2019 Implementation Strategy Report

Kaiser Foundation Hospital: Vallejo

License number: 110000026

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

March 18, 2020

KAISER PERMANENTE®

Kaiser Permanente Northern California Region Community Health

IS Report for KFH-Vallejo

Contents

I. General information

Contact Person:	Shiyama Clunie
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 15th day of the fifth month after the end of the taxable year the CHNA was completed?	Yes ☒ No ☐
Date facility's prior written plan was adopted by organization's governing body:	March 16, 2017
Name and EIN of hospital organization operating hospital facility:	Kaiser Foundation Hospitals, 94-1105628
Address of hospital organization:	One Kaiser Plaza, Oakland, CA 94612

II. About Kaiser Permanente (KP)

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

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

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

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

III. About Kaiser Permanente Community Health

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

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

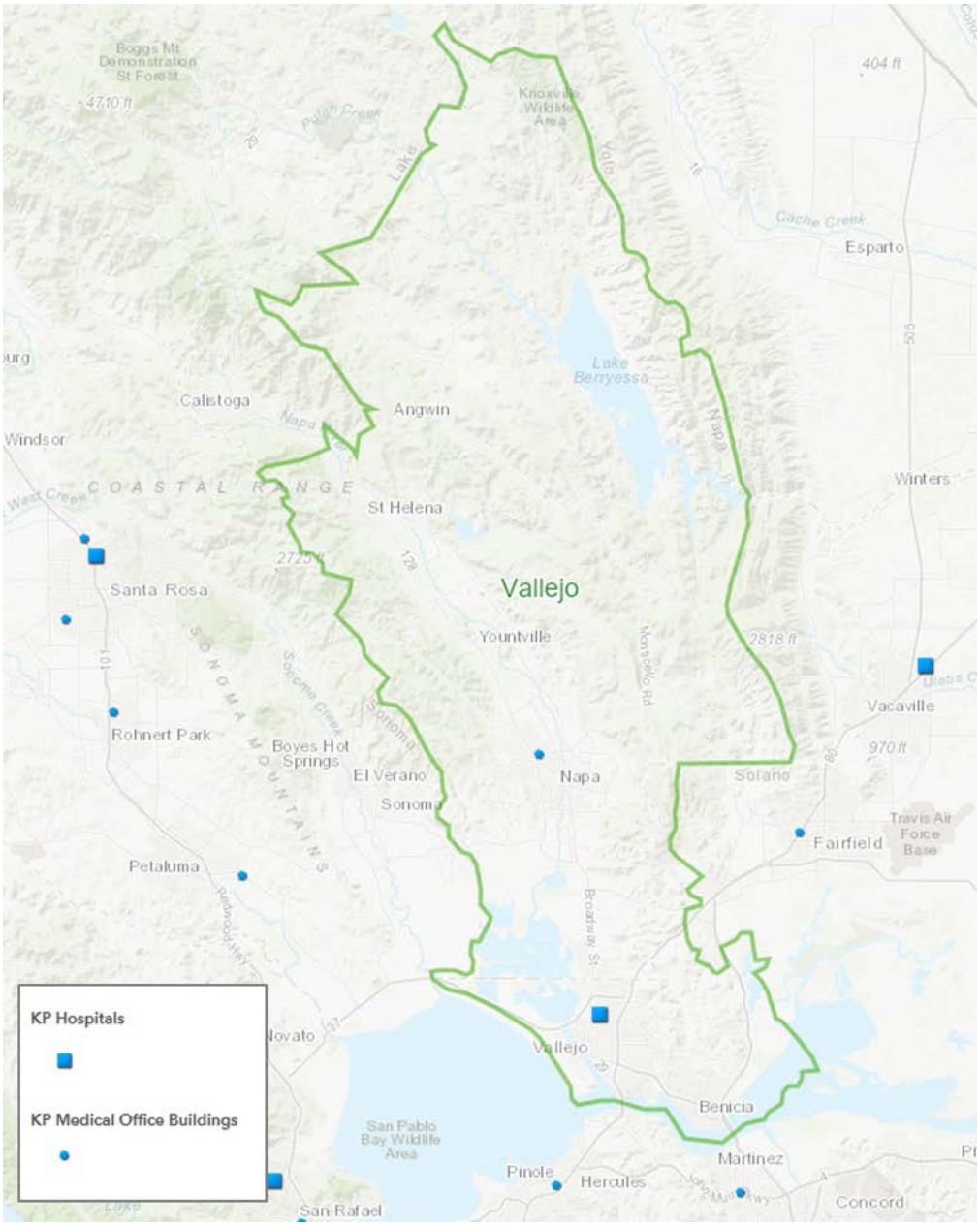
- Ensuring health access by providing individuals served at KP or by our safety net partners with integrated clinical and social services;
- Improving conditions for health and equity by engaging members, communities, and Kaiser Permanente's workforce and assets; and
- Advancing the future of community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

A. Map of facility service area



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

The KFH-Vallejo service area includes communities in Napa and Solano counties. The major communities are Benicia and Vallejo in Solano County and American Canyon, Calistoga, Napa, Oakville, Rutherford, St. Helena, and Yountville in Napa County. The service area is further defined by Highway 29 leading from Vallejo to Napa and Interstate 80 in Solano County.

C. Demographic profile of community served

Race/ethnicity		Socioeconomic Data	
Total Population	284,616	Living in poverty (<100% federal poverty level)	12.2%
Asian	15.0%	Children in poverty	15.6%
Black	10.8%	Unemployment	3.6%
Hispanic/Latino	27.8%	Uninsured population	9.9%
Native American/Alaska Native	0.6%	Adults with no high school diploma	13.4%
Pacific Islander/Native Hawaiian	0.5%		
Some other race	8.4%		
Multiple races	5.6%		
White	59.0%		

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

1. Violence and Injury Prevention
2. Education
3. Economic Security
4. Healthy Eating and Active Living (HEAL)
5. Housing
6. Access to care
7. Behavioral Health
8. Maternal and Infant Health

VI. Who was involved in the Implementation Strategy development

A. Partner organizations

KFH-Vallejo did not collaborate with any other hospitals on this Community Health Implementation Strategy (CHIS). Through the community engagement process described below, local community stakeholders contributed to the development of the CHIS.

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. 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-Vallejo 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-Vallejo service area provided additional suggestions for key stakeholders to include for the Implementation Strategy development community engagement.

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 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 outcomes seemed to be most achievable. They also shared insights on what outcomes were missing and where some outcomes overlapped. Collectively this information and feedback refined the outcomes and strategies selected for the KFH-Vallejo service area. For example, a breakout discussion group focused on Community and Family and Safety suggested that families experiencing domestic violence have few social service options apart from police involvement. This feedback informed the recommendation to invest in support programs and preventive services for at-risk families.

	Data collection method	Title/name	Number	Notes (e.g., input gained or role in IS process)
1	*Community Engagement Meeting*	Participants included representatives from non-profit agencies, community organizations, community clinics, county government	25	Representatives provided insights to refine strategies across four health needs: economic opportunity, mental health and wellness, access to care and coverage, and community and family safety. Some key takeaways included: • need for more flexible funding opportunities related to housing services and the barriers presented by affordable housing NIMBY-ism • support needed by transitional age youth (TAY) such as mentorship, soft skill development, employment, and housing • better transportation for seniors and low-income people • need for additional resources responding to domestic/intimate partner violence and child abuse • importance of “trusted messengers” for the Spanish speaking community • other than the police force, especially for the working poor

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 Roseville, Sacramento, San Bernardino, San Rafael, Santa Rosa, South Sacramento, and Vacaville.

VII. Health needs that KFH–Vallejo Name plans to address

A. Process and criteria used

The ability to make meaningful change in the health of KFH-Vallejo service area residents is dependent on understanding the community needs, identifying opportunities to partner with and leverage existing resources and initiatives, and consider the feasibility of making an impact. To achieve this level of understanding, Harder+Company and KFH-Vallejo hosted a meeting with the service area Community Health Investment Committee (CHIC) to present quantitative and qualitative data from the 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 community prioritization 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 one or more vulnerable population groups

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 (e.g., how we hire, how we purchase, how we build, and how we advocate)
4. Feasibility	Kaiser Permanente has the ability to have an impact given the local CB budget, and the opportunity to collaborate with existing community partnerships working to address the need (e.g., build on current programs, emerging opportunities)

Each meeting participant ranked the health needs on a scale of 1-3 for criteria (2) Health Disparities/ Equity, (3) Ability to leverage organizational assets, and (4) feasibility.

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.

However, scoring for criteria (1) CHNA Prioritization had been previously determined. During CHNA prioritization, stakeholders had already voted on top health needs with the agreed-upon criteria. Therefore, aggregate scoring for the CHIS health needs selection resulted in high priority health needs automatically receiving a score of 3, middling priority health needs receiving a score of 2, and lower priority health needs receiving a score of 1 on the CHNA Prioritization criterion.

The final results of this voting were discussed by participating members. Considering the scores and discussion as input, KFH Vacaville selected the health needs with the highest scores to be addressed by the 2020-22 Implementation Strategies.

B. Health needs that KFH-Vallejo plans to address

1. **Mental Health and Wellness.** Behavioral health is the foundation for healthy living and encompasses mental illness, substance use and overdoses, and access to service providers for preventive care and treatment. This health need was recommended for selection by the Community Health Investment Committee because it received a high score across all selection criteria, most notably the *feasibility,* and the *ability to leverage organizational assets*.

2. **Community and Family Safety**: Referred to as Violence & Injury Prevention in the CHNA: Direct and indirect exposure to violence and injury, such as domestic and community violence, have significant effects on well-being and health. This health need was recommended for selection by the Community Health Investment Committee because it received a high score across all selection criteria, most notably the *Vallejo prioritization score*, *feasibility,* and *disparities/equity*.

3. **Economic Opportunity**: Economic security means having the financial resources, public supports, career and educational opportunities, and housing necessary to be able to live your fullest life. Intrinsically related to all health issues, from housing to behavioral health, economic security is a strong determinant of an individual's health outcomes. This health need was

recommended for selection by the Community Health Investment Committee because it received a high score across all selection criteria, most notably the *Vacaville and Vallejo prioritization scores*, *feasibility,* and *disparities/equity*.

4. **Access to Care and Coverage:** Access to quality health care includes affordable health insurance, use of preventive care, and ultimately reduced risk of unnecessary disability and premature death. Importantly, it is also one of the key drivers in achieving health equity. This health need was recommended for selection by the Community Health Investment Committee because it received a high score across all selection criteria, most notably the *feasibility,* and *disparities/equity*.

VIII. KFH-Vallejo's Implementation Strategies

A. About Kaiser Permanente's Implementation Strategies

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

KFH-Vallejo 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: Mental Health and Wellness

Long term goal	All community members have access to high quality, culturally and linguistically appropriate health care services in coordinated delivery systems
Intermediate goal(s)	• Increase capacity of organizations and institutions to provide trauma-informed services and programs • Increased access to behavioral health care services for low-income and vulnerable populations • Develop a diverse, well trained behavioral health care workforce that provides culturally competent care
Strategies	• Provide funding to address trauma and adverse childhood experiences (ACEs) (including screening and counseling). • Provide grants for programs that support a network of services for children and families (e.g. family resource centers). • Support culturally appropriate programming to promote healing in communities with high rates of trauma and/or violence. • Provide funding for programs providing certified, evidence-based parenting programs to vulnerable populations. • Provide support for organizations providing trauma-informed and trauma-responsive trainings for staff/providers. • Provide grant funding to school districts participating in KP Thriving Schools initiatives to support staff and school leadership professional development and resilience. • Fund grants to improve early identification of behavior health needs (e.g. schools, clinics). • 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 • Participate in Healthy Solano Collaborative, Live Healthy Napa County Collaborative, and Solano Elder Justice Coalition. • Provide funding for programs focused on providing mental health services in vulnerable census tracks. • Provide grants for behavioral health case management. • Provide grants for programs that offer substance and tobacco education. • Provide grants for programs that offer resources and support for youth and families dealing with substance abuse. • Support the capacity of clinics, schools or other community-based organizations to provide trauma-informed care to youth. • Provide KP's Education Theater programs Ghosted, Nightmare on Puberty St., and Peace Signs.

	• Participate in Medi-Cal Managed care. • Provide Charitable Health Coverage. • KP Mental Health Training Program participants rotate through community clinics and other community-based organizations to provide behavioral health services and education. • The Thrive Local bi-directional directory will allow KP staff to directly refer patients to community-based resources and services. • Support the rotation of residents and other trainees in community health centers and other community settings. • Provide and distribute KP health education materials and resources to community-based organizations, including community clinics • ACEs screening through pilot at NSA KP facilities that link KP patients to community resources and services. • Provide direct linkages to social non-medical resources and services to new Medi-Cal members during onboarding through Social Medicine services.
Expected outcomes	• Increased enrollment in programs to improve social/emotional wellness • Increased screening for behavioral health needs • Increased organizational capacity to provide Adverse Childhood Experiences screenings • Increased trauma-informed and trauma-responsive services, policies, and systems • Increased participation in drug and alcohol prevention programs • Improved capacity of systems or organizations to implement non-violent solutions to conflict and offer alternatives to punitive responses • Increased number of low-income patients who receive behavioral health care services • Increased integration of primary and behavioral health care services • Improved access to quality care for youth, families and communities experiencing violence • Increased number of individuals receiving mental health services

Health need #2: Community and Family Safety

Long term goal	Cycles of violence are interrupted and toxic stress is alleviated
Intermediate goal(s)	• Increased access to safe parks and public spaces • Increased access to programs and support services for those experiencing or at risk of family violence • Improve job readiness for people with barriers to employment

Strategies	• Provide funding for programs focusing on development and/or beautification of neighborhood outdoor spaces servicing low income and vulnerable populations. • Provide funding for programming that promotes physical activity and social cohesion in underserved or vulnerable communities. • Participate in Healthy Solano Collaborative and Live Healthy Napa County Collaborative. • Participate in Vibe Solano collaborative. • Participate in Food, Agricultural, Nutrition Network of Solano (FANNS). • Provide grants for programs that support a network of services for children and families (e.g. family resource centers, family justice centers). • Fund prevention programs and support services for those at risk of family violence. • Support domestic violence and child abuse prevention programs that work with victims and/or perpetrators. • Support programs that provide access to job training programs for high-risk populations (e.g. homeless, reentry, foster youth, transition age youth). • Support organizations who work with re-entry population by providing training, wraparound services, and help them successfully access and maintain employment. • Support pathway programs to increase the diversity of the healthcare workforce by providing mentorship, academic enrichment, leadership development, and career exposure to disadvantaged and minority youth. • Implement health care workforce pipeline programs to introduce diverse, underrepresented school age youth and college students to health careers (KP LAUNCH) • Utilize KP Cares to recruit volunteers for community-based projects (e.g. neighborhood beautification projects). • Provide opportunities for KP business resource groups to support volunteer projects in the community. • Provide opportunities for KP business resource groups to service as speakers or present to local students regarding career paths. • Provide mentorship opportunities for Vallejo high school students through the KP/Touro University California Partnership for Achievement of Total Health in Students (KP/TUC PATHS) program. • Local KP participation in collaboratives of local health care institutions, community colleges, workforce development organizations, and chambers of commerce to support the pipeline and hiring of diverse populations in health care.
Expected outcomes	• Increased use of parks and public spaces • Increased community perception of safety • Increased trust between law enforcement and community members • Increased community perception that violence is a preventative public health issue • Increased participation in prevention programs and support services for those at risk of family violence • Increased organizational capacity to offer quality services to individuals and

	communities experiencing trauma/violence • Increased number of families receiving responsive services • Increased number of families screened for family violence • Increased proportion of referrals made for families experiencing family violence • Increased enrollment and completion of education and job training programs • Decreased recidivism • Increased number of individuals completing job-training program

Health need #3: Economic Opportunity

Long term goal	All community members are economically secure in order to thrive
Intermediate goal(s)	• Increase high school graduation for underrepresented youth • Prevent individuals and families from falling into homelessness • Increase connections to supportive services for individuals experiencing homelessness • Improve job readiness for people with barriers to employment • Increase access to living-wage jobs for people with barriers to employment
Strategies	• Provide grants for youth development programs that support underrepresented students prepare academically for college. • Provide grant funding for programs assisting vulnerable youth access support and resources needed to graduate from high school and prepare them for college. • Provide grant funding for programs working to assist disconnected youth complete high school level education. • Provide support for programs offering education and resources around tenant protections and/or providing free or low-cost legal assistance for tenants facing eviction. • Provide funding for programs that support the connection of residents in affordable housing to a range of critical health and human services. • Provide funding to support rapid rehousing programs. • Support non-profit housing developers, housing programs, and shelters focused on expanding supportive housing and resources for those who are experiencing or at risk of homelessness. • Provide funding to support coordinated entry systems. • Support for programs providing emergency rental assistance to prevent eviction and homelessness. • Participate in Healthy Solano Collaborative and Live Healthy Napa County Collaborative.

	• Participate in regular partnership meetings with Solano County hospital systems and health plans. • Support programs that provide access to job training programs for high-risk populations (e.g. homeless, reentry, foster youth, transition age youth). • Support organizations who work with re-entry population by proving training, wraparound services, and help them successfully access and maintain employment. • Support pathway programs to increase the diversity of the healthcare workforce by providing mentorship, academic enrichment, leadership development, and career exposure to disadvantaged and minority youth. • Funding to strengthen local homeless system of care through the Housing and Health Initiative. • Implement health care workforce pipeline programs to introduce diverse, underrepresented school age youth and college students to health careers (KP LAUNCH). • Provide mentorship opportunities for Vallejo high school students through the KP/Touro University California Partnership for Achievement of Total Health in Students (KP/TUC PATHS) program. • Provide opportunities for KP employees (e.g. Multi-cultural business resource groups) to service as speakers or present to local students regarding career paths. • Partnership with KP Division of Research to develop a predictive model for housing instability. • Provide opportunities for KP business resource groups to service as speakers or present to local students regarding career paths. • Local KP participation in collaboratives of local health care institutions, community colleges, workforce development organizations, and chambers of commerce to support the pipeline and hiring of diverse populations in health care. • NSA Local impact hiring strategy will provide opportunities for people with barriers to employment. • Impact purchasing and small business capacity building to strengthen local and diverse businesses through sourcing strategies and programs.
Expected outcomes	• Decreased rates of chronic absenteeism • Reduced high school dropout rate among low income and vulnerable youth • Increased college access among low income and vulnerable youth • Improvement of reading proficiency scores for third grade students • Increased availability and utilization of affordable housing • Increase in referral and coordination between medical providers and social non-medical services and providers • Increased number of families remaining stably housed while receiving prevention assistance • Increase in the number of assisted families who do not enter or re-enter emergency shelter or transitional housing after receiving housing assistance • Increased number of clients connected to housing opportunities

- Increased enrollment and completion of education and job training programs
- Decreased recidivism

Health need #4: Access to Care and Coverage

Long term goal	All community members have access to high quality, culturally and linguistically appropriate health care services in coordinated delivery systems
Intermediate goal(s)	• Increase access to comprehensive health care coverage for low income individuals • Increase access to social non-medical services for low income and vulnerable populations • Reduce food insecurity among low-income families and individuals • Increase access to a diverse, culturally competent health care workforce. • Improve the capacity of health care systems to provide quality health care services
Strategies	• Provide grants for programs focused on (increasing) enrollment in affordable health coverage options. • Funding programs and/or organizations to conduct targeted outreach and screening for chronic unmanaged health conditions specific to target populations or census tracks. • Funding to support FQHCs around health education and outreach. • Fund FQHCs to expand and improve primary care access, navigation, and services. • Provide subsidized health care coverage to children (18 & under) in low-income families who lack access to other sources of coverage. • Provide Medical Financial Assistance to patients who are unable to afford the cost of care. • Participate in regular partnership meetings with Solano County hospital systems and health plans. • Provide grants for programs that increase enrollment in federal food programs. • Support programs that advocate for equitable access to healthy food (e.g., community gardens, food systems, and local markets). • Support Market Match to provide incentives for CalFresh users to purchase produce at farmers markets. • Support programs focused on connecting vulnerable populations (e.g. seniors, low income families) to social non-medical services and resources (e.g. transportation, food). • Participate in Healthy Solano Collaborative and Live Healthy Napa County Collaborative. • Participate in Vibe Solano collaborative. • Participate in Food, Agricultural, Nutrition Network of Solano (FANNS).

	• Provide grant funding for programs providing respite and recuperative care for people without stable housing after being discharged. • Support pathway programs to increase the diversity of the healthcare workforce by providing mentorship, academic enrichment, leadership development, and career exposure to disadvantaged and minority youth. • 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 (e.g. Thrive Local). • Support population health management approaches that improve health outcomes for safety net patients with diabetes and hypertension (PHASE). • Support community clinic consortia to develop programs and advocate for policies that improve access to quality health care for low income individuals • Participate in Medi-Cal Managed care. • Provide Charitable Health Coverage. • The Thrive Local bi-directional directory will allow KP staff to directly refer patients to community-based resources and services. • Provide direct linkages to social non-medical resources and services to new Medi-Cal members during onboarding through Social Medicine services. • Support the rotation of residents and other trainees in community health centers and other community settings. • Collaborate with HR and other internal stakeholders to develop a high-impact hiring program in NSA.
Expected outcomes	• Increased number of low-income patients who receive health care services/coverage provided by KP • Increased number of low-income patients that enroll in health care coverage programs • Increased use of preventative medical services by low utilizers • Increased referrals and coordination between healthcare providers and social non-medical services • Increased enrollment and participation in public benefit programs • Improved transportation for vulnerable populations (e.g. seniors) to necessary healthcare and social non-medical services • Improved capacity of health systems to provide population health management • Increased integration of primary and specialty health care services • Improved capacity of safety net providers to assuming capitated risk • Increased number of people from underrepresented groups enrolling in job training programs • Increased number of culturally and linguistically competent and skilled healthcare providers

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

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

- Housing: This health need was not selected because, compared to other health needs, it scored relatively lower on the following criteria: disparities, leveraging organizational assets, and feasibility. The strategies identified within Economic Security will largely address the need associated with Housing. Additionally, there is significant existing attention and resources dedicated to addressing this issue in the community.
- Education: This health need was not selected because, compared to other health needs, it scored relatively lower on the ability to leverage organizational assets. Significant attention and resources in the service area are currently dedicated to addressing this health need, especially in the secondary education system by supporting programs providing mentorship and educational support systems for high school students and disconnected youth. ..
- Healthy Eating and Active Living (HEAL): This health need was not selected because, compared to other health needs, it scored relatively lower on disparities and leveraging organizational assets. Significant attention and resources in the service area are currently dedicated to this need around the issues of reducing food insecurity, providing access to healthy food, and increasing access to safe parks and outdoor spaces.
- Maternal & Infant Health: This health need was not selected because, compared to other health needs, it scored relatively lower on disparities and leveraging organizational assets. The strategies identified within Access to Care will largely address the challenges specific to the population of mothers and young children.