2016 Implementation Strategy Report
for Community Health Needs

Kaiser Foundation Health Plan of the Mid-Atlantic States

Approved by KFH Board of Directors
March 16, 2017

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

TABLE OF CONTENTS

List of Tables

List of Figures

List of Appendices

I. General Information

Contact Person:	Karen Blair, Vice President, Marketing Communication, Brand Management and Public Relations
Date of Written Plan:	December 19, 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
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Name and EIN of Health Plan Organization:	Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., 52-0954463
Address of Hospital Organization:	2101 E. Jefferson Street, Rockville MD 20852

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.

Care for members and patients is focused on their **total health**[a] [1] and guided by their personal physicians, specialists, and team of caregivers. Our expert and caring medical teams are empowered and supported by industry-leading technology advances and tools for health promotion, disease prevention, state-of-the-art care delivery, and world-class chronic disease management.

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.

Across these areas, we work to inspire and support people to be healthier in all aspects of their lives, and build stronger, healthier communities. Good health for the entire community requires a focus on **equity**[b] as well as social and economic well-being. In addition, Kaiser Permanente seeks to promote community health upstream by leveraging its assets to positively influence **social determinants of health**[c] [1] – social, economic, environmental – in the communities we serve.

[a] **Total health**: Total health is defined as "a state of complete physical, mental, and social well-being for all people." These three inter-related facets include focusing on the "whole-person" (resilience factors); delivering highest quality health care services focused on community assets (i.e. transportation, safe housing); and leveraging all available assets to support positive health outcomes.

[b] **Equity**: Kaiser Permanente used a health-equity lens to understand why certain groups are most at-risk for poor health outcomes. The goal in using an equity lens is to successfully alleviate disproportionate negative health outcomes for these populations by addressing policies and programs related to relevant social, economic, and environmental issues.

[c] **Social determinants of health**: An individual's health is not solely determined by genetics, but rather is determined by social, economic, and environmental issues representing "a complex of factors related to where people are born, grow, work, live, and age" that affect the daily conditions of an individual's environment. Specifically, these determinants include quality of care; access to care; physical environment; healthy behaviors; and social and economic factors.

IV. Kaiser Foundation Hospitals – KFHP-MAS Service Area

Kaiser Foundation Health Plan of the Mid-Atlantic States, Incorporated (KFHP-MAS) operates in 29 locations, serving over 665,000 members in Maryland, Virginia, and the District of Columbia. The KFHP-MAS region consists of three service areas: greater Baltimore (BALT), District of Columbia and Suburban Maryland (DCSM), and Northern Virginia (NOVA). Thirteen cities and counties from the KFHP-MAS region were selected for inclusion in this study based on the following criteria: 1) the city or county contains a Kaiser Permanente Medical Office Building and, 2) the population of the city or county represents greater than 1% of the population served within the Mid-Atlantic States. Table 1 presents the cities and counties selected for inclusion in the CHNA by service area. A map of the KFHP-MAS region is presented in Figure 1.

Table 1. KFHP-MAS Cities and Counties Included in CHNA Report

BALT	DCSM	NOVA
Anne Arundel County	District of Columbia	Alexandria City
Baltimore City	Frederick County	Arlington County
Baltimore County	Montgomery County	Fairfax County
Howard County	Prince George's County	Loudoun County
		Prince William County

Figure 1. Map of KFHP-MAS Communities Served

An overall demographic profile of the region is presented in Tables 2 and 3. Demographic data for each of the cities and counties included in this report are presented by service area in Figures 2, 3, and 4.

Table 2. Regional Demographic Profile

KFHP-MAS Demographic Data	
Total Population	7,303,724
White	54.3%
Black	28.6%
Asian	9.0%
Native American/ Alaskan Native	0.3%
Pacific Islander/ Native Hawaiian	0.1%
Some Other Race	4.3%
Multiple Races	3.4%
Hispanic/Latino	12.3%

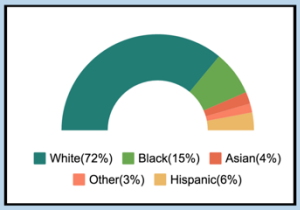
Table 3. Regional Socioeconomic Profile

KFHP-MAS Socio-economic Data	
Living in Poverty (<200% FPL)	21.6%
Children in Poverty	12.3%
Unemployed	4.5%
Uninsured	10.6%
No High School Diploma	10.3%

Figure 2. Greater Baltimore Service Area Demographic Profile

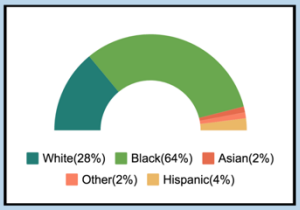
Anne Arundel County

- Population: 544,426
- 50.5% 49.5%
- High school graduation rate: 85.0%
- Uninsured: 7.8%
- Below 100% FPL: 6.3%
- Unemployed: 4.8%
- Median age: 38.5
- 24.0% of service area



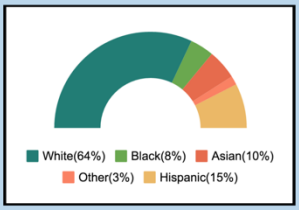
Baltimore City

- Population: 621,445
- 52.9% 47.1%
- High school graduation rate: 66.0%
- Uninsured: 13.1%
- Below 100% FPL: 23.8%
- Unemployed: 8.1%
- Median age: 34.5
- 27.3% of service area



Baltimore County

- Population: 812,261
- 52.7% 47.3%
- High school graduation rate: 84.0%
- Uninsured: 9.4%
- Below 100% FPL: 8.9%
- Unemployed: 5.8%
- Median age: 39.1
- 35.8% of service area



Howard County

- Population: 293,821
- 51.0% 49.9%
- High school graduation rate: 90.0%
- Uninsured: 7.2%
- Below 100% FPL: 4.6%
- Unemployed: 4.2%
- Median age: 38.6
- 12.9% of service area

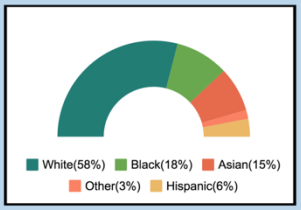


Figure 3. District of Columbia-Suburban Maryland Service Area Demographic Profile

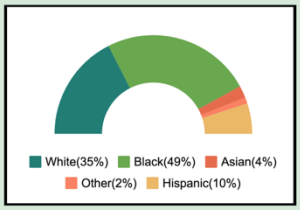
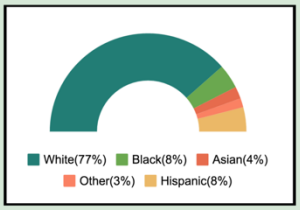
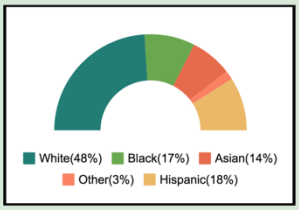
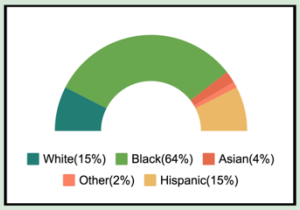
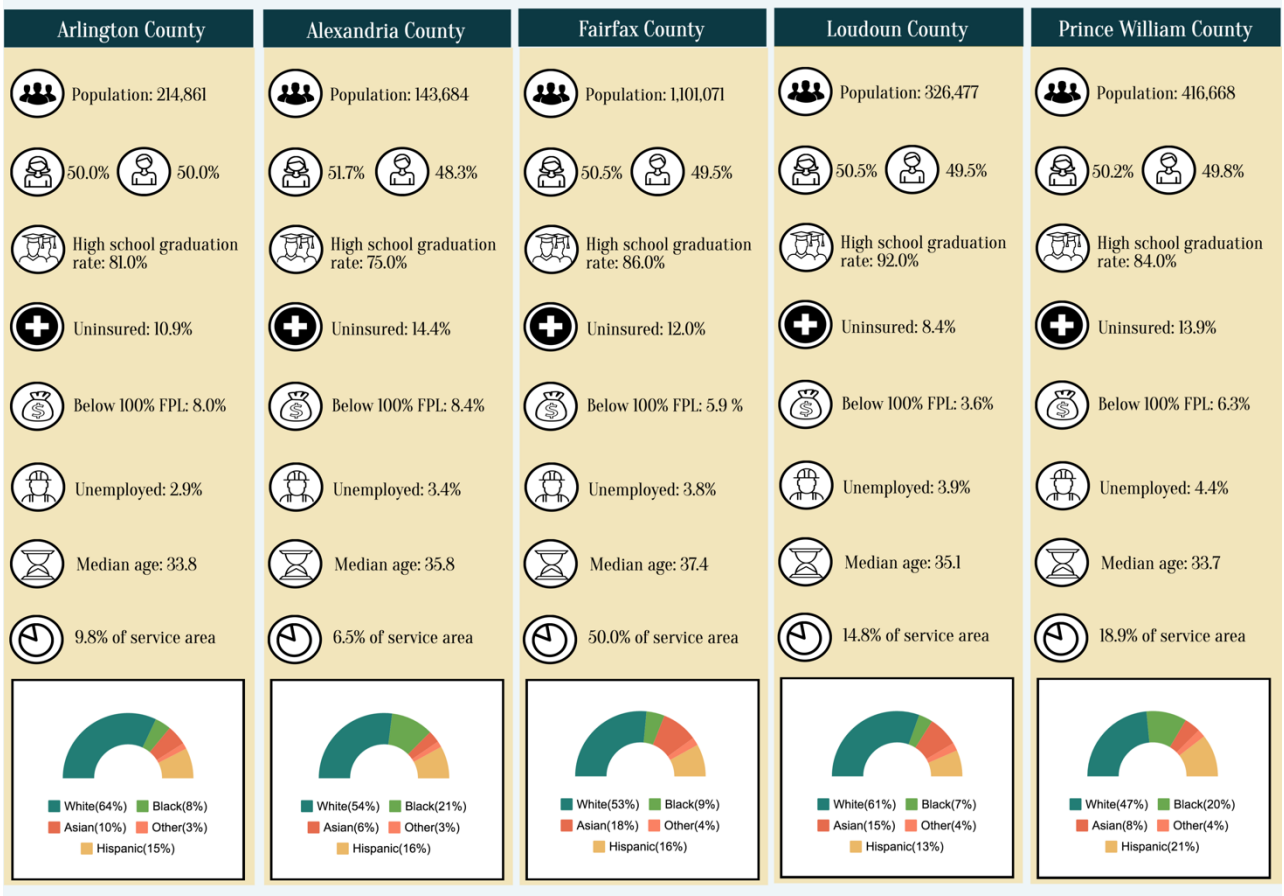
District of Columbia	Frederick County	Montgomery County	Prince George's County
Population: 619,371	Population: 236,668	Population: 989,474	Population: 873,481
52.7% 47.3%	50.8% 49.2%	51.9% 48.1%	52.0% 48.0%
High school graduation rate: 54.0%	High school graduation rate: 93.0%	High school graduation rate: 87.0%	High school graduation rate: 73.0%
Uninsured: 6.7%	Uninsured: 7.8%	Uninsured: 11.5%	Uninsured: 15.4%
Below 100% FPL: 18.7%	Below 100% FPL: 6.1%	Below 100% FPL: 6.7%	Below 100% FPL: 9.4%
Unemployed: 7.7%	Unemployed: 7.7%	Unemployed: 4.2%	Unemployed: 5.5%
Median age: 33.7	Median age: 38.9	Median age: 38.5	Median age: 35.5
22.8% of service area	8.7% of service area	36.4% of service area	32.1% of service area
			

Figure 4. Northern Virginia Service Area Demographic Profile



V. Purpose of Implementation Strategy

As Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. does not own nonprofit hospital facilities, this Implementation Strategy has been voluntarily 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 KFHP-MAS' planned response to the needs identified through the 2016 Community Health Needs Assessment (CHNA) process. For more information about KFHP-MAS'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

This CHNA was completed through a multi-stage and mixed methods approach designed to integrate findings from secondary data with the experiences, expertise, and opinions of key community stakeholders gathered through primary data collection. Table 4 summarizes the health needs identified for the KFHP-MAS region through the 2016 Community Health Needs Assessment process, and offers a brief description of each health needs. Each health need is presented in order of priority.

Table 4. Priorities Health Needs

Prioritized health needs	Description
Socioeconomic Security	Research shows particularly strong and consistent associations between socioeconomic security, such as access to employment, education, and income across time and geography, and a variety of health outcomes. There are also solid, credible mechanisms explaining why lower socioeconomic groups have poorer health outcomes [2].
Health Care Access	Access to affordable, quality health care is important to physical, social, and mental health, as well as to the achievement of health equity. Health insurance helps individuals and families access needed primary care, specialists, and emergency care, but it does not ensure access on its own. Providers must also offer affordable care, be available to treat patients, and be in relatively proximity to patients [3].
Obesity/ Overweight	The environments where we live, learn, work, and play affect our access to healthy food and opportunities for physical activity that, along with genetic factors and personal choices, shape our health and risk of being overweight or obese [4].
Mental Health	Mental health includes our emotional, psychological, and social well-being. It affects how we think, feel, and act. It also helps determine how we handle stress, relate to others, and make choices. Mental health is important at every stage of life, from childhood and adolescence through all phases of adulthood [5].
Diabetes	Diabetes is a condition where blood sugar glucose levels are erratic. It is associated with cardiovascular disease, kidney failure, blindness, and amputations [3]. Moderate weight loss and exercise can prevent or delay Type 2 diabetes in individuals at high risk.
Physical Environment	The housing options and transit systems that shape our communities' built environment affect where we live and how we get from place to place. The choices we make about housing and transportation, and the opportunities underlying these choices, also affect our health [6].

VII. Who was Involved in the Implementation Strategy Development

The CHNA team applied key principles of community-based participatory research (CBPR) to foster authentic engagement from trusted members of the local community during the development of the Implementation Strategy [7]. Community-based participatory research is a research paradigm that integrates education and social action to improve health and reduce health disparities [8]. CBPR emphasizes a collaborative approach to research that equitably involves partners in all stages of the process. Some key principles of CBPR that were applied in the development of Implementation Strategy activities include: building on community strengths and assets, facilitating collaborative partnerships, integrating knowledge and action for the benefit of all partners, and addressing social inequalities [9].

In keeping with CBPR principles, KFHP-MAS made it a priority to engage community members, public health experts and internal Kaiser Permanente stakeholders in the Implementation Strategy process. Between February and September 2016, the CHNA team thoughtfully organized events to reach community organizations and community residents, and invite them to voice their opinion about how to make sustainable improvements in the health of their communities. Community engagement was heightened during the Implementation Strategy process rather than the needs identification process to create a superior touchpoint for dialogue that focused on finding solutions, rather than on identifying problem areas.

The 2016 Implementation Strategy process applied three principles to meaningfully engage the community. These principles involved identifying geographic pockets of highest need through the creation of an index to **measure** social and health indicators at the census tract level; **engage** the community in meaningful discussions around community health needs and solutions; and create opportunities to **innovate** by generating novel solutions to address complex issues in our communities. Through these guiding principles, the CHNA team engaged community residents, public health experts and internal KP staff to co-create a vision that meets the needs identified through the CHNA, while embracing a Total Health approach. Below is a brief overview of these activities, followed by the partner organizations who helped plan them.

In total, over 200 organizations around the MAS region participated in the Measure, Engage, and Innovate activities. These organizations were invited to learn about the CHNA findings, and share their voice as part of our community engagement efforts. For a complete list of organizations who participated in our Implementation Strategy activities, please refer to Appendix A.

a. Partner Organizations

Table 5 lists the partners involved in each of the three activities, and defines their roles in the Implementation Strategy development. KFHP-MAS contracted with four primary partner organizations who helped plan and coordinate the three Implementation Strategy activities. A brief description of each organization is provided below.

Table 5. Partnerships during Implementation Strategy

Strategy	Activity	Organization	Primary roles
Measure	Total Health Index	Morgan State University	Develop Total Health Index to conduct additional analyses of neighborhood-level data, and inform a "place-based strategy" to select communities in highest need by census tract.
Engage	Town Halls	Washington Regional Association of Grantmakers Community Health Action	Organize three town hall style community dialogues to incorporate stakeholder feedback into 2016 Implementation Strategy report.
Innovate	Social Innovation Challenge	The Living Well BeMyApp Coppin State University Baltimore Innovation Week Technical.ly Baltimore Leaders of a Beautiful Struggle Innovation Village Juxtopia Urban Innovation and Cooperative Entrepreneurship Oracle RELI Group Microsoft	Organize a Social Innovation Challenge for Baltimore City to create opportunities for millennials to find meaningful solutions to CHNA identified needs.

Morgan State University: Morgan State University is a historically black college located in northeast Baltimore City. Morgan State University is responsible for addressing "the needs of residents, schools, and organizations within the Baltimore Metropolitan Area". Their core values of excellence, integrity, respect, diversity, innovation, and leadership reflect their mission in graduating socioeconomically and academically diverse students with a wide range of experiences who then pursue the university's core goal in "addressing societal problems, particularly those prevalent in urban communities" [10].

Washington Regional Association of Grantmakers (WRAG): WRAG functions as a membership association for grantmakers in the Greater Washington area, including Northern Virginia, suburban Maryland, and the District of Columbia. WRAG's mission is to promote "increased, effective, and responsible philanthropy to improve the health and vitality of the region and all who live here" [11].

Be My App: BeMyApp is a developer relations agency focusing on digital transformation and innovation across the globe. Working as a third-party guide in collaboration with clients, they aid in company-based or event-based technical operations and logistics. Currently, they have organized 400+ hackathons, accelerators, and customized innovation programs in 24 countries [12].

Coppin State University: Located in northwest Baltimore City, Coppin State University is a historically black university that promotes student learning and growth in conjunction with "primarily focusing on the problems, needs and aspirations of the people of Baltimore's central city and its immediate metropolitan area". Their student body is comprised of mostly Baltimore residents who are ethnically, religiously, and socioeconomically diverse. These students pursue careers within the State of Maryland, mostly dedicating their efforts to Human Services [13].

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

KFHP-MAS launched an ambitious initiative to bring together key stakeholders as partners in helping produce improved community health. Recognizing the existing strengths in our diverse communities, the CHNA team was intentional in leveraging the expertise of local leaders, and gaining feedback on challenges and solutions affecting community health. By promoting an atmosphere of bidirectional learning, KFHP-MAS positioned participating organizations as equal partners, thus favoring a collaborative approach to work in the region. The following section describes KFHP-MAS' community engagement strategies in more detail.

MEASURE - Total Health Index

Overview: KFHP-MAS engaged Morgan State University to develop a Total Health Index that would build on the findings from the CHNA to determine community-level (in addition to county level) health indicators. The overarching goal of the Total Health Index was to inform the selection of a "place" for the "place-based strategy" by mapping out distinguishable spaces that exhibited "health at risk density (HARD)" across multiple indicators. HARD zones are defined as at-risk areas based on poor performance on multiple health indicators.

Methods/ findings: Based on a thorough review of existing data and literature, as well as community generated data to identify critical indicators for inclusion in the index, Morgan State University identified four existing indexes to be incorporated into the Total Health Index. As such, the Total Health Index is a composite index of census tract data from four existing indexes: Low Poverty Index [14], School Proficiency Index [15], Social Vulnerability Index [16], and Environmental Hazard Index [17]. The indexes have the following domains in common – socioeconomics, public safety, housing, transportation, and health/health care access. Available data were reported at census tract level.

Morgan State University also collected primary data in Baltimore City, Prince George's County, and Fairfax, Virginia to gather community insights that would inform the Total Health Index via 16 focus groups with 100 participants and eight targeted key informant interviews.

Focus groups revealed commonalities across the three jurisdictions regarding social attributes that distinguish healthy versus unhealthy communities (e.g., social cohesion, strong leadership, and community attitudes) and prioritized community concerns around public safety (e.g., gangs, violence, fear of violence), police engagement (e.g., brutality versus protection), sanitation issues (e.g., rats, trash, litter), and structural investments (e.g., sidewalks, abandoned houses). Jurisdictional variation existed (e.g., focus on policing in Baltimore and immigration in Northern Virginia) as did variations in perceptions of earmarks of healthy community by age (e.g., interpretation of the value of parks and dirt bikes).

During one of the Baltimore focus group discussions, a Baltimore resident shared a sense of helplessness, exacerbated by the uprising following the death of Freddie Gray. This respondent indicated that after the Freddie Gray murder, people from communities were demanding positive change but eventually everyone stopped fighting. When it became apparent they were no longer fighting, the authorities took back the things they promised to give. Below is a direct quote: *"After they took pictures of us, like, you know, we were in a zoo, they came and they poked sticks at us. And they watched us and gave us little trinkets and stuff like that. Then they backed off and they watched to see what we were going to do. If we were going to keep fighting...we didn't […]. The purpose wasn't about Freddie Gray, it was about all of us as a whole."*

ENGAGE – Community Dialogues

Overview: Supported by Washington Regional Association of Grantmakers, KFHP-MAS organized three Community Dialogues (one in each of the three services areas) to connect with stakeholders beyond organizations and leaders with whom KFHP-MAS typically collaborates. The goal of the Community Dialogues was to implement community-informed strategies in the highest need areas by having stakeholders weigh in on implementation strategies. More than 300 individuals from 168 organizations attended the Community Dialogues and provided feedback on implementation strategies that meet the needs of prioritized health needs identified through the CHNA process. Table 6 includes the number of participants and organizations who attended the three Community Dialogues.

Table 6. Number of attendees/ organizations who attend the town hall events

Service Area	Number of attendees	Number of organizations
BALT	128	54
DCSM	103	72
NOVA	77	42

Methods/ findings: The Community Dialogues incorporated two workgroup sessions to solicit feedback about identifying and designing community-based solutions to the region's most pressing health challenges. To this end, participants were asked to: 1) identify gaps that currently exist in available services, geographic distribution of services, and/or funding for each of the six identified health needs, and 2) plan to invest $1 million to address one, a few, or all six of the identified health needs over the next year. Refer to Appendix B for a complete description of workgroup instructions.

Participants recorded responses to the questions onto flip charts, which were collected after each session. All entries were transcribed and analyzed using Microsoft Excel. Entries were associated with a priority health need, and then compared to one another to identify common themes. In DCSM for example, 51 responses related to health care access. Of the 51 responses, 12 responses addressed the question of gaps in available services. Response clusters were compared to identify common themes. For gaps in health care access, the common themes identified were: lack of wrap-around services, lack of affordable health care options, and poor infrastructure to track referrals and outcomes.

INNOVATE – Social Innovation Challenge

Overview: The Social Innovation Challenge was a community-led social venture contest and incubation program designed to gather Baltimore City residents with local leaders, social entrepreneurs, artists, technology specialists, and public health experts to brainstorm, design, and build solutions to improve the health of their community, create a business, or both. The theme of the Challenge, "Transforming our Health through Social Innovation," was aimed at mobilizing residents to develop solutions to Baltimore City's most complex issues: education and workforce development, access to health care, and mental health.

Methods/ findings: The Social Innovation Challenge consisted of three major phases (ideation, hackathon, and incubation) over a six-month period starting in the fall of 2016. Contestants competed for seed funding for a diverse range of existing or new social ventures. Over 100 participants attended the Social Innovation Challenge with the majority representing members of the local community (Baltimore residents). More than 25 ideas were pitched at the beginning of the hackathon, and 17 ideas were presented in the final pitch competition. Three winning teams were identified by a judging panel, and enrolled in a 12-week social entrepreneurship incubation program to fast track the creation of these solutions, rapidly nurture ideas, and evaluate new technologies. The total value of the prizes and awards totaled over $30,000.

How did each activity inform the Implementation Strategy?

The Implementation Strategy was informed by the three activities described above. The Total Health Index augmented the CHNA work by providing community-level data, and allowed for the identification of at-risk areas (HARD zones). Pinpointing at-risk neighborhoods informed KFHP-MAS' place-based strategy and strategic investment decisions. The Community Dialogues provided community-informed strategies pertaining to health needs prioritized in the CHNA. And finally, the Social Innovation Challenge provided the opportunity to translate ideas generated at the Community Dialogues into tangible solutions through a social entrepreneurship lens.

Table 7. Summary of Community Engagement Activities

	DATA COLLECTION METHOD	TYPE	NUMBER
	Meeting, focus group, interview, survey, written correspondence, etc.	**Respondent's title/role and organization or focus group name**	**Number of participants**
MEASURE - TOTAL HEALTH INDEX			
1	16 Focus groups	Community residents	100
2	15 Key Informant Interviews	Executive directors and experts on community health	15
ENGAGE - COMMUNITY DIALOGUES			
3	1 Community Dialogue – BALT	Nonprofits, funders, universities, government health officials and community leaders	128
4	1 Community Dialogue - DCSM		102
5	1 Community Dialogue - NOVA		77
INNOVATE - SOCIAL INNOVATION CHALLENGE			
6	1 Social Innovation Challenge	Developers, activists, idea generators and designers	100

c. Consultant Used

Stacey Williams Lloyd, M.P.H., Ph.D. Candidate: Ms. Lloyd is a Ph.D. candidate in the Department of Mental Health and a Brown Scholar in Community Health at the Johns Hopkins Bloomberg School of Public Health. As a Brown Community Health Scholar, she is currently working on several public health issues in Baltimore City, including adverse childhood experiences, early educational attainment, injection drug use, and youth/young adult mortality. In 2008, Ms. Lloyd earned a Master in Public Health degree from the University of North Carolina, Department of Maternal and Child Health. Both before and during her degree pursuit at the University of North Carolina (UNC), Ms. Lloyd worked with the UNC Program on Health Disparities. Over the past decade, she has worked in a wide range of research positions with duties, ranging from door-to-door participant recruitment and data collection to study design and implementation. With a fresh perspective on geographic health inequities and spatial epidemiology, Ms. Lloyd is working to inform effectively and efficiently target place-based interventions to promote the health and well-being of children and youth.

Maya Nadison, Ph.D., M.H.S.: Dr. Nadison earned her Ph.D. from the Johns Hopkins Bloomberg School of Public Health, focusing on health communication and education sciences. She has extensive experience in program evaluation, quantitative and qualitative data collection and analysis, message development, creation of educational material, and report writing for diverse audiences. Her research interest relates to the design, implementation, and evaluation of school and community-based interventions focused on the prevention of cross-cultural risk behaviors. Interested in early prevention and intervention, Dr. Nadison was awarded six research grants to design school-based public outreach interventions to tackle the problems of school bullying and child sexual abuse. She is passionate about the potential of combining public health interventions with education methodologies and health communication strategies. An avid linguist, Dr. Nadison speaks six languages and has exceptional cross-cultural competencies with work and travel experiences in 60 countries.

Destiny-Simone Ramjohn, Ph.D.: For over a decade, Destiny-Simone Ramjohn, Ph.D., has provided state-of-the-art strategic planning, research, and evaluation expertise to philanthropic institutions, federal agencies, universities, and social profit enterprises in domestic and international communities. She earned her doctorate in Sociomedical Sciences from Columbia University in the City of New York. Dr. Ramjohn's current work advances the social mission of Kaiser Permanente by developing measurement and evaluation strategies for the financial, material, and human resource investments that directly address the social determinants of health and promote health equity across the Mid-Atlantic region.

The authors would like to acknowledge the support of Tanya Edelin, Maritha Gay, Nathaniel Abrams, Jessica Minor and Nicole Rodriguez-Hernandez in developing this report. Tanya Edelin and Maritha Gay provided much needed strategic guidance, ensuring that the strategies presented in this report were aligned with regional imperatives. Nathaniel Abrams played an integral part in the analysis of qualitative data retrieved from the town halls, and participated in the focus groups organized by Morgan State University for the Total Health Index development. Jessica Minor (formerly Finkel) was involved in the development of the CHNA and assisted with the transcription of data from the town hall events. Finally, Nicole Rodriguez-Hernandez assisted with literature reviews and created several of the tables included in this report.

VIII. Health Needs that KFHP-MAS Plans to Address

a. Process and Criteria Used to Select Health Needs

The following section describes the process for selecting a subset of health needs to address from the six regional health needs identified in the CHNA (socioeconomic status, health care access, obesity/ overweight, mental health, diabetes and physical environment).

The process of selecting health needs to address began with a review of responses collected during the Community Dialogues. These responses, documented in a structured appendix, captured community members' input on the most pressing health concerns in their respective neighborhoods. This appendix underwent a quantitative analysis to obtain frequency distribution information, including the number of submitted entries that were associated with each health needs identified in the CHNA. Individual responses associated with a health need were counted as "one" for that need.

Due to the high volume of responses that were not clearly associated with a health need by the submitting respondent, the CHNA team members held a work session to assign the most appropriate priority health need to all responses lacking this pertinent identifier. For example, an entry that read "school-based mental health counseling", and lacking an accompanying health need for the response, was categorized under "Mental Health" based on consensus from the team. Upon completion of this exercise, a final frequency count was derived for each of the six CHNA priority health needs. In each of the service areas where the Community Dialogues were held, frequency of responses associated with each of the priority needs were totaled, and the three most frequently occurring health needs were selected as the priority health needs to be addressed by our team's Implementation Strategy. Table 8 presents information regarding community prioritization of health needs from the Community Dialogues.

Table 8. Community prioritization of health needs from the Community Dialogues

	BALT	DCSM	NOVA	TOTAL
Socioeconomic security	175	98	38	**311**
Health care access	92	121	73	**286**
Mental health	113	65	13	**191**
Obesity/overweight	96	64	17	**177**
Physical environment	91	46	37	**174**
Diabetes	74	14	1	**89**

The needs to be addressed as part of the 2016 Implementation Strategy are: 1) socioeconomic security, 2) health care access and 3) mental health. Gaining buy-in from the entire Community Benefit team during an all-day meeting held in November 2016, the decision was made to select the top three prioritized needs from the CHNA to maximize resources and focus on these complex needs. Other considerations for the selection of health needs included: 1) selecting fewer needs so that more resources can be allocated to each, 2) aligning strategies with existing efforts in the community and promote collaborations with community partners, 3) aligning strategy selected with health needs to maximize the chances of having an impact, and 4) investing in health needs that are currently lacking services.

b. Health Needs that KFHP-MAS Plans to Address

Socioeconomic security: Research, including this study, shows particularly strong and consistent associations between various health outcomes and socioeconomic security, including indicators such as access to employment, education, and income across time and geography. There are also solid, credible mechanisms explaining why lower socioeconomic groups have poorer health outcomes [18]. For example, social and economic conditions adversely affect people's ability to access health care and understand health information. These conditions also constrain a person's ability to make healthy choices, particularly when healthy food or active living options are unaffordable or not nearby [19]. Socioeconomic factors also directly affect an individual's physiology.

Health care access: Access to health care services is a key aspect of the social determinants of health framework. For the CHNA, inequities in access to health care relate to regular source of care, population living in areas with a shortage of health care professionals, and the ratio of physicians to the general population. Lack of culturally competent providers is also a barrier to proper health care.

Mental health: It is estimated that one in four adults in the U.S. have been diagnosed with one or more mental health disorders [5]. Mental health is often characterized by emotional, psychological and social well-being. Mental disorders have been associated with substance abuse, chronic diseases, self-destructive behavior, and suicide. Social determinants that promote positive mental health include safe neighborhoods, quality and affordable housing, employment, education, and access to quality care.

KFHP-MAS selected the top three health needs identified by the above analytic approach; for additional information and indicator performance on each of the identified needs, please see the CHNA report.

IX. KFHP-MAS's Implementation Strategies

As part of the Kaiser Permanente integrated health system, KFHP-MAS 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

KFHP-MAS 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, KFHP-MAS welcomes future opportunities to enhance its strategic plans by relying on and building upon the strong community partnerships it currently has in place.

Leveraging KP Assets to Meet Community Health Needs and Deliver Total Health Impact

Kaiser Permanente has a unique opportunity to focus and operationalize our Total Health Impact (THI) work at the intersection of several national functions and defined community priorities in our regions. The objective is to stimulate innovative thinking and effective action/resource allocation by strategically aligning and leveraging key KP organizational assets with identified community needs. This is core to the Total Health value proposition endorsed by the National Executive Team (NET) and Regional Presidents.

The CHNA processes present a strategic opportunity to carefully target operational assets such as those in functional areas (to complement Community Benefit grantmaking and partnerships) to address demonstrated community challenges, as well as the social, economic and behavioral needs of our communities. Through the 2016 CHNA process, we believe we can strengthen how we leverage Kaiser Permanente's impact in the spirit of Total Health. This, while also setting the stage for bringing increased organizational resources to bear to address communities' most pressing needs over the long term (including outside of the formal IS).

KFHP-MAS' Commitment to Total Health

KFHP-MAS 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 KFHP programs. The section below provides a more detailed roadmap of how KFHP-MAS intends to address the prioritized health needs identified through the CHNA process. Strategies that relate to KP's Total Health work are marked by an asterisk (*).

Socioeconomic Security

Long-term Goal

- People experience equitable educational and economic conditions that support health, well-being, and quality of life

Intermediate Goals

- Expand access to education, skills training, entrepreneurship and employment among high-school and college-aged young people by creating a workforce pipeline
- Establish workforce pipeline for high school students and young adults interested in allied health, construction or IT careers
- Increase economic viability of small businesses/nonprofits serving low income communities

Strategies

- Build capacity of small local businesses to secure additional capital, create jobs, and support KP's procurement needs *
- Implement workforce pipeline to introduce and place diverse, underrepresented school-age and college students to careers that promote health and wellness at a livable wage *
- Support development of community-based organizations and leaders by building their capacity to advance equity
- Support equitable community development (e.g. housing, entrepreneurship, innovation and inclusive growth) by implementing a multi-sector place-based strategy in communities with high geographic concentrations of vulnerability through partnerships/ collaborations
- Create job opportunities for populations with employment obstacles (e.g. returning citizens) through investment in social services, mentorship and workforce development programs
- Accelerate the potential of innovation, technology and entrepreneurship to stimulate economic growth *

Expected Outcomes

- Qualified youth are graduating college and/or entering the workforce in careers at a livable wage
- Trusted nonprofits and small businesses are economically viable, sustainable and actively contributing to community development
- Strategic partners from multiple sectors collaborate to revitalize neighborhoods with a common agenda, aligned efforts, and shared measures of success

Health Care Access

Long-term Goal

- People have access to high quality health care and coverage, and experience optimal levels of Total Health in the communities where they live, work and play

Intermediate Goals

- Increase coverage and access to comprehensive, quality health care services for uninsured and underinsured populations
- Increase economic viability of safety net clinics to expand service capacity, coordinate culturally-competent care and encourage cost-effective use of providers to achieve better health care results for uninsured and underinsured populations
- Support the implementation of Health in All Policies (HiAP) using an equity lens to improve population health through advocacy in health, and decision-making across sectors and policy areas

Strategies

- Deploy KP resources to provide high-quality medical care to Medicaid participants who would otherwise struggle to access care
- Deploy KP resources to provide access and comprehensive health care to low income individuals and families who do not have access to public or private health coverage
- Deploy KP resources to provide financial assistance to low income individuals who receive care at KP facilities and can't afford medical expenses and/or cost-sharing
- Support the development of health leaders to build capacity for sustainability, advance health equity and promote Health in All Policies (HiAP) through partnerships/ collaborations
- Improve health care services and delivery systems through partnerships/ collaborations inside and outside of KP to:
    - Increase capacity of health care systems to provide quality health care services
    - Increase capacity of primary care workforce to meet social non-medical needs and chronic conditions
    - Promote integration of care (primary/behavior/oral)
- Invest in school-based health centers including primary care, mental/behavioral health care, dental care and case management services for students and their families

Expected Outcomes

- Uninsured and underinsured populations who are served by KP are treated with dignity, receive quality health care services, and have their unique needs met
- Safety net clinics expand capacity and achieve better health outcomes for uninsured and underinsured populations
- Strategic partners from multiple sectors advance the Health in All Policies agenda

Mental Health

Long-term Goal

- People have access to high quality mental health services when needed, and thrive in an environment that fosters improved social, mental, emotional health and well-being

Intermediate Goals

- Destigmatize mental health by raising awareness of mental health problems, and promoting a positive mental attitude
- Provide arts-based learning experiences to students and teaching staff that are aligned with educational standards and designed for cognitive appropriateness to improve social and emotional wellbeing and life opportunities for students after high school

- Increase access to mental health providers and case management services to serve low income populations

Strategies

- Support Thriving Schools to expand behavioral health (e.g. mental health and substance abuse) and well-being knowledge, skills and social services including efforts to:
    - Increase social and emotional health skills and knowledge
    - Create opportunities to improve social cohesion and support in schools and communities
    - Enhance youth and family prevention services
- Increase access to appropriate behavioral health (e.g. mental health and substance abuse) services including effort to:
    - Promote integration of care (primary/behavior care)
    - Support early childhood interventions in schools and in clinical settings
    - Expand access to providers and enhance provider knowledge and practice
- Identify assets, gaps and best-practices in mental health services by engaging subject matter experts through convenings and stakeholder engagement

Expected Outcomes

- The public is educated about mental health issues and can access resources in a stigma free environment
- Behavioral health services are available in schools and communities
- Social and emotional health skills and knowledge increase using arts-integration in schools and communities

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

KFHP-MAS 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, KFHP-MAS 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.

The tables presented below map health needs to address as part of the implementation strategy process to goals (both long-term and intermediate), desired outcomes, and outcome metrics. The outcome metrics will be used to assess the impact of KFHP-MAS' strategic investments through 2019. Reach and level of funding will be tracked across all needs and strategies, in addition to the detailed metrics listed in the table below.

Table 9. Evaluation plan by health need

Socioeconomic Security		
Long-term goal: People experience equitable educational and economic conditions that support health, well-being, and quality of life		
Intermediate goals	**Outcomes**	**Potential outcome metrics**
Expand access to education, skills training, entrepreneurship and employment among high-school and college-aged young people by creating a workforce pipeline	Qualified youth are graduating college and/or entering the workforce in careers at a livable wage	- Number of students who progress to the next grade level - Number of students attaining a certificate or degree - Number of young people placed in internships/jobs - Percent of youth who obtain and keep employment at a livable wage
Increase economic viability of small businesses/nonprofits serving low income communities	Trusted nonprofits and small businesses are economically viable, sustainable and actively contributing to community development	- Percent increase in number of employees from economically distressed areas - Percent increase in revenue for small businesses/nonprofits located in economically distressed areas - Number of small businesses and nonprofits with enhanced leadership capacity (board placement, provide subject matter expertise) and organizational functioning (changes in capacity for strategic planning, human resource development and financial management)
Build community leadership and establish an Executive Steering Committee for a placed-based strategy using a collective impact framework	Strategic partners from multiple sectors collaborate to revitalize neighborhoods with a common agenda, aligned efforts, and shared measures of success	- Number of participants with a shared vision for change (show commitment, common understanding of the problem, joint approach to solving it) - Number of partners who leverage assets and knowledge through shared ownership of the initiative - Number of partners who use data to inform selection of strategies and actions

Health Care Access		
Long-term goal: People have access to high quality health care and coverage, and experience optimal levels of Total Health in the communities where they live, work and play		
Intermediate goals	**Outcomes**	**Potential outcome metrics**
Increase coverage and access to comprehensive, quality health care services for uninsured and underinsured populations	Uninsured and underinsured populations who are served by KP are treated with dignity, receive quality health care services, and have their unique needs met	- Number of low income patients who have access to KP's services through CHC, Medicaid and MFA - Number of Medicaid/ CHC patients receiving high-quality care (HEDIS measure) - Ratio of awards to MFA recipients less than 200% of FPL - Number of Medicaid patients who report excellent experience and customer satisfaction - Number of Medicaid patients who are screened, referred, and receive services to support social non-medical needs (e.g., language, cultural sensitivity, social-economic)
Increase economic viability of safety net clinics to expand service capacity, coordinate culturally-competent care and encourage cost-effective use of providers to achieve better health care results for uninsured and underinsured populations	Safety net clinics expand capacity and achieve better health outcomes for uninsured and underinsured populations	- Number of safety net patients receiving high-quality care (HEDIS measure) - Number of unique patients seen by safety net providers - Number of patient encounters - Number of safety net patients with access to efficient and cost effective services - Number of safety net patients who are screened, referred, and receive services to support social non-medical needs (e.g., language, cultural sensitivity, social-economic) - Number of safety net patients who report excellent experience and customer satisfaction - Number of safety net partners who provide increased access to primary and specialty care
Support the implementation of Health in All Policies (HiAP) using an equity lens to improve population health through advocacy in health, and decision-making across sectors and policy areas	Strategic partners from multiple sectors advance the Health in All Policies agenda	- Number of collaboratives with a shared vision for change (show commitment, common understanding of the problem, joint approach to solving it) - Number of collaboratives who leverage assets and knowledge through shared ownership of the initiative - Number of collaboratives who use data to inform selection of strategies and actions

Mental Health		
Long-term goal: People have access to high quality mental health services when needed, and thrive in an environment that fosters improved social, mental, emotional health and well-being		
Intermediate goals	**Outcomes**	**Potential outcome metrics**
Destigmatize mental health by raising awareness of mental health problems, and promoting a positive mental attitude	The public is educated about mental health issues and can access resources in a stigma free environment	- Number of participants who can identify signs and symptoms of common mental health issues - Number of participants who report appropriate help-seeking behavior and are comfortable seeking treatment - Number of participants who report knowing where to access mental health services
Provide arts-based learning experiences to students and teaching staff that are aligned with educational standards and designed for cognitive appropriateness to improve social and emotional wellbeing and life opportunities for students after high school	Social and emotional health skills and knowledge increase using arts-integration in schools and communities	- Number of participants who can identify signs and symptoms of common mental health issues - Number of participants who display a positive mental attitude (resiliency, coping, prosocial behaviors)
Increase access to mental health providers and case management services to serve low income populations	Behavioral health services are available in schools and communities	- Number of clients who are screened, referred, and receive mental health services - Number of clients who receive referrals for social non-medical needs (e.g., language, cultural sensitivity, social-economic) - Number of low income individuals who are accessing free or low cost mental health services

XI. Health Needs Facility Does Not Intend to Address

The remaining prioritized health needs for the Mid-Atlantic Region will not be addressed by KFHP-MAS since they were not ranked as highly as socioeconomic security, health care access and mental health during the community engagement process. KFHP-MAS intends to allocate its finite resources and capacity to the most wanting needs to make the largest impact possible.

Therefore, the needs that KFHP-MAS will not address are:

- Obesity/Overweight
- Diabetes
- Physical Environment

KFHP-MAS recognizes that while the implementation strategy activities do not target the lower ranking needs, certain activities underway touch upon those needs, and certain strategies selected as part of this report may have an indirect effect on the lower priority needs such as HEAL Cities (e.g. Physical Environment and Obesity/Overweight). While this Implementation Strategy report responds to the CHNA and Implementation Strategy requirements in the Affordable Care Act and IRS notices, it does not represent an exhaustive list of everything that KFHP-MAS does to enhance community health. KFHP-MAS will remain prepared to engage in collaboration opportunities that address needs not selected if appropriate.

Appendix A. List of Organizations Represented at the Community Dialogues

BALTIMORE SERVICE AREA
Organization
Adrian Harpool Associates
African American Health Program Executive Committee
Afya Baltimore
Alliance for a Healthier Generation
Associated Black Charities
Association of Baltimore Area Grantmakers
Baltimore City Community College
Baltimore Area Grantmakers
Baltimore City Community College
Baltimore City Community College Foundation, Inc.
Baltimore City Health Department
Baltimore County Department of Health
Baltimore Internet Radio
Baltimore Office of Sustainability/Department of Planning
Baltimore's Promise
Bevi
Black Mental Health Alliance
Bon Secours Community Works
BridgeEdU
Brown and Healthy
Catholic Charities
Chase Brexton Health Care
City Seeds, A Humanim Social Enterprise
College of Health Professions, Coppin State University
CommonHealth ACTION
Coppin State University
Core Staffing
Democracy Collaborative
Dewmore Baltimore
Drumondawmin healthy families inc.
Enterprise Community Partners
Equity Matters
Examiner.com
Family League of Baltimore
FOX45
Future Harvest Inc.
Gateway Health Care Consulting
GirlTrek
Holistic Life Foundation, Inc
Humanim
Impact Hub Baltimore
Innovation Village
Invested Impact
Johns Hopkins Bloomberg School of Public Health, Center for Adolescent Health
Johns Hopkins Center for a Livable Future
Johns Hopkins School of Public Health
Kaiser Permanente
Morgan State University
Mount Royal Community Development Cooperation
My Brother's Keeper, Irvington
NAACP, Baltimore
University of Maryland School of Nursing
Wide Angle Youth Media
Wim Family Services

District of Columbia and Suburban Maryland (DCSM)
Organization
11th Street Bridge Park
Access to Wholistic and Productive Living Institute, Inc.
Alliance for a Healthier Generation
Asian American Center of Frederick
CASA de Maryland
CCI Health and Wellness Services
Central Baptist Church
City First Enterprises
Common Health Action
Crittenton Services of Greater Washington
DC Hunger Solutions
DC SCORES
de Beaumont Foundation
District of Columbia Office of Planning
District of Columbia Primary Care Association
E*TRADE Financial
Eco City Farms
Ecumenical Health Council
End Time Harvest Ministries
Enterprise Community Partners
Equity Matters
Everybody Wins! DC
Future Harvest - A Chesapeake Alliance for Sustainable Agriculture
Gateway Health Care Consulting
Generation Hope
George Washington University
Greater Baden Medical Services
Greater Washington Urban League
Institute for Public Health Innovation
Kaiser Permanente
La Clinica del Pueblo
LA Perez Consulting
Latin American Youth Center
Manna Food Center
Martha's Table
Maryland Assembly on School-Based Health Care
Maryland Department of Health and Mental Hygiene
Maryland Hunger Solutions
Maryland Nonprofits
Mary's Center
Metropolitan Washington Council of Governments
Miriam's Kitchen
Montgomery College
Montgomery County Department of Health
Morgan State University
NAMI Howard County
Nonprofit Montgomery
Office of Council Chairman Derrick Leon Davis - Prince George’s County Council
Partners for Livable Communities
Port Towns Community Health Partnership
Primary Care Coalition
Prince George’s County Health Department
Prince George's Community College
Prince George's County Chamber of Commerce
Prince George's County Food Equity Council
Real School Gardens
Regional Primary Care Coalition
Suburban Hospital
The Arc of Prince George's County

The Community Foundation for the National Capital Region
The Homeless Children's Playtime Project
The Mid-Atlantic Association of Community Health Centers
The National Kidney Foundation
The Training Source, Inc.
The Urban Alliance
UMD School of Public Health
University of Maryland
Us Helping Us, People Into Living, Inc.
Vehicles for Change
Venture Philanthropy Partners
Washington Area Women's Foundation, Inc.
Washington Regional Association of Grantmakers

Northern Virginia (NOVA)
Organization
Adams Compassionate Healthcare Network
Alexandria Neighborhood Health Services
Alliance for Alexandria's Uninsured
Alliance for a Healthier Generation
Arlington Food Assistance Center
Arlington Free Clinic
Arlington Health District
Arlington Pediatric Center: Virginia Hospital Center
Child and Family Network Centers
Community Foundation for Loudoun and Northern Fauquier
Department of Neighborhood and Community Services
ENROLL Virginia!
Fairfax County Government
Legal Services of Northern Virginia
Loudoun Free Clinic
Medical Society of Virginia Foundation
Northern Virginia Community College
Northern Virginia Dental Clinic
Northern Virginia Family Service
Northern Virginia Health Foundation
Nova ScriptsCentral
Fairfax County Government
Fairfax County Health Department
Fairfax County Office of Public Private Partnerships
Fairfax County Public Schools
Fairfax Health District
Flip the Clinic, Incorporated
Health Communities Working Group
HealthWorks for Northern Virginia
Inova
Kaiser Permanente
Legal Services of Northern Virginia
Loudoun Citizens for Social Justice
Loudoun County Health Department
Loudoun County Public Schools
Potomac Health Foundation
Regional Primary Care Coalition
SCAN
The Morris and Gwendolyn Cafritz Foundation
Virginia Health Department
Virginia Hospital Center Foundation
Washington Regional Association of Grantmakers

Appendix B. Community Dialogue Work Group Instructions

Community Dialogue Group Work Instructions

Kaiser Permanente of the Mid-Atlantic States is committed to developing and implementing effective strategies to address community health needs in collaboration with community stakeholders and leaders.

12:00-12:40pm
Identifying and designing community-based solutions to our region's most pressing health challenges

You've just heard an overview of the top six health needs in the Mid-Atlantic region as identified by Kaiser's 2016 Community Health Needs Assessment:

- Socioeconomic security
- Health care access
- Obesity/ overweight
- Mental health
- Diabetes
- Physical environment

With so many experts in the room today, we want your input! Over the next 40 minutes, please put your heads together with your tablemates to identify:

- **WHAT WE HAVE**: Please take 15 minutes to brainstorm the most effective existing solutions, organizations, and/or programs that are working to address the top six identified health needs in our region. Use the first 3 minutes to write your ideas on the sticky notes provided (one idea per sticky note) and the next 12 minutes putting them on the flip chart and sharing some of your best ideas with the group.
    - **Note**: The organizations/ programs identified should be effectively addressing at least one of the priority health needs, not necessarily all size simultaneously – though that would be fantastic!
- **WHAT WE NEED**: Please take 12 minutes to identify the gaps that currently exist in available services, geographic distribution of services, and/or funding for each of the six identified health needs. Use the first few minutes to write your ideas on the sticky notes provided (one idea per sticky note) and the next 10 minutes putting them on the flip chart and sharing some of your best ideas with the group.
- **WHAT WE WISH WE COULD DO:** Now, for the fun part! In our final 12 minutes, imagine that you have $1 million dollars to address one, a few, or all six of the identified health needs over the next year. Again, using the sticky notes, take a few minutes to write down your ideas (one idea per sticky note). Then, in the final 10 minutes, add your sticky notes to the flip chart and share your best ideas with the group.

1:45-2:25pm

The benefits, barriers, and opportunities of working together

As part of its new community investment strategy, Kaiser Permanente is dedicated to working with and supporting collaborative community efforts. Please put your heads together with your tablemates to brainstorm:

- **WHAT WE HAVE:** Please take 15 minutes to brainstorm some of the existing health-related collaborations happening in our region (cross-sector or otherwise). Use the first 3 minutes to write your ideas on the sticky notes provided (one idea per sticky note) and the next 12 minutes putting them on the flip chart and sharing some of your best ideas with the group.
- **BENEFITS/ BARRIERS**: Please take 12 minutes to brainstorm the benefits and barriers of working in collaboration. If you have suggestions for overcoming some of the identified barriers, please share those as well. Again, take the first few minutes to write your ideas on the sticky notes provided (one idea per sticky note) and the next 10 minutes putting them on the flip chart and sharing some of your best ideas with the group.
- **WHAT WE WISH WE COULD DO:** Please take 12 minutes to imagine what collaborations (cross-sector or otherwise) in our region could effectively address the health needs identified in the 2016 CHNA. Take the first few minutes to write your ideas on the sticky notes provided (one idea per sticky note) and the next 10 minutes putting them on the flip chart and sharing some of your best ideas with the group.

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