



2019 Implementation Strategy Report

Kaiser Foundation Hospital: San José

License number: 070000117

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-San José

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I. General information

Contact Person:	Karla Lomax, Public Affairs Director
Date of written plan:	December 16, 2019
Date written plan was adopted by authorized governing body:	March 18, 2020
Date written plan was required to be adopted:	May 15, 2020
Authorized governing body that adopted the written plan:	Kaiser Foundation Hospitals Board of Directors' Community Health Committee
Was the written plan adopted by the authorized governing body on or before the 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:

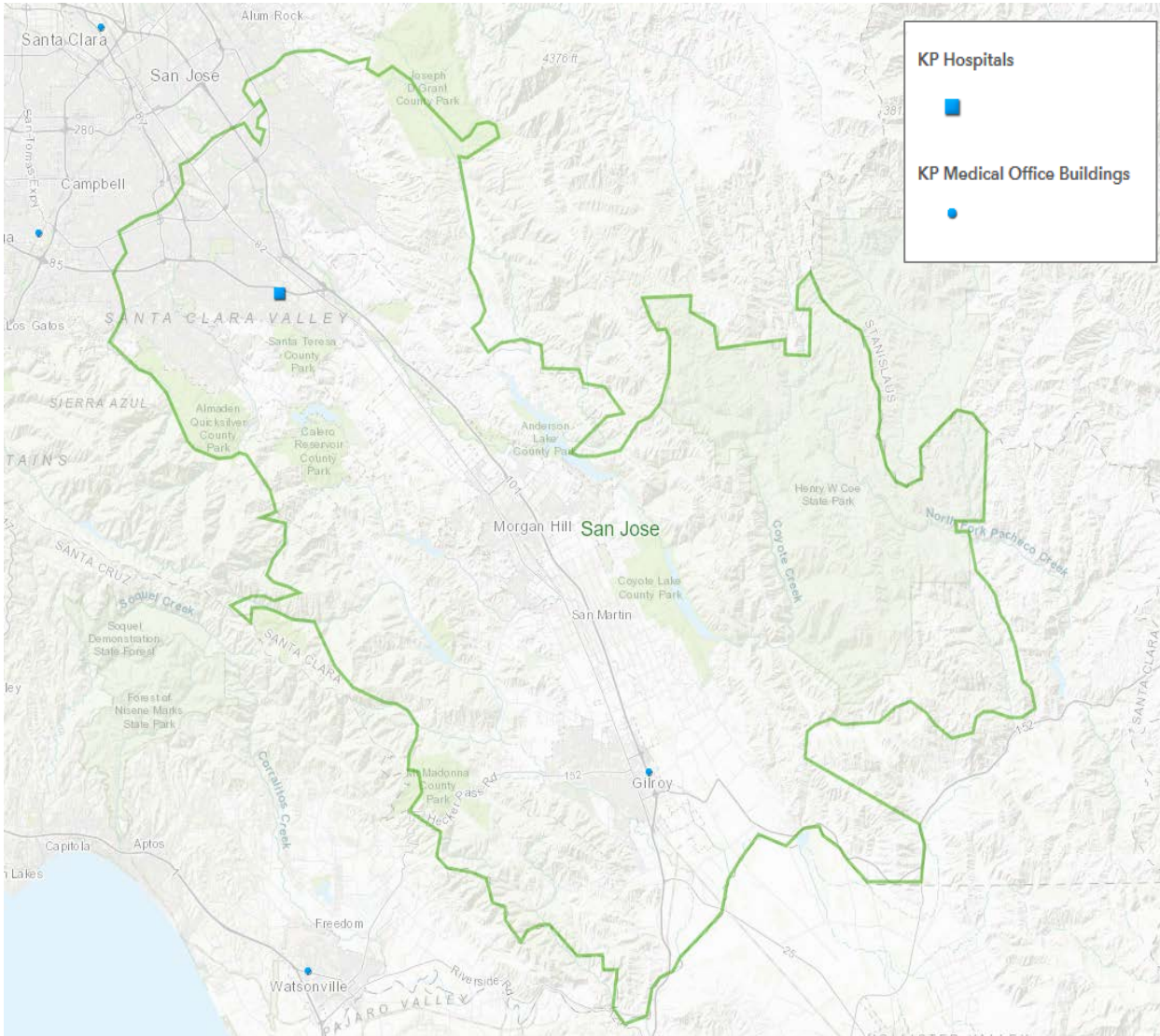
- Ensuring health access by providing individuals served at KP or by our safety net partners with integrated clinical and social services;
- Improving conditions for health and equity by engaging members, communities, and Kaiser Permanente's workforce and assets; and
- Advancing the future of community 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 – San José Service Area/Region

A. Map of facility service area



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

The KFH-Santa José service area comprises roughly the southern half of Santa Clara County. It includes the major cities of Gilroy, Morgan Hill, and parts of San José, as well as unincorporated areas covered by the map above.

C. Demographic profile of community served

KFH-San José is very diverse, with nearly 30% of the population identifying as Asian, over 32% identifying as Hispanic or Latinx, and multiple other races represented (see table).

Race/ethnicity		Socioeconomic Data	
Total Population	509,488	Living in poverty (<100% federal poverty level)	8.7%
Asian	29.6%	Children in poverty	11.0%
Black	2.9%	Unemployment	2.6%
Hispanic/Latino	32.5%	Uninsured population	7.9%
Native American/Alaska Native	0.5%	Adults with no high school diploma	15.0%
Pacific Islander/Native Hawaiian	0.3%		
Some other race	9.3%		
Multiple races	5.5%		
White	52.0%		

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

1. Behavioral Health
2. Health Care Access and Delivery
3. Healthy Eating/Active Living
4. Housing and Homelessness
5. Asthma
6. Environment
7. Community and Family Safety
8. Economic Security
9. Cancer
10. Transportation and Traffic

VI. Who was involved in the Implementation Strategy development

A. Partner organizations

KFH San José partnered with KFH Santa Clara to select the health needs for their respective service areas, to elicit community input, and to develop their strategies to address the selected health needs.

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.

KFH San José partnered with KFH Santa Clara to hold a community engagement event at the Kaiser Permanente Skyport Medical Offices on August 15, 2019. The meeting began with an overview of the Community Health Needs Assessment process and findings by consultants from Actionable Insights, LLC. Next, two grantee organizations, The Health Trust and SPUR's Double Up Food Bucks Project, gave short presentations. After this, the attendees broke out into small groups divided by health needs: Health Care Access and Delivery, Healthy Eating and Active Living, Homelessness, and Mental Health and Wellness. Each group had a facilitator to guide the conversation and a scribe to take notes and thus enhance the accountability process. Following the group discussions, each individual was asked to write their main takeaway on a post-it note, and the notes were placed on a group poster.

Scribes' notes were compiled along with the main takeaways and the information was considered in developing both hospitals' 2020-2022 implementation strategies. For example:

- Anti-bullying and youth coping skills strategies were included in part due to community feedback identifying youth mental health as a significant concern.
- Continued support for bi-lingual patient navigation as a strategy was driven in part by community concern for the lack of access among monolingual non-English speakers.
- The decision to support organizations that make healthy food available to low-income families was driven in part by community reminders that poverty contributes to obesity.
- The choice to continue supporting school-based physical fitness programming was due in part to the community's emphasis on youth physical inactivity.
- Strategies around housing and homelessness, including helping low-income homeowners stay housed, supporting efforts to house transitional-aged foster youth, and support for employment opportunities for individuals experiencing homelessness, were identified in part because the input from the community engagement convening conveyed high concern for this topic.

The main feedback about the needs and implementation strategies is summarized below:

Health Care Access and Delivery

Advocates for vulnerable populations are needed to provide education and help link people to existing resources. Participants felt it is best when these advocates are of the same culture and speak the same language as the population of concern. Populations of concern, in addition to those named in the CHNA, include LGBTQ youth, monolingual non-English speakers, food-insecure people, those who are housing unstable, individuals who may be experiencing domestic violence, and current and former (transitionally-aged) foster youth.

Behavioral Health

A major point made in the small group discussions was that reimbursement rates for mental health care are low, which leads to lower salaries for providers. Providers' salaries are not adequate to the cost of living; therefore, there are not enough providers in the county. Participants were especially concerned about the lack of bilingual behavioral health care providers. Populations of concern, in addition to those named in the CHNA, include youth, adults age 65 and older, LGBTQ individuals, disabled individuals and their caregivers, and monolingual non-English speakers. All of these groups may be affected by social isolation.

Healthy Eating/Active Living

Participants made two major points in their discussions: (1) Equitable opportunities for physical activity and healthy eating should be ubiquitous. Youth who are not athletes should have the same level of opportunities for enjoyable physical activities as do youth who are athletes. Delicious, healthy food should be available wherever food can be served, not only in institutions such as schools. (2) Food insecurity is far more widespread than most people realize, and all community organizations and health care systems should be working towards screening for it and connecting individuals who are at-risk with assistance programs. Populations of concern, in addition to those named in the CHNA, include children, youth, and food-insecure individuals.

Housing and Homelessness

A key concern identified by participants was multiple points of entry to the system of care for homeless individuals; coordination is needed so that once individuals enter, they have access to all the types of assistance they need and don't fall through the cracks. Participants indicated that community partners needed support in generating comprehensive approaches. Populations of concern, in addition to those named in the CHNA, include adults age 65 and older (it was noted that this population will double by 2030), individuals with mental health issues, and people experiencing housing instability, including those residing in impermanent housing such as RVs. All of these populations are vulnerable to being at risk of homelessness.

	Data collection method	Title/name	Number	Notes (e.g., input gained or role in IS process)
Organizations				
1	Community Engagement Session	South Bay IS Community Engagement Convening	41	Input provided by representatives of nonprofits (both medical and nonmedical), social services organizations, foundations, associations, cultural institutions, local and regional initiatives, county public health department

C. Consultant(s) used

Actionable Insights, LLC (AI), an independent, local research firm, helped prepare the IS. AI developed a presentation describing the CHNA process and findings, developed a video of the presentation that was distributed to members of KFH Santa Clara’s and KFH San José’s Community Health Improvement Committee (CHIC), developed a survey for the CHIC members to select the health needs the hospitals would address, compiled the survey responses, discussed the selected needs with the Community Benefit Manager, assisted with research and development of the implementation strategy workplans, assisted with community engagement, and documented the processes and strategies in a report.

AI helps organizations discover and act on data-driven insights. The firm specializes in research and evaluation in the areas of health, housing, STEM (science, technology, engineering, and math) education, youth development, and community collaboration efforts. AI conducted community health needs assessments for over 25 hospitals during 2019 CHNA cycle. More information about Actionable Insights is available at <http://actionablellc.com>.

VII. Health needs that KFH San José plans to address

A. Process and criteria used

Before beginning the Implementation Strategy health need prioritization process, KFH-Santa Clara chose a set of criteria to use in selecting the list of health needs. The criteria were:

- **CHNA Prioritization score:** This overall prioritization score, given by the Kaiser Permanente South Bay Area Community Health Investment Committee (CHIC, representing both KFH San José and KFH Santa Clara) during the CHNA process, was informed by the following criteria:
 - **Community prioritization:** This refers to the extent to which the community prioritizes the issue over other issues about which it has expressed concern during the CHNA primary data collection process. This criterion was ranked based on the frequency with which the community expressed concern about each health outcome during the CHNA primary data collection.
 - **Magnitude/scale of the need:** This criterion combines **magnitude** and **severity**; magnitude refers to the number of people affected by the health need, while **severity** refers to how severe the health need is (such as its potential to cause death or disability) and its degree of poor performance against the relevant benchmark.

- **Clear disparities or inequities:** This refers to differences in health outcomes by subgroups. Subgroups may be based on geography, languages, ethnicity, culture, citizenship status, economic status, sexual orientation, age, gender, or others.
- **Prevention opportunity:** There is an opportunity to intervene at the prevention level.

CHNA prioritization scores ranged from 1 to 3. A score of 3 = highest priority and a score of 1 = lowest priority.

- **Ability to Leverage Local Assets:** Opportunity to collaborate with existing community partnerships working to address the need, or to build on current programs, emerging opportunities, or other community assets. Scores were based on the number of countywide community partner investments/assets listed for the need in the 2019 CHNA report. A score of 1 = 0-9 assets, a score of 2 = 10-19 assets, and a score of 3 = 20 or more assets.
- **Existing or Promising Approaches Exist:** There are effective or promising strategies, preferably evidence-based, that could be applied to address the need. Scores were based on the number of evidence-based strategies (EBS) listed for related topics on the website of the U.S. Office of Disease Prevention and Health Promotion, Healthy People 2020 (<https://www.healthypeople.gov/>), as of June 2019. A score of 1 = 0-15 EBS listed, a score of 2 = 16-30 EBS listed, and a score of 3 = 31 or more EBS listed.
- **Leveraging KP Assets:** KP can make a meaningful contribution to addressing the need because of its relevant expertise, existing strategies, and/or unique business assets as an integrated health system and because of an organizational commitment to improving community health. This criterion was scored by the CHIC based on the informed and considered opinions of its members. A score of 1 = the need does not meet the criterion, a score of 2 = the need somewhat meets the criterion, and a score of 3 = the need meets the criterion well.
- **Feasibility:** Kaiser Permanente has the ability to have an impact given the community benefit resources available. This criterion was scored by the CHIC based on the informed and considered opinions of its members. A score of 1 = the need does not meet the criterion, a score of 2 = the need somewhat meets the criterion, and a score of 3 = the need meets the criterion well.

The consultants developed a health needs selection scoring survey for use by the CHIC that included definitions of all the criteria, the scoring rubric for each criterion, and pre-assigned scores to each health need for all criteria except the last two: Leveraging KP Assets and Feasibility.

The CHIC was then asked to participate in a process to select health needs for both the KFH San José and the KFH Santa Clara hospitals to address in FY2020–FY2022. The consultants provided a summary of the 2019 CHNA health needs to the CHIC via a video available on-line, accompanying the 2019 CHNA health needs profiles for both hospitals. In the video, the consultants explained the CHNA process and findings for both service areas, and described the selection criteria that the CHIC was asked to consider. CHIC members reviewed each hospital's list of needs, viewed the video, and were encouraged to review the information provided in the health needs profiles for each identified health need, keeping in mind the selection criteria. CHIC members then scored each health need on the last two criteria (Leveraging KP Assets and Feasibility) via the on-line survey described in the

previous paragraph. The consultants compiled the scores for each health need, averaging each need's scores for all five criteria to come up with a single final score for each need. The four health needs that received the highest scores were selected by the CHIC to be addressed by the hospitals. The results of the selection survey also provided support for the reasons (justifications) the CHIC did not select the other needs.

B. Health needs that KFH-San José plans to address

Health Care Access and Delivery

- Barriers to receiving quality care including lack of availability, high cost, lack of insurance coverage, limited English proficiency, and lack of provider cultural competence
- Concern with attracting and retaining staff (especially those who are bilingual) to work in the health care sector due to the high cost of living in the Bay Area
- Belief that undocumented immigrants have been accessing health care less often in recent years due to the political climate and fear of being identified and deported
- Fewer Federally Qualified Health Centers serve low-income residents locally vs. the state

Health care access and delivery was selected as a need to address because it tied for highest community prioritization score with the other three needs, tied for highest local assets score with the other three needs, tied for highest evidence-based or promising approaches score with HE/AL and Mental health and wellness, tied for highest organizational assets score with HE/AL, and given available resources, the CHIC believes Kaiser Permanente can make an impact.

Behavioral Health

- One of the needs about which the service area community expressed the strongest concern
- Lack of services, including preventative mental health and detox centers, a major concern
- Higher proportion of high school youth seriously considered suicide vs. statewide peers
- Ethnic disparities in rates of suicide, suicide attempts, mental health hospitalizations
- LGBTQ residents expressed need for mental health care and suicide prevention assistance
- Economic insecurity (including housing instability) a driver of poor behavioral health

Mental health and wellness was selected as a need to address because it tied for highest community prioritization score with the other three needs, tied for highest local assets score with the other three needs, and tied for highest evidence-based or promising approaches score with HE/AL and Access. In addition, there are significant organizational assets dedicated to it, and given available resources, the CHIC believes Kaiser Permanente can make an impact.

Healthy Eating/Active Living

- Includes access to food and recreation, diabetes, nutrition, diet, fitness, and obesity
- Concern regarding high rates of diabetes and obesity; diabetes prevalence trending up
- Community said increased stress and poverty contribute to diabetes and obesity
- Ethnic and gender disparities in diabetes management, obesity, youth physical activity
- Kids in the service area less likely to walk or bike to school than kids statewide
- Barriers to healthy eating: Higher proportions of fast food restaurants, lower proportions of grocery stores and WIC-authorized food stores vs. statewide

Healthy eating/active living was selected as a need to address because it tied for highest community prioritization score with the other three needs, tied for highest local assets score with the other three needs, and tied for highest evidence-based or promising approaches score with Access and Mental health and wellness. It also received the highest organizational assets score and the highest feasibility score.

Housing and Homelessness

- Topic was the highest concern of community, including stress about high costs of housing
- Reports of increase in families seeking help from food banks, making difficult choices about how to spend remaining funds (food, medicine, health care, therapy, and housing)
- Reports of families moving within or exiting the area due to increased cost of living
- Significant ethnic disparities in income, a key factor driving housing instability
- Number of individuals & proportion of minors experiencing homelessness increased
- Lack of stable housing can prolong recovery time from diseases and surgical procedures
- Poor housing quality associated with asthma; asthma prevalence higher than state average

Homelessness was selected as a need to address because it tied for highest community prioritization score with the other three needs and tied for highest local assets score with the other three needs. In addition, there are a number of evidence-based or promising approaches to address it, and there are significant organizational assets dedicated to it.

VIII. KFH San José's Implementation Strategies

A. About Kaiser Permanente's Implementation Strategies

As part of the Kaiser Permanente integrated health system, KFH San José has a long history of working internally with Kaiser Foundation Health Plan, the Kaiser Permanente San José 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 San José 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 San José welcomes future opportunities to enhance its strategic plans by relying on and building upon the strong community partnerships it currently has in place.

KFH San José 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 and 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"> • <i>Increase access to comprehensive health care coverage for low income individuals</i> • <i>Increase access to subsidized care for those facing financial barriers to health care</i> • <i>Increase access to social non-medical services for low income and vulnerable populations</i> • <i>Improve the capacity of health care systems to provide quality health care services</i> • <i>Increase access to a diverse, culturally competent health care workforce</i>
Strategies	<ul style="list-style-type: none"> • <i>Medicaid.</i> Deploy KP resources to provide high-quality medical care to Medicaid participants who would otherwise struggle to access care. • <i>Charitable health coverage.</i> Deploy KP resources to provide access and comprehensive health care to low-income individuals and families who do not have access to public or private health coverage. • <i>Medical financial assistance.</i> Deploy KP resources to provide financial assistance to low-income individuals who receive care at KP facilities and can't afford medical expenses and/or cost sharing. • <i>Support patient navigation programs associated with community clinics and school health clinics, especially for low-income community members and/or monolingual non-English-speakers</i> • <i>Support increased access to oral health care for low-income and geographically remote community members via comprehensive low- or no-cost mobile dental services</i> • <i>Support medically tailored meal programs for low-income individuals</i> • <i>Support outreach and enrollment campaigns to increase CalFresh enrollment for eligible community members</i> • <i>Support screening for social non-medical service needs and connect low-income individuals and families to community and government resources</i> • <i>Support population health management approaches that improve health outcomes for safety net patients with diabetes and hypertension</i> • <i>Support community clinic consortia to develop programs and advocate for policies that improve access to quality health care for low income individuals</i>

	<ul style="list-style-type: none"> • <i>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.</i> • <i>Implement health care workforce pipeline programs to introduce diverse, underrepresented school age youth and college students to health careers</i> • <i>School for Allied Health expanding access to training and certificate programs for underrepresented individuals</i>
Expected outcomes	<ul style="list-style-type: none"> • <i>For low-income and vulnerable populations:</i> <ul style="list-style-type: none"> ○ <i>Improve access to health care coverage</i> ○ <i>Reduce financial barriers to care</i> ○ <i>Increase use of preventive care</i> ○ <i>Increase quality of care provided</i> ○ <i>Increase diversity of care providers</i>

Health need #2: Behavioral Health

Long term goal	<i>All community members experience social emotional health and wellbeing and have access to high quality behavioral health care services when needed</i>
Intermediate goal(s)	<ul style="list-style-type: none"> • <i>Increase capacity of organizations and institutions to provide trauma-informed services and programs</i> • <i>Enhance community supports to mitigate impact of ACEs</i> • <i>Increased access to behavioral health care services for low-income and vulnerable populations</i> • <i>Develop a diverse, well trained behavioral health care workforce that provides culturally competent care</i> • <i>Prevent and reduce misuse of drugs and alcohol</i>
Strategies	<ul style="list-style-type: none"> • <i>Support organizations offering behavioral health services to individuals experiencing homelessness</i> • <i>Support organizations working with service providers on strategies to address opioid use disorder</i> • <i>Support for substance use recovery-related programming</i> • <i>Support for grief and loss counseling and related support for low-income and/or minority populations</i> • <i>Support for programs that strengthen families and lead at-risk teens to make positive life choices</i> • <i>Support for programs that improve parenting skills among at-risk populations</i> • <i>Support for mentoring programs for youth of color</i> • <i>Support social-emotional learning for children and youth</i>

	<ul style="list-style-type: none"> • <i>Support programs that train youth to intervene in peer bullying</i> • <i>Support the capacity of clinics, schools or other community-based organizations to provide trauma-informed care to youth</i> • <i>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</i> • <i>Provide KP's Education Theater program, Resilience Squad</i> • <i>Participate in Medi-Cal Managed care</i> • <i>Provide Charitable Health Coverage</i> • <i>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</i>
Expected outcomes	<ul style="list-style-type: none"> • <i>Reduce the likelihood of family and community trauma</i> • <i>Increase individuals' coping skills to reduce the impact of trauma, including reducing use of drugs and alcohol</i> • <i>Increase use of behavioral health services, especially among low-income and vulnerable populations</i> • <i>Increase diversity and cultural competence of behavioral health care providers</i>

Health need #3: Healthy Eating and Active Living

Long term goal	<i>All community members eat better and move more as part of daily life</i>
Intermediate goal(s)	<ul style="list-style-type: none"> • <i>Reduce food insecurity among low-income families and individuals</i> • <i>Improve access to healthy food in schools</i> • <i>Increase access to safe parks and public spaces</i> • <i>Increase opportunities for physical activity in schools</i>
Strategies	<ul style="list-style-type: none"> • <i>Support healthy food incentive programs for CalFresh participants</i> • <i>Support medically tailored meal programs for low-income individuals</i> • <i>Support organizations that make healthy food available to low-income, minority families</i> • <i>Support farmers markets on college campuses for low-income young adults and other community members</i> • <i>Support for school-based healthy meals and health & wellness policies</i> • <i>Support fitness programs for older adults at public community centers</i>

	<ul style="list-style-type: none"> • <i>Support after-school fitness programs at schools</i> • <i>Support outreach and enrollment campaigns to increase CalFresh enrollment for eligible community members</i> • <i>Support high-need schools with the adoption and implementation of HEAL policies and practices</i>
Expected outcomes	<ul style="list-style-type: none"> • <i>For low-income community members, improve food security</i> • <i>Improve food environment, especially in schools</i> • <i>Increase healthy eating, especially among youth, older adults, and low-income individuals</i> • <i>Increase physical activity, especially among youth and older adults</i>

Health need #4: Housing and Homelessness

Long term goal	<i>All community members have access to quality, affordable, and stable housing</i>
Intermediate goal(s)	<ul style="list-style-type: none"> • <i>Prevent individuals and families from falling into homelessness</i> • <i>Increase connections to supportive services for individuals experiencing homelessness</i> • <i>Increase and preserve the stock of affordable housing, including deeply affordable and Permanent Supportive Housing</i> • <i>Increase and enhance transitional housing and shelter availability</i> • <i>Improve job readiness for people with barriers to employment</i>
Strategies	<ul style="list-style-type: none"> • <i>Support programs that help low-income homeowners stay in their homes</i> • <i>Support temporary rental subsidies and related supportive services for individuals experiencing homelessness</i> • <i>Support for transitional housing, which includes case management, job & housing search assistance, financial literacy, and life skills education</i> • <i>Support long-term housing and support services for domestic violence victims and their children who are homeless or at risk of homelessness</i> • <i>Support efforts to house transitional-aged former foster youth</i> • <i>Explore partnership with Santa Clara County to support medical social work through backpack medicine, mobile clinics, medical respite, and/or KP volunteers at local clinics</i> • <i>Support mobile hygiene outreach programs offered in combination with supportive services</i> • <i>Support employment opportunities for individuals experiencing homelessness</i>

	<ul style="list-style-type: none"> • <i>Funding to strengthen local homeless system of care through the Housing and Health Initiative</i> • <i>Implement Community Solutions' Built for Zero to address chronic and veteran homelessness</i> • <i>Implement health care workforce pipeline programs to introduce diverse, underrepresented school age youth and college students to health careers</i> • <i>Partnership with KP Division of Research to develop a predictive model for housing instability</i>
Expected outcomes	<ul style="list-style-type: none"> • <i>Prevent homelessness among low-income and vulnerable individuals</i> • <i>Increase number of permanent housing units</i> • <i>Improve access to support for individuals experiencing homelessness</i> • <i>Improve access to jobs for individuals experiencing homelessness</i>

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 San José 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 San José tracks outcomes, including behavior and health outcomes, as appropriate and where available.

X. Health needs facility/region name does not intend to address

- **Asthma.** This need scored lower on CHNA priority, and scored much lower on leveraging local assets and existence of evidence-based or promising approaches, compared to the four needs

that were selected to be addressed. It also scored lower than two of the four chosen needs with regard to leveraging KP assets.

- **Cancer.** This need scored much lower on CHNA priority and leveraging local assets compared to the four needs that were selected to be addressed. It also scored lower than three of the four chosen needs with regard to both feasibility and leveraging KP assets.
- **Community and Family Safety.** This need scored lower on CHNA priority and leveraging KP assets, and scored much lower on evidence-based or promising approaches, compared to the four needs that were selected to be addressed. It also scored lower than three of the four chosen needs on feasibility.
- **Economic Security.** This need scored lower on CHNA priority compared to the four needs that were selected to be addressed. With regard to evidence-based or promising approaches, leveraging KP assets, and feasibility, it scored lower than three of the four chosen needs.
- **Environment.** This need scored lower on all five selection criteria compared to the four needs that were selected to be addressed.
- **Transportation and Traffic.** This need scored lower on four of the five selection criteria compared to the four needs that were selected to be addressed. With regard to the fifth criterion, evidence-based or promising approaches, it scored lower than three of the four chosen needs.