2016 Implementation Strategy Report
for Community Health Needs

Kaiser Foundation Hospital – Oakland
Kaiser Foundation Hospital – Richmond
License #140000052

Approved by KFH Board of Directors
March 16, 2017

To provide feedback about this Implementation Strategy Report,
email chna-communications@kp.org

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

Kaiser Foundation Hospitals – Oakland and Richmond
License #140000052
3600 Broadway, Oakland, CA 94611
and
901 Nevin Avenue, Richmond, CA 94801

I. General Information

Contact Person:	Angela Jenkins, Director, Public Affairs
Date of Written Plan:	December 6, 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 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:	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.

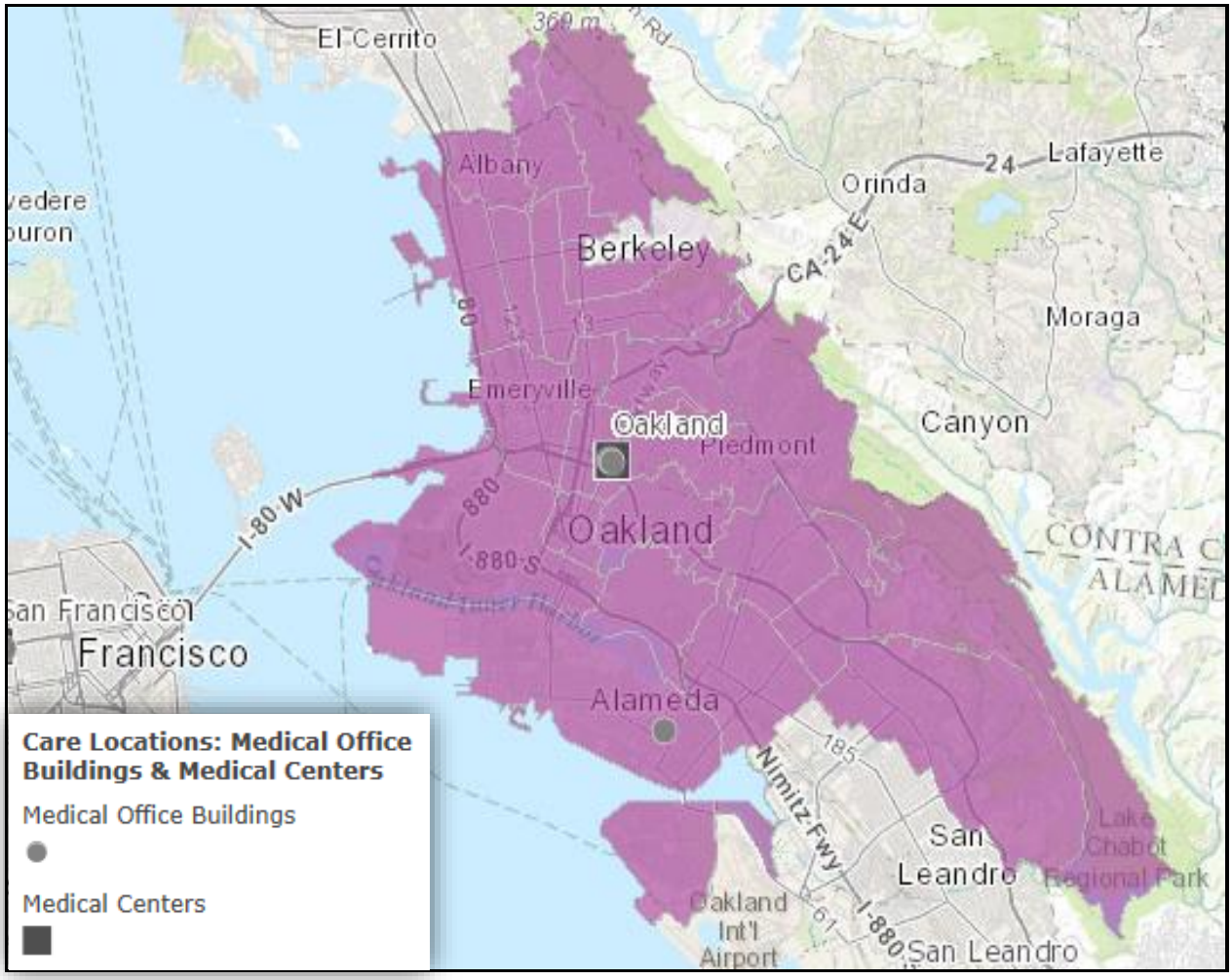
In addition, Kaiser Permanente seeks to promote community health upstream by leveraging its assets to positively influence social determinants of health – social, economic, environmental – in the communities we serve.

IV. Kaiser Foundation Hospitals – Oakland and Richmond Service Areas

The Kaiser Foundation Hospital (KFH) Oakland service area includes the major cities of Alameda, Albany, Berkeley, Emeryville, Oakland, and Piedmont, as well as unincorporated areas covered by the map below.

KFH Oakland Demographic Data	
Total Population	574,123
White	48.36%
Black	17.51%
Asian	20.93%
Native American/ Alaskan Native	0.6%
Pacific Islander/ Native Hawaiian	0.48%
Some Other Race	5.72%
Multiple Races	6.4%
Hispanic/Latino Ethnicity	16.69%

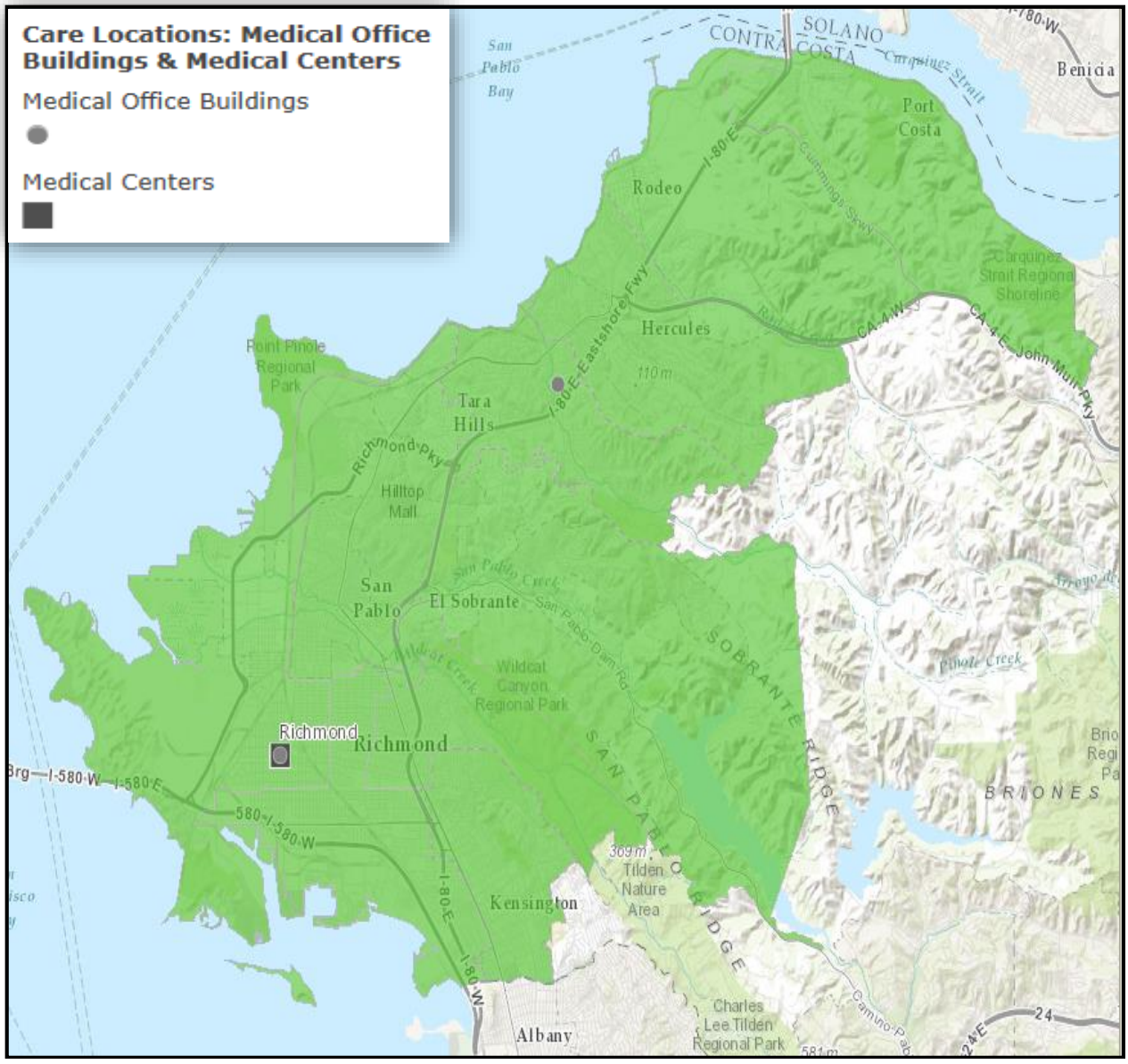
KFH Oakland Socio-economic Data	
Living in Poverty (<200% FPL)	33.43%
Children in Poverty	20.43%
Unemployed	6.6%
Uninsured	12.32%
No High School Diploma	12.5%



The KFH Richmond service area includes the major cities and towns of Crockett, El Cerrito, El Sobrante, Hercules, Pinole, Richmond, Rodeo, and San Pablo, as well as unincorporated areas covered by the map below.

KFH Richmond Demographic Data	
Total Population	251,325
White	46.8%
Black	17.31%
Asian	19.19%
Native American/ Alaskan Native	0.48%
Pacific Islander/ Native Hawaiian	0.37%
Some Other Race	9.67%
Multiple Races	6.19%
Hispanic/Latino Ethnicity	33.99%

KFH Richmond Socio-economic Data	
Living in Poverty (<200% FPL)	33.59%
Children in Poverty	19.75%
Unemployed	6.9%
Uninsured	16.35%
No High School Diploma	18.7%



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 Oakland's and KFH Richmond's planned response to the needs identified through the 2016 Community Health Needs Assessment (CHNA) process. For information about KFH Oakland's and KFH Richmond's 2016 CHNA process and for a copy of the report please visit 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 Oakland and KFH Richmond service areas through the 2016 Community Health Needs Assessment process. The health needs are listed in priority order from highest (#1) to lowest (#10).

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

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 Oakland and KFH Richmond's Community Benefit team, in partnership with the hospitals' consultants and in collaboration with the hospitals' 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 hospitals' Contributions Committee consists of individuals in the following positions:

Continuum Administrator
Chief Compliance and Privacy Officer
Pediatrician and Director of the Pediatric Residency Program
Two Assistant Medical Group Administrators
Area Finance Officer
Director, Public Affairs
Senior Vice President and Area Manager

a. Partner Organizations

In addition to Kaiser Permanente's Northern California Regional Community Benefit as described above, KFH Oakland and KFH Richmond, which share a hospital license, worked together at every step in the development of their single Implementation Strategy. The hospitals share the same Community Benefit team 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 Oakland held a community engagement event in Oakland, California on October 27, 2016. Invitees included community leaders and representatives from community-based organizations and non-profits, including other non-profit hospitals and clinics. A total of 40 people attended.

KFH Richmond held a community engagement event in Richmond, California on October 28, 2016. Invitees included community leaders; experts in violence prevention, behavioral health, community health, and environmental health; and representatives from the Contra Costa County Family Service Center. A total of 29 people attended.

During each event, staff from Actionable Insights, KFH Oakland and KFH Richmond's consulting firm, explained the CHNA and Implementation Strategy development processes that each hospital followed, presented the 2016 CHNA findings and the health needs each hospital selected, and facilitated small group discussions among the event participants based upon each hospital's chosen health needs. The discussions focused on promising practices for addressing the chosen health needs, including collaboration among organizations, and gaps in addressing the chosen health needs, including access-related issues. Participant feedback was collected through note-taking by staff and provided to each hospital's Community Benefit team.

Important insights from participants at the Oakland event included the importance of providers and systems considering the needs of the entire person (such as addressing both behavioral health and physical health) and also working with the entire family. Participants' shared family support is key to create change in the community. The need to hire community members that represent the community served was highlighted and the importance of staff retention was also highlighted. Lastly, all discussion groups emphasized the need for the community to work together collaboratively, but acknowledged the lack of time and dedicated funding to support collective impact efforts. Competition was also a common barrier that was discussed, and the groups felt that funders could encourage collaboration by offering joint funding that is long-term and flexible.

Important insights from participants at the Richmond event included emphasis from participants that the social determinants of health need to be addressed together. Barriers to addressing health needs included language barriers, social isolation, the lack of transportation, and the lack of culturally-relevant amenities (e.g., grocery stores) for some populations. Behavioral health discussion groups stressed the need for using a trauma-informed lens when serving the community, and the need for urgent psychiatric services. Across all chosen health needs, discussion groups encouraged the provision of resources and services at schools. Participants agreed that increasing awareness about the work that others are doing is essential to improving communication and breaking down silos, but that a backbone agency is needed to convene the community. Another idea from participants for delivering health-related information was the use of multiple forms of media to reach the populations with messages about behavioral health, healthy eating, active living, and community safety. Lastly, the need for more services and programs that meet potential clients where they live and work was deemed essential to reaching the people in most need of behavioral and medical health care.

KFH Oakland and KFH Richmond's Community Benefit team considered this community feedback in refining the Implementation Strategies outlined in Section IX of this report. For example, strategies focused on linguistically and culturally relevant support for behavioral health services, support for

organizations that use a multi-generational approach to healing from trauma, support for early behavioral health detection and prevention strategies, and promotion of integrated health efforts to promote continuity of care and collaboration were added.

c. Consultant Used

KFH Oakland and KFH Richmond 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 Oakland and KFH Richmond to review the findings of each 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 Oakland and KFH Richmond Plan to Address

a. Process and Criteria Used to Select Health Needs

The Implementation Strategy development process began when KFH Oakland and KFH Richmond's Director of Public Affairs decided, with the consultants, the criteria (listed below) that would be used to select the health needs that KFH Oakland and KFH Richmond would address.

1. **CHNA prioritization:** How did the health need rank in the CHNA (takes into account severity, scale, health disparities/equity, existence of good interventions, and community prioritization).
2. **Ability to leverage local community assets:** Opportunity to collaborate with existing community partnerships working to address the need, or to build on current programs, emerging opportunities, or other community assets. The consultants gave each need a score on this criterion based on the number of countywide community partner investments/assets listed for this need in the 2016 CHNA report.
3. **KP expertise:** Kaiser Permanente 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. Contributions Committee members assessed this criterion and the two following criteria based on their informed and considered opinions.
4. **Ability to leverage KP-Regional assets:** Opportunity to have Kaiser Permanente Regional CB funding deployed due to alignment with region-wide needs as well as opportunity to draw down other assets of the organization (Total Health).
5. **Feasibility:** Kaiser Permanente has the ability to have an impact given the community benefit resources available.

To score the first criterion, the Director of Public Affairs directed the consultants to assign to each health need its overall prioritization score obtained during the 2016 CHNA process. To score the second criteria, the Director of Public Affairs directed the consultants to develop and assign each health need scores based on information available to them. The consultants proposed the following and the Director of Public Affairs agreed:

- 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.

To score the final three criteria, the consultants proffered the following rubric and the Director of Public Affairs agreed:

- The scores would be based on the informed and considered opinions of the members of the Kaiser Permanente East Bay Area Contributions Committee (representing both KFH Oakland and KFH Richmond). A score of 1 = the need does not meet the criterion, a score of 2 = the need somewhat meets the criterion, and a score of 3 = the need meets the criterion well.

The consultants developed a health needs selection scoring worksheet for use by the Contributions Committee that included definitions of all five criteria, the scoring rubric for each criterion, and pre-assigned scores to each health need for each of the first two criteria.

Prior to the development of the scoring worksheet, the separate needs of Mental Health and Substance Abuse were combined into an 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 two 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 the second criterion.

The Contributions Committee was then asked to participate in a process to select health needs for the hospitals to address in FY2017–2019. The consultants provided a summary of the 2016 CHNA health needs to the Contributions Committee at an in-person meeting on July 22, 2016. During the meeting, the consultants explained the criteria that the Contributions Committee was being asked to consider, the scoring rubrics developed, and facilitated a discussion about the identified health needs.

Contributions Committee members reviewed each hospital's list of needs and discussed each identified health need, keeping in mind the selection criteria. Each health need was then rated by Committee members on how well it met each of criteria #3-#5, and individual Committee members' ratings were then averaged by the consultants to generate one score on each of criteria #3-#5 for each need. Each health need achieved a final score that was the sum of its five selection criteria scores.

Based on committee scoring and additional discussion, CB staff and the Contributions Committee came to consensus on recommendations for selection and provided justifications for the needs they did not recommend for selection.

b. Health Needs that KFH Oakland and KFH Richmond Plan to Address

Behavioral health

Description/definition:

Mental health (including sub-clinical stress, anxiety, and depression in addition to diagnosed mental health disorders) and substance abuse were identified as separate needs in the CHNA but 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 Oakland and KFH Richmond to address the need for behavioral health in the community. KFH Oakland and KFH Richmond have a long history of addressing behavioral health in community settings. Behavioral health strategies, particularly in school-based settings, have been prioritized in past community health needs assessments prior to ACA implementation.

There are substantial local community assets and Kaiser Permanente regional assets that can be leveraged in support of this need. In addition, Kaiser Permanente's vision is to be a leader in the area of behavioral health. Kaiser Permanente, like many other organizations, is feeling the impact of the growing need for behavioral health services via non-member emergency room visits. Kaiser Permanente leadership is committed to investing in prevention and intervention strategies to improve health professionals' response to behavioral health needs. Finally, the need is of high priority to the community, as described below.

The CHNA data supporting the health need is summarized:

- The rate of suicide in Contra Costa County (where KFH Richmond is located) is higher than the Healthy People 2020 target, and the suicide rate in the KFH Richmond service area specifically is higher than the state rate.
- The rate of severe mental illness emergencies in Alameda County (where KFH Oakland is located) is substantially higher than the state rate, and the rates of ER visits for intentional injuries (including self-harm) among youth in both the KFH Oakland and KFH Richmond service areas are higher than the state.
- Levels of excessive alcohol consumption among adults in both service areas are higher than the state average. In addition, in both service areas residents' total household expenditures towards alcohol are slightly higher than the state average of 13%.
- Community input indicates:
    - Residents use substances to self-medicate (to help them cope and sleep).
    - Alcohol is especially easy to access.
    - Cultural barriers make it harder to access mental health care; in addition, there is a lack of providers who are culturally and linguistically diverse.
    - The need for more linkages between primary care and mental health care
    - The community expressed concern about treatment options and that many are too expensive for people to use.
    - There is a shortage of services, both for prevention/early intervention and for inpatient treatment.

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. Children exposed to family and community violence are more likely to develop chronic illness as adults. 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:

Community and family safety is of extremely high priority to the community. The Contributions Committee feels it is feasible for KFH Oakland and KFH Richmond to address the need for community and family safety given past experience with working with community partners to address violence in our communities. There are substantial local community assets and quite a few Kaiser Permanente regional assets that can be leveraged in support of this need, and Kaiser Permanente also has expertise in the subject.

The CHNA data supporting the health need is summarized:

- There are higher rates of domestic violence and assault injury in the KFH Oakland and KFH Richmond service areas than the state averages.
- Both service areas have rates of homicide that are higher than the state rate. Both areas also experience stark ethnic disparities in homicide rates, with Blacks having much higher homicide mortality rates than those of other ethnicities.
- Both service areas have rates of school suspensions that are higher than the state rate. This indicator is relevant because exclusionary school discipline policies, including suspensions and expulsions, are associated with lower educational attainment, higher dropout rates, engagement with the juvenile justice system, incarceration as an adult, decreased economic security as an adult, and poor mental health outcomes, including experiences of stress and trauma.
- Community input indicates:
    - Gang violence is a major issue.
    - There are not enough programs/providers to address violence in the community.
    - Residents explained that exposure to violence is connected to health problems later in life, both physical and mental (related to the trauma of living in an environment where there is crime happening).

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 Oakland and KFH Richmond to address the need for health care access and delivery in the community give our experience as an integrated not-for profit health care delivery system. There are substantial local 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. Finally, the need is of high priority to the community, as described below.

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

- There are high rates of preventable hospital events in both the KFH Oakland and KFH Richmond service areas compared to the state average.
- In both service areas, nonwhites are more likely to be uninsured and also to lack a consistent source of primary care.
- The closure of Doctors Medical Center has created a significant gap in the availability of health care services in West Contra Costa County, leaving KFH Richmond, a small 50-bed facility, as the only hospital in the region.
- Community input indicates:
    - Insurance premiums and co-payments are too high.
    - Wait times for appointments are too long.
    - There is a shortage of trained providers.
    - In many cases, health facilities are far away from community members' homes.
    - Transportation is a significant barrier for many; the nearest county hospital for those in Richmond (which is in Contra Costa County) is in Martinez, nearly 19 miles from downtown Richmond. Paratransit is limited, people need to take buses, and the expense of taking a taxi is prohibitive for most.
    - There is concern about how asthma can be managed when patients do not have a hospital nearby.

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 Oakland and KFH Richmond 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. 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:

- There are higher levels of youth obesity in the KFH Oakland and KFH Richmond service areas than in the state overall.
- Black and Latino youth are disproportionately obese compared to youth overall in the service areas.
- Community input:
    - Community 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.
    - Obesity among youth is of highest concern, and lack of access to affordable, healthy food is driving this health need.
    - The community also noted that students get progressively heavier between elementary school and high school.
    - There is not enough nutrition and health education available.
    -

FOR KFH OAKLAND ONLY:

Economic security

Description/definition:

An individual's health-related behaviors, surrounding physical environments and health care all contribute significantly to how long and how well we live. However, none of these factors is as important to population health as are the social and economic environments in which we live, learn, work, and play. These economic and social conditions are referred to as the "social determinants of health." Research has increasingly shown how strongly social and economic conditions determine population health and differences in health among subgroups, much more so than medical care. For example, research shows that poverty in childhood has long-lasting effects limiting life expectancy and worsening health for the rest of the child's life, even if social conditions subsequently improve. By working to establish policies that positively influence economic and social conditions, we can improve health for large numbers of people in ways that can be sustained over time.

Rationale:

Because of a clear and substantial commitment to this need by the City of Oakland, and because of the dedication of additional regional assets to this need in the KFH Oakland service area, the Committee recommended that Economic Security be selected as a health need by KFH Oakland.

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

- In the KFH Oakland and KFH Richmond service areas, the proportions of Black, Latino, and Pacific Islander residents, and residents of "some other race," living below the Federal Poverty Level (FPL) are higher than the state average. In addition, minority households with children in the service areas are more likely to be below 100% FPL than White households with children in the service areas.
- Food insecurity is associated with chronic diseases such as hypertension, diabetes, and obesity. Compared to the Healthy People 2020 goal, nearly triple the proportion of households in the KFH Oakland service area and more than double the proportion of households in the KFH Richmond service area experienced food insecurity in the prior year.

- The cost of housing in the Bay Area is high. Across the state, for 54% of renters, housing costs are more than 30% of their income (cost-burdened households). In the KFH Oakland and KFH Richmond service areas, nearly the same proportions of households are cost-burdened as at the state level.
- A high school diploma is often a requirement for a well-paying job. The four-year high school graduation rate for youth in the KFH Oakland and KFH Richmond service areas were lower than the HP2020 goal.
- Community input:
    - Gentrification is causing people not to feel at home in their own neighborhoods.
    - Even if policy is passed to help ease the cost of housing, housing stock is still limited.
    - Lower income jobs are less secure and easily succumb to the ups and downs of the economy.
    - Difficult to prioritize your health when you are homeless.
    - Lack of full-access supermarkets (i.e., food deserts) and cost of food is keeping people away from healthy food.

IX. KFH Oakland's and KFH Richmond's Implementation Strategies

As part of the Kaiser Permanente integrated health system, KFH Oakland and KFH Richmond each 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 Oakland and KFH Richmond each 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 Oakland and KFH Richmond welcome future opportunities to enhance their strategic plans by relying on and building upon the strong community partnerships it currently has in place.

KFH Oakland and KFH Richmond each 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.

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 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 systems 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 services 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.

For example:

- Participate in Medi-Cal Managed care.
- Participate in 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.
- Support effort to improving health care access and utilization
- Fund programs and/or providers to improve access to care for chronic health conditions (i.e. asthma, diabetes, comorbidities).
- Fund programs and/or organizations to conduct targeted outreach and screening for chronic unmanaged health conditions specific to geographic area.
- Fund safety net providers (e.g., community clinics) to expand & improve primary care access, navigation, & services.
- Fund programs and/or organizations via local grants to provide case management and social services at health care centers.
- Participate in Healthy Richmond Collaborative and Oakland and West Contra Costa Clinic Consortium.
- Participate in Community Health Center Network (CHCN), a partnership of community health centers committed to enhancing our ability to provide comprehensive, quality health care in a manner respectful of community traditions and values.
- Partner with Operation Access, a nonprofit dedicated to providing access to free surgery and specialty care, to enable KP medical volunteers to provide free outpatient consultations, specialty care, and same-day surgery appointments to uninsured patients.
- Support via regional grants population health management approaches that improve health outcomes for safety net patients with diabetes and hypertension.

- Support community health centers and public hospital organizations to participate successfully in waiver and demonstration programs moving from fee for service to capitation.
- Support screening for social non-medical service needs and referrals to community services.
- Support pilot demonstration projects with faith-based organizations to connect caregivers and patients with end of life planning and other services.
- 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 via programs that prepare under-represented students for success in the medical school application process.
- Support successful recruitment and retention efforts to address workforce shortages in the health care safety net.
- Implement health care workforce pipeline programs to introduce diverse, under-represented school age youth and college students to health careers.
- Provide workforce training programs to train current and future health care providers, including physicians, mental health practitioners, physical therapy, pharmacy, nurses, and allied health professionals, with the skills and linguistic and cultural competence to meet the health care needs of diverse communities.
- Provide National Facility Services in-kind consultation at the institutional level on design and construction for safety net capital projects.
- Provide access to KP expertise related to population health management via trainings and consultation.
- Support at the institutional level 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.
- 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.

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.

HEALTHY EATING ACTIVE LIVING

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.

For example:

- Fund programs to help community residents learn to shop for and cook healthy food (i.e., to change their behaviors with regard to food).
- Support garden to dinner table programs for youth and families.
- Support programs that advocate for equitable access to healthy food (i.e., community gardens, food systems and local markets).
- Fund programs and/or organizations to provide physical activities to children and youth in local schools.
- Participate in Oakland Healthiest City Initiative and HOPE Collaborative
- Partner with YMCA, community clinics and thriving schools
- Support institutional healthy food procurement.
- Support an optimized supply chain for fresh local produce and small farmers.
- Support the supply of fresh produce to local food banks.
- Support institutional healthy food and beverages policies.
- Support the development and use of innovative technology to decrease barriers to CalFresh enrollment.
- Support the creation and revitalization of park and playgroup spaces.
- Support programs and policies in schools that maximize opportunities for physical activity.
- Provide KP's Educational Theater, programming that provides education in schools on health and wellness.
- Support sustainable food distributors at the institutional level by purchasing locally produced fruits and vegetables.
- Support at the institutional level local restaurants and caterers that meet healthy food guidelines.
- Host farmers markets at KP facilities.
- Include space for physical activity, play & active transportation in new KP facility design, 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

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.

For example:

- Fund grants to improve early identification of behavior health needs in schools and clinics.
- Support trauma-informed screening and counseling services.
- Fund programs and/or organizations that provide cognitive behavioral therapy for families, in schools and community-based organizations.
- Fund programs that are linguistically and culturally relevant for targeted populations to destigmatize behavioral health issues and services.
- Fund programs that increase minority representation in the behavior health field.
- Support culturally appropriate programming to promote healing in communities with high rates of trauma and/or violence.
- Partner with faith-based organizations and CBOs focused on providing school-based mental health services.
- Participate in Healthy Richmond and Oakland and West Contra Costa Clinic Consortium.

- Support depression screening and follow-up as part of population health management initiatives.
- Support the use and adoption of screening tools for risk of exposure to trauma.
- Support the creation and revitalization of park and playgroup spaces.
- Support programs that promote social and emotional wellness in community-based organizations and schools.
- Support programs that reduce stigma for mental health in schools and community settings.
- Support programs that increase minority representation in the behavioral health field.
- Support health care workforce pipeline programs to introduce diverse, underrepresented school age youth and college students to health careers, including in behavioral health.
- Support programs to promote integration of care between primary and behavioral health care.
- Support community health workers who assist community members with obtaining appropriate services.
- Support the capacity of clinics, schools and other community-based organizations to provide trauma-informed care.
- Provide KP's Educational Theater, programming that provides education in schools on health and wellness.
- Conduct outreach by KP to under-represented populations to support entering behavioral health professions.
- KP Mental Health Training Program – provide training to future mental health providers.
- At the institutional level, mental health training program participants rotate through community clinics and other community-based organizations to provide behavioral health services and training.
- Share KP PSAs about depression with community organizations.

Expected Outcomes

Prevention:

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

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.

For example:

- Support organizations and programs who focus resources on youth with current or previous juvenile justice involvement and who have a history of violence related offenses into education, job training and enrichment programs.
- Fund youth development and wraparound services for youth from high-risk communities.
- Support restorative justice programs in schools and in the community.
- Support domestic violence and child abuse prevention programs that work with victims and/or perpetrators.
- Fund organizations and/or providers for cognitive behavioral therapy particularly for the reentry population.
- Support outreach and crisis response programs.
- Support hospital-based programs and crisis response programs.
- Partner with faith-based organizations, RYSE, Youth Alive and Public Health Departments
- Participate in Oakland Healthiest City Initiative.
- Participate in Oakland Promise, Richmond Promise and Healthy Richmond
- Explore collaborations coordinated by Urban Strategies Council, e.g., Oakland-Alameda County Alliance for Boys and Men of Color (BMoC) and/or Oakland-Alameda County Opportunity Youth Initiative (OYI).
- Support law enforcement and community engagement and trust-building activities.
- Support training for law enforcement officers and departments on trauma, adolescent development, community stressors and resilience.
- Support safe, free, youth-engagement programs and organizations in after-school and neighborhood settings particularly in low-income communities.
- Support Restorative Justice programs and other trauma-informed programs/efforts within schools.
- Support and increase availability and use of multi-service, family justice centers.
- Support programs and services that support disenfranchised and high-risk youth including foster and homeless youth, with a focus on safety and long-term health and stability for youth.

- Support programs and services that provide outreach and long-term skilled case management for gang affiliated and/or youth at high-risk for being engaged in violence.
- Support efforts that strengthen capacity of clinics, schools and other community-based organizations to provide trauma-informed care to youth and individuals seeking care.
- Support trauma-informed, mental/behavioral health counseling and services in community-based organizations and schools via regional grants.
- Support hospital-based, violence intervention programs that provide long-term support and case management services to youth, injured by violence starting at bedside, to reduce retaliation and improve outcomes.
- Implement a paid summer internship program for underserved high school students at KP medical centers and administrative offices.
- Provide college-level internship programs for underrepresented college students at Kaiser Permanente medical centers and administrative offices.
- Provide KP's Educational Theater, programming that provides education in schools on health and wellness.
- Technical consultation and logistical support from KP's Multimedia & Communications for media efforts.

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.

FOR KFH OAKLAND ONLY:

ECONOMIC SECURITY

Long-term Goal

All community members have access to the basic needs necessary to thrive.

Intermediate Goals

- Increase access to safe, quality affordable housing and support services for the most vulnerable populations affected by homelessness and housing displacement.
- Increase opportunities for education, training and employment for vulnerable and low-income populations.
- Increase enrollment in and use of public benefit programs among vulnerable and low-income populations, including social non-medical services.
- Improve community revitalization and economic health.

Strategies

Housing and support strategy:

- Support innovative solutions to develop affordable, sustainable housing to increase availability and decrease displacement for low and moderate income families

Education, training & employment strategies:

- Increase availability of job training programs for high risk populations.
- Improve educational attainment and college readiness among youth from educationally disadvantaged backgrounds.
- 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.

Connection to services strategies:

- Provide support to increase enrollment in public benefit programs (including federal food programs) among vulnerable and low income populations.
- Increase and systematize access to needed social non-medical services.
- Increase access to safe, affordable transportation to promote access to necessary services (Active transportation/HEAL).

Community revitalization strategy:

- Provide support to improve economic outcomes for communities.

For example:

- Participate in Oakland Thrive Council which preserves and protects affordable housing.
- Partner with community college districts and workforce coalitions on strategies to address academic success of youth from educationally disadvantaged backgrounds at the Regional and State level.
- Participate 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.
- Support non-profit housing developers who are exploring innovative solutions to the affordable housing shortage.
- Support the connection of residents in affordable housing to a range of critical health and human services.
- Support programs that provide access to job training programs for high-risk populations.
- Support organizations focused on improving academic success of youth from educationally disadvantaged backgrounds.
- Support organizations who work with re-entry population to help them successfully access jobs.
- 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 programs that prepare underrepresented students for success in the medical school application process.
- Support successful recruitment and retention efforts to address workforce shortages in the health care safety net.
- Support Market Match to provide incentives for CalFresh users to purchase produce at farmers markets.
- Support the development and use of innovative technology to decrease barriers to enrollment in CalFresh.
- Support programs that provide financial literacy support.
- Implement a paid summer internship program for underserved high school students at KP medical centers and administrative offices.

- Implement KP health care workforce pipeline programs to introduce diverse, underrepresented school age youth and college students to health careers.
- Provide KP workforce training programs to train current and future health care providers, including physicians, mental health practitioners, physical therapy, pharmacy, nurses, and allied health professionals, with the skills and linguistic and cultural competence to meet the health care needs of diverse communities.
- Explore social impact investing opportunities in service of promoting affordable housing.
- At the institutional level, support vendors that hire under/unemployed residents in specific communities and provide living wages and benefits.
- Explore implementing policies and standards at the institutional level to procure supplies and services from diverse vendors.
- Build capacity of small businesses to be able to contract with KP in target neighborhoods/populations.
- At the institutional level, target recruitment activities in underrepresented or lower socio-economic communities, focused primarily on working with local organizations to educate the community on hiring practices and jobs available.
- At the institutional level, focus efforts on local hiring.

Expected Outcomes
- Increased availability and utilization of affordable housing.
- Increased enrollment and completion of education and job training programs.
- Improved educational outcomes.
- Increase in number of culturally and linguistically competent and skilled healthcare providers.
- Increased enrollment and participation in public benefit programs.
- Increase in referrals and coordination between healthcare providers and social non-medical services.
- Improved transportation access to necessary services.

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 disproportionally impacted by heath 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.

X. Evaluation Plans

KFH Oakland and KFH Richmond each 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 Oakland and KFH Richmond each 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 Facilities Do Not Intend to Address

The Contributions Committee was careful to choose a set of health needs to address that best met all of the selection criteria and for which KFH Oakland and KFH Richmond each could make an impact in the community. The Contributions Committee thought it was feasible to address the health needs listed above, given its local community benefit resources and, in the case of Economic Security for Oakland, the clear and substantial local commitment to addressing the need. The remaining health needs did not meet the criteria to the same extent as the chosen needs did; therefore, KFH Oakland and KFH Richmond do not plan to address them at this time. They are listed below in alphabetical order.

Asthma

Although Asthma was not selected as a standalone top priority, the Contributions Committee agreed to address asthma under Healthcare Access and Delivery.

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. Kaiser Permanente in the East Bay is better positioned to address asthma management via healthcare access and delivery strategies.

Cancer

Although cancer was not selected as standalone top priority, the Contributions Committee agreed to address cancer under Health Access and Delivery.

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. Kaiser Permanente in the East Bay 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.

Economic Security (selected for KFH Oakland but not KFH Richmond)

Economic Security, defined 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. KFH Richmond did not select this need because it is much less feasible to address locally than the other selected health needs given the resources required to have an impact. However, we understand that the causes are broad, and the solutions can 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 regionally 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 diseases

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 diseases were 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. Kaiser Permanente in the East Bay 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.

Sexually-Transmitted Infections

Sexually- transmitted infections are diseases that are primarily transmitted through direct sexual contact with an infected individual or their discharge (such as blood or semen). They include HIV/AIDS, syphilis, chlamydia, gonorrhea, and genital herpes. Communicable diseases such as sexually transmitted infections are closely monitored by various public health agencies to identify outbreaks and epidemics, provide preventive treatment and/or targeted education programs, and allocate resources effectively. Sexually-transmitted infections were 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. Kaiser Permanente in the East Bay believes that certain healthcare access and delivery strategies, such as screenings and vaccinations, have the potential to decrease sexually-transmitted infections in the community as well.