2019 Implementation Strategy Report

Kaiser Foundation Hospital: San Francisco

License number: 220000188

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

March 20, 2020

KAISER PERMANENTE®

Kaiser Permanente San Francisco Region Community Health

IS Report for KFH San Francisco

Contents

I. General information

Contact Person:	Kirk Kleinschmidt, Interim Public Affairs Director
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 – San Francisco Service Area/Region

A. Map of facility service area
KFH San Francisco Service Area
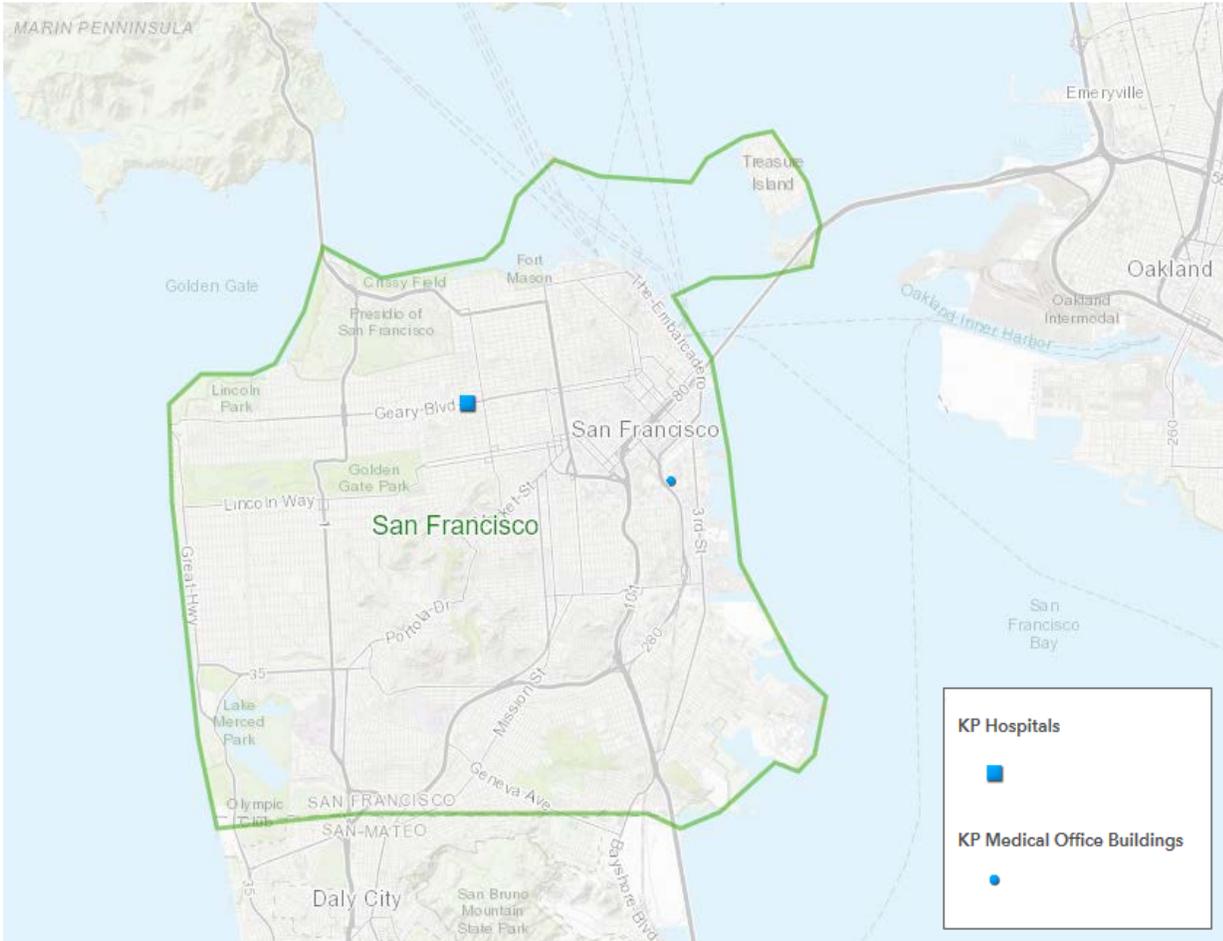
B. Geographic description of the community served (towns, counties, and/or zip codes)
The community served includes the City and County of San Francisco. The primary focus of KFH San Francisco's Community Benefit Programs is on the needs of vulnerable populations, which include low-income residents with health disparities and significant barriers to care.

C. Demographic profile of community served
Demographic profile: KFH San Francisco

Race/ethnicity		Socioeconomic Data	
Total Population	850,282	Living in poverty (<100% federal poverty level)	12.5%
Asian	33.8%	Children in poverty	11.5%
Black	5.3%	Unemployment	2.3%
Native American/Alaska Native	0.4%	Uninsured population	6.9%
Pacific Islander/Native Hawaiian	0.3%	Adults with no high school diploma	12.6%
Some other race	7.0%		
Multiple races	4.9%		
White	48.2%		
Hispanic/Latino	15.3%		

Data from the San Francisco Health Improvement Partnership (SFHIP) 2019 Community Health Needs Assessment show that San Francisco has a relatively small proportion of households with children (19%) as compared to the state overall (34%). Meanwhile, the proportion of San Francisco's population that is 65 years and older is expected to increase from 17% in 2018 to 21% in 2030. The proportion of working age residents (25 to 64 years old) is estimated to decrease from 61% in 2018 to 56% in 2030. In 2018, the age demographic profile of San Francisco was as follows: 17% ages 65 and older; 61% ages 25 to 64; 7% ages 18 to 25; 10% ages 5 to 17; and 5% ages birth to 4 years. According to a 2015 Gallup Poll, the percentage of LGBTQ-identifying persons in the San Francisco metropolitan area (San Francisco-Oakland-Hayward) was the highest in the nation at 6.2% of the population, compared to 3.6% nationwide.

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 San Francisco's planned response to the needs identified through the 2019 Community Health Needs Assessment (CHNA) process. For information about KFH San Francisco'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 San Francisco service area through the 2019 Community Health Needs Assessment process. These health needs were identified by KFH San Francisco in collaboration with the San Francisco Department of Public Health and San

Francisco Health Improvement Partnership (SFHIP) using established criteria and based on extensive data review and the results of many community input meetings and key informant interviews:

Higher Priority Needs
- Access to Care
- Housing and Homelessness/Economic Security
- Mental Health
- Obesity/Health Eating–Active Living/Diabetes
- Substance Abuse/Tobacco

Lower Priority Needs
- HIV/AIDs/STDs
- Violence/Injury Prevention

VI. Who was involved in the Implementation Strategy development

A. Partner organizations
KFH San Francisco worked independently on the development of its Implementation Strategy.

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.

On July 26, 2019, KFH San Francisco met with twelve representatives from local service organizations to provide input on the hospital's 2019 community health needs assessment implementation strategy. Participants were selected from a broad range of service organizations in the region and represented agencies that each focused on one of the following health needs prioritized by KFH San Francisco: **access to care**, **behavioral health** (**mental health and substance abuse)**, **healthy eating/active living**, and **housing and homelessness**.

The group began by reviewing the data that KFH San Francisco had collected on the four selected health needs and then brainstormed ideas for promising practices, potential partners, challenges, and indicators for addressing these needs locally. Participants then broke out into small groups to summarize and prioritize the ideas and record their thoughts on worksheets.

In the table below, the left-hand column shows the recommendations from participants. Following the meeting, the Community Benefit Advisory Committee (CBAC) reviewed the community engagement discussion summary and used the community input to inform the KFH San Francisco Implementation Strategy. The strategies that they included in the Implementation Strategy as a result of community recommendations are shown in the right-hand column in the table below.

	Recommendations from community members	Corresponding CBAC Strategies
Access to Care	– Support the coordination of case managers to share resources across organizations	– Improve the coordination of social non-medical services across the healthcare delivery system for low income and vulnerable populations
Behavioral Health (Mental Health and Substance Abuse)	– Train professionals in trauma-informed care – Support case manager coordination across organizations – Provide mobile support to people in shelters or in their homes – Emphasize harm reduction strategies – Support drug-free social spaces	– Provide training for front line staff in direct service organizations and schools on trauma-informed care – Increase the capacity of case managers to coordinate across agencies – Support mobile case management teams – Support harm-reduction strategies
HEAL (Healthy Eating / Active Living	– Expand access to food pantries – Address unhealthy food and drink – Write "food prescriptions" for food that could be filled with food vouchers – Work with schools to prioritize physical activity – Support better lighting to increase park safety	– Increase access to healthy food through CalFresh enrollment, food pantries, and other programs – Encourage schools to partner with non-profits that work to increase physical activity, especially for Latinx and African American youth – Bring programming to parks and open spaces to encourage physical activity
Housing and Homelessness	– Provide direct monetary support to those at risk of homelessness – Support case management to stabilize families at risk of homelessness – Create a system for coordinating care between case management systems – Support case management services in shelters	– Support individuals and families at risk of falling into homelessness – Increase the capacity of case managers working with the homeless to coordinate across agencies

The table below describes the participants in the community engagement meeting:

	Data collection method	Title/name	Number	Notes (e.g., input gained or role in IS process)
Organizations				
1	Focus Group	4 nonprofits working in health eating/active living 3 nonprofits working in access to care and coverage 3 nonprofits working in mental health 2 nonprofits working in housing and homelessness *Included 8 San Francisco residents*	12	Informed local strategies for the IS process

C. Consultant(s) used

Engage R+D is a consulting firm dedicated to helping foundations, nonprofits, and public agencies achieve their greatest possible impact. The firm's founding was inspired by the belief that creating social change requires bringing together good data, stakeholder voice, and field insights in creative ways to inform strategy and drive results. Engage R+D approaches its work with an organizational development lens, recognizing that people and relationships are central to this work.

Engage R+D's staff bring experience conducting CHNAs in multiple California communities, as well as needs assessments with vulnerable populations (e.g., homeless youth, rural farmworkers, and low-income families). Some of their key qualifications and relevant project experience include:

- **Expertise in public health**. Engage R+D's work is rooted in public health and social change with a solid commitment to equity. Their staff has expertise in supporting a range of public health efforts.
- **Gathering data from vulnerable populations**. Engage R+D has conducted focus groups and interviews with youth and adults from a diverse range of demographics and experiences. They also have experience conducting focus groups in Spanish and other languages and working with community partners to coordinate focus group logistics.
- **Presenting secondary data in compelling ways**. When synthesizing data for clients, Engage R+D strives to present it in ways that are visually compelling, user-friendly, and engaging to a variety of audiences and stakeholders.

VII. Health needs that KFH San Francisco plans to address

A. Process and criteria used

On June 20, 2019, fourteen members of the hospital's internal Community Benefit Advisory Committee, attended a meeting to review the health needs included in the CHNA and recommend a subset of them for the KFH San Francisco Implementation Strategy. The CBAC represents diverse areas of expertise and includes physicians, clinicians, administrators, managers, and direct services staff from throughout the medical center. They are active in the grant application review process and

meet with grantees during the course of the year, which keeps them in touch with local health needs and successful programs.

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

- **Ability to leverage community assets:** The existence of opportunities to collaborate with existing community-wide partnerships working to address the need, build on current programs or emerging opportunities, and partner with other community assets.
- **Evidence-based or promising approaches:** The existence of effective or promising strategies (preferably evidence-based) that could be applied to address the health need.
- **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.
- **Feasibility:** The extent to which KP has the ability to make an impact, given the resources available.
- The priority given to the health need in the CHNA report was also considered in the ranking.

Process:

On June 20, 2019, the KFH San Francisco Community Benefit Advisory Committee (CBAC) met to select priority health needs for implementation during the 2020-2022 Community Health Needs Assessment (CHNA) cycle. The meeting was informed by data presented at prior CBAC meetings in 2018 as well as a summary of the health needs provided in the CHNA report and distributed prior to the meeting. The CBAC used this information and their professional backgrounds and knowledge to rank the identified health needs from the CHNA based on the following scale:

	Ability to leverage community assets	Evidence-based or promising practices	Ability to leverage KP assets	Feasibility	CHNA priority
Score of 3	*many partners*	*many approaches*	*many ways*	*strong potential*	*higher priority*
Score of 2	*some partners*	*some approaches*	*some ways*	*moderate potential*	*n/a*
Score of 1	*few/no partners*	*few/no approaches*	*few/no ways*	*low potential*	*lower priority*

The scores from this ranking were averaged to create a single score for each health need, shown below:

Based upon this process, the CBAC recommended the following health needs to the KFH San Francisco Senior Vice President and Area Manager for implementation in the 2020-2022 CHNA cycle. The health needs are shown in alphabetical order:

1. Access to Care
2. Behavioral Health (Mental Health and Substance Abuse)
3. Health Eating/Active Living
4. Housing and Homelessness

B. Health needs that KFH San Francisco plans to address

1. **Access to Care:** This health need draws upon data related to health insurance, care access, and preventative care utilization for physical, mental, and oral health. Access to care represents more than the hours and availability of services to include location, affordability, cultural and linguistic appropriateness, and coordination of health care and non-medical social services. A review of the secondary data shows San Franciscans were significantly less likely than residents in the entire state of California to have had a recent primary care visit. This was especially true for African Americans. Focus group themes surfaced the need for a more flexible and adaptable health care system that could provide equitable and inclusive services that expand access to care. This included the need for more culturally appropriate care and coordinated approach. SFHIP also identified "access to coordinated, culturally and linguistically appropriate care and services" as a community priority.

   Based on this data and their knowledge of KFH San Francisco, the CBAC gave Access to Care the highest score for implementation. The Committee reported that KP has strong expertise and many community partners in this area, and that there are many promising approaches for working on this health need as well as strong feasibility. The health need was also ranked as a high priority in the CHNA.

2. **Behavioral Health (Mental Health and Substance Abuse):** This health need draws upon data related to mental health and well-being, access to and utilization of mental health care, mental health outcomes and forms of substance abuse including alcohol, marijuana, tobacco, illegal drugs, and prescription drugs. A review of the secondary data shows residents of San Francisco were significantly more likely to have seriously considered suicide than residents of California as a whole. Furthermore, certain racial/ethnic groups — White, Hispanic, and African American — were at higher risk for mental health services and distress. Although the age-adjusted mortality rate due to substance use disorder has decreased in San Francisco since 2015, African Americans were five times more likely to experience a substance use disorder than other ethnicities. Focus group themes identified behavioral health, including mental health and substance abuse, as an exacerbating factor to other health needs. SFHIP also identified "social, emotional, and behavioral health" as a community priority.

   Based on this data and their knowledge of KFH San Francisco, the CBAC gave Behavioral Health the third highest score for implementation. The Committee reported that KP has many community partners in this area and that there are many promising approaches for working on this health need as well as strong feasibility. The health need was also ranked as a high priority in the CHNA. However, they reported that KP has only medium expertise in this area.

3. **Healthy Eating/Active Living:** This health need draws upon data related to healthy eating and food access, physical fitness and active living, overweight and obesity prevalence, and downstream health outcomes including diabetes. A review of the secondary data shows Hispanics, African Americans, and Native Hawaiians/Pacific Islanders were significantly more likely than white residents of San Francisco and residents of California as a whole to experience indicators of youth obesity such as physical inactivity. Focus group themes elevated the affordability of food as the number one concern cited by both providers and community members related to health eating and active living. SFHIP also identified "food security, healthy eating, and active living" as a community priority.

Based on this data and their knowledge of KFH San Francisco, the CBAC gave Healthy Eating/Active Living the second highest score for implementation. The Committee reported that KP has strong expertise and many community partners in this area, and that there are many promising approaches for working on this health need as well as strong feasibility. The health need was also ranked as a high priority in the CHNA.

4. **Housing and Homelessness:** This health need draws upon data related to economic wellbeing, the cost of housing, and drivers of poverty including educational attainment. A review of the secondary data shows Hispanics, African Americans, Native Americans/Alaskan Natives, and Native Hawaiians/Pacific Islanders were significantly more likely than residents of California as a whole to have incomes below the federal poverty level, use SNAP benefits, and report a low median income. In focus groups, participants also connected economic security and homelessness as key drivers of other issues affecting the city such as mental health, substance abuse, HIV/AIDS, food insecurity, and access to care. SFHIP also identified "housing security and an end to homelessness" as a community priority.

Based on this data and their knowledge of KFH San Francisco, the CBAC gave Housing and Homelessness the fourth highest score for implementation. The Committee reported that KP has many community partners in this area and that there are many promising approaches for working on this health need. The health need was also ranked as a high priority in the CHNA. However, they reported that KP has only medium expertise in this area and that working on this health need was somewhat less feasible.

VIII. KFH San Francisco's Implementation Strategies

A. About Kaiser Permanente's Implementation Strategies

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

- Are available broadly to the public and serve low-income individuals
- 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 San Francisco 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 San Francisco welcomes future opportunities to enhance its strategic plans by relying on and building upon the strong community partnerships it currently has in place.

KFH San Francisco 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, culturally and linguistically appropriate health care services in coordinated delivery systems
Intermediate goals	- Increase access to comprehensive health care coverage for low income individuals - Increase access to subsidized care for those facing financial barriers to health care - Increase access to social non-medical services for low income and vulnerable populations - Increase access to a diverse, culturally competent health care workforce - Improve the capacity of health care systems to provide quality health care services
Strategies	- Participate in Healthy San Francisco to provide subsidized coverage and care for low-income, uninsured individuals and families - Participate in Medi-Cal managed care - Provide Charitable Health Coverage - Provide Medical Financial Assistance - Improve the coordination of social non-medical services across the healthcare delivery system for low income and vulnerable populations, including the homeless - Support outreach and enrollment campaigns to increase CalFresh enrollment for eligible community members (Food for Life) - Support screening for social non-medical service needs and connect low-income individuals and families to community and government resources (Thrive Local)

	• Provide workforce training programs to train current and future health care providers, including physicians, mental health practitioners, physical therapists, pharmacists, nurses, and allied health professionals, with the skills and linguistic cultural competence to meet the health care needs of diverse communities • Implement health care workforce pipeline programs to introduce diverse, underrepresented school age youth and college students to health careers (KP LAUNCH) • School for Allied Health expanding access to training and certificate programs for underrepresented individuals • Support population health management approaches that improve health outcomes for safety net patients with diabetes and hypertension (PHASE) • Support community clinic consortia to develop programs and advocate for policies that improve access to quality health care for low-income individuals
Expected outcomes	• Low income individual will have increased access to comprehensive health care coverage • Those facing financial barriers to health care with have increased access to subsidized care • Low income and vulnerable populations will have expanded access to social non-medical services • The health care workforce will be increasingly diverse and culturally competent • Health care systems will have improved capacity to provide quality health care services

Health need #2: Behavioral health (mental health and substance abuse)

Long term goal	All community members experience social emotional health and wellbeing and have access to high quality behavioral health care services when needed
Intermediate goals	• Increase capacity of organizations and institutions to provide trauma-informed services and programs • Increased access to behavioral health care services for low-income and vulnerable populations • Develop a diverse, well trained behavioral health care workforce that provides culturally competent care • Prevent and reduce misuse of drugs and alcohol
Strategies	• Provide training for front line staff in direct service organizations and schools on trauma-informed care • Support the capacity of clinics, schools, or other community-based organizations to provide trauma-informed care to youth organizations

	• Provide KP's Education Theater program, Resilience Squad
	• Increase the capacity of case managers to coordinate across agencies.
	• Support mobile case management teams
	• Implement the Public Good Projects' Action Minded campaign, a digital community health intervention using education, social engagement and multi-media tools to engage the general public, issue-advocates and community partners, and KP employees as partners in reducing stigma towards mental health conditions
	• Participate in Medi-Cal managed care
	• Provide Charitable Health Coverage
	• Provide workforce training programs to train current and future mental health practitioners with the skills and linguistic and cultural competence to meet the health care needs of diverse communities
	• Support harm-reduction strategies
	• Advance city policies – City Health:
	    ○ Control the amount of alcohol sales
	    ○ Raise the legal age for the sale of tobacco products to 21
	    ○ Smoke-free indoor air policies

Expected outcomes	• Organizations and institutions will have an increased capacity to provide trauma-informed services and programs • Low-income and vulnerable populations will have increased access to behavioral health care services • The behavioral health care workforce will be increasingly diverse and well-trained to provide culturally competent care • The misuse of drugs and alcohol will be reduced

Health need #3: Healthy eating/active living

Long term goal	All community members eat better and move more as part of daily life
Intermediate goals	• Reduce food insecurity among low-income families and individuals • Increased access to safe parks and public spaces • Increase opportunities for physical activity in schools
Strategies	• Increase access to healthy food through CalFresh enrollment, food pantries, and other programs • Support outreach and enrollment campaigns to increase CalFresh enrollment for eligible community members (Food For Life) • Bring programming to parks and open spaces to encourage physical activity • Advance complete streets policies (City Health)

	• Encourage schools to partner with non-profits that work to increase physical activity, especially for Latinx and African American youth
Expected outcomes	• Low-income families and individuals will have reduced food insecurity • Parks and public spaces will be increasingly safe and accessible • Schools will offer increased opportunities for physical activity

Health need #4: Housing and homelessness

Long term goal	All community members have access to quality, affordable, and stable housing
Intermediate goals	• Prevent individuals and families from falling into homelessness • Increase connections to supportive services for individuals experiencing homelessness • Increase and preserve the stock of affordable housing, including deeply affordable and Permanent Supportive Housing
Strategies	• Support individuals and families at risk of falling into homelessness • Partnership with KP Division of Research to develop a predictive model for housing instability • Increase the capacity of case managers working with the homeless to coordinate across agencies • Funding to strengthen local homeless system of care through the Housing and Health Initiative • Advance inclusionary zoning policies
Expected outcomes	• Individual and families will be increasingly prevented from falling into homelessness • Individuals experiencing homelessness will have increased connections to supportive services • The stock of affordable housing, including deeply affordable and Permanent Supportive Housing, will be increased and preserved

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 San Francisco 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 San Francisco tracks outcomes, including behavior and health outcomes, as appropriate and where available.

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

Based upon the process described in section VII, the CBAC selected certain health needs identified in the CHNA to be addressed in the implementation strategy. The following are the health needs that were not selected for implementation.

- **HIV/AIDS/STDs:** The CBAC gave HIV/AIDS/STDs the second lowest ranking of all the health needs rated for implementation. Though they rated the health need highly in terms of partnerships, approaches, expertise, and feasibility, they noted that KFH San Francisco has been focused on treating HIV for many years. The hospital has had a dedicated HIV unit since the 1980s. Furthermore, CHNA data show that, while the incidence of HIV is still significantly higher in San Francisco compared to other areas, strong local health efforts have resulted in a relatively low rate of new infection. For this reason, the health need was ranked as a lower priority during the CHNA process and not selected by the CBAC for implementation.

- **Violence/Injury Prevention:** The CBAC gave Violence/Injury Prevention the lowest ranking of all the health needs rated for implementation. The Committee reported that KP only has medium expertise and some community partners in this area, and that there are only some promising approaches for working on this health need as well as medium feasibility. The health need was also ranked as a lower priority in the CHNA. Rather than addressing this health need by itself, the committee plans to address concerns about violence and injury prevention as part of its work on trauma under the Behavioral Health need.