioral health needs of the Roseville service area, as reflected in the qualitative and quantitative CHNA data. Community members identified increasing mental health needs in the community that have exacerbated existing disparities and affect equitable access to needed services.

VIII. KFH-Roseville's Implementation Strategies

A. About Kaiser Permanente's Implementation Strategies

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

KFH-Roseville 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: Access to Care

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|----------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Long term goal | <ul style="list-style-type: none"> ● 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"> ● 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 |

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|-------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| | <ul style="list-style-type: none"> • Improve the capacity of health care systems to provide quality health care services • Increase literacy and practice of healthy behaviors proven to reduce downstream chronic conditions |
| Strategies | <ul style="list-style-type: none"> • Support access to care for patients through collaboration among community clinics, clinic networks, and other safety net providers • Support school-based health centers • Increase access to health care coverage and access for underserved communities (e.g., low income, rural, Latinx/Hispanic), including targeted outreach, enrollment, and retention strategies • Train and support community health workers and promotoras, including those with lived experience, to help people navigate the system and use evidence-based tools • Participate in Medi-Cal Managed care • Provide Charitable Health Coverage • Provide Medical Financial Assistance • Support outreach and enrollment campaigns to increase CalFresh enrollment for eligible community members (Food For Life) • Support screening for social non-medical service needs and connect low income individuals and families to community and government resources (Thrive Local) • 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 • 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 • Support collaborations and partner with local community-based organizations to promote healthy behaviors that mitigate chronic diseases • Educate and raise public awareness of healthy lifestyles resources |
| Expected outcomes | <ul style="list-style-type: none"> • Increased number of low income individuals who have comprehensive health care coverage • Increased access to and utilization of individuals with health care subsidies • Increased referrals and coordination between healthcare providers and social non-medical services • Increased number of culturally and linguistically competent health care providers • Increased number of health care career pipelines, training, and certificate programs |

- Improved capacity of health systems to provide population health management
- Ongoing advocacy efforts of community clinic consortia to improve quality health care access for low income individuals
- Evidence of increased management of chronic diseases (e.g., diabetes, hypertension) in priority populations

Health need #2: Economic Security

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|----------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Long term goal | <ul style="list-style-type: none"> • All community members are economically secure in order to thrive |
| Intermediate goal(s) | <ul style="list-style-type: none"> • 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 access to living-wage jobs for people with barriers to employment • Increase high school graduation for underrepresented youth • Increase availability of affordable housing • Increase connections to support services for individuals experiencing homelessness |
| Strategies | <ul style="list-style-type: none"> • Increase baseline spending for local and diverse businesses • Support outreach and enrollment campaigns to increase CalFresh enrollment for eligible community members (Food For Life) • Support adult and young adult vocational training; programs may include job search assistance, personal development resources, and other comprehensive support services (e.g., child care) during training • Implement health care workforce pipeline programs to introduce diverse, underrepresented school age youth and college students to health careers (KP LAUNCH) • Support the development of transitional jobs (time-limited, subsidized, paid jobs intended to provide a bridge to unsubsidized employment) • Provide educational attainment and pathway programs for youth focused on increasing high school graduation rates, college readiness, preparation for careers in Science, Technology, Engineering, and Mathematics (STEM), or health care workforce training • Support impact investing strategies to preserve, rehabilitate, and/or expand affordable housing • Enhance the infrastructure and capacity of service providers to serve individuals at risk or experiencing homelessness • Funding to strengthen local homeless system of care through the Housing and Health Initiative |
| Expected | <ul style="list-style-type: none"> • Increased hospital spending in local and diverse businesses |

| | |
|----------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| outcomes | <ul style="list-style-type: none"> • Increased in enrollment and participation in public benefit programs • Increased job pipelines for individuals with barriers to employment • Increased enrollment in training and education programs for living wage employment for individuals • Increased availability of affordable housing • Greater infrastructure for supporting individuals who are at risk of or experiencing homelessness • Strengthened network of support services, as well as coordinated efforts and funding for individuals who are homeless or at risk of homelessness as a result of strategic partnerships |
|----------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

Health need #3: Healthy Eating Active Living (HEAL)

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|----------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Long term goal | <ul style="list-style-type: none"> • All community members eat better and move more as part of daily life |
| Intermediate goal(s) | <ul style="list-style-type: none"> • Reduce food insecurity among low income families and individuals • Increase access to healthy food options • Increase access to safe parks and public spaces • Increase practice of healthy behaviors proven to reduce downstream chronic conditions |
| Strategies | <ul style="list-style-type: none"> • Support outreach and enrollment campaigns to increase CalFresh enrollment for eligible community members (Food For Life) • Leverage Kaiser Permanente clinical expertise to develop a pilot program to promote healthy eating, active living practices in the community as an obesity and diabetes mitigation strategy • Support community networks that promote for physical activity and use of existing public spaces • Support collaborations and partner with local community-benefit organizations to promote healthy behaviors that mitigate chronic diseases • Educate and raise public awareness of health care resources |
| Expected outcomes | <ul style="list-style-type: none"> • Increased in enrollment and participation in public benefit programs • Reduction in food insecurity • Increased access to healthy and affordable foods in schools • Increased access to safe parks and green spaces • Strengthened network of support services, coordinated efforts, and funding to promote HEAL and reduce chronic diseases |

Health need #4: Mental and Behavioral Health

| | |
|----------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Long term goal | <ul style="list-style-type: none"> • 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"> • Increase the capacity of organizations and institutions to provide trauma-informed services and programs • Enhance community supports to mitigate impact of ACEs • Increase access to mental and behavioral health care services for low income and vulnerable populations • Develop a diverse, well trained behavioral health care workforce that provides culturally competent care • Increase access to programs and support services for those experiencing or at risk of family violence |
| Strategies | <ul style="list-style-type: none"> • Support the capacity of clinics, schools, or other community-based organizations to provide trauma-informed care to youth • Provide KP's Education Theater program, Resilience Squad • Support local efforts to improve the community, school, and social support systems' knowledge, attitudes, beliefs, and perceptions about mental health, trauma, and resilience across the lifespan • Increase quality and effectiveness of mental health services in local schools • Reduce stigma in the workplace for accessing mental health care • Enhance community supports and leverage Kaiser Permanente clinical expertise to mitigate impact of adverse childhood experiences • Train and support community health workers and promotoras, including those with lived experience, to help people navigate the mental health care system and use evidence-based tools • 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 • Integrate mental health care, case management, and navigation services into clinical care and community settings (e.g., schools, faith-based, and other organizations) • Participate in Medi-Cal Managed care • Provide Charitable Health Coverage • Create partnerships to place mental health post-doctoral residents in local schools and with CBO partners • Support culturally competent mental health services for low income and uninsured individuals • Develop or strengthen local mental health professions pipeline and training programs to increase the number of licensed and diverse mental health professionals (e.g., career pathways at local high schools with existing health care programs) |

| | |
|-------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| | <ul style="list-style-type: none"> • 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 • Support local efforts to screen and serve victims of intimate partner violence (including teens), elder abuse, and abuse of vulnerable adults |
| Expected outcomes | <ul style="list-style-type: none"> • Increased trauma-informed services, policies, and systems • Increased organizational capacity to provide adverse childhood experiences screenings • Increased enrollment in programs to improve social/emotional wellness. • Increased screening for behavioral health needs • Increased integration of primary and behavioral health care services • Strengthened network of support services as a result of strategic partnerships to promote mental and behavioral health • Increased number of mental and behavioral health training programs with modules addressing linguistic and cultural competency • Increased number of providers trained in addressing linguistic and cultural competency • Increase participation in prevention programs and support services for those at risk of family violence |

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-Roseville 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-Roseville tracks outcomes, including behavior and health outcomes, as appropriate and where available.

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

One health need prioritized in the 2019 KFH-Sacramento CHNA report will not be addressed with the 2020-2022 implementation strategies: Women and Children's Well-being. Roseville CHIC members ranked it lowest among the health needs as part of the Implementation Strategies prioritization process. This health need was not selected as a standalone priority, based on the 2019 CHNA data. Rather, the KFH-Roseville and the Roseville CHIC members decided that, there was ample evidence that women and children should be priority populations within each of the other health needs, such as Access to Care and Economic Security.