



# 2016 Implementation Strategy Report for Community Health Needs

Kaiser Foundation Hospital Fremont  
License # 140000053

Approved by KFH Board of Directors  
March 16, 2017

To provide feedback about this Implementation Strategy Report,  
email [chna-communications@kp.org](mailto:chna-communications@kp.org)

**Kaiser Foundation Hospitals  
Community Health Needs Assessment (CHNA)  
Implementation Strategy Report  
2016**

Kaiser Foundation Hospitals – Fremont  
License #140000053  
39400 Paseo Padre Parkway, Fremont, CA 94538

**I. General Information**

Contact Person: Debra Lambert, Director, Public Affairs

Date of Written Plan: December 14, 2016

Date Written Plan Was Adopted by Authorized Governing Body: March 16, 2017

Date Written Plan Was Required to Be Adopted: May 15, 2017

Authorized Governing Body that Adopted the Written Plan: Kaiser Foundation Hospital/Health Plan Boards of Directors

Was the Written Plan Adopted by Authorized Governing Body On or Before the 15<sup>th</sup> Day of the Fifth Month After the End of the Taxable Year the CHNA was Completed? Yes  No

Date Facility's Prior Written Plan Was Adopted by Organization's Governing Body: December 4, 2013

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**

Kaiser Permanente is a not for profit, integrated health care delivery system comprised of Kaiser Foundation Hospitals, Kaiser Foundation Health Plan, and The Permanente Medical Groups. For more than 65 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. Today we serve more than 10.2 million members in eight states and the District of Columbia. Since our beginnings, we have been committed to helping shape the future of health care. Kaiser Permanente is dedicated to care innovations, clinical research, health education and the support of community health.

**III. About Kaiser Permanente Community Benefit**

We believe good health is a basic aspiration shared by all, and we recognize that promoting good health extends beyond the doctor's office and the hospital. 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 leverage financial resources with medical research, physician expertise, and clinical practices. Historically, we have focused our investments in three areas—Health Access, Healthy Communities, and Health Knowledge—to address critical health issues in our communities.

For many years, we have worked collaboratively with other organizations to address serious public health issues such as obesity, access to care, and violence. We have conducted Community Health Needs Assessments (CHNA) 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.

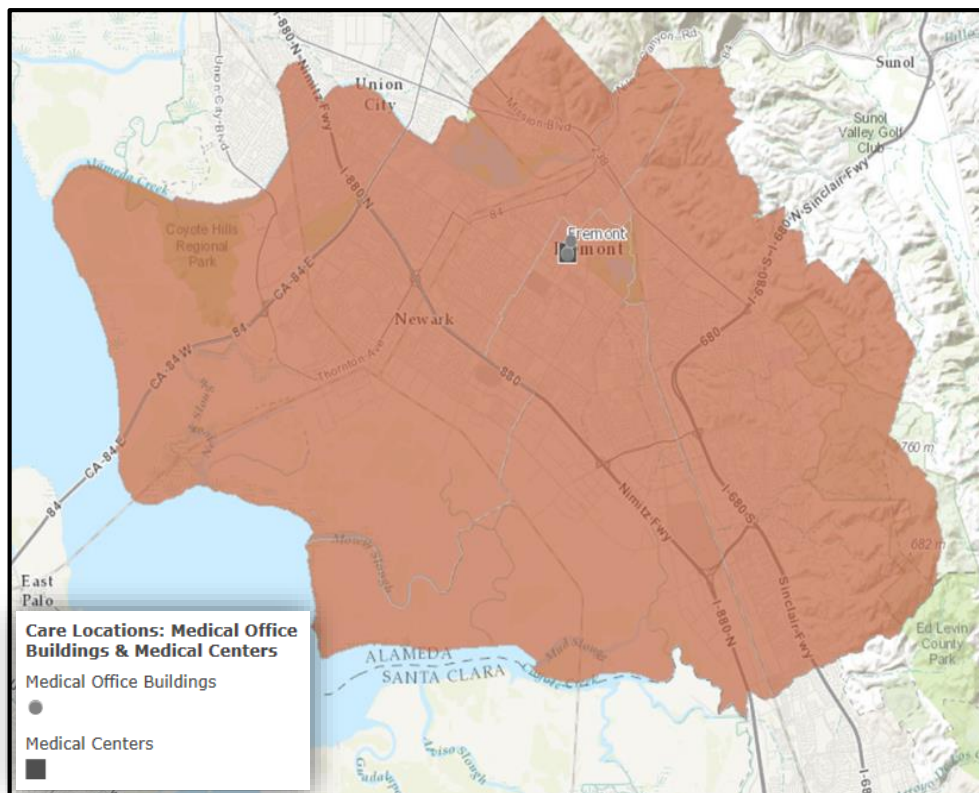
In addition, Kaiser Permanente seeks to promote community health upstream by leveraging its assets to positively influence social determinants of health – social, economic, environmental – in the communities we serve.

**IV. Kaiser Foundation Hospitals – Fremont Service Area**

The Kaiser Foundation Hospital (KFH) Fremont service area covers the southern-most part of the Alameda County. The cities served include Fremont and Newark. The map below shows the service area, which also includes unincorporated areas.

KFH Fremont Demographic Data	
Total Population	265,391
White	30.67%
Black	3.84%
Asian	48.45%
Native American/ Alaskan Native	0.56%
Pacific Islander/ Native Hawaiian	0.71%
Some Other Race	9.23%
Multiple Races	6.54%

KFH Fremont Socio-economic Data	
Hispanic/Latino Ethnicity	17.22%
Living in Poverty (<200% FPL)	17.36%
Children in Poverty	7.77%
Unemployed	6.6%
Uninsured	8.02%
No High School Diploma	9.1%



## **V. Purpose of Implementation Strategy**

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

This Implementation Strategy is intended to satisfy each of the applicable requirements set forth in final regulations released in December 2014. This implementation strategy describes KFH Fremont's planned response to the needs identified through the 2016 Community Health Needs Assessment (CHNA) process. For information about KFH Fremont's 2016 CHNA process and for a copy of the report please visit [www.kp.org/chna](http://www.kp.org/chna).

## **VI. List of Community Health Needs Identified in 2016 CHNA Report**

The list below summarizes the health needs identified for the KFH Fremont service area through the 2016 Community Health Needs Assessment process. The health needs are listed in priority order from highest (#1) to lowest (#11).

1. Obesity, Diabetes, Healthy Eating/Active Living
2. Mental Health
3. Economic Security
4. Cardiovascular Disease/Stroke
5. Substance Abuse (Alcohol, Tobacco, and Other Drugs)
6. Violence/Injury Prevention
7. Healthcare Access and Delivery, Including Primary and Specialty Care
8. Cancer
9. Asthma
10. Infectious Disease, Including Sexually Transmitted Infections
11. Maternal and Child Health

## **VII. Who was Involved in the Implementation Strategy Development**

Kaiser Permanente (KP) Northern California Regional Community Benefit worked with Community Benefit staff from each local KFH facility as well as internal experts to develop a menu of strategies for each selected health need. KFH Fremont's Director of Public Affairs, in partnership with the hospital's consultants and in collaboration with the hospital's Contributions Committee (see below), then selected certain strategies from the region-wide menu and developed local approaches to those strategies. These local approaches were combined with Regional investments, KP Programs, and in-kind assets of the organization to make up the full Implementation Strategy for the hospital.

The hospital's Contributions Committee consists of individuals in the following positions:

- Area Finance Officer
- Continuing Care Service Director
- Assistant Medical Group Administrator
- Director of Health Education
- Director of Public Affairs

## **a. Partner Organizations**

KFH Fremont and KFH San Leandro worked together at every step in the development of their Implementation Strategy reports. The hospitals share the same Director of Public Affairs and Contributions Committee.

## **b. Community Engagement Strategy**

While not required by Federal CHNA regulations, Kaiser Permanente encourages all KFH facilities developing Implementation Strategy plans to elicit community input throughout the plan development process. Voluntary 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 Fremont held a community engagement event at the Silliman Center in Newark, California on October 20, 2016. Invitees included community leaders, representatives from the Department of Public Health, local clinicians, representatives of community-based organizations and safety net clinics, and elected officials. A total of 28 people attended.

During the event, staff from Actionable Insights, KFH Fremont's consultant, explained the CHNA and Implementation Strategy development processes that the hospital followed, presented the 2016 CHNA findings and the health needs the hospital selected, and facilitated small group discussions among the event participants based upon KFH Fremont's chosen health needs. The discussions focused on best practices for addressing the chosen health needs, and barriers to addressing them. Participant feedback was collected through note-taking by event staff and provided to the hospital's Director of Public Affairs.

Important insights from participants in the realm of gaps and barriers across needs included the need for more funding for programs, the need for services and information in multiple languages, and the need for culturally competent workforce which goes beyond language (including competency for the LGBTQ population). Every group also focused on the need for organizations to network (share information), partner with each other, and coordinate services. Community-based organizations recognized the benefits of including partners in other sectors including K-12 schools, universities and colleges, hospitals and government agencies. Participants specifically mentioned the potential benefit of sharing best practices among partners including the possibility of prioritizing strategies together and co-designing programs. KFH Fremont staff considered this community feedback in refining the Implementation Strategies outlined in Section IX of this report by, for example, adding expanded partnerships with local youth centers, an education foundation, and local school districts. Community feedback also validated strategies for providing workforce training programs to train current and future health care and behavioral health care providers with the skills, linguistic, and cultural competence to meet the needs of diverse communities.

## **c. Consultant Used**

KFH Fremont consulted with Actionable Insights, LLC. Actionable Insights is a consulting firm that helps organizations discover and act on data-driven insights to achieve better outcomes. Melanie Espino and Jennifer van Stelle, Ph.D., the co-founders and principals of Actionable Insights, have experience

conducting CHNAs and providing expertise on Implementation Strategy development and IRS reporting for hospitals. Actionable Insights worked with KFH Fremont to review the findings of the hospital's 2016 CHNA, facilitate selection of certain health needs, present the 2016 CHNA findings and selected health needs to the community, elicit community input into the Implementation Strategy development process, assist in developing the Implementation Strategy, and document the process in this Implementation Strategy Report.

## VIII. Health Needs that KFH Fremont Plans to Address

### a. Process and Criteria Used to Select Health Needs

The following criteria were used for the health need selection process:

1. **CHNA prioritization:** How did the health need rank in the CHNA (takes into account severity, scale, health disparities/equity and community prioritization).
2. **Ability to leverage local community assets:** Opportunity exists to collaborate with existing community partnerships working to address the need, or to build on current programs, emerging opportunities, or other community assets.
3. **Existing or promising approaches exist:** There are effective or promising strategies, preferably evidence-based, that could be applied to address the need.
4. **KP expertise:** KP can make a meaningful contribution to addressing the need because of its relevant expertise as an integrated health system and because of an organizational commitment to addressing the need.
5. **Ability to leverage KP-Regional assets:** Opportunity exists to have Regional CB funding deployed due to alignment with region-wide needs as well as opportunity to draw down other assets of the organization.
6. **Feasibility:** Kaiser Permanente has the ability to have an impact given the community benefit resources available.

To score the first criterion, each health need was assigned its overall prioritization score obtained during the 2016 CHNA process.

The scores for the second criterion were based on the number of countywide community partner investments/assets listed for the need in the 2016 CHNA report. A score of 1 = 0-24 assets, a score of 2 = 25-49 assets, and a score of 3 = 50 or more assets.

The scores for the third criterion 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 May 2016. A score of 1 = 0-24 EBS listed, a score of 2 = 25-49 EBS listed, and a score of 3 = 50 or more EBS listed.

The fourth, fifth, and sixth criteria were scored by members of the Kaiser Permanente Greater Southern Alameda Area Contributions Committee (representing both KFH Fremont and KFH San Leandro). 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 combined health needs selection scoring worksheet for use by the Contributions Committee that included definitions of all six criteria, the scoring rubric for each criterion, and pre-assigned scores to each health need for each of the first three criteria.

Prior to the meeting, the Director of Public Affairs and the Community Benefit Manager decided to merge the separate needs of Mental Health and Substance Abuse into the larger overall need of Behavioral Health, in order to align with the approach being taken by other KFH facilities in the Northern California Region. Behavioral Health's first three criteria were re-scored as the average of the Mental Health and Substance Abuse scores for the first criterion and as the greater of the two scores for each of the second and third criteria.

The Contributions Committee, which represents both KFH Fremont and KFH San Leandro, was then asked to participate in a process to select health needs for the hospitals to address in FY2017–FY2019. The consultants provided a summary of the 2016 CHNA health needs to the Contributions Committee at an in-person meeting on July 27, 2016. During the meeting, the consultants explained the criteria that the Committee was being asked to consider and facilitated a discussion about the identified health needs in each hospital's area.

Contributions Committee members reviewed each hospital's list of needs and discussed each identified health need, keeping in mind the selection criteria. Through discussion, show-of-hands polling, and iterative decision-making, the Contributions Committee came to consensus on its recommendations for selection and provided justifications for the needs it did not recommend for selection.

#### **b. Health Needs that KFH Fremont Plans to Address**

##### **Obesity, diabetes, healthy eating, active living (renamed Healthy Eating, Active Living)**

###### Description/definition:

Healthy diets and achievement and maintenance of healthy body weights reduce the risk of chronic diseases, including diabetes and obesity. Efforts to change diet and weight should address individual behaviors, as well as the policies and environments that support these behaviors in settings such as schools, worksites, health care organizations, and communities. For example, having healthy food available and affordable in food retail and food service settings allows people to make healthier food choices. When healthy foods are not available, people may settle for foods that are higher in calories and lower in nutritional value. Similarly, having access to appropriate, safe, and free or low-cost physical activity options in their local community allows people to engage in more active living. When such opportunities are not available locally, people are likely to be less physically active. Creating and supporting healthy environments allow people to make healthier choices and live healthier lives.

###### Rationale:

The Contributions Committee feels it is very feasible for KFH Fremont to address the need for healthy eating and active living in the community. There are substantial local community assets and Kaiser Permanente regional assets that can be leveraged in support of this need, and Kaiser Permanente also has strong expertise in the subject. Also, based on scoring of the selection criteria, there are many evidence-based or promising approaches to addressing the need for healthy eating and active living. Finally, the need is of extremely high priority to the community, as described below.

The CHNA data supporting the health need may be summarized as follows:

- Rates of fruit and vegetable consumption among youth in Alameda County are worse than the state.
- Alameda County has a slightly lower percentage of Medicare enrollees with diabetes who have an annual diabetes test compared to the state averages.

- The KFH Fremont service area contains a higher proportion of residents who experienced food insecurity than the state overall, and also contains a higher percentage of residents living in areas designated as food deserts than the state average.
- In the KFH Fremont service area, there are lower proportions of adults who bike or walk to work than the state.
- The ratios of fast food establishments and WIC-authorized food stores to residents in the KFH Fremont service area are worse than the state.
- Community input:
  - Concern about these needs was strong, and expressed the connection between obesity, diabetes, and related health behaviors such as poor nutrition and lack of physical activity.
  - Lack of access to affordable, healthy food is driving this health need.
  - Providers do not give culturally-specific nutrition recommendations.

## **Behavioral health**

### Description/definition:

Mental health (including sub-clinical stress, anxiety, and depression in addition to diagnosed mental health disorders) and substance abuse are often co-occurring problems, and as such are grouped together under the larger umbrella term “behavioral health.” Substance abuse is related to mental health because many cope with mental health issues by using drugs or abusing alcohol.

*Mental health* is a state of successful performance of mental function resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with challenges. Good mental health is essential to personal wellbeing, family and interpersonal relationships, and the ability to contribute to the community or society. It also plays a major role in people’s ability to maintain good physical health. Mental issues, depression and anxiety, and the impact of trauma affect people’s ability to participate in health-promoting behaviors. In turn, problems with physical health, such as chronic diseases, can have a serious impact on mental health and decrease a person’s ability to participate in treatment and recovery.

*The abuse of substances*, including alcohol, tobacco, and other drugs, has a major impact on individuals, families, and communities. For example, smoking and tobacco use cause many diseases, such as cancer, heart disease, and respiratory diseases. The effects of substance abuse contribute to costly social, physical, mental, and public health problems. These problems include, but are not limited to: teenage pregnancy, domestic violence, child abuse, motor vehicle crashes, HIV/AIDS, crime and suicide. Advances in research have led to the development of effective evidence-based strategies to address substance abuse. Improvements in brain-imaging technologies and the development of medications that assist in treatment have shifted the research community’s perspective on substance abuse. Substance abuse is now understood as a disorder that develops in adolescence and, for some individuals, will develop into a chronic illness that will require lifelong monitoring and care.

### Rationale:

The Contributions Committee feels it is very feasible for KFH Fremont to address the need for behavioral health in the community. There are substantial local community assets and Kaiser Permanente regional assets that can be leveraged in support of this need. Also, based on scoring of the selection criteria, there are many evidence-based or promising approaches to address behavioral health needs. Finally, the need is of relatively high priority to the community, as described below.

The CHNA data supporting the health need may be summarized as follows:



- The Alameda County rate of Emergency Department visits for injury due to intentional self-harm among youth (including attempted suicide) is higher than the state rate.
- Whites in the service area report a need for mental health care at a higher percentage than the state and other ethnic groups in the service area. Similarly, Whites in the service area commit suicide at rates higher than the HP2020 target and rates higher than those of other ethnic groups in the service area.
- In Alameda County, the rate of severe mental illness emergencies is substantially higher than the state rate, and the rate is much higher among Black county residents compared to the rate for the state.
- The level of excessive alcohol consumption among adults in Alameda County is higher than the state average. Related to this, service area residents are spending a larger proportion of their household budgets on alcohol than Californians generally.
- In Alameda County, the rate of Emergency Room (ER) visits for substance abuse is higher than the state, and is especially high for Black county residents.
- Community input indicates:
  - A lack of mental health providers and also lack of “placement care” and behavioral health services for adolescents.
  - Experiencing poor discharge procedures and lack of follow-up after mental health emergencies.
  - Concern about having only one sobering center in the area, which is not sufficient to meet the need.
  - Concerns about the growing number of residents addicted to prescription pain medication.

## **Violence and injury prevention (renamed Community and family safety)**

### Description/definition:

Lack of community and family safety – violence and intentional injury – contributes to poorer physical health for victims, perpetrators, and community members. In addition to direct physical injury, victims of violence are at increased risk of depression, substance abuse disorders, anxiety, reproductive health problems, and suicidal behavior, according to the World Health Organization’s “World Report on Violence and Health.” Crime in a neighborhood causes fear, stress, unsafe feelings, and poor mental health. In one international study, individuals who reported feeling unsafe to go out in the day were 64% more likely to be in the lowest quartile of mental health. Witnessing and experiencing violence in a community can cause long term behavioral and emotional problems in youth. For example, a study in the San Francisco Bay area showed that youth who were exposed to violence showed higher rates of self-reported PTSD, depressive symptoms, and perpetration of violence.

### Rationale:

The Contributions Committee feels it is very feasible for KFH Fremont to address the need for behavioral health in the community. There are substantial local community assets and Kaiser Permanente regional assets that can be leveraged in support of this need. Also, based on scoring of the selection criteria, there are many evidence-based or promising approaches to address behavioral health needs. Finally, the need is of relatively high priority to the community, as described below.

The CHNA data supporting the health need may be summarized as follows:

- In Alameda County, indicators of violence such as rates of non-fatal ER visits for injuries due to both assault and domestic violence, and the rate of rapes, are all worse than state rates.
- The KFH Fremont service area experiences ethnic disparities in homicide rates: the populations of Blacks and Native Hawaiians/Pacific Islanders in the service area experience much higher

rates of homicide than the HP2020 objective. Homicide rates are also worse in the city of Newark than in the rest of the KFH-Fremont service area.

- The KFH Fremont service area has a rate of school suspensions that is much higher than the state.
- Community input indicates:
  - Special concern about domestic violence (DV), e.g., a lack of effective DV screening and few facilities/providers for DV victims.
  - Worry about being attacked when they walk along the streets.
  - Feeling there is a lack of empathy from health care and law enforcement towards victims.

## **Health care access and delivery**

### Description/definition:

Access to comprehensive, quality health care services is important for the achievement of health equity and for increasing the quality of a healthy life for everyone. Components of access to care include: insurance coverage, adequate numbers of primary and specialty care providers, and timeliness. Components of delivery of care include: quality, transparency, and cultural competence. Limited access to health care and compromised health care delivery impact people's ability to reach their full potential, negatively affecting their quality of life.

### Rationale:

The Contributions Committee feels it is very feasible for KFH Fremont to address the need for health care access and delivery in the community. There are substantial Kaiser Permanente regional assets and quite a few local assets that can be leveraged in support of this need, and Kaiser Permanente also has considerable expertise in the subject. Based on scoring of the selection criteria, there are many evidence-based or promising approaches to addressing the need for health care access and delivery. Finally, the need is of relatively high priority to the community, as described below.

The CHNA data supporting the health need may be summarized as follows:

- There are wide disparities in insurance coverage across multiple racial and ethnic groups.
- In Alameda County, a much higher percentage of people delayed or had difficulty obtaining care, and a smaller percentage of people had a usual source of care, compared to the respective Healthy People 2020 objectives.
- Community input indicates:
  - Insurance premiums and co-payments are too high.
  - Wait times for appointments are too long.
  - People lack knowledge of how the health system works and young people do not know how to access preventative care.

## **IX. KFH Fremont's Implementation Strategies**

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

- ✓ Are available broadly to the public and serve low-income individuals.

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

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

KFH Fremont will draw on a broad array of strategies and organizational resources to improve the health of vulnerable populations within our communities, such as grantmaking, in-kind resources, 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.

## **HEALTHY EATING ACTIVE LIVING**

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### **Long-term Goal**

All community members eat better and move more as part of daily life in order to prevent and reduce the impact of chronic conditions (e.g., obesity, diabetes, cardiovascular disease).

### **Intermediate Goals**

- Improve healthy eating among residents in low-income, under-resourced communities.
- Increase physical activity among residents in low-income, under-resourced communities.

### **Strategies**

Healthy eating strategies:

- Increase access to healthy, affordable foods (including fresh produce), and decrease access to unhealthy food.
- Increase access to free, safe drinking water.
- Reduce access to and appeal of sugar sweetened beverages.
- Increase enrollment in and use of federal food programs.

Physical activity strategies:

- Increase access to safe parks and public spaces.
- Increase opportunities for active transportation.
- Increase access to physical activity opportunities in the community.
- Increase access to physical activity opportunities in schools.

### **Examples:**

- Provide grants to increase access to affordable, healthy foods in schools, workplaces, community settings, and programs that serve low-income persons.
- Support Thriving Schools, an initiative that targets resources to schools in low income neighborhoods to improve the health and wellness of students and employees through improved nutrition, increased physical activity, and access to health care.
- Participate in the Alameda County Building Blocks Collaborative and other coalitions to support policies that promote healthy eating and encourage access to affordable, healthy foods.
- Provide grants for use of promotores (i.e., peer educators) through safety net clinics to assist with enrollment in SNAP.
- Provide grants to food banks and other local nonprofit organizations in underserved neighborhoods to assist in SNAP enrollment.

- Participate in coalitions to support evidence-based, community-driven advocacy efforts to influence infrastructure and policies that increase the use of safe public spaces.
- Support institutional healthy food procurement.
- Provide KP’s Educational Theater, programming that provides education in schools on health and wellness.
- Design new KP facilities in ways that promote active transportation, whenever possible.

**Expected Outcomes**

Healthy eating:

- Increased consumption of fruits and vegetables.
- Increased consumption of water.
- Decreased consumption of sugar sweetened beverages (SSBs).
- Increased enrollment and participation in federal food programs.

Physical activity:

- Increased use of parks and public spaces.
- Increased walking and biking to school and work.
- Increased physical activity.

**BEHAVIORAL HEALTH**

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**Long-term Goal**

All community members experience social/emotional health and wellbeing and have access to high-quality behavioral health care services when needed.

**Intermediate Goals**

- Expand prevention and support services for mild to moderate behavioral health conditions.
- Decrease stigma associated with seeking behavioral health services among vulnerable and diverse populations.
- Develop a diverse, well-trained behavioral health care workforce that provides culturally sensitive behavioral health care.
- Increase access to culturally and linguistically appropriate behavioral health services for vulnerable and low-income populations.

**Strategies**

Prevention strategies:

- Provide screening and identification related to behavioral health needs among low-income, vulnerable, and uninsured populations and connect them with the appropriate services or support.
- Support opportunities to prevent and reduce the misuse of drugs and alcohol.
- Provide access to programs, services or environments that evidence suggests improves overall social/emotional wellness.

Destigmatization strategies:

- Support opportunities to reduce stigma through education and outreach in school, community and workforce settings.

Workforce strategies:

- Support the recruitment, hiring and retention of a diverse, culturally competent behavioral health care workforce in the clinical and community-based settings.
- Increase access to training and education for diverse populations currently underrepresented in the behavioral health care workforce.

#### Access strategies:

- Provide high-quality behavioral health care to Medi-Cal participants.
- Promote integration of care between primary and behavioral health care.
- Improve navigation to appropriate care within the health care system and support services in the community.
- Increase the capacity to respond appropriately to individuals and/or communities that have experienced trauma and/or violence.

#### Examples:

- Provide grants to improve identification of at-risk youth in need of behavioral health services.
- Partner with local foundations, youth centers, and school districts on behavioral health screening.
- Provide grants for evidence-based alcohol and drug prevention, education, and intervention programs.
- Partner with local community-based organizations and agencies on evidence-based alcohol and drug prevention, education, and intervention programs.
- Provide grants to support programs on resiliency, self-respect, self-esteem, self-management, coping skills, adult-youth mentoring, school climate, community safety, and integration.
- Provide grants for skills training on healthy relationships for youth.
- Provide grants for social/emotional skill training to children, youth, and teachers.
- Partner with local school districts, foundations, and other community-based organizations on programs, services, and environments intended to reduce stress, anxiety, and depression.
- Provide grants to implement workforce investment strategies that seek to improve college and career readiness among underserved populations and youth from educationally disadvantaged backgrounds.
- Partner with county office of education and local youth centers on access to employment, advanced training, and education among diverse populations underrepresented in the behavioral healthcare workforce.
- Partner with local foundations and school districts on curricula, training, and behavioral health career pipeline programs.
- Provide local funding to coordinate the deployment of TPMG training on trauma-informed care for community clinicians.
- Provide KP's Educational Theater, programming that provides education in schools on health and wellness.
- Mental health training program participants rotate through community clinics and other community based organizations to provide behavioral health services and training.

#### Expected Outcomes

##### Prevention:

- Increased enrollment in programs to improve social/emotional wellness.
- Increased screening for behavioral health needs.
- Increased participation in drug and alcohol programs.

##### Destigmatization:

- Increase in help-seeking behavior for accessing behavioral health care.

##### Workforce:

- Increase in the number of culturally and linguistically competent and skilled behavioral healthcare providers.
- Increase in the number of people from underrepresented groups enrolling in education and job training programs.

##### Access:

- Increase in the 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.

## **COMMUNITY AND FAMILY SAFETY**

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### **Long-term Goal**

All community members live in safe environments and individuals who are victims or at-risk of violence have the support they need.

### **Intermediate Goals**

- Improve safety in communities with high rates of violence.
- Support prevention and early intervention efforts targeting youth that promote positive youth development and that focus on youth assets and resilience.
- Improve safety in families through family violence prevention, screening and treatment efforts.
- Improve the quality of responsive care and services for youth and families experiencing violence and/or trauma to break the cycle of violence.

### **Strategies**

Community safety strategies:

- Increase availability of safe parks and public spaces.
- Build social cohesion in neighborhoods and community.
- Improve law enforcement and community relations.
- Promote public understanding of violence as a public health issue.

Prevention and early intervention strategies:

- Increase availability of education, job training and enrichment programs for youth.
- Support programs that promote non-violent solutions to conflict and alternatives to punitive responses.

Healthy family strategy:

- Support programs that prevent and address family violence through reducing risk factors, enhancing protective (resilience) factors and linking to appropriate resources.

Responsive care and service strategies:

- Support targeted gang/offender outreach and case management.
- Increase the capacity to respond appropriately to individuals and/or communities that have experienced trauma and/or violence.
- Provide victims of violence with services needed for recovery and resilience.
- Support integration of health care with community based programs and services that address violence-related issues among patients and the community.

### **Examples:**

- Provide grants to support efforts to improve infrastructure for safe public spaces.
- Participate in new and/or existing coalitions that influence policy and improve infrastructure for safe public spaces.
- Provide grants for social/emotional skills training provided by local mentors to children.
- Provide grants to support efforts in which local adult volunteers educate students about community safety.
- Partner with community-based organizations and foundations around social cohesion strategies.
- Provide grants for employment training for youth involved in the criminal justice system and for those in alternative/continuation schools.
- Provide grants to support the introduction of health workforce pipeline programs to youth/young adults.

- Partner with community-based organizations on school literacy programs and employment training, including programs specifically focused on diverting violence-impacted youth from entering/re-entering the juvenile justice system.
- Partner to support tattoo removal programs.
- Partner to provide prevention services for youth that build resiliency, manage risk, and help youth problem-solve and resolve conflicts appropriately.
- Provide grants for parent-child communication skill-building, which is a protective factor against child abuse, and family engagement around healthy relationships for youth.
- Provide grants for programs that provide skills training on healthy relationships for youth.
- Partner with community-based organizations to provide prevention services for youth that build resiliency, manage risk, and help youth problem-solve and resolve conflicts appropriately.
- Partner with community based organizations regarding integration of healthcare and community-based programs and services for victims of violence.
- Provide KP's Educational Theater, programming that provides education in schools on health and wellness.
- For any new KP buildings, consider designing spaces that are open to the public, including gardens, public areas, outdoor group meeting spaces, and meditative spaces.

### **Expected Outcomes**

#### Community safety:

- 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.

#### Prevention and early intervention:

- Increased enrollment and completion of education and job training programs for youth.
- Improved capacity of systems or organizations to implement non-violent solutions to conflict and alternatives to punitive responses.

#### Healthy family:

- Increased participation in prevention programs and support services for those at risk of family violence.

#### Responsive care and service:

- Decreased recidivism.
- Increased organizational capacity to offer quality services to individuals and communities experiencing trauma/violence.
- Increased enrollment and completion of education and job training programs for youth.

## **ACCESS TO CARE AND COVERAGE**

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### **Long-term Goal**

All community members have access to high quality, culturally and linguistically appropriate health care services in coordinated delivery systems.

### **Intermediate Goals**

- Increase access to comprehensive health care services for low-income and vulnerable populations.
- Improve the capacity of health care systems to provide quality health care services.
- Increase access to social non-medical services that support health for low-income and vulnerable populations.
- Develop a diverse, well-trained health care workforce that provides culturally sensitive health care.

### **Strategies**

#### Access strategies:

- Provide high-quality medical care to Medi-Cal participants.
- Provide access to comprehensive health care coverage to low-income individuals and families.
- Provide financial assistance to low-income individuals who receive care at KP facilities and can't afford medical expenses and/or cost sharing.
- Support outreach, enrollment, retention and appropriate utilization of health care coverage programs.
- Increase access to primary and specialty care.

#### Capacity of health system strategies:

- Increase capacity of systems and individuals to adopt population health management.
- Increase capacity of systems to participate in value-based care.
- Improve navigation to obtain access to appropriate care within the health care system.
- Promote integration of care between primary and specialty care, including behavioral health care.

#### Social non-medical service strategies:

- Increase and systematize access to needed social non-medical services.
- Provide support to increase enrollment in public benefit programs (including federal food programs) among vulnerable and low-income populations.

#### Workforce strategies:

- Increase access to training and education for diverse populations currently underrepresented in the health care workforce.
- Support the recruitment, hiring and retention of a diverse, culturally competent health care workforce in the clinical and community based settings.

#### Examples:

- Provide grants to expand use of promotores (peer health educators) to provide culturally sensitive assistance & care coordination.
- Fund safety net providers and other community-based organizations to expand and improve primary care access and services.
- Provide grants to fund access to social non-medical services for the homeless.
- Provide grants for use of promotores (i.e., peer educators) through safety net clinics to assist with enrollment in SNAP.
- Provide local grants to food banks and other local nonprofit organizations in underserved neighborhoods to assist in SNAP enrollment.
- Provide grants to implement workforce investment strategies that seek to increase access to employment and advanced training and education among diverse populations currently underrepresented in the healthcare workforce, such as mentoring, tutoring, internships, career exploration programs, and simulations.
- Provide local grants for workforce training programs to train current and future health care providers with the skills, linguistic, and cultural competence to meet the health care needs of diverse communities.
- Partner with county office of education and local youth centers on access to employment, advanced training, and education among diverse populations underrepresented in the healthcare workforce.
- Partner with local foundations and school districts on curricula, training, and health career pipeline programs.
- 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.
- Participate in Medi-Cal Managed Care and Medi-Cal Fee for Service.
- Provide subsidized health care coverage to children (18 & under) in low-income families (up to 300% FPL) who lack access to other sources of coverage.
- Provide Medical Financial Assistance.



- Provide physician and KP staff volunteers at events that provide surgical, specialty, and diagnostic services to low-income, uninsured people.
- Support rotation of residents and trainees in community health centers.

### **Expected Outcomes**

#### Access:

- Increase in the number of low-income patients who receive health care services/coverage.
- Increase in the number of low-income patients that enroll in health care coverage programs.

#### Capacity of health systems:

- Increase in the quality of care provided by safety net providers through PHASE protocol.
- Improve 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.

#### Social non-medical services:

- Increase in referrals and coordination to non-medical social services.
- Increased enrollment and participation in public benefit programs.

#### Workforce:

- Increase in the number of people from underrepresented groups enrolling in education and job training programs.
- Increase in the number of culturally and linguistically competent and skilled healthcare providers.

### **Additional Community Benefit Priorities**

In addition to addressing the selected health needs described above, Kaiser Permanente, as an integrated health care delivery system, dedicates resources that target broader health system needs and upstream determinants of health.

Kaiser Permanente deploys dedicated research expertise to conduct, publish, and disseminate high-quality epidemiological and health services research to improve the health and medical care throughout our communities. Access to reliable data is a significant need of the overall health care system and can also be implemented in service of the identified health needs. Deploying a wide range of research methods contributes to building general knowledge for improving health and health care services, including clinical research, health care services research, and epidemiological and translational studies on health care that are generalizable and broadly shared. 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.

In addition to our significant Community Benefit investments, Kaiser Permanente is aware of the significant impact that our organization has on the economic vitality of our communities as a consequence of our business practices including hiring, purchasing, and environmental stewardship. We will explore opportunities to align our hiring practices, our purchasing, our building and our environmental stewardship efforts with the goal of improving the conditions that contribute to health in our communities.

## X. Evaluation Plans

KFH Fremont will monitor and evaluate the strategies listed above for the purpose of tracking the implementation of those strategies as well as to document the anticipated impact. Plans to monitor will be tailored to each strategy and will include the collection and documentation of tracking measures, such as the number of grants made, number of dollars spent, and number of people reached/served. In addition, KFH Fremont will require grantees to propose, track and report outcomes, including behavior and health outcomes as appropriate. For example, outcome measures for a strategy that addresses obesity/overweight by increasing access to physical activity and healthy eating options might include number of students walking or biking to school, access to fresh locally grown fruits and vegetables at schools, or number of weekly physical activity minutes.

## XI. Health Needs Facility Does Not Intend to Address

The Contributions Committee was careful to recommend a set of health needs to address that could make an impact in the community: Healthy Eating, Active Living, Behavioral Health, Community and Family Safety, and Health Care Access and Delivery. Therefore, the remaining health needs for this area (listed below in alphabetical order) will not be addressed by KFH Fremont, because these needs did not meet the criteria to the same extent that the chosen needs did, and more specifically for the following reasons.

### Asthma

*Asthma is a chronic inflammatory disorder of the airways characterized by episodes of reversible breathing problems due to airway narrowing and obstruction. These episodes can range in severity from mild to life threatening. Asthma affects people of every race, sex, and age; however, significant disparities in asthma morbidity and mortality exist, in particular for low-income and minority populations. Asthma was not a high priority of the community (i.e., the prioritization score was lower) compared to other needs. In addition, few evidence-based strategies were identified that could be applied to this health need. KFH Fremont is better positioned to address asthma management via healthcare access and delivery strategies.*

### Cancer

*Cancer the second most common cause of death in the United States. Behavioral and environmental factors play a large role in reducing the nation's cancer burden, along with the availability and accessibility of high-quality screening. Cancer was not a high priority of the community (i.e., the prioritization score was lower) compared to other needs. KFH Fremont is better positioned to address drivers of cancer via strategies related to healthy eating and active living, and ethnic disparities in cancer incidence and mortality rates via healthcare access and delivery strategies.*

### Cardiovascular Disease/Stroke

*Nationally, more than one in three adults (81.1 million) lives with one or more types of cardiovascular disease. In addition to being the first and third leading causes of death in the U.S., heart disease and stroke result in serious illness and disability, decreased quality of life, and hundreds of billions of dollars in economic loss every year. KFH Fremont is better positioned to address drivers of these needs via strategies related to healthy eating and active living. Kaiser Permanente believes that strategies intended to address the community's healthy eating and active living needs have the potential to decrease cardiovascular disease and stroke in the community as well.*

### Economic Security

*Economic Security, defined principally by community residents as deep concerns about housing costs, the need for good paying jobs, and affordable public transportation, was identified in each of the communities served by Kaiser Foundation Hospitals. While KFH Fremont did not select this need because the Contributions Committee believed it was much less feasible to address this need given limited resources, we understand that the causes are broad, and the solutions extend beyond specific communities across*

the Region, and State. Investments into community infrastructure, and solving the crisis of affordable housing requires many non-traditional partners, beyond health care providers. Kaiser Permanente intends to explore opportunities to support innovative solutions to promote affordable housing, prepare community residents to be successful in seeking jobs and careers, and support effective connections to social services, to address both the causes and impact of economic security.

#### Infectious Disease

*Infectious diseases remain a major cause of illness, disability, and death. Various public health agencies closely monitor infectious diseases to identify outbreaks and epidemics, provide preventive treatment and/or targeted education programs, and allocate resources effectively.* Infectious Disease was not a high priority of the community (i.e., the prioritization score was lower) compared to other needs. In addition, relatively few community resources were identified, providing fewer opportunities for leverage. This need is already being monitored and addressed by the county public health department. KFHM Fremont believes that certain healthcare access and delivery strategies, such as screenings and vaccinations, have the potential to decrease infectious disease in the community as well.

#### Maternal and Child Health

*Improving the well-being of mothers, infants, and children is an important public health goal. The topic area of maternal and child health addresses a wide range of conditions, health behaviors, and health systems indicators that affect the health, wellness, and quality of life of women, children, and families. The risk of maternal and infant mortality and pregnancy-related complications can be reduced by increasing access to quality preconception (before pregnancy) and interconception (between pregnancies) care.* Maternal/child health was not a high priority of the community (i.e., the prioritization score was lower) compared to other needs. In addition, relatively few community resources were identified, providing fewer opportunities for leverage. KFHM Fremont is better positioned to address this need from a prevention standpoint via healthcare access and delivery strategies and via strategies related to healthy eating and active living.