2019 Implementation Strategy Report

Kaiser Foundation Health Plan Georgia

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

March 18, 2020

KAISER PERMANENTE®

Kaiser Permanente Georgia Region Community Health

IS Report for KFH Georgia

Contents

I. General information....3

II. About Kaiser Permanente (KP) 4

III. About Kaiser Permanente Community Health 4

IV. Kaiser Foundation Hospitals – Facility Name Service Area/Region....5

A. Map of facility service area 5

B. Geographic description of the community served (towns, counties, and/or zip codes) 5

C. Demographic profile of community served 5

V. Purpose of Implementation Strategy 6

List of Community Health Needs Identified in 2019 CHNA Report.... 6

VI. Who was involved in the Implementation Strategy development....7

A. Partner organizations.... 7

B. Community engagement strategy 7

C. Consultant(s) used 9

VII. Health needs that KFH Facility/Region Name plans to address 9

A. Process and criteria used 10

B. Health needs that KFH Facility/Region Name plans to address 12

VIII. KFH Facility/Region Name's Implementation Strategies 14

A. About Kaiser Permanente's Implementation Strategies 14

B. 2019 Implementation Strategies by selected health need 14

C. Our commitment to Total Health 15

IX. Evaluation plans 21

X. Health needs facility/region name does not intend to address....21

I. General information

Contact Person:	Madelyn Adams
Date of written plan:	December 16, 2019
Date written plan was adopted by authorized governing body:	March 18, 2020
Date written plan was required to be adopted:	May 15, 2020
Authorized governing body that adopted the written plan:	Kaiser Foundation Hospitals Board of Directors' Community Health Committee
Was the written plan adopted by the authorized governing body on or before the 15th day of the fifth month after the end of the taxable year the CHNA was completed?	Yes ☒ No ☐
Date facility's prior written plan was adopted by organization's governing body:	March 16, 2017
Name and EIN of hospital organization operating hospital facility:	Kaiser Foundation Hospitals, 94-1105628
Address of hospital organization:	One Kaiser Plaza, Oakland, CA 94612

II. About Kaiser Permanente (KP)

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

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

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

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

III. About Kaiser Permanente Community Health

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

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

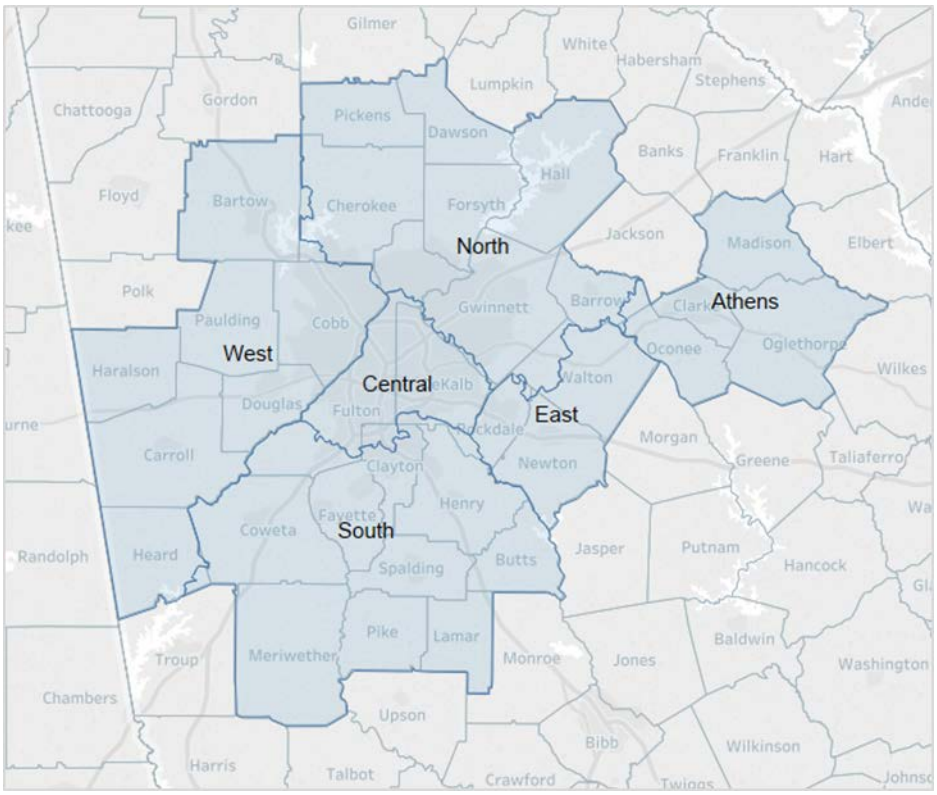
- Ensuring health access by providing individuals served at KP or by our safety net partners with integrated clinical and social services;
- Improving conditions for health and equity by engaging members, communities, and Kaiser Permanente's workforce and assets; and
- Advancing the future of community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

For many years, we've worked side-by-side with other organizations to address serious public health issues such as obesity, access to care, and violence. And we've conducted Community Health Needs

Assessments to better understand each community's unique needs and resources. The CHNA process informs our community investments and helps us develop strategies aimed at making long-term, sustainable change—and it allows us to deepen the strong relationships we have with other organizations that are working to improve community health.

IV. Kaiser Foundation Hospitals – Georgia Service Area/Region

A. Map of facility service area



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

The KFH Georgia service region is geographically comprised of 32 counties within an area of just under 9,400 square miles. The five principal counties that make up the metro-Atlanta area—DeKalb, Cobb, Clayton, Gwinnett and Fulton—are included in the service area and are the most densely populated counties in the state. Much of the service area is dissected by the primary interstate network (i.e. I-75, I-85 and I-20). The outer extent of the service region is generally more rural than the core of the region and some communities in the north/northeast sectors are part of the Appalachian foothills.

C. Demographic profile of community served

The population of the KPHP-GA service region is diverse and relatively young (i.e., 1 in 4 are less than 18 years old). Nearly 6 million people live within the region and approximately one third identify as African American with a growing number of Latino residents.

The population in the region has increased since 2016 and is expected to grow faster than the national average over the next five years, with 25 counties increasing in total population by 4.0% to 10.3%.

Because counties in the KFH Georgia service regions are rather large, there is great variability within counties and many subpopulations are clustered by race and socioeconomic status. Accordingly, county level data, especially in more urban and diverse counties, do not necessarily represent the nuanced picture of health for all county residents.

Race/ethnicity		**Socioeconomic Data**	
Total Population	5,971,911	Living in poverty (<100% federal poverty level)	15.3%
Race		Children in poverty	21.9%
Asian	5.3%	Unemployment	4.2%
Black	32.2%	Uninsured population	15.5%
Native American/Alaska Native	0.3%	Adults with no high school diploma	11.9%
Pac. Islander/Native Hawaiian	0.0%		
Some other race	3.3%		
Multiple races	2.3%		
White	56.5%		
Ethnicity			
Hispanic	21.3%		
Non-Hispanic	78.7%		

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 Georgia's planned response to the needs identified through the 2019 Community Health Needs Assessment (CHNA) process. For information about KFH Georgia's 2019 CHNA process and for a copy of the report please visit www.kp.org/chna.

List of Community Health Needs Identified in 2019 CHNA Report

The list below summarizes the health needs identified for the KFH Georgia service area through the 2019 Community Health Needs Assessment process.

1. Healthy Eating and Active Living
2. Access to Care
3. Social Determinants of Health
4. Chronic Disease

5. Mental Health Conditions
6. Infectious Disease (HIV/AIDS/STIs)
7. Maternal and Child Health
8. Substance Abuse
9. Violence and Injury

VI. Who was involved in the Implementation Strategy development

A. Partner organizations

Although there was extensive community and peer engagement in the Community Health Needs Assessment process, no external partner organizations were engaged in the development of the Implementation Strategy Report. After the draft Implementation Strategy report was written, the Atlanta Regional Commission on Health Improvement (ARCHI) played an integral role in helping KFH Georgia identify specific geographies/neighborhoods on which to focus. The feedback was contextually based on local partnerships, past and present philanthropic work in those neighborhoods, and the unique elements that KFH Georgia can bring to the table. This will be discussed further in the report.

B. Community engagement strategy

While not required by Federal CHNA regulations, Kaiser Permanente requires all KFH facilities developing Implementation Strategy plans to elicit community input throughout the plan development process. Community member and stakeholder engagement in the implementation strategy development process is intended to enable:

- KFH facilities to develop a deeper understanding of community perspective in developing Implementation Strategies, allowing opportunities for increased collaboration, potential impact, and sustainability
- Opportunities to engage community members beyond organizations and leaders with whom facilities may typically collaborate
- Transparency throughout the implementation strategy development process
- Opportunities to inform community leaders about Kaiser Permanente's unique structure and resources to effectively foster meaningful partnerships.

Extensive community engagement occurred throughout the CHNA process preceding the Implementation Strategy. This process included 51 key informant interviews with community leaders and 12 focus groups with over 100 residents living and working in communities served by KFH Georgia. A streamlined community engagement approach was taken during the Implementation Strategy period whereby an internal group of Community Health stakeholders and regional leaders provided feedback on the Implementation Strategy Plan. Reviewers were asked to read the draft plan and provide general feedback. They were also asked to consider feasibility of the proposed strategies in the context of the regional budget, evolving priorities at the National Level, current major investments, and regional business interests. Finally, ARCHI, an external partner, was asked to review the first full draft of the document and to provide feedback on the following questions:

- Based on the strategies addressed, are there certain populations or geographic areas where KFH Georgia should focus?
- What do you think would make KFH Georgia more successful in implementing the strategies outlined?
- What is your vision on how our two organizations can continue to work together to improve health in the Atlanta area?

	Data collection method	Title/name	Number	Notes (e.g., input gained or role in IS process)
1	*Written correspondence and embedded notes/comments*	*Internal Community Health Team*	*4*	· *Edits to verbiage to reflect the work as accurately as possible.* · *Edits to eliminate redundancy in the report, specifically in the strategy table* · *Narrowed focus by merging related health needs into larger categories. This resulted in going from 7 health needs to 5.*
2	*Written correspondence and embedded notes/comments*	*Government Relations Team*	*2*	· *Edits to verbiage to reflect the work as accurately as possible, particularly in the strategies related to City Health and policy work*
3	*In-person meeting*	*Community Health Leadership Team*	*2*	· *Edits to verbiage to reflect the work as accurately as possible* · *Edits to eliminate redundancy in the report, specifically in the strategy table*

	Data collection method	Title/name	Number	Notes (e.g., input gained or role in IS process)
4	*Phone interview*	*Kathryn Lawler, ARCHI Executive Director*	*1*	*Following are specific notes from a conversation with the Atlanta Regional Commission on Health Improvement (ARCHI):* *1. Based on the strategies addressed, are there certain populations or geographic areas where KFH Georgia should focus? [paraphrased] South Fulton and South DeKalb have been focus areas for KFH Georgia. The work should continue there because the level of disparity that exists in those areas take a long time to fix and require ongoing, long-term commitment..* *2. What do you think would make KFH Georgia more successful in implementing the strategies outlined? [paraphrased] Several health systems are beginning to make advancements in Community Health and the social determinants of health, but KFH Georgia is uniquely poised to focus on prevention. KFH Georgia's integrated system makes access to data, health outcomes, and financial models invaluable in a state that didn't expand Medicaid. Helping the community to understand the economic impact of prevention would help to strengthen the Implementation Strategy plan.* *3. What is your vision on how our two organizations can continue to work together to improve health in the Atlanta area? [paraphrased] We want to understand Thrive Local and how we can help make this a long-term infrastructure/resource that is a collective and sustainable initiative. Preliminary work has been done with the Community Resource Hub and we have been preparing the way for something like Thrive Local.*

Community feedback allowed for a more tailored, concrete focus on feasible strategies given our current and future resources and partnerships. Partner engagement also served as a validation test as it showed that we are on the right track and intending to provide needed programs, initiatives, and collaborations in the communities we serve.

C. Consultant(s) used

The Georgia Health Policy Center (GHPC) has been engaged in the KFH Georgia Community Health Needs Assessment and Implementation Strategy processes since 2009. Established in 1995, GHPC is housed within Georgia State University's Andrew Young School of Policy Studies and serves to provide evidence-based research, program development and policy guidance locally, statewide, and nationally to improve community health. The external CHNA consultant team is led by Dr. Chris Parker, GHPC Associate Project Director. As a trained physician having worked with underserved communities and faith-based organizations, he brings a wealth of significant clinical and community engagement experiences. Supporting Dr. Parker on this project are GHPC team members who have

expertise in health impact assessments, built environment analysis, health disparities, health system evaluation, obesity, physical activity and nutrition interventions, epidemiology and geographical information systems. The 2019 Implementation Strategy was supported by this knowledgeable team, led internally by the KFH Georgia Manager for Strategy and Evaluation, Renata Hilson, Ph.D., MPH, and was completed in collaboration with other leading healthcare organizations in the Atlanta area (i.e., Grady Health System, Piedmont Healthcare, and WellStar Health System).

VII. Health needs that KFH Georgia plans to address

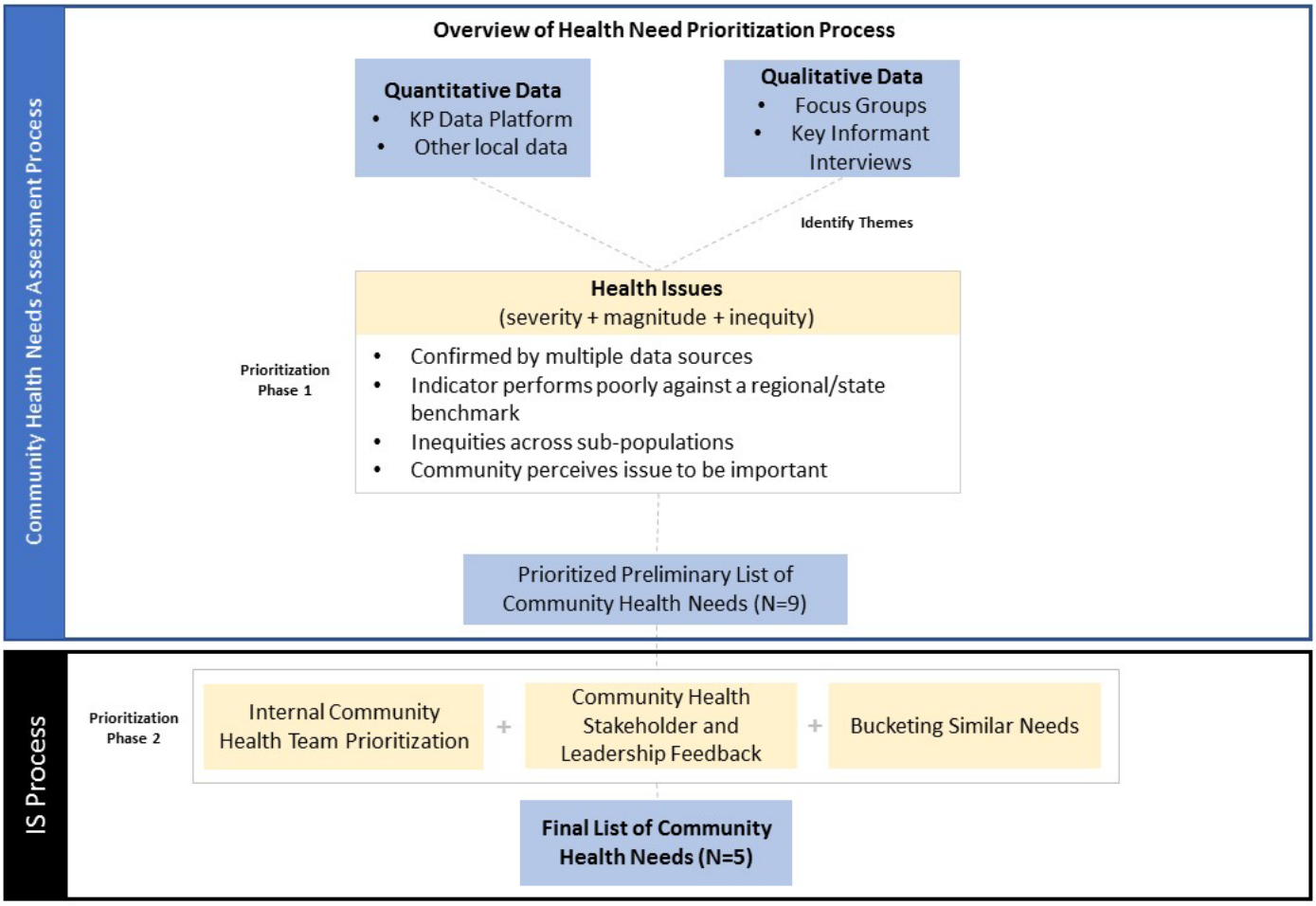
A. Process and criteria used

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

- **Severity of need:** This refers to how severe the health need is (such as its potential to cause death or disability) and its degree of poor performance against the relevant benchmark.
- **Magnitude/scale of the need:** The magnitude refers to the number of people affected by the health need.
- **Clear disparities or inequities:** This refers to differences in health outcomes by subgroups. Subgroups may be based on geography, languages, ethnicity, culture, citizenship status, economic status, sexual orientation, age, gender, or others.
- **Leveraging KP Assets:** KP can make a meaningful contribution to addressing the need because of its relevant expertise, existing strategies, and/or unique business assets as an integrated health system and because of an organizational commitment to improving community health.

Additional criteria included:

- Issue is getting worse over time/not improving
- Community prioritizes the issue over other issues
- Existing attention/resources dedicated to the issue

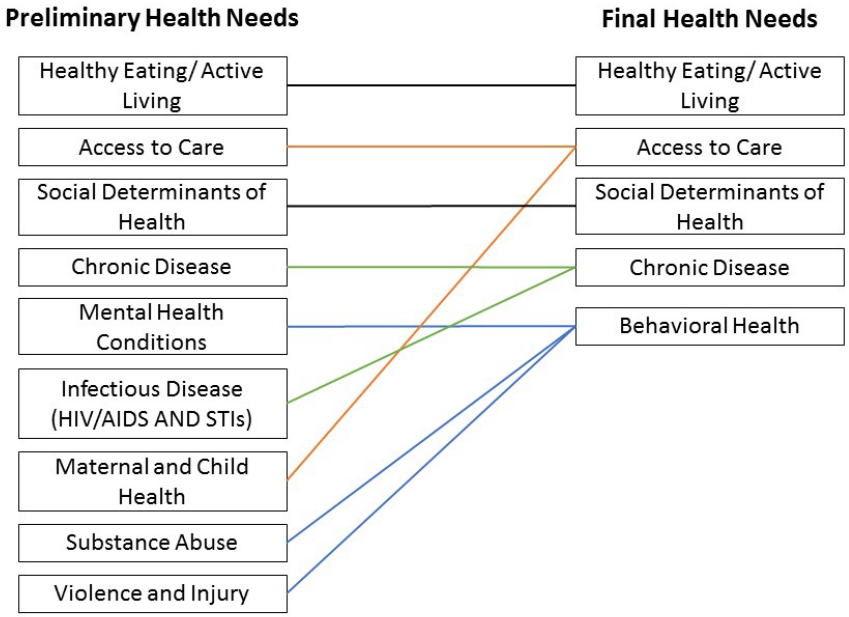


As illustrated above, prioritization tools were used to rationalize data and information sources from the CHNA. A list of nine health needs was generated using a culling method that focused on the intersection of findings from primary and secondary data. The second phase of the prioritization process occurred during the Implementation Strategy process and included three steps:

1. Solicitation of feedback from the KFH Georgia Community Health staff. The team was asked to prioritize considering the nature of the need, existing health disparities, the potential for population impact, available KFH Georgia resources and current work, and potential partnerships that might be strengthened or leveraged to address each need.
2. Solicitation of feedback from Community Health stakeholders (healthcare peers) and internal leadership. Healthcare peers and internal leaders were engaged to assess the feasibility of focusing on each of the identified health needs in the context of work being done in the region.
3. Bucketing of similar needs based on the definitions of those needs. Finally, there was a Community Health Leadership engagement process where specific feedback was solicited and participants were asked to consider ongoing regional priorities and business limitations.

During engagement conversations, it became clear that there was no practical need for keeping 9 distinct health priorities, as they could be grouped in a more efficient manner. As illustrated in the figure below, the engagement conversations resulted in a condensed list of five health needs where Access to Care and Maternal and Child Health were bucketed into one “Access to Care” category, Chronic Disease and HIV/AIDS/STIs were bucketed into one “Chronic Disease” category, and Mental

Health Conditions, Substance Abuse, and Violence and Injury were bucketed into one “Behavioral Health” category. These categories were merged based on the definitions previously highlighted in our CHNA. For example, because maternal and infant mortality rates are so often related to the level of access women have to affordable health care (particularly during the prenatal and immediate post-partum period), our focus on maternal and child health would primarily focus on increasing access to care for this vulnerable population. Similarly, from a public health perspective mental health conditions, substance use disorders, and violence are all related topics and have related drivers. Considering these needs as a broader Behavioral Health category will allow us to focus on the conditions that impact behavioral health in a more general, yet purposeful way.



B. Health needs that KFH Georgia plans to address

Access to Care

In general, access to care (primary, specialty, mental health, and dental care) is above benchmark levels in urbanized-affluent areas while there is a shortage in areas with lower levels of employment, income, and insurance coverage – regardless of population density. Access encompasses the availability of providers proportionate to population size and the affordability of care in relation to average household income. Other barriers to care include transportation, language, and cultural appropriateness. Although the percentage of uninsured residents has decreased over time, it remains higher in the KFH Georgia Region compared to national rates. Limited access to primary and preventive care is associated with higher than average emergency room utilization, hospitalization rates, and mortality rates due to undiagnosed prenatal or postpartum conditions and complications from chronic conditions. Because lack of access to care continues to be a major barrier, most of the region’s annual funding goes toward supporting Access to Care initiatives.

Healthy Eating / Active Living

In the KFH Georgia Region, there remains wide variation in diet quality and active living. Wealthier areas generally have better access to healthy food retailers and places to exercise; these areas also demonstrate higher rates of fruit and vegetable consumption and physical activity compared to more

economically distressed areas. Given the association between obesity and certain chronic diseases with poor diet quality and inactivity, healthy food accessibility in low-income areas makes this a geographic issue as well. In several counties, obesity rates have decreased slightly, but additional barriers to healthy eating and active living remain (these include time spent commuting, perception of safety, and poor infrastructure such as sidewalks, lighting, and recreation areas).

Social Determinants of Health

Social Determinants of Health are the economic, social, and cultural conditions that influence health, health outcomes, and health inequities. This preliminary health need encompasses the following three health need priorities from the 2016 CHNA (educational attainment, poverty, and transportation), and includes broader concepts as well, such as Economic Opportunity.

- *Educational Attainment* is one of the strongest predictors of life expectancy and lifetime health status. Many of the educational outcome inequities are based in early childhood experiences related to economic instability, parent involvement, and loss of or inconsistent housing.
- *Poverty* is a measure of household income relative to household size. Neighborhoods with a high concentration of poverty are less desirable to businesses, leading to disinvestment, further distress, and decreased employment opportunities. There is also growing interest in the concept of economic mobility as individuals born into poverty are highly unlikely to overcome it.
- *Transportation* is a key component to accessing the essentials of a healthy life, such as employment opportunities, social enrichment, medical care, food, and other daily needs. There is limited access to healthy life essentials for individuals and families without a private automobile.

Chronic Disease

Chronic Diseases are ongoing—often preventable—health conditions that increase likelihood of premature mortality and comorbid conditions that contribute to poor health. The diagnoses in this category include cardiovascular conditions, diabetes, cancer, and HIV/AIDS. Although these are drastically different diagnoses, this health need acknowledges that there are common root causes and drivers among them related to lifestyle, health behaviors, diet, environmental exposures, and access to care. By addressing the drivers of chronic disease, impact across diagnosis categories may be possible.

Behavioral Health

Behavioral Health includes biologically-based mental disorders as well as health behaviors that contribute to or compromise mental and social wellbeing, such as substance use disorders and violence. There are many risk factors for poor behavioral health, which include inability to cope with stress, chronic exposure to traumatic events, and social isolation. Untreated mental illness is associated with poor health, social, and economic outcomes, and substance abuse is associated with elevated ER visit rates, drug overdoses, and increased mortality. Given the paucity of mental health service providers relative to the population, this is an important focus area for the KFH Georgia Region.

VIII. KFH Georgia's Implementation Strategies

A. About Kaiser Permanente's Implementation Strategies

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

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

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

KFH Georgia will draw on a broad array of strategies and organizational resources to improve the health of vulnerable populations within our communities, such as grant making, leveraged assets, collaborations and partnerships, as well as several internal KFH programs. The goals, outcomes, strategies, and examples of resources planned are described below for each selected health need.

B. 2019 Implementation Strategies by selected health need

Health need #1: Access to Care	
Long term goal	All community members have access to high quality health care services in coordinated delivery systems
Intermediate goal(s)	• Increase coverage and access to comprehensive, quality health care services for low income and uninsured populations • Improve health care services & deliver systems for low-income and uninsured populations • Increase access to social services for under-resourced and low-income populations
Strategies	• Medicaid: o Deploy KP resources to provide high-quality medical care to Medicaid participants who would otherwise struggle to access care

	- Plan and implement a collaborative study with the Center for Research and Evaluation to evaluate the effectiveness of Medicaid care among pediatric patients, identify areas for program improvement, and explore related health outcomes - Collaborate with the Strategy, Government Relations, and National Medicaid team to explore policy changes that might occur and assess feasibility of expanding Medicaid coverage to adult patients if state Medicaid expansion waivers get approved - Charitable Health Coverage (CHC): - 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 - Consider Georgia's Charitable Health Coverage program evaluation recommendations for program improvement and assess feasibility of implementing changes in light of evolving national priorities in the CHC space - Mobile Health Vehicle - Continue to implement the Mobile Health Vehicle project to provide access to health screening services and referrals for social and health needs for low income individuals in the communities we serve - Medical Financial Assistance (MFA): - 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 - Plan and implement a collaborative study with the Center for Research and Evaluation to evaluate the effectiveness of MFA, identify areas for improvement, and explore related health outcomes
Expected outcomes	Increased access: Low-income and underserved individuals in KP communities receive the right care, at the right times, in the right settings. Health outcomes improve over time
Health need #2: Behavioral Health	
Long term goal	All community members experience social emotional health and wellbeing and have access to high quality behavioral and mental health care services, including treatment, when needed
Intermediate goal(s)	- Increase screening & identification of substance use disorders and mental health issues among individuals living in under-resourced communities - Increase access to and uptake of behavioral and mental health treatment services for individuals living in under-resourced communities - Expand knowledge, skills, and support services related to behavioral health and mental health/wellbeing among individuals living in under-resourced communities

Strategies	• Thrive Local:
	  o Launch Thrive Local to connect low-income individuals and families to community and government resources and close the loop on social needs referrals
	• Thriving Schools:
	  o Implement the Resilience in School Environments (RISE) and RISE Understanding and Practice (RISE UP) initiative to build student and staff resilience and to address trauma and the impact of adverse childhood experiences on the school environment
	  o Consider feasibility of getting more schools onboarded with RISE and RISE UP initiatives
	• Access to Behavioral Health Care
	  o Support initiatives focused on increasing access to mental health care in schools and other community-based settings
	  o Continue participation in the Georgia Children's Mental Health Collaborative to improve access to mental and behavioral health care for children and adolescents in Georgia
	• City Health:
	  o Collaborate with the City Health initiative and the local Government Relations team to support local adoption and implementation of evidence-based policies to advance health and health equity in the areas of substance abuse, tobacco, and alcohol sales
	• Housing for Health:
	  o Work with local organizations that seek to improve mental health symptoms among chronically homeless populations
	• Stigma Reduction
	  o Participate in an on online mental health stigma reduction effort led by the Public Good Project

Expected outcomes	• Healthy Environments: Low-income and underserved individuals living and working in KP communities have increased access to health-promoting environments, programs, and services related to mental health and behavioral health • Healthy Behaviors: People develop the knowledge, skills, and attitudes that support healthy behaviors and demonstrate improved health behavior, functioning, and well-being over time • Reduced Stigma: Individuals and communities have healthy online conversations about mental health and behavioral health
Health need #3: Chronic Disease	
Long term goal	All community members are able to manage chronic conditions and live a healthy life (i.e., have the knowledge, skills, access, etc. required to do so)

Intermediate goal(s)	• Improve treatment and management of chronic conditions

Strategies	• Thrive Local:
	  o Launch Thrive Local to connect low-income individuals and families to community and government resources and close the loop on social needs referrals
	• Food for Life:
	  o Support national efforts to improve food security in the communities we serve
	• *Access to Care:*
	  o Collaborate with local health systems to improve access to affordable health care, screenings, and treatment for individuals with chronic conditions
	  o Develop and strengthen partnership with the office of the City of Atlanta's new Chief Health Officer, whose role will include increasing access to HIV screening, prevention, and treatment services in the City of Atlanta.

Expected outcomes	• Chronic Disease Management: Low-income and underserved individuals in KP communities have the knowledge, skills, and self-efficacy for managing their chronic condition(s); paired with access to medical and social services, they will be better able to manage their conditions, experience fewer ED visits, have better clinical outcomes, and healthcare costs will decrease • Healthy Behaviors: People make health-promoting behavior changes related to chronic disease management
Health need #4: Obesity/HEAL	
Long term goal	All community members eat healthier and move more as a part of daily life
Intermediate goal(s)	• Improve healthy eating among low-income, under-resourced communities • Increase physical activity among residents in low-income, under-resourced communities • Improve prevention, treatment, and management of obesity and related chronic conditions

Strategies	• Social Health/Thrive Local:
	  o Launch Thrive Local to connect low-income individuals and families to community and government resources and close the loop on social needs referrals
	• Social Health/Food for Life
	  o Support national efforts to improve food security in the communities we serve
	• Continue to support the Atlanta BeltLine and related physical activity initiatives

	• City Health: o Participate in and support City Health initiatives to adopt and implement evidence-based policies to advance equity, health, and prosperity. In the area of Obesity/HEAL, this could include topic areas such as complete streets, food safety, and healthy food procurement. • Leverage KP assets by supporting public spaces that increase access to healthy food and physical activity, including community gardens, farmers markets, exercise paths, and safe play areas for children
Expected outcomes	• Healthy Places: The physical and institutional environments in communities support healthy behaviors and reduce environmental contributors of disease • Healthy Behaviors: People make health-promoting behavior changes related to healthy eating and active living, and people develop the knowledge, skills, and attitudes that support healthy behaviors related to healthy eating and active living
Health need #5: Social Determinants of Health	
Long term goal	All community members' social needs are met, including secure, safe, and affordable housing, economic and food security, access to employment and education, and other factors that influence health
Intermediate goal(s)	• Increase access to safe, quality, affordable housing and support services for populations at-risk and affected by homelessness and housing displacement • Increase opportunities for education throughout the life course, beginning with quality rated early learning and including training and education for low-income populations, college for those who want it, and advanced education in the health sciences and beyond • Increase opportunities for families in poverty to earn more income to meet their basic needs (including food), to build and maintain wealth, and for local businesses to grow and thrive

Strategies	• Social Health
	  o Thrive Local:
	  ▪ Launch Thrive Local to connect low-income individuals and families to community and government resources and close the loop on social needs referrals
	  o Food for Life:
	  ▪ Support national efforts to improve food security in the communities we serve
	  ▪ Support work by the Atlanta Community Food Bank and Meals on Wheels to reduce food insecurity in the Atlanta area
	  o Continue participation in the Atlanta Regional Collaborative for Health Improvement (ARCHI) through engagement with other health systems and state/county health officials

	o Continue to participate in the Georgia Community Health Worker Initiative. This is a partnership between Kaiser Permanente Georgia, the Georgia Department of Public Health, United Way of Greater Atlanta, Morehouse School of Medicine, ARCHI, and Grady Hospital, which seeks to focus state conversations around Community Health Workers in effort to make their health-related activities reimbursable by Medicaid and other forms of insurance • City Health: o Collaborate with the Government Relations team to participate in the City Health Initiative, which supports the adoption and implementation of evidence-based policies to advance health and health equity in the City of Atlanta o Contribute to policy conversations currently led by Voices for Georgia's Children, including those focusing on mental health promotion and early childhood development, care, and learning. • Housing and Homelessness: o Support efforts to reduce chronic homelessness and increase housing stability by strengthening systems to reduce/end homelessness and increase the affordable housing supply o Support efforts to end chronic homelessness through partnership with the Community Solutions' Built for Zero project o Participate in the Kaiser Permanente Rx Home Fund through Enterprise Community Partners, which seeks to develop and preserve affordable housing in the communities we serve o Support the Grove Park community and Westside Future Fund to increase accessibility of affordable housing for low-income residents in the communities we serve • Economic Opportunity: o Consider the feasibility of supporting long-term economic vitality of communities through small business development, impact investing, and impact hiring o Participate in the Inner-City Capital Connections initiative to provide education and mentorship to one small business cohort seeking to increase their capacity and access new sources of funding o Support efforts around educational attainment at all stages of life to increase economic potential for residents in the communities we serve o Explore opportunities to leverage regional assets to engage underrepresented populations through employment opportunities within KP
Expected outcomes	• Equitable social and economic conditions: People in KP communities have access to conditions that create wealth, including employment and educational opportunities, social support, and other socioeconomic factors that influence health • Policy change: Our partners advance a policy agenda to create conditions that

support health and advance equity
- People receive the food, housing, and social support they need to survive and thrive, using available resources to fill gaps in their ability to provide these things when necessary

C. Our commitment to Community Health

At Kaiser Permanente, our scale and permanence in communities mean we have the resources and relationships to make a real impact, and wherever possible, our regions and facilities collaborate with each other and with key institutions in our communities, such as schools, health departments, and city/county governments to create greater impact. The CHNA/IS process also presents the opportunity to reinforce and scale national strategies to address health needs that impact all of our communities, even if those health needs are not prioritized locally. The following strategies illustrate the types of organizational business practices we implement to address health needs and contribute to community health and well-being:

- **Reduce our negative environmental impacts and contribute to health at every opportunity.** We have optimized the ways in which we manage our buildings; purchase food, medical supplies and equipment; serve our members; consume energy; and process waste. The following strategies illustrate several of our practices that enable us to operate effectively while creating a healthier environment for everyone. Our Environmentally Preferable Purchasing Standard prioritizes the procurement of products with fewer chemicals of concern and less resource intensity, thus encouraging suppliers to increase the availability of healthier products. We are building renewable energy programs into our operations, with plans to be carbon neutral in 2020. We recognize that mitigating the impacts of climate change and pollution is a collective effort, and we are therefore proud to work with like-minded organizations and individuals, including the United Nations, Health Care Without Harm, government entities, as well as other influencers that advocate for environmental stewardship in the healthcare industry and beyond.
- **Deploy research expertise to conduct, publish, and disseminate epidemiological and health services research.** Conducting high-quality health research and disseminating its findings increases awareness of the changing health needs of diverse communities, addresses health disparities, and improves effective health care delivery and health outcomes in diverse populations disproportionately impacted by health disparities. Research projects encompass epidemiologic and health services studies as well as clinical trials and program evaluations. They cover a wide range of topics including cardiovascular disease, cancer, diabetes, substance abuse, mental health, maternal and child health, women's health, health care delivery, health care disparities, pharmaco-epidemiology, and studies of the impact of changing health care policy and practice.
- **Implement healthy food policies to address obesity/overweight**, such as purchasing sustainable, locally produced fruits and vegetables; supporting local restaurants and caterers that meet KP’s Healthy Picks and to make more available healthier food options in our

communities; and supporting vendors that hire under/unemployed residents (with living wages and benefits) in the food production/distribution process. We also partner with school districts and city governments to support them in adopting and implementing healthy food procurement policies.

- **Contribute toward workforce development, supplier diversity, and affordable housing to address economic security.** We support supplier diversity by implementing policies and standards to procure supplies and services from a diverse set of providers; working with vendors to support sub-contracting with diverse suppliers; partnering with community-based workforce development programs to support a pipeline for diverse suppliers; and building the capacity of local small businesses through training on business fundamentals. We also seek to reduce homelessness and increase the supply of affordable housing by strengthening systems to end homelessness and shaping policies to preserve and stimulate the supply of affordable housing.

IX. Evaluation plans

Kaiser Permanente has a comprehensive measurement strategy for Community Health. Our vision at Kaiser Permanente is for our communities to be the healthiest in the nation. To that end, we are committed to pursuing a deep and rigorous understanding of the impact of our community health efforts. We monitor the health status of our communities and track the impact of our many initiatives on an ongoing basis. And we use our measurement and evaluation data, and information gathered through our Community Health Needs Assessments, to improve the effectiveness of our work and demonstrate our impact. The Community Health Needs Assessments can help inform our comprehensive community health strategy and can help highlight areas where a particular focus is needed and support discussions about strategies aimed at addressing those health needs.

In addition, KFH Georgia will monitor and evaluate the strategies listed above for the purpose of tracking the implementation and documenting the impact of those strategies in addressing selected CHNA health needs. Tracking metrics for each prioritized health need include the number of grants made, the number of dollars spent, the number of people reached/served, collaborations and partnerships, and metrics specific to KFH leveraged assets. In addition, KFH Georgia tracks outcomes, including behavior and health outcomes, as appropriate and where available.

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

Given the broad nature of the National Community Health strategy, KFH Georgia intends to address all the health needs identified during its CHNA process. For convenience of highlighting the overlap between regional needs and national Common Areas of Focus, the 9 originally identified needs were condensed down to 5 broader health need topic areas. Further evaluation and monitoring will take place within the five health need topic areas previously identified.