I. General Information

Contact Person: Jennifer Resch-Silvestri, Senior Director of Public Affairs and Brand Communications
Date of Written Plan: September 18, 2013
Date Written Plan Was Adopted by Authorized Governing Body: December 4, 2013
Date Written Plan Was Required to Be Adopted: December 31, 2013
Authorized Governing Body that Adopted the Written Plan: Kaiser Foundation Hospital/Health Plan Boards of Directors
Was the Written Plan Adopted by Authorized Governing Body by End of Tax Year in Which CHNA was Made Available to the Public? Yes ☒ No ☐
Date Facility’s Prior Written Plan Was Adopted by Organization’s Governing Body: N/A
Name and EIN of Hospital Organization Operating Hospital Facility: Kaiser Foundation Hospitals, 94-1105628
Address of Hospital Organization: One Kaiser Plaza, Oakland, CA 94612

II. About Kaiser Permanente

Kaiser Permanente is an integrated health care delivery system comprised of Kaiser Foundation Hospitals and Kaiser Foundation Health Plan (both California nonprofit public benefit corporations and exempt organizations under Section 501(c)(3) of the Internal Revenue Code), and a separate Permanente Medical Group in each region in which Kaiser Permanente operates. For more than 65 years, Kaiser Permanente has been dedicated to providing high-quality, affordable health care services and to improving the health of our members and the communities we serve. Today we serve more than 9 million members in eight states and the District of Columbia. Kaiser Permanente is dedicated to improving the health of our communities through broad coverage, high quality care and continuous quality improvement and innovation in the care we deliver, clinical research, workforce development, health education and the support of community health interventions.
Community Benefit is central to our mission. We believe good health is a fundamental aspiration of all people. We recognize that promotion of good health extends beyond the doctor’s office and the hospital. Like our approach to medicine, our work in the community takes a prevention-focused, evidence-based approach. To be healthy, people need access to healthy and nutritious food in their neighborhood stores, clean air, successful schools, and safe parks and playgrounds. Good health for the entire community also requires a focus on equity as well as social and economic well-being.

We focus our work on three broad areas:

- Providing access to high-quality care for low-income, underserved people
- Creating safe, healthy communities and environments where people live, work, and play
- Developing important new medical knowledge and sharing it widely with others and training a culturally competent health care workforce of the future.

Across these areas, we work to inspire and support people to be healthier in all aspects of their lives, and build stronger, healthier communities.

In pursuit of our mission we go beyond traditional corporate philanthropy and grant-making to leverage our financial resources with medical research, physician expertise, and clinical practices. In addition to dedicating resources through Community Benefit, we also leverage substantial additional assets that improve community health, including our purchasing practices, our environmental stewardship efforts and workforce volunteerism.

For many years, we have worked collaboratively with other organizations to address serious public health issues such as obesity, access to care, and violence. We have conducted Community Health Needs Assessments (CHNA) to better understand each community’s unique needs and resources. The CHNA process informs our community investments and helps us develop strategies aimed at making long-term, sustainable change—and it allows us to deepen the strong relationships we have with other organizations that are working to improve community health.

Kaiser Foundation Hospitals (KFH) defines the community served by a hospital as those individuals residing within its hospital service area. A hospital service area includes all residents in a defined geographic area surrounding the hospital and does not exclude low-income or underserved populations. The Kaiser Foundation Hospital – Fontana includes most of the densely populated areas of San Bernardino County, including the High Desert, Mountain, Eastern, and Central areas east to the 15 Freeway. The service area includes the communities of Angelus Oaks, Apple Valley, Banning, Beaumont, Big Bear City, Big Bear Lake, Bloomington, Calimesa, Cedar Glen, Cedarpines Parks, Cherry Valley, Colton, Crestline, Crest Park, Diamond Bar, Fawnskin, Fontana, Forest Falls, Glen Avon, Grand Terrace, Green Valley, Hesperia, Highland, Lake Arrowhead, Loma Linda, Lytle Creek, Mentone, Mountain View Acres, Muscoy, Patton, Phelan, Pinon Hills, Redlands, Rialto, Rimforest, Rubidoux, Running Springs, San Bernardino, Skyforest, Sugarloaf, Twin Peaks, Victorville, Wrightwood, and Yucaipa. The map on the following page describes the geographic area covered by the KFH – Fontana Service Area.

In 2010, the total population of the KFH-Fontana Service Area was 1,248,081. Hispanics/Latinos made up 50.1% of the total population. The races of the KFH-Fontana Service Area were comprised of the following: White
(69.23%), Black (17.4%), Asian (8.23%), Native American /Alaska Native (0.85%), Native Hawaiian/Pacific Islander (0.44%), Some Other Race (0.47%), Multiple Races (3.32%). Education attainment in the KFH-Fontana Service Area was lower than that of California; 24.5% of the population aged 25 and above lacked a high school diploma. The KFH-Fontana Service Area’s poverty rates were higher than that of San Bernardino County; 17.74% of the population lived below 100% of the Federal Poverty Level (FPL). KFH-Fontana Service Area’s unemployment rate was at 10.82%.
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 the proposed regulations released in April 2013. This implementation strategy describes KFH – Fontana’s planned response to the needs identified through the 2013 Community Health Needs Assessment (CHNA) process. For information about KFH – Fontana’s 2013 CHNA process and for a copy of the report please visit http://share.kaiserpermanente.org/article/community-health-needs-assessments-3/.

This Implementation Strategy also serves as a foundation for further alignment and connection of other Kaiser Permanente initiatives that may not be described herein, but which together advance KFH – Fontana’s commitment to improving the health of the communities it serves. Such other initiatives include but are not limited to our Supplier Diversity Program to promote the socio-economic vitality that correlates with the health of our communities, our environmental stewardship to reduce waste and pollution, and organized matching of the altruism of our workforce with community volunteer opportunities that promote health.

VI. List of Community Health Needs Identified in CHNA Report

The list below summarizes the 16 health needs identified for the KFH – Fontana through the 2013 Community Health Needs Assessment process.

- Economic Instability
- Mental Health
- Health Care Access/Utilization
- Diabetes
- Substance Use
- Service Infrastructure
- Overweight/Obesity
- Oral Health
- Community Violence
- Cardiovascular Disease
- Teen Pregnancy
- HIV/AIDS & Other STDs
- Cancer
- Asthma
- Prenatal/Perinatal Health
- Hepatitis

VII. Who was Involved in the Implementation Strategy Development

KFH—Fontana established a hospital Implementation Strategy Engagement Team (ISET) to help achieve the goal of developing more thoughtful, intentional and impactful strategies to realize Kaiser Permanente’s mission “to improve the health of our members and the communities we serve.” The ISET team assisted in the selection of health needs that the hospital will focus on for the next three years as part of the community benefit investment strategy. Further, the ISET helped identify and champion more opportunities for collaboration and support of a wide range of Community Benefit strategies within the hospital by leveraging of existing capacity, resources and assets.

The ISET team included the following internal leadership partners across the Kaiser Foundation Hospital (KFH), Kaiser Foundation Health Plan (KFHP) and Southern California Permanente Medical Group (SCPMG):
VIII. Health Needs that KFH – Fontana Plans to Address

a. Process and Criteria Used

In order to select the health needs that KFH-Fontana will address, the team used the criteria listed below, with a particular focus on choosing needs that Kaiser Permanente would have the ability to have a significant and meaningful impact on given our expertise, our resources and the evidence. In addition, KFH-Fontana limited the number of needs selected to only a few in order to maximize the hospital's ability to have an impact and not spread resources too thinly across many needs.

KFH – Fontana worked with a group of internal stakeholders and applied a criteria-based decision making process to examine the list of health needs identified through the CHNA process, select the community health needs it will address, and to develop an implementation strategy plan to address those selected health needs. These strategies build on Kaiser Permanente’s assets and resources, as well as evidence-based strategies, wherever possible. The information from this report will be submitted to the Internal Revenue Service (IRS) as an attachment to Kaiser Foundation Hospital’s 2013 Form 990.

Process/methodology used to select the health needs hospital will address

The selection process’s intent was to select health needs that would make a meaningful impact in each community and build strategies to alleviate disparities. With this in mind, KFH – Fontana used criteria to assess and leverage both internal and community assets. The health need criteria analysis included: the magnitude/scale of the problem, the severity of the problem, the health disparities, as well as KFH’s assets and their ability to leverage these assets.

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Magnitude/scale of the problem</td>
<td>The health need affects a large number of people within the community.</td>
</tr>
<tr>
<td>Severity of the problem</td>
<td>The health need has serious consequences (morbidity, mortality, and/or economic burden) for those affected.</td>
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<tr>
<td>Health disparities</td>
<td>The health need disproportionately impacts the health status of one or more vulnerable population groups.</td>
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<tr>
<td>KP assets</td>
<td>KP can make a meaningful contribution to addressing the health need because of its relevant expertise and/or unique assets as an integrated health system and because of an organizational commitment to addressing the health need.</td>
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</tbody>
</table>
The criteria above were applied to each health need to help identify which health needs to select. The Kaiser Permanente Fontana Medical Center Implementation Strategy Engagement Team (ISET) identified the KFH assets and leveraging opportunities to meet the health needs; identified possible strategies to address selected health needs; reviewed and finalized the final IS workplan; and reviewed and finalized the final IS report.

The criteria were divided into two categories: Need and Feasibility. Using a rating system, each health need was evaluated, giving each a composite score with respect to “Need” and “Feasibility”.

<table>
<thead>
<tr>
<th>Need Criteria</th>
<th>Feasibility Criteria</th>
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<tbody>
<tr>
<td>1. Magnitude</td>
<td>4. KP Assets</td>
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<tr>
<td>2. Severity</td>
<td>5. Ability to Leverage</td>
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<tr>
<td>3. Disparities</td>
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Once scored, each health need was plotted in a Strategy Grid (2x2 grid) as a way to evaluate which health needs KFH – Fontana will address to achieve maximum results with limited resources. A composite “Need” score of 9 or higher was considered a “High Need.” A composite “Feasibility” score of 7 or higher was considered “High Feasibility.” As a rule, health needs categorized as “High Need/High Feasibility” were selected.

Eight of the health needs scored in the “High Need/High Feasibility” category and a few of these health needs had overarching strategies that could address more than one health need, resulting in four health needs getting “rolled up” and incorporated into other health needs to maximize overall impact.

**Process and methods used to identify and develop strategies to address the selected needs**

The strategy development process included six key steps in developing effective strategies. The steps included using evidence to guide intermediate and long-term goal development; reviewing and analyzing existing internal Kaiser Permanente programs and resources; designing effective strategies to impact the health needs keeping in mind the barrier to health needs; and identifying metrics for monitoring those strategies.

All strategies developed focused on four key broad areas: 1) Grantmaking- Dedicate CB dollars to grant programs focused on addressing an intermediate goal; 2) Leveraging Kaiser Permanente Resources- Dedicating Kaiser Permanente expertise and/or resources to address a specific health need; 3) Administering programs- Providing or partnering with a Kaiser Permanente program aimed at addressing a certain health need; 4) Collaboration and Partnerships- Engaging with community partners or formal coalition in an effort to address the health need and/or its drivers.

**b. Health Needs that KFH – Fontana Plans to Address**

To address the needs of the overall health care delivery system in the KFH – Fontana Service Area, KFH – Fontana plans to address both health outcomes and health drivers. The following are the health needs KFH – Fontana plans to address (listed in alphabetical order):

- Chronic Conditions, which include Obesity/Overweight, Diabetes, and Cardiovascular Disease
- Economic Instability
• Health Care Access and Utilization, including Oral Health
• Mental Health, including Substance Use

Selection of these four health needs was based on their relative magnitude, severity and disproportionate impact among vulnerable groups within KFH – Fontana, as well as existing potential for collaborative action. Data collected throughout the CHNA and inventory of internal and external assets demonstrated significant opportunity to address these needs through existing or emerging community infrastructure. When concurrently implemented, the strategies associated with each of the four health needs are intended to result in sustainable, cross-sector collaborations that enhance positive health outcomes and reduce health disparities in the KFH – Fontana.

Moreover, improving Service Infrastructure within KFH – Fontana and overall San Bernardino County was a common thread among all health needs. As such, Service Infrastructure was integrated by developing a capacity building related strategy for each health need. Service Infrastructure includes aspects of the non-profit sector, funding to community organizations, public health infrastructure (prevention and screening), coordination/collaboration amongst service providers, capacity building, leadership and advocacy.

1. **Chronic Conditions**

Chronic Conditions include Obesity/Overweight, Diabetes, and Cardiovascular Disease (CVD). These three health needs have similar prevention strategies that can reduce the onset and prevalence of these health outcomes, such as increasing healthy eating and physical activity, as well as disease management.

**Obesity/Overweight**

Obesity and obesity rates have been increasing over the past few years in San Bernardino County. The County has also been identified as an area most impacted by childhood obesity as it has one of the highest rates in the state. Over one-third (36.3%) of adults are overweight and over one-quarter of adults (27.8%) are obese. Among 5th, 7th and 9th graders in the County, 13.6% are overweight and 33.1% are obese. Overweight and obesity affects all income levels, age groups, and racial/ethnic groups. However, Hispanic/Latinos, African Americans, Asian Americans, and immigrants are disproportionately affected as a higher proportion of these groups live in low-income neighborhoods with poor neighborhood characteristics (e.g. low neighborhood safety, poor access to fresh fruits and vegetables, high density of liquor store and convenient stores) and eat traditional foods that are sometimes high in fat, salt, and sugar. Obesity prevalence is highest among Hispanic/Latino and African American adults and children. Seniors are also affected due to a low fixed-income and decreased mobility.

Healthy eating and physical activity are the most important behaviors to promote, which can also impact other health outcomes (e.g. CVD, high blood pressure, diabetes, cancer, mental health, etc.). Poverty and education (economic instability), availability and access to preventive health programs (service infrastructure) and built environment (e.g. access to parks/recreation, availability of and accessibility to affordable healthy foods, community safety, and poor air quality) greatly impact overweight/obesity outcomes. Obesity/overweight is also associated with prenatal/perinatal health and musculoskeletal conditions. Overweight and obesity can be debilitating as it increases the likelihood of developing chronic disease risk factors (e.g. high blood pressure), developing chronic diseases, experiencing medical complications and complications during pregnancy, having worse mental health, and dying prematurely.
Diabetes

Adult diabetes cases in San Bernardino County have increased 47% within the past 5 years and the County has the second highest percentage of diabetes in California. In KFH – Fontana, adult diabetes prevalence and the adult diabetes discharge rate are higher than the California average. Diabetes among children in KFH – Fontana is also increasing, as youth diabetes discharge rates are almost 2 times higher than California. Although the County diabetes mortality rate has remained the same from 2002 to 2010, it is higher than the California rate. Moderate to high prevalence of diabetes has been seen in some racial/ethnic minority and vulnerable groups. Native Americans have the highest diabetes rates in San Bernardino County. Hispanic/Latino and African Americans are disproportionately impacted by diabetes due to high rates of obesity/overweight. Increases in diabetes cases in children and youth have been seen in the school setting. Older adults are impacted by diabetes due to economic instability, lack of health insurance coverage and may experience more complications. Homeless individuals are also affected by diabetes and diabetes complications as they lack access to health care services.

Obesity is the precursor to diabetes and is greatly impacted by eating habits, lack of exercise, health care access, and economic instability. Diabetes is also associated with prenatal/perinatal health, CVD, service infrastructure, and indirectly linked to mental health. Diabetes can be debilitating and/or life threatening as it increases medical complications and health care costs, leads to kidney failure and increased risk of CVD, decreases quality of life, and causes premature death.

Cardiovascular Disease

Heart disease and stroke are the first and third leading cause of death in the United States. Although heart disease and stroke mortality rates have been decreasing from 2002 to 2010 in San Bernardino County, heart disease and stroke mortality rates in KFH – Fontana are higher than the California average. Heart disease impacts all racial/ethnic groups as all racial/ethnic groups have higher heart disease mortality rates higher than the California average. However, Native Americans and Hispanic/Latinos are more disproportionately impacted – Native Americans have 5 times higher and Hispanic/Latinos have 2 times higher heart disease mortality rates than whites in the County. Although not thought of as having cardiovascular disease (CVD), Asian Americans are affected by unhealthy eating, high blood pressure, and high cholesterol. Low-income populations and older adults are also impacted by heart disease and stroke. Children and youth are at greater risk for heart disease when they become older because of high obesity/overweight rates and poor eating habits.

Risk factors that influence CVD prevalence and outcomes are stress, smoking, and obesity (due to eating and exercise habits). CVD is also associated with other chronic conditions (e.g. diabetes, HIV/AIDS), substance use, oral health, and prenatal/perinatal health. CVD can be debilitating and/or life threatening as it results in serious illness and disability, decreased quality of life, and produces billions of dollars in medical costs and economic loss.

2. Economic Instability

Economic instability includes poverty, unemployment, public assistance, food insecurity, home foreclosures, homelessness, and educational attainment.

Unemployment, poverty and low educational attainment are major health barriers and economic instability is considered one of the root causes to poor health outcomes. According to many indicators, KFH – Fontana is doing worse than California and public assistance has been increasing. The percent of the total population living below 100% Federal Poverty Level (FPL; 17.7%), the percent of children living below 100% FPL (24.2%), and the percent of people unemployed (10.8%) is higher than California. This translates to higher percentages of people
receiving CalFresh (12.7%) and Medicaid (24%), and children being eligible for free/reduced lunch (70.5%). Because community residents are suffering from financial hardship, 44% of homes in the Riverside-San Bernardino metro area are “financially under water.” Economic instability impacts everyone. However, the homeless and reentry populations, undocumented individuals, seniors, children, veterans, the disabled and racial/ethnic minorities are heavily impacted. Moreover, in the 2009-2010 school year, 22,658 San Bernardino County children and youth were identified as homeless.

The stress caused by economic instability contributes to poor mental health and chronic illness issues (e.g. asthma, diabetes, cancer, overweight/obesity, etc.). Economic instability is also associated with health care access and utilization. Economic instability is life threatening and debilitating as it is a primary social determinant of health and increases the risk of chronic diseases, mental health problems, deprives child development and educational opportunities, causes low quality of life and premature death.

3. Health Care Access & Utilization

Increasing access to appropriate and effective health care services addresses a wide range of specific health needs. Achieving the goal of increased access to care requires reducing barriers to preventive screening, primary care, and specialty care through deploying a wide range of strategies encompassing programs, outreach, training, and policies.

Factors related to health care access and utilization include health care professional shortages, the number of Federally Qualified Health Centers (FQHC) in the County, language and cultural barriers, health insurance coverage, transportation issues, cost barriers, and knowledge of resources.

Health care access and utilization is one of the main determinants of health. In KFH – Fontana, a high proportion of people were without health insurance (21.2%). Research showed health professional shortages in the County (primary care providers, specialists) and the number of primary care providers per person is lower than the California average. As such, the percent of the population living in a geographic Health Professional Shortage Area (HPSA) is higher than the state average. These factors contribute to a higher percentage of preventable hospital events than the state average. Many of these factors are prevalent in all racial/ethnic groups and subgroups. Undocumented immigrants, older adults, homeless and people of color are disproportionately affected. Hispanic/Latinos have the highest percent of uninsured (66%) followed by whites (60%). The re-entry population is impacted because they often reenter their communities without access to health care or other social services.

Education, poverty, unemployment, and transportation issues exacerbate health care access/utilization issues. Transportation is a greater issue in the High Desert and Mountain communities. Reductions in and barriers to Health Care Access and Utilization are associated with many poor health outcomes (e.g. mental health, asthma, diabetes, oral health, substance use, cancer, etc.) and are linked to other health drivers. This health need is considered life threatening and debilitating as it impacts overall physical, social, and mental health, prevention of disease and disability, detection and treatment of health conditions, quality of life, and life expectancy.

Oral Health

Health care access incorporated oral health because Dental Health Professional Shortage Areas (HPSA) and dental professional shortages have been identified in San Bernardino County. The percent of adults with poor dental health (11.9%) and who haven’t seen a dental professional in the past year (35.4%) are higher than the California average. The percentage of youth who haven’t seen a dental professional in the past year (15.6%) is also higher than the California average. Poor dental health is a top chronic disease for children.
Vulnerable populations (e.g. children, elderly, low-income, uninsured, disabled, racial/ethnic minorities, HIV-infected, homeless, and reentry individuals) are mostly impacted by poor oral health outcomes as they face many barriers to dental care that are greater than the general population.

4. Mental Health

The percent of adults who self-reported the need to see a mental health professional (14.8%) and suicide mortality rate (12.3 per 100,000 population) in KFH – Fontana are higher than the California average. CHNA participants voiced strong concern regarding mental health as they feel it is getting worse, especially among children and youth. Men are nearly four times more likely and whites are over two times more likely to die of suicide. African Americans have high incidence of suicidal thoughts and suffer higher degrees of stress. Native Americans have high incidences of medication for mental health, suffer from psychological stress due to economic instability, and are less likely to seek behavioral healthcare because of cultural beliefs. Hispanic/Latinos are affected by mental health due to stigma. Immigrants are also affected by mental health due to stigma, as well as stress and discrimination. Aging research shows that mental health conditions increase with age, so seniors are the highest group to receive mental health services. Providers are concerned with dementia, depression and suicide in seniors. Mental health issues are increasing in children and youth as they have limited resources and skills to cope with stress and depression, come from unhealthy family situations, and have few treatment facilities. Homeless individuals are impacted as 30% suffer from a severe mental illness and 22% have a developmental disability. Veterans are suffering more from PTSD due to lack of receiving adequate mental health services after multiple tours overseas. New mothers also suffer from postpartum depression.

Barriers to treating mental health issues are stigma, lack of mental health facilities, lack of access to those facilities (e.g. insurance) and economic instability. Mental illness also acts as a barrier to seeking care for other health issues. Mental health is indirectly associated with overweight/obesity, chronic diseases (e.g. CVD and diabetes), and infectious diseases (e.g. HIV/AIDS). Mental health can be life threatening or debilitating as mental health is the leading cause of disability in the US (accounts for 25% of all years of life lost due to disability and premature mortality), is closely connected with physical health, and decreases a person’s ability to participate in treatment and recovery.

Substance Use

Because mental health and substance use disorders usually coexist and people with mental health issues are greatly impacted by substance use, Substance Use was included in Mental Health. Admissions to County substance abuse treatment facilities rose 11% from 2009 to 2011 with methamphetamine-related treatment being the highest of all admissions (44%). Increases in admissions have been seen for methamphetamine, heroin and marijuana, but decreased in alcohol and cocaine/crack. Alcohol use among youth is greater than the California average with increased usage of synthetic and prescription drugs. Veterans struggling with PTSD and individuals with depression, attention deficit disorder, and stress are greatly impacted. Native Americans and Hispanic/Latinos have high incidence of alcohol use. Whites have the highest incidence of alcohol and drug-related deaths.

Substance use is life threatening and debilitating as debilitating 95% of people who use substances do not believe they have a substance use problem, many relapse, and substance use contributes to costly social and public health problems (e.g. teen pregnancy, STDs, domestic violence, child abuse, crime, homicide, suicide), lost wages and leads to premature death.
5. **Broader Health Care Delivery System Needs in Our Communities**

Kaiser Foundation Hospitals, which includes 37 licensed hospital facilities as of 2013, has identified a number of significant needs in addition to those identified above through the CHNA process which we are committed to addressing as part of an integrated healthcare delivery system. These needs, which are manifest in each of the communities we serve, include: 1) health care workforce shortages and the need to increase linguistic and cultural diversity in the health care workforce, and 2) access to and availability of robust public health and clinical care data and research.

Supporting a well-trained, culturally competent and diverse health care workforce helps ensure access to high quality care; this activity is also essential to making progress in the reduction of healthcare disparities which persist in most of our communities. Individuals trained through these workforce training programs are able to seek employment through Kaiser entities or at other health care providers in our communities.

Deploying a wide range of research methods contribute to building general knowledge for improving health and health care services, including clinical research, health care services research, and epidemiological and translational studies on health care that are generalizable and broadly shared. Conducting high-quality health research, and disseminating findings from it, increases awareness of the changing health needs of diverse communities, addresses health disparities and improves effective health care delivery and health outcomes.

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**IX. KFH-Fontana’s Implementation Strategies**

As part of the Kaiser Permanente integrated health system, KFH-Fontana has a long history of working with Kaiser Foundation Health Plan, The Permanente Medical Group, and other Kaiser Foundation Hospitals, as well as external 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 consumers.
- 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
- Address needs that would otherwise become the responsibility of government or another tax-exempt organization

KFH-Fontana 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-Fontana will continue to work in partnership to refine its goals and strategies over time so that they most effectively address the needs identified.

1. **Chronic Conditions**

Obesity/Overweight, Diabetes and Cardiovascular Disease have similar prevention strategies that can reduce the onset and prevalence of these health outcomes, such as increasing healthy eating, physical activity, and improving disease management.
**Obesity/Overweight**

**Long-term Goal**
- Reduce Obesity / Overweight among general population but especially among Native American, Latino, and African American adults and children.

**Intermediate Goals**
- Increase healthy eating among Native American, Latino, and African American adults and children.
- Increase active living among Native American, Latino, and African American adults and children.
- Improve capacity (service infrastructure) of community clinics to more effectively manage adult and child weight.

**Strategies**
- Provide grants to adopt policies, implement practices, and to increase availability of healthy food, fruits, and vegetables in schools, workplaces, and community settings.
- Partner with KP Educational Theatre Program to promote healthy eating in schools.
- Participate in Healthy Communities Collaborative (23 Healthy Cities) focused on increasing healthy eating using an array of approaches across schools, neighborhood, workplace, parks, etc.
- Support KP Thriving Schools Initiative targeting 10-15 local schools, a partnership to increase healthy eating, active living among students, staff, and teachers.
- Continue to offer our Farmer’s Market program on the hospital campus to provide access to largely locally produced fresh fruits and vegetables and to educate the public on the benefits of healthy eating and active living.
- Engage Southern California Permanente Medical Group (SCPMG) physician speakers and provide resources (Weight of the Nation, Drink Water, Don’t Drink Sugar DVD, health education brochures) to increase awareness about healthy eating and active living related to the obesity epidemic.
- Provide grants to provide physical activity opportunities before, during, after school in various settings (schools, workplaces, neighborhoods, parks, etc.) combined with education and informational outreach activities.
- Facilitate and support efforts to promote and enhance the built environment, land use, joint use agreements, create space/parks in communities to improve access to physical activity.
- Engage SCPMG adult/pediatric obesity physician champions to provide training, consultative support, and technical assistance to community clinics to assess existing clinical practices and weight management efforts to identify areas to enhance and/or integrate use of various tools and resources (CPGs, proactive office encounter, BMI as vital sign, physical activity questions, physical activity prescription pads, set clinical strategic goals, etc.). Includes engage SCPMG LVNs as needed to provide peer to peer technical assistance to community clinic MAs, LVNs, or Nurses.
- Provide SCPMG healthy lifestyles training, curriculum, health education material, and technical assistance on how to integrate into community clinic setting or consulting on how to modify existing curriculum.
- Promote and make SCPMG Healthier Living/Tomando Control de su Salud (general chronic disease management) available to community clinics.

**Expected Outcomes**
- Increase healthy food choices and access to affordable fruits, and vegetables
- Increase healthy eating
- Increase active living
- Increase quality weight management services for overweight/obese patients
Diabetes

Long-term Goal
- Reduce morbidity and mortality from diabetes among general population but especially among Native American, Latino, and African American adults and children.

Intermediate Goals
- Increase healthy eating, physical activity, and improve weight management skills.
- Improve clinical care for and management.
- Improve capacity (service infrastructure) of community clinics to more effectively manage Type II diabetes among adults and early onset of Type I diabetes among children.

Strategies
- Provide grants for diabetes disease management that involve an organized, proactive, multicomponent approach towards clinical care for and management of diabetes (interventions to improve glycemic control, intensive counseling for people with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease).
- Engage SCPMG diabetes physician, RN, or CDE champions to provide training, consultative support, and technical assistance to assess existing clinical practices and diabetes management efforts, identify improvement areas and integration of tools and resources (CPGs, proactive office encounter, BMI as vital sign, physical activity questions, physical activity prescription pads, set clinical strategic goals, etc.).
- Provide SCPMG diabetes training, curriculum, health education material, and technical assistance on how to integrate these tools into community clinic settings or consulting on how to modify existing curriculum.
- Promote and make SCPMG Healthier Living/Tomando Control de su Salud (general chronic disease management) available to community clinics.
- Make available existing and free SCPMG CME and CEU opportunities to community clinic physicians, NP, PA, and nurses through KP diabetes symposium, online nurse training, etc.

Expected Outcomes
- Increase glycemic control and self-management skills
- Increase quality diabetes management services

Cardiovascular Disease

Long-term Goal
- Reduce morbidity and mortality from heart disease and stroke among general population but especially among Native American, Latino, and African American adults and children.

Intermediate goal
- Increase healthy eating, physical activity, and improve weight management skills among general population but especially among Native American, Latino, and African American adults and children.
- Improve clinical care for and management of Cardiovascular Disease.
- Improve capacity (service infrastructure) of community clinics to more effectively manage heart disease and stroke among adults.

Strategies
- Provide grants for heart disease and stroke that entail an organized, proactive, multi-component approach of prevention and risk reduction (e.g. screenings based on clinical practice guidelines, prescriptions, intensive dietary counseling, computer-based information systems designed to implement
clinical guidelines at the point of care—reminders for overdue CVD preventive services, assessment of patient risk for CVD and recommendations for clinical treatment or behavior change approaches—including team-based care to improved blood pressure control).

- Provide training on KP ALL HEART, tools, and resources (CVD manuals, health education material, CPGs) and technical assistance on integrating within community clinic system. Engage internal Kaiser Permanente RN to provide technical assistance related to clinical quality.

**Expected Outcomes**
- Increase management of risk factors
- Increase quality heart disease and stroke prevention services

2. **Economic Instability**

**Long-term Goal**
- Reduce barriers (lack education attainment, poverty, basic needs, un/der-employment, and homelessness) to economic stability.

**Intermediate Goal**
- Improve food security.
- Improve education opportunities.
- Improve employment opportunities.
- Improve housing opportunities.

**Strategies**
- Provide grants to: 1) Support food distribution programs; 2) Establish Electronic Benefit Transfer (EBT) payment at farmers markets.
- Provide grants with a strong parental engagement component to support: 1) Career academies, small learning communities within high schools that focus on specific vocational fields; 2) Dropout prevention programs; 3) Mentoring programs for at-risk students, homeless or in foster care; 4) Targeted programs to increase college enrollment.
- Maintain and/or expand appropriate Kaiser Permanente programs and resources (Educational Theatre MPWR, Summer Youth, Hippocrates Circle, Phlebotomy Training, LVN Pathway, speakers, etc.) to motivate youth, parents, and adults to achieve educational attainment.
- Participate in key countywide initiative/collaboration targeting educational attainment.
- Provide grants for: 1) Transitional employment programs which offer time-limited, subsidized, paid jobs intended to provide a bridge to unsubsidized employment; 2) Career pathway and bridge programs that help low-skilled adults successfully participate in postsecondary education and the labor market; 3) Youth apprenticeship programs that provide participating high school students with professional opportunities that combine academic and on-the-job training/mentorship.
- Provide grants to support for: 1) Housing First program which addresses chronic homelessness by providing rapid re-housing as well as support services like crisis intervention, needs assessment, and case management; 2) Tenant-based rental assistance programs provide vouchers or direct cash assistance to allow low-income families more housing options than they could afford by themselves.

**Expected Outcomes**
- Increase self-sufficiency
- Decrease % with no high school diploma
- Increase education attainment
- Improve capacity (service infrastructure)
- Increase people employed
- Decrease number of people becoming homeless

3. **Health Care Access & Utilization**

**Long-term Goal**
- Increase the number of people who have access to appropriate health care services among uninsured, underinsured, low income older adults, homeless and improve the overall system of care in San Bernardino County.

**Intermediate Goal**
- Increase health care coverage for uninsured, underinsured, low income older adults, homeless
- Increase access to primary care.
- Increase access to dental care.
- Provide case management for medically underserved patients who are frequent users of emergency room services for non-urgent cases.
- Improve access to specialty care/diagnostics.
- Improve service infrastructure and capacity of community clinics to more adequately serve medically uninsured or underinsured and be sustainable.
- Reduce workforce shortages.

**Strategies**
- Participate in government-sponsored programs for low-income individuals (i.e., Medi-Cal Managed Care and Medi-Cal Fee-For-Services).
- Provide care to low income children under 19 in families at or below 300% of FPL who lack access to employer-subsidized coverage and do not qualify for public programs pursuant to a program that provides these children with heavily subsidized health care coverage.
- Provide Kaiser Permanente Medical Financial Assistance (charity care) to help patients with limited or no resources to pay for care provided at KP facilities.
- Provide grants and in-kind donations to community clinics/community based organizations to provide primary care, including culturally sensitive education about the use of primary care vs. emergency room and care coordination (promotoras/community health workers).
- Expand and deepen SCPMG Physician Engagement to support provision of primary care at community clinics.
- Provide grants to support: 1) School-Based Dental Programs (including sealant delivery programs); 2) Dental services; 3) Educate and advocate about overconsumption of sugar-sweetened beverages.
- Plan, develop, and implement an Emergency Room Patient Navigator program to provide case management for medically indigent patients with high emergency room usage for non-urgent cases.
- Provide community access program (SCPMG; KFH/HP Community Surgery Day; SCPMG pathology services).
- Expand and deepen SCPMG Physician Engagement to support delivery of specialty care at community clinics.
- Provide grants and technical assistance to clinics to assess readiness, create a viable plan, and implement changes to achieve FQHC-Look Alike status. Other FQHC can share learning’s or provide technical assistance to clinics interested in becoming FQHC-Look Alike.
- Facilitate a convening with the local dental clinics, dental centers, etc. for dental care coordination, cross referral, and to form San Bernardino County Dental Coalition.
- Participate and support the Specialty Care Coalition and related workgroups (guidelines, scope of practice, volunteer network) to improved access to and utilization of specialty care services and overall improve the specialty system of care in San Bernardino County.
- Provide SCPMG training, speakers, symposium opportunities, resources (Health education material, proactive office encounter tools, adult preventive clinical practice guidelines), and technical assistance on integration.
- Participate in key strategic partnerships (Countywide Vital Sign Initiative; County Workforce Investment Board) to build on existing health professions pipeline efforts and support related programs. Share KP youth pipeline programs (i.e., Summer Youth and INROADS).
- Train new physicians (i.e., Graduate Medical Education)

**Expected Outcomes**
- Increase number of people with coverage
- Increase number of people with a medical home
- Improve access to oral health services and prevent dental caries
- Increase awareness of resources among medically underserved patients who are frequent users of emergency room services for non-urgent cases
- Increase availability of specialty care and diagnostic services
- Support Federally Qualified Health Centers (FQHC) readiness in San Bernardino County
- Improved service infrastructure among dental service providers
- Increase collaboration around Specialty Care
- Increase availability of quality improvement resources
- Improved diversity of trained physicians
- Trained physicians work in shortage areas

4. **Mental Health**

*Mental Health*

**Long-term goal**
- Reduce and prevent mental illness in vulnerable populations.

**Intermediate Goal**
- Decrease mental health symptoms.
- Increase emotional and behavioral stability; among adults, teens, and children.
- Improve access to mental health care.
- Improve capacity (service infrastructure) of mental health providers.

**Strategies**
- Provide grants that focus on one of the following: 1) Collaborative care for the management of depressive disorders - a multicomponent, healthcare system-level intervention that uses case managers to link primary care providers, patients, and mental health specialists; 2) Home-based depression care management among older adults which includes: active screening for depression, measurement-based outcomes, trained depression care managers, case management, patient education, and a supervising psychiatrist; 3) Clinic-based depression care management among older adults which includes: active screening for depression, measurement-based outcomes, trained depression care managers providing case management, and primary care provider and patient education, antidepressant treatment and/or psychotherapy, and a supervising psychiatrist; 4) Individual and group cognitive-behavioral therapy to
reduce psychological harm among children and adolescents who have physiological symptoms resulting from exposure to traumatic events.

- Provide grants that focus on knowledge, attitudes, and skills related to one or more of the following approaches: 1) Home visiting programs starting during pregnancy that provide parenting education, information about child development, social support to parents, encouragement of positive parent–child interactions; 2) Interventions focused on parenting skills to encourage parents to use praise and rewards to reinforce desirable behavior; replace criticism and physical punishment with mild and consistent negative consequences and increase positive involvement with their children; 3) Preventive interventions for divorcing families; 4) School-based interventions that involve social skills training to change behaviors to improve social relationships or promote non-response to provocative situations; 5) Combined school and family interventions focused on building skills and communication; 6) Cognitive-behavioral prevention intervention programs for adolescents focused on coping with stress in a group setting.

- Through the SCPMG Physician Engagement, identify bilingual Psychiatrist to provide Psychiatric services on volunteer basis, addressing cultural barriers to mental health (language, cultural competence, culturally sensitive, increasing # of minority mental health providers).

- Participate and support the mental health collaborative and provide health educational materials to partners.

**Expected Outcomes**

- Improve management of mental health symptoms among Latinos, African-American, Asians-Americans, homeless, foster children, teens, seniors, veterans, men
- Improve family and social environments of children and youth
- Increase access and availability
- Increase quality and availability to provide mental health

**Substance Use**

**Long-term Goal**

- Reduce Substance Abuse among high Risk populations.

**Intermediate Goal**

- Reduce excess alcohol consumption among veterans struggling with Post Traumatic Stress Disorder, males, pregnant women Native Americans and Latinos.

**Strategies**

- Support advocacy efforts lead by Healthy Cities partners that look at policies and practices that: 1) Regulate alcohol outlet density; 2) Maintain limits on hours and days of alcohol sale; 3) Increase alcohol taxes; 4) Vigorously enforce existing underage drinking laws & minimum legal drinking age.
- Provide grants to support interventions that include group and family support to the individual (social support and family dynamics) in a culturally appropriate and sensitive manner.
- Provide grants to conduct media campaigns to reduce alcohol-impaired driving; conduct multi-component interventions with community mobilization to reduce alcohol-impaired driving (includes sobriety checkpoints, training in responsible beverage service, education and awareness-raising efforts, and limiting access to alcohol).

**Expected Outcomes**

- Decrease access to alcohol in community
- Decrease alcohol dependency and abuse
Change attitudes and beliefs around alcohol-impaired driving

5. Broader Health Care Delivery System Needs in Our Communities

**Workforce**

**Long-term Goals**
- To address health care workforce shortages and cultural and linguistic disparities in the health care workforce

**Intermediate Goals**
- Increase the number of skilled, culturally competent, diverse professionals working in and entering the health care workforce to provide access to quality culturally relevant care

**Strategies**
- Implement health care workforce pipeline programs to introduce diverse, underrepresented school age youth and college students to health careers
- Provide workforce training programs to train current and future health care providers with the skills, linguistic, and cultural competence to meet the health care needs of diverse communities
- Disseminate knowledge to educational and community partners to inform curricula, training and health career ladder/pipeline programs
- To leverage CB funded programs to develop strategies to increase access to allied health, clinical training and residency programs for linguistic and culturally diverse candidates
- Increase capacity in allied health, clinical training and residency programs to address health care workforce shortages through the provision of clinical training and residency programs
- Leverage KP resources to support organizations and research institutions to collect, standardize and improve access to workforce data to enhance planning and coordination of workforce training and residency training programs

**Expected Outcomes**
- Increase the number of diverse youth entering health care workforce educational, training programs and health careers
- Increase the number of culturally and linguistically competent and skilled providers
- Increase awareness among academia of what is required to adequately train current and future allied health, clinical and physician residents on how to address the health care needs of our diverse communities
- Increase the participation of diverse professionals in allied health, clinical training and residency programs
- Improve access to relevant workforce data to inform health care workforce planning and academic curricula

**Research**

**Long-term Goals**
- To increase awareness of the changing health needs of diverse communities

**Intermediate Goals**
- Increase access to, and the availability of, relevant public health and clinical care data and research
Strategies

➢ Disseminate knowledge and expertise to providers to increase awareness of the changing health needs of diverse communities to improve health outcomes and care delivery models

➢ Translate clinical data and practices to disseminate findings to safety net providers to increase quality in care delivery and to improve health outcomes

➢ Conduct, publish and disseminate high-quality health services research to the broader community to address health disparities, and to improve effective health care delivery and health outcomes

➢ Leverage KP resources to support organizations and research institutions to collect, analyze and publish data to inform public and clinical health policy, organizational practices and community health interventions to improve health outcomes and to address health disparities

Expected Outcomes

➢ Improve health care delivery in community clinics and public hospitals

➢ Improve health outcomes in diverse populations disproportionately impacted by health disparities

➢ Increase the availability of research and publications to inform clinical practices and guidelines

X. Evaluation Plans

KFH – Fontana will monitor and evaluate the strategies listed above for the purpose of tracking the implementation of those strategies as well as to document the anticipated impact. Plans to monitor will be tailored to each strategy and will include the collection and documentation of tracking measures, such as the number of grants made, number of dollars spent, number of people reached/served, number and role of volunteers, and volunteer hours. In addition, KFH – Fontana will require grantees to propose, track and report outcomes, including behavior and health outcomes as appropriate. For example, outcome measures for a strategy that addresses obesity/overweight by increasing access to physical activity and healthy eating options might include number of students walking or biking to school, access to fresh locally grown fruits and vegetables at schools, or number of weekly physical activity minutes.

XI. Health Needs Facility Does Not Intend to Address

Below is the list of health needs that were not selected for KFH – Fontana, in alphabetical order. These health needs were not selected because they did not simultaneously meet the high need and high feasibility criteria threshold mentioned in Section VIII. In other words, each of the health needs in some fashion did not demonstrate a combination of high magnitude and severity, large health disparities, a high number of Kaiser Foundation Hospital (KFH) assets, or a high ability to leverage internal and external KFH assets. It also made more sense to select health needs that impacted several other health needs and/or were the underlying causes of poor health outcomes.

1. Asthma
2. Cancer
3. Community Violence
4. Hepatitis
5. HIV/AIDS and Other STDs
6. Prenatal/Perinatal Health
7. Teen Pregnancy
While this Implementation Strategy Report responds to the CHNA and Implementation Strategy requirements in the Affordable Care Act and IRS Notices, it is not exhaustive of everything we do to enhance the health of our communities. KFH-Fontana will look for collaboration opportunities that address needs not selected where it can appropriately contribute to addressing those needs.