



2019 Implementation Strategy Report

Kaiser Foundation Health Plan of the Mid-Atlantic States, Incorporated

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

March 18, 2020

Kaiser Permanente Mid-Atlantic Region Community Health IS Report for Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.

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I. General information

Contact Person:	Jill Feldon, Vice President of Marketing, Communication, and Community Relations
Date of written plan:	September 30, 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 15 th day of the fifth month after the end of the taxable year the CHNA was completed?	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
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 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 (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, and safe, accessible parks and playgrounds.

However, it does not end there. If most of what contributes to your health happens outside of the doctor's office, in places where communities live, work, and play, fundamental definitions of health must also include conditions like peace, shelter, a stable eco-system, social justice, and equity¹. Any improvement in health requires a secure foundation in these basic principles.

Our vision is a world where all people have a fair and just opportunity to be healthy². Our commitment to achieving this vision is in part accomplished by our efforts to minimize health disparities and remove obstacles to optimal health, especially poverty, discrimination, and their consequences. Through our programs, grants and public policy advocacy, we make way for

¹ World Health Organization. Milestones in health promotion: Statements from global conferences. Available from: https://www.who.int/healthpromotion/Milestones_Health_Promotion_05022010.pdf

² Robert Wood Johnson Foundation. Achieving Health Equity. Available from: www.rwjf.org/en/library/features/achieving-health-equity.html

courageous conversations and decisive action about powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care. Kaiser Permanente’s vision for health equity, where all people can achieve the healthiest life possible, is the basis for our community health strategies.

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 grantmaking 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 community clinics with integrated clinical and social services
- Improving conditions for health and equity by engaging members, communities, and Kaiser Permanente’s workforce and assets
- Advancing the future of community health by innovating with technology and social solutions

For many years, we have worked side-by-side with other organizations to address serious public health issues such as obesity, access to care and violence. We have conducted Community Health Needs Assessments to better understand each community’s unique needs and resources. The Community Health Needs Assessment (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 Health Plan of the Mid-Atlantic States, Inc. (KFHP-MAS)

A. Map of facility service area

Figure 1: Map of KFHP-MAS communities



B. Geographic description of the community served

KFHP-MAS operates in 30 locations, serving more than 770,000 members in Maryland, Virginia and the District of Columbia. The Mid-Atlantic States region is comprised of three service areas: Greater Baltimore (BALT), District of Columbia/Suburban Maryland (DCSM) and Northern Virginia (NOVA). Fifteen cities and counties from the KFHP-MAS region were selected for CHNA inclusion based on the following criteria: 1) the city or county contains a Kaiser Permanente Medical Office Building (MOB), and 2) the population of the city or county represents at least 1% of the population served within the Mid-Atlantic States region. **Table 1** displays the cities and counties selected for inclusion in the CHNA by service area.

Table 1: List of cities and counties selected for inclusion in the CHNA

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

C. Demographic profile of community served

An overall demographic profile of the region is presented below.

Table 2: Demographic profile for KFHP-MAS

Race/ethnicity	Socioeconomic data		
Total Population	8,560,810	Living in poverty (<100% federal poverty level)	9.2%
Race		Children in poverty	11.9%
Asian	8.5%	Unemployment	3.8%
Black	27.2%	Adults with no high school diploma	9.7%
Native American/Alaska Native	0.3%		
Pacific Islander/Native Hawaiian	0.1%		
Some other race	4.3%		
Multiple races	3.6%		
White	56.1%		
Ethnicity			
Hispanic	12.1%		
Non-Hispanic	87.9%		

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 IRS regulations released in December 2014. This Implementation Strategy describes KFHP-MAS's planned response to the needs identified through the 2019 Community Health Needs Assessment (CHNA) process. For information about KFHP-MAS's 2019 CHNA process and for a copy of the report please visit www.kp.org/chna.

A. List of Community Health Needs identified in 2019 CHNA Report

The list below summarizes the ranked health needs identified for KFHP-MAS through the 2019 Community Health Needs Assessment process.

1. Economic security
2. Access to care
3. Obesity/HEAL/diabetes
4. Behavioral health (including substance use)

VI. Who was involved in the Implementation Strategy development

Recognizing the existing strengths in our diverse communities, the CHNA team launched an ambitious initiative to engage community members directly in the prioritization of needs and in the generation of strategies to address them. In an effort to meet people where they are, the CHNA team partnered with local organizations that work closely with the populations identified for outreach, providing guidance on outreach strategies and supporting recruitment efforts. The Implementation Strategy development offered an opportunity for bidirectional learning and collaborative work.

A. Partner organizations

Partner organizations were critical in supporting the CHNA team's community engagement activities.

- The following partner organizations helped with recruiting study participants:
 - **American Association of People with Disabilities (AAPD)** aims to increase the political and economic power of people with disabilities through advocacy activities, and workforce development programs.
 - **DC Central Kitchen (DCCK)** fights hunger by training jobless adults for culinary careers and then hiring dozens of their own graduates to prepare the 3 million meals they provide for homeless shelters, schools, and nonprofits each year.
 - **Helping Up Mission (HUM)** is an addiction recovery program in Baltimore that helps men fighting addiction and homelessness reclaim their lives back with comprehensive recovery programs that address root causes of substance use and poverty.
 - **Latin American Youth Center (LAYC)** provides low-income youth with year-round academic support, job readiness training, transitional living programs, and non-clinic sexual health education and behavioral health services.
 - **Northern Virginia Family Services (NVFS)** - SERVE Campus houses a variety of programs that provide immediate assistance with food and shelter, rapid re-housing, health access and services for children in the Greater Prince William community.

- **Public Good Projects (PGP)** developed a customized dashboard tracking all Twitter conversations relating to behavioral health between January 1, 2018 and May 1, 2019. PGP is a nonprofit performing public health monitoring and behavior change communication. PGP harnesses all of media's big data (television, radio, print news and magazines, online news, video, blogs, and social media) specifically relating to public health and healthcare.
- **Loudoun, Prince William, Fairfax, Alexandria and Arlington County Health Departments** provided thought-partnership relating to the community engagement activities.

B. Community engagement strategy

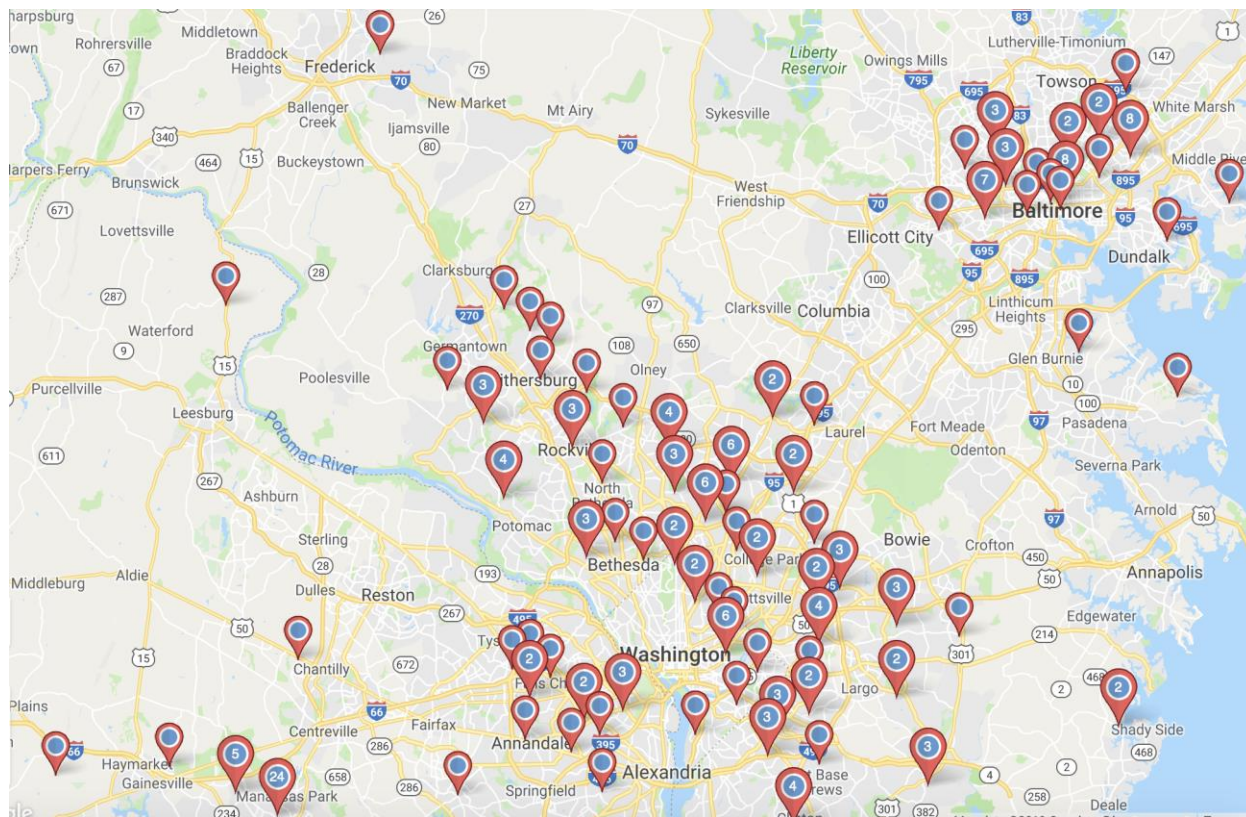
Kaiser Permanente goes above and beyond IRS regulations in developing Implementation Strategy plans, eliciting community input throughout the plan development process. Stakeholder engagement in the process is intended to:

- Enable KFHP facilities to develop a deeper understanding of community perspective, thus allowing opportunities for increased collaboration, potential impact and sustainability
- Engage the community beyond organizations and leaders with whom facilities typically collaborate
- Foster transparency throughout the Implementation Strategy development process
- Create opportunities to inform community leaders about KP's unique structure and resources

KFHP-MAS used innovative communications strategies to reach out to the broadest possible audience to co-create a vision for improved community health. The CHNA team approached community residents across the three MAS service areas who have not historically been engaged due to language barriers, geography, or social biases in order to support KP's strategy formulation and decision-making with insights informed by the voice of the community. Dialogue with the community focused on eliciting solutions to prioritized health needs and developing actionable strategies. Each data collection activity was tailored to the specific needs of community residents and partner organizations supporting our recruitment efforts.

Between April and August 2019, the CHNA team engaged 236 community members in the Implementation Strategy development process. Demographic information was collected using an original "word cloud" survey, available in English and Spanish. Participants were asked to provide their birth year and zip code and to circle descriptive labels they most identified with. **Figure 2** charts the residences of community members that were engaged in the various Implementation Strategy activities. In total, we engaged with 49 individuals from BALT, 104 from DCSM and 66 from NOVA. Below is a brief description of our six outreach projects.

Figure 2: Residence of community members engaged in the IS process



Outreach to individuals experiencing homelessness

Overview: The CHNA team facilitated informal conversations with individuals and small groups in order to gain an understanding of economic security and behavioral health issues of those who are currently experiencing or have experienced homelessness, and/or food insecurity, unemployment.

Methods/findings: KP staff visited one program in each of the three service areas (Helping Up Mission, DC Central Kitchen, Northern Virginia Family Services – Serve Campus) that offered food and shelter to people experiencing homelessness. The CHNA team conducted two focus groups (with 11 participants total) and 19 interviews. Transcripts of the interviews and focus groups were analyzed for common themes. The most frequently mentioned themes for economic security included: lack of subsidized housing and excessive requirements to buy a home (n=6), high rent/cost of living (n=5) and the importance of motivating youth and providing them training opportunities (n=5). Key themes relating to behavioral health included: adverse childhood experiences (n=4), increased length of drug addiction treatment periods (n=3), and the need to address mental health issues, including pharmacological treatment (n=3).

Outreach to seniors

Overview: “Thriving After 60” is a local event hosted by KP for Medicare members 60+ years. This summit includes a half day of health education. A table with information relating to the Community Health Needs Assessment was at the event.

Methods/findings: The CHNA team administered a survey to 80 participants, asking them to rank CHNA health needs in order of priority and to list the top 3 socio-medical/legal services they would like to see made available in their communities. Additionally, the team elicited responses to two open-ended questions: “What would make your community a better place for seniors?”, and “What three words come to mind when you think of a healthy senior community?”

Participants ranked economic security as the top health need, followed by access to care, obesity/diabetes and behavioral health. The top 3 health services needs listed by respondent were: health insurance (19%), prescription drug coverage (19%) and navigating the health system (18%). The top 3 social services needs requested were: recreation, social and volunteer opportunities (19%), legal help (16%) and affordable housing (16%).

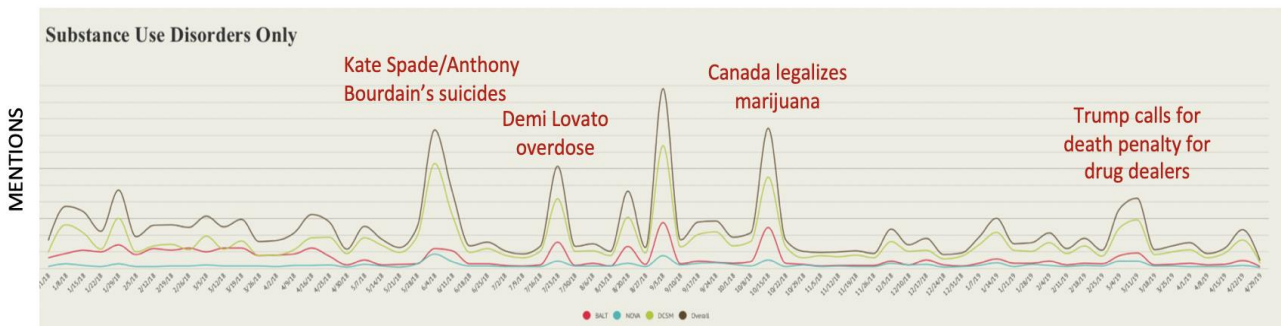
Outreach to the general population using social media

Overview: The CHNA team partnered with Public Good Projects (PGP), a non-profit organization employing cutting-edge technology to monitor and analyze public health social media and behavior change communication. PGP collects all publically available media data around the topic of mental health.

Methods/findings: In collaboration with the CHNA team, PGP designed regional and service area dashboards displaying top issues in behavioral health, top social media authors by engagement, mentions and influence, word clouds, trending stories and the most popular Twitter mentioned (measured by retweet counts). **Figure 3** displays trends in conversations about behavioral health, mapped onto historical events.

In total, 326,000 mentions of health behaviors were captured between January 2018 and May 2019. The top 20 tweets (based on retweets) for each of the three service areas were analyzed for common themes. The top 3 themes identified include: the need to raise awareness about mental health, in particular for minority groups (n=19); the need for direct resources for mental health services, including mHealth (mobile health) (n=12) and the importance of stigma reduction (n=8).

Figure 3: Trends in conversations about behavioral health



Outreach to youth and individuals living with a disability

Overview: The CHNA team engaged youth through a novel arts-based research activity, a non-traditional research method utilized in the social sciences. The CHNA team created a repository of photographs taken by young people, and corresponding to a health need identified through the CHNA process. Youth were instructed to select a photograph that represented the most critical need in their community. By this means, they “prioritized” CHNA health needs.

Youth were then asked to consider how to address the issue depicted in the photograph and communicate possible solutions graphically by drawing, making a collage or writing about the solution on transparent acetate film overlaid on their selected photograph. While depicting their proposed solutions, youth discussed how solutions would benefit their communities and what resources/allies were required to make the proposed solution a reality. See **Figure 4** for an example of the activity. The CHNA team adapted this activity to engage individuals living with disabilities, creating a mail-in process by preparing packets with 4 images (one per CHNA health need), together with an instruction sheet so that participants could complete this activity without the need for meeting at a physical location.

Methods/findings: Thirty seven participants selected economic security as their top need, followed by behavioral health (n=34), obesity/diabetes (n=18) and access to care (n=6). Based on a thematic analysis of participants’ worksheets, priorities identified include: the importance of availability and affordability of professional mental health services (n=6), the need for communities/local organizations to invest more in their own built environment, e.g. renovating houses, maintaining playgrounds, recycling (n=6); the need for more after-school activities and/or recreational centers (n=6) and the importance of improving work conditions by raising pay, providing benefits, creating unions, etc. (n=4).

Figure 4: Arts-based research activity depicting the original and modified images



Outreach to the Hispanic community

Overview: The CHNA team developed a facilitated movie discussion guide based on the Netflix-produced movie “Roma”, which portrays a domestic worker’s journey in the context of domestic and political turmoil in 1970s Mexico. Three segments of the movie – each relating to a need identified in the CHNA, were presented and a Spanish-speaking facilitator engaged the audience in discussion about personal experiences related to these identified needs. A Spanish-speaking scribe took detailed notes about participants’ proposed solutions.

Methods/findings: A total of 21 individuals participated in the focus groups. Based on a thematic analysis of the transcripts, key themes for economic security included the need for financial support for education/training programs (n=7), better compensation and benefits (n=6) and help prioritizing, e.g. work versus family (n=5). Key themes for access to care included the need for affordable health care and insurance (n=8), dissatisfaction with the overall quality of medical care in the United States (n=6) and issues with delayed/mishandled care (n=5). Key themes for behavioral health included the importance of stress reducing activities, e.g. exercise (n=8); additional access to therapy and services (n=4) and the need for a centralized location for information about services (n=4).

Outreach to community clinics

Overview: The Center for Community Health and Evaluation was engaged to support the development of strategies for community clinic partnerships across the Mid-Atlantic states. The objective was to align KP common areas of focus with CHNA results, taking into account differences in needs/assets across the region.

Methods/findings: Recommendations for community clinic strategies were based on 11 interviews with community clinics (federally qualified health centers and free clinics) and 5 interviews with KP stakeholders. These included: 1) supporting capacity of community clinics and social service providers to improve access, quality of services and sustainability of business operations, 2) engaging with relevant stakeholders to understand community needs and be part of collaborative solutions and 3) leveraging KP’s influence to contribute to systemic solutions related to health, health care and the social determinants of health.

How did each activity inform the Implementation Strategy?

The Implementation Strategy was informed by each of the six activities described above. The community engagement activities provided community-level data and strategies pertaining to the health needs prioritized in the CHNA. The social media monitoring activity, led by PGP, provided insight into conversations around behavioral health at the population level, whereas the other community engagement activities provided more localized recommendations. **Table 3** below enumerates the community engagement activities.

Table 3: Summary of community engagement activities

	Data collection method	Types of participants	# participants
1	Arts-based research activity	Youth, people with disability	94
2	2 focus groups (Spanish)	Hispanic community	21
3	2 focus groups (English)	Individuals experiencing homelessness	11
4	Brief interviews	Individuals experiencing homelessness	19
5	Community survey	Seniors (both KP members and non-members)	80
6	In-depth interviews	Community clinic staff	11
7	Social media tracking	General public (Twitter users)	326,000 mentions

C. Who was involved in the assessment?

Maya Nadison, Ph.D., M.H.S.: Dr. Nadison led the 2019 KFH-MAS CHNA/IS, overseeing the quantitative and qualitative data collection and analysis, the data triangulation methodology and the CHNA/IS report writing. She 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 interests relate to the design, implementation, and evaluation of school and community-based interventions focused on the prevention of risk behaviors.

Jessica Minor, M.P.P., B.S.: Ms. Minor supported qualitative data collection and analysis, and provided logistical support for all community engagement activities. She is currently a Program Coordinator at Kaiser Permanente Community Health, where she manages data for all contributions and the sponsorship program. Previously, she worked as a Public Health Program Manager at the Association of University Centers on Disability. Ms. Minor has a special interest in health disparities as it relates to people with disabilities and other minority populations.

Abigail Alberico, M.P.H.: Ms. Alberico supported qualitative data collection and analysis. Ms. Alberico earned her MPH in Public Health Communication and Marketing from the George Washington University (GWU). Previously, Abigail worked as a Senior Public Health Program Manager at the Association of University Centers on Disabilities and Research Assistant at GWU.

Center for Community Health and Evaluation (CCHE) conducted interviews with community clinic providers and analyzed data. For over 25 years, CCHE has provided evaluation, assessment and strategic consulting services to foundations and health organizations to improve community health. CCHE brings experience conducting tailored needs assessments and engaging stakeholders to conduct planning and prioritize strategies based on data.

Shattuck and Associates (S&A) supported qualitative data analysis. S&A is a small, woman-owned business dedicated to providing high quality, client-focused planning, facilitation and evaluation services to organizations in the fields of public health and education.

VII. Health needs that KFHP-MAS plans to address

A. Process and criteria used

Before beginning the Implementation Strategy health need prioritization process, KFHP-MAS 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 other.
- **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, as well as its organizational commitment to improving community health.
- **Community priority:** The frequency with which community members expressed concern about certain health outcomes during the CHNA primary data collection.
- **Existing resources dedicated to the issue:** The availability of resources in the local community devoted to addressing a particular health need.
- **Potential for partnering with local organizations:** The existence of local organizations working toward addressing particular health needs in the community.

Throughout the CHNA process, KFHP-MAS used primary and secondary data to rank health needs based on performance, presence of disparities, and community priorities. For more details on the CHNA process, refer to the KFHP-MAS 2019 CHNA report at www.kp.org/chna.

The CHNA team used a three-pronged approach to engage community members and KP internal stakeholders in ranking CHNA needs. Participants in the arts-based research activity selected an image that represented their top health need, seniors at the Thriving after 60 event ranked health needs in order of perceived priority, and KP internal stakeholders ranked health needs using a live polling application (www.mentimeter.com) during a team meeting in September 2019. **Table 4** below displays the number of individuals who selected each health need as their top need.

Table 4: Community and KP internal stakeholder prioritization of health needs

	KP internal stakeholders	Arts-based research	Thriving after 60	Total
Economic security	12	37	33	82
Behavioral health	4	34	6	44
Access to care	1	6	33	40
Obesity/HEAL/diabetes	0	19	6	25
Total responses	17	94	80	191

All three groups prioritized economic security as their top health need, but there were variations in the ranking of other health needs. Based on feedback received during this prioritization exercise, the decision was made to address all four health needs identified through the CHNA process. Considerations for this decision included: 1) continuing to invest in programs and strategies that are already in place within the region to build on early successes, 2) aligning strategies with existing efforts in the community so that more resources can be allocated to each, 3) aligning strategies selected with health needs to maximize the chances of having an impact, and 4) aligning regional needs with those prioritized by Kaiser Permanente nationally in order to pool existing resources and leverage assets and expertise internally.

B. Health needs

Economic security: Research shows particularly strong and consistent associations between socioeconomic security, to include areas such as access to employment, education and income across time and geography; and, a variety of health outcomes³. There are solid, credible mechanisms explaining why lower socioeconomic groups have poorer health outcomes.

Economic security was identified as the highest health need in the KFHP-MAS region. In the Baltimore service area, 10.9% of the population lives below 100% of the Federal Poverty Line (FPL), compared to 10.1% in the District of Columbia/Suburban Maryland, and 6.7% in Northern Virginia (national benchmark: 15.4%). Health disparities were observed in the percentage of adults without a high school diploma – Hispanics (33.1%) and Native American/Alaskan Natives (17.7%) were least likely to complete high school compared to the national benchmark (13.2%).

“We’ve got more millennials and more white people moving into urban areas which is kicking up the cost of living in those areas there [and] displacing the people who have historically been there. That is a major factor that is leading to some housing insecurity because what we’re really seeing is the suburbanization of poverty.”

Key informant for Fredericksburg City

Access to care: Access to affordable, quality health care is important to physical, social, and mental health, as well as 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. Health care must be affordable, available and in relatively close proximity to where patients live⁴.

³ Lynch, J. W., Smith, G. D., Kaplan, G. A., & House, J. S. (2000). Income inequality and mortality: importance to health of individual income, psychosocial environment, or material conditions. *BMJ*, 320(7243), 1200-1204.

⁴ Hood, C. M., Gennuso, K. P., Swain, G. R., and Catlin, B. B. (2016). County health rankings: Relationships between determinant factors and health outcomes. *American Journal of Preventive Medicine*, 50(2): p. 129-135.

Approximately 8.7% of the KFHP-MAS region population is uninsured compared to the national benchmark (11.6%). While better than the national average, this health need is still quite significant given that 26.4% of Hispanics, 11.5% of Native American/Alaskan Natives, 10.8% of Asians, 8.5% of Blacks and 4.3% of Whites are uninsured in the Mid-Atlantic States region.

“We are especially having difficulty with our immigrant population, whether they’re documented or undocumented, requesting or seeking health services or any other services that are related to any type of government intervention.”

Key informant from Alexandria City

Obesity/HEAL/Diabetes: 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/obese and/or having diabetes. Diabetes affects 29.1 million people in the US (one in eleven people) and is the seventh-leading cause of death⁵. Moderate weight loss and exercise can prevent or delay Type 2 diabetes in individuals at high risk.

Nutritious and affordable food options are inaccessible for populations in many counties across the KFHP-MAS region. For example, 23.8% of Baltimore City’s population and 15.5% of the Prince George’s County’s population experienced food insecurity in the past year (national benchmark: 14.3%). Moreover, the percentage of obese adults in Baltimore City (33.5%), Prince George’s County (33.0%) and Stafford County (29.0%) trail the national benchmark (27.5%).

“We have challenges with concentrated areas of poverty that make it difficult to engage in healthy behaviors. If you don’t have access to grocery store or don’t feel safe, you don’t want to be outside walking or exercising.”

Key informant from Baltimore City

Behavioral health (including substance use): In the U.S., an estimated one in five adults live with mental illness⁶. A person’s social, economic and physical conditions affect their mental health wellness. People with poor mental health have an increased risk of substance use disorder. Factors which affect mental wellness include a person’s education/employment options, ability to live in safe neighborhoods, and access to high quality/affordable health care⁷.

⁵ Adult obesity facts | Overweight & Obesity | CDC. (2018, August 14). Available from: <http://www.cdc.gov/obesity/data/adult.html>

⁶ National Institute of Mental Health. (2017). Mental illness. Available from: <https://www.nimh.nih.gov/health/statistics/mental-illness.shtml>

⁷ Abuse, N. I. on D. (2012). Health Consequences of Drug Misuse. Available from: <https://www.drugabuse.gov/related-topics/health-consequences-drug-misuse>

The number of beer, wine and liquor stores per 10,000 population is significantly elevated in the Baltimore region (2.4 per 10,000) and in the District of Columbia/Suburban Maryland (2.0 per 10,000) compared to the national benchmark (1.1 per 10,000). Additionally, racial and ethnic disparities in the suicide death rate per 100,000 population were observed. Non-Hispanic Whites have a significant disparity at 12.2 per 100,000 population compared to non-Hispanic Blacks (5.21 per 100,000), non-Hispanic Asians (5.36 per 100,000) and Hispanics (2.51 per 100,000).

“I think when it comes to behavioral health and mental health, a lot of what we’re seeing is there is not enough access to services, specifically to treatment when individuals are ready to enter [treatment] for substance use.”

Key informant from Baltimore City

VIII. KFHP-MAS’s Implementation Strategies

A. About Kaiser Permanente’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 Mid-Atlantic Permanente Medical Group, other Kaiser Foundation Hospitals, and externally with multiple stakeholders to identify, develop and implement strategies to address health needs in the community. These strategies:

- Are broadly available to the public and serve low-income individuals
- Are informed by evidence
- Reduce geographic, financial, or cultural barriers to accessing health services
- Address federal, state, or local public health priorities
- Leverage or enhance public health department activities
- Advance general knowledge through education or research that benefits the public
- If they were not employed, would burden government or other tax-exempt organizations

KFHP-MAS is committed to understanding about how best to develop and implement effective strategies to address community health needs. We recognize 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 expand upon the strong community partnerships it currently has in place.

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 grant making, leveraged assets, collaborations and partnerships, and other several internal KFHP 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: Economic security	
Long-term goal	All community members experience improved economic security, including access to employment, education, and housing opportunities, and other factors that influence health.
Intermediate goals	<ul style="list-style-type: none"> • Increase access to safe, quality affordable housing and support services for populations affected by homelessness and housing displacement. • Increase opportunities for local and diverse hiring and entrepreneurship. • Increase access to employment and careers that provide a living wage for youth and young adults who face barriers to employment and economic security, focusing on youth of color. • Increase economic viability of small businesses and non-profits serving low-income communities.
Strategies	<p>Common Areas of Focus*</p> <ul style="list-style-type: none"> • Thriving Cities (CityHealth). Participate in the CityHealth initiative to support cities in adopting and implementing evidence-based policies that advance health, prosperity and equity. Policy priorities related to economic security include earned sick leave, universal pre-kindergarten and affordable housing/inclusionary zoning. Support specific policy campaigns that advance health, prosperity and equity for a priority city. • Economic opportunity. Support long-term economic vitality of communities through procurement, hiring and workforce development, small business development, impact investing and public policy. • Food for life. Deliver a multi-pronged approach to transform economic, social and policy environments to improve food security for the communities we serve. • Housing/homelessness. Support efforts to reduce homelessness and increase housing stability by transforming health care and housing, and strengthening systems to reduce/end homelessness, increase the affordable housing supply, shape policy and catalyze innovations. • Thrive Local. Deploy Thrive Local at priority sites, connecting low-income individuals and families with community and government resources, while confirming their needs have been addressed, incorporating information into ongoing care plans. • Thriving Schools. Implement a workforce pipeline to introduce, develop and place diverse, underrepresented school-age and college students in careers that promote health and wellness at a livable wage. <p>Regional strategies</p> <ul style="list-style-type: none"> • Place-based initiatives. Support equitable community development by implementing a multi-sector place-based strategy in communities with high geographic concentrations of vulnerable persons through partnerships/ collaborations. • Community leadership. Support development of community-based organizations and leaders by building their capacity to advance equity.

* Common Areas of Focus are initiatives that Kaiser Permanente is committed to delivering at scale across the nation.

	<ul style="list-style-type: none"> • Workforce development. Create job opportunities and employment pathways for populations with employment obstacles (e.g. returning citizens) through investment in social services, mentorship and workforce development programs. • Equity. Leverage our grantmaking in support of community-driven efforts to improve structural factors that contribute to poverty and oppression.
Expected outcomes	<ul style="list-style-type: none"> • Healthy social and economic conditions. People in KP communities experience improved economic and educational opportunities, improved family and social support, and other social and economic factors that influence health. • Policy change. Community partners advance a public policy agenda that supports the health of low-income and underserved individuals, ensuring that our communities are amongst the healthiest in the nation, while advancing equity. • Healthy places. Strategic partners from multiple sectors collaborate to revitalize neighborhoods with a common agenda, aligned efforts and shared measures of success.

Health need #2: Access to care

Long-term goal	All community members have access to high quality health care and social services in coordinated delivery systems.
Intermediate goals	<ul style="list-style-type: none"> • Increase coverage and access to comprehensive, high quality health care services for low income and uninsured populations. • Improve health care services and delivery systems for low-income and uninsured populations. • Increase access to social non-medical services for vulnerable and low-income populations.
Strategies	<p>Common Areas of Focus</p> <ul style="list-style-type: none"> • Charitable health coverage. 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. • Medicaid. Deploy KP resources to provide high-quality medical care to Medicaid participants who would otherwise struggle to access care. • Medical financial assistance. 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. • Thrive Local. Deploy Thrive Local at priority sites, connecting low-income individuals and families to community and government resources, confirming that their needs have been addressed, and incorporating that information into ongoing care plans. <p>Regional strategies</p> <ul style="list-style-type: none"> • Community clinics. Strengthen the capacity and sustainability of community clinics and social service providers that address essential medical and social/non-medical needs. • Health outreach. Build capacity of community anchors (e.g. barbershops and beauty salons) so they can provide medical and social services to their clients, with expertise from KP. • MFA–Healthy Outcomes. Eliminate financial barriers for patients that have protracted and/or expensive treatment plans for managing specific chronic conditions, in collaboration with the KP revenue cycle team.

	<ul style="list-style-type: none"> • Residency program. Launch an accredited Internal Medicine Residency Program that will provide residents the unique opportunity to receive high-quality health care in an integrated, prepaid, multi-specialty care setting. • Transportation. Engage community partners to promote safe transportation and address barriers to health access, in partnership with the KP care delivery team. • Equity. Support community-driven efforts to provide equitable access to health care and social services.
Expected outcomes	<ul style="list-style-type: none"> • Increased access. Uninsured and underinsured populations who are served by KP are treated with dignity, receive quality health care services and have their unique needs met. Community clinics expand capacity and achieve better health outcomes for uninsured and underinsured populations. • Improved experience. Low-income and underserved individuals who are served by community partners and KP are treated with dignity and have their unique needs met. • Policy change. Community partners advance a public policy agenda that supports the health of low-income and underserved individuals, ensuring that our communities are amongst the healthiest in the nation, while advancing equity.

Health need #3: Obesity/HEAL/diabetes

Long-term goal	All community members eat healthier and are more active in their daily lives.
Intermediate goals	<ul style="list-style-type: none"> • Improve healthy eating among low-income, under-resourced communities. • Increase physical activity among members in low-income, under-resourced communities. • Improve prevention, treatment and management of obesity, and/or heart disease.
Strategies	<p>Common Areas of Focus</p> <ul style="list-style-type: none"> • Thriving Cities (CityHealth). Implement/participate in the CityHealth initiative to support cities to adopt and implement evidence-based policies that advance health, prosperity and equity. Policy priorities related to obesity/HEAL/diabetes include Complete Streets, food safety/restaurant inspection rating and healthy food procurement. Support specific policy campaigns that advance health, prosperity and equity for a priority city. • Food for Life. Deliver a multi-pronged approach to transform economic, social and policy environments to improve food security for the communities we serve. • Thrive Local. Deploy Thrive Local at priority sites, connecting low-income individuals and families to community and government resources, confirming their needs have been addressed, and incorporating that information into ongoing care plans. • Thriving Schools. Implement/participate in the KP Thriving Schools HEAL initiative to support high-need schools with the adoption and implementation of HEAL policies and practices, continuously improving the school's environment and culture of health. <p>Regional strategies</p> <ul style="list-style-type: none"> • Community vitality. Build spaces that are open to the public, blurring the lines between community and KP facilities (gardens, farmer markets, children's play areas), and supporting active transportation policies and practices, whenever possible. • Equity. Support community-driven efforts to provide equitable access to healthy food through culinary workforce training, health awareness and urban agriculture programs.

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, while developing the knowledge, skills, and attitudes that support healthy behaviors related to healthy eating and active living.
- **Policy change.** Community partners advance a public policy agenda that supports the health of low-income and underserved individuals, ensuring that our communities are amongst the healthiest in the nation, while advancing equity.

Health need #4: Behavioral health (including substance use)

Long-term goal

All community members experience improved mental health and have access to high quality behavioral health care services.

Intermediate goals

- Increase screening and identification related to mental health/illness and substance use among low-income and uninsured populations.
- Expand knowledge of substance use and behavioral health issues and skills needed to manage both, while supporting services for low-income and uninsured populations.
- Increase access to appropriate behavioral health services for vulnerable and low-income populations.
- Destigmatize mental health.

Strategies

Common Areas of Focus

- **Thriving Cities (CityHealth).** Implement/participate in the CityHealth initiative to support cities in adopting and implementing evidence-based policies that advance health, prosperity and equity. Policy priorities related to substance use and tobacco include alcohol sales control, Tobacco 21 and smoke-free indoor air. Support specific policy campaigns that advance health, prosperity and equity for a priority city.
- **Media campaign.** Implement the Public Good Projects' Action Minded campaign, a digital community health intervention that uses education, social engagement and multi-media tools to engage the general public, issue-advocates, community partners and KP employees toward the goal of reducing stigma regarding mental health conditions.
- **Thrive Local.** Deploy Thrive Local at priority sites, connecting low-income individuals and families with community and government resources, confirming their needs have been addressed, and incorporating information into ongoing care plans.
- **Thriving Schools.** Implement/participate in the KP Thriving Schools Resilience in School Environments (RISE) initiative to build student and staff resilience to address trauma and adverse childhood experiences.

Regional strategies

- **Behavioral health.** Increase access to community-based, culturally competent behavioral health services with a particular focus on integration of services (primary/behavioral care), early childhood interventions and building provider knowledge.
- **Arts-based learning.** Provide arts-based learning experiences to students and teaching staff that are aligned with educational standards to improve social and emotional wellbeing.

	<ul style="list-style-type: none"> • Equity. Support community-driven efforts to provide equitable access to behavioral health services.
Expected outcomes	<ul style="list-style-type: none"> • Increased access. Low-income and underserved individuals living in KP communities have increased access to health-promoting environments, programs, and services related to mental health and substance use. • Healthy behaviors. People develop knowledge, skills, and attitudes that support healthy behaviors related to reducing stigma associated with behavioral health.

C. Our commitment to Community Health

At Kaiser Permanente, our scale and longstanding presence in communities means we have the resources and relationships to make a real impact on community health. Wherever possible, our regions and facilities collaborate with each other and with key institutions such as schools, health departments and city/county governments to create even greater impact. The CHNA/IS process presents a 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 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 and less resource intensity, thus encouraging suppliers to provide 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, and other influencers that advocate for responsible environmental stewardship in the healthcare industry and beyond.
- **Deploy research expertise to conduct, publish, and disseminate epidemiological and health services research to the greater community.** 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, HIV, sexually transmitted infections, hepatitis and other infectious diseases, substance use, 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 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 rigorously pursuing a deep 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 highlight areas where a particular focus is needed, while facilitating discussions about strategies aimed at addressing those health needs.

In addition, KFHP-MAS tracks and monitors implementation of the strategies listed above, while documenting their impact upon 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, number of collaborations and partnerships, and metrics specific to KFHP leveraged assets. In addition, KFHP-MAS tracks outcomes, including behavior and health outcomes, as appropriate and where feasible.

X. Health needs KFHP-MAS does not intend to address

KFHP-MAS will address all four identified CHNA health needs. It is important to note that the implementation strategies described in this document do not represent an exhaustive list of all that KFHP-MAS does to enhance community health.