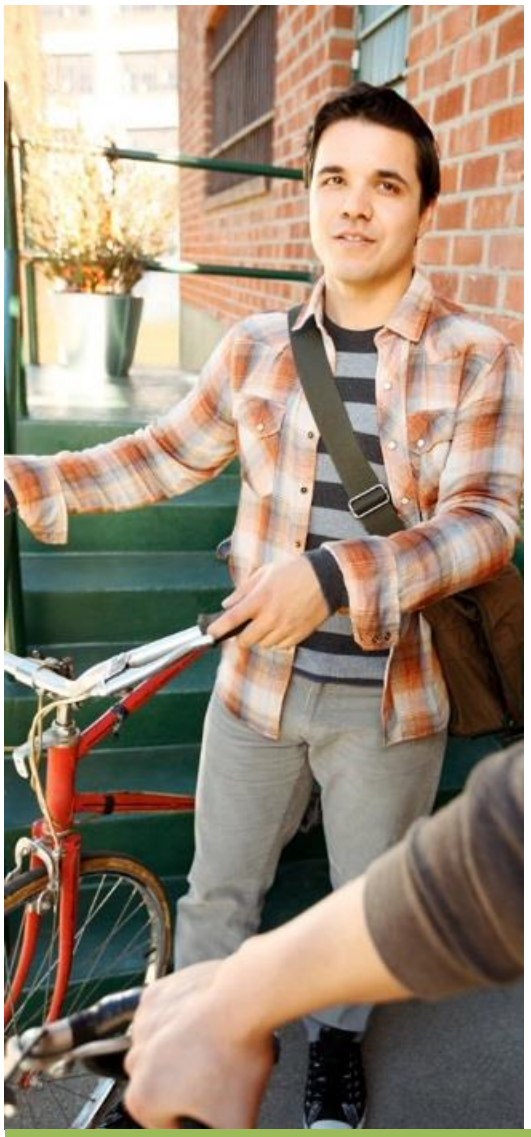


2016 Implementation Strategy Report
for Community Health Needs

Kaiser Foundation Hospital San Diego
License # 080000062

Approved by KFH Board of Directors
March 16, 2017

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

Kaiser Foundation Hospitals
Community Health Needs Assessment (CHNA)
Implementation Strategy Report
2016
Kaiser Foundation Hospitals – San Diego
License #080000062
4647 Zion Avenue
San Diego, CA 92120

I. General Information

Contact Person:	Lindsey Wright, Community Benefit Manager
Date of Written Plan:	December 13, 2016
Date Written Plan Was Adopted by Authorized Governing Body:	March 16, 2017
Date Written Plan Was Required to Be Adopted:	May 15, 2017
Authorized Governing Body that Adopted the Written Plan:	Kaiser Foundation Hospital/Health Plan Boards of Directors
Was the Written Plan Adopted by 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:	December 4, 2013
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 a not for profit, integrated health care delivery system comprised of Kaiser Foundation Hospitals, Kaiser Foundation Health Plan, and The Permanente Medical Groups. For more than 65 years, Kaiser Permanente has been dedicated to providing high-quality, affordable health care services and to improving the health of our members and the communities we serve. Today we serve more than 10.2 million members in eight states and the District of Columbia. Since our beginnings, we have been committed to helping shape the future of health care. Kaiser Permanente is dedicated to care innovations, clinical research, health education and the support of community health.

III. About Kaiser Permanente Community Benefit

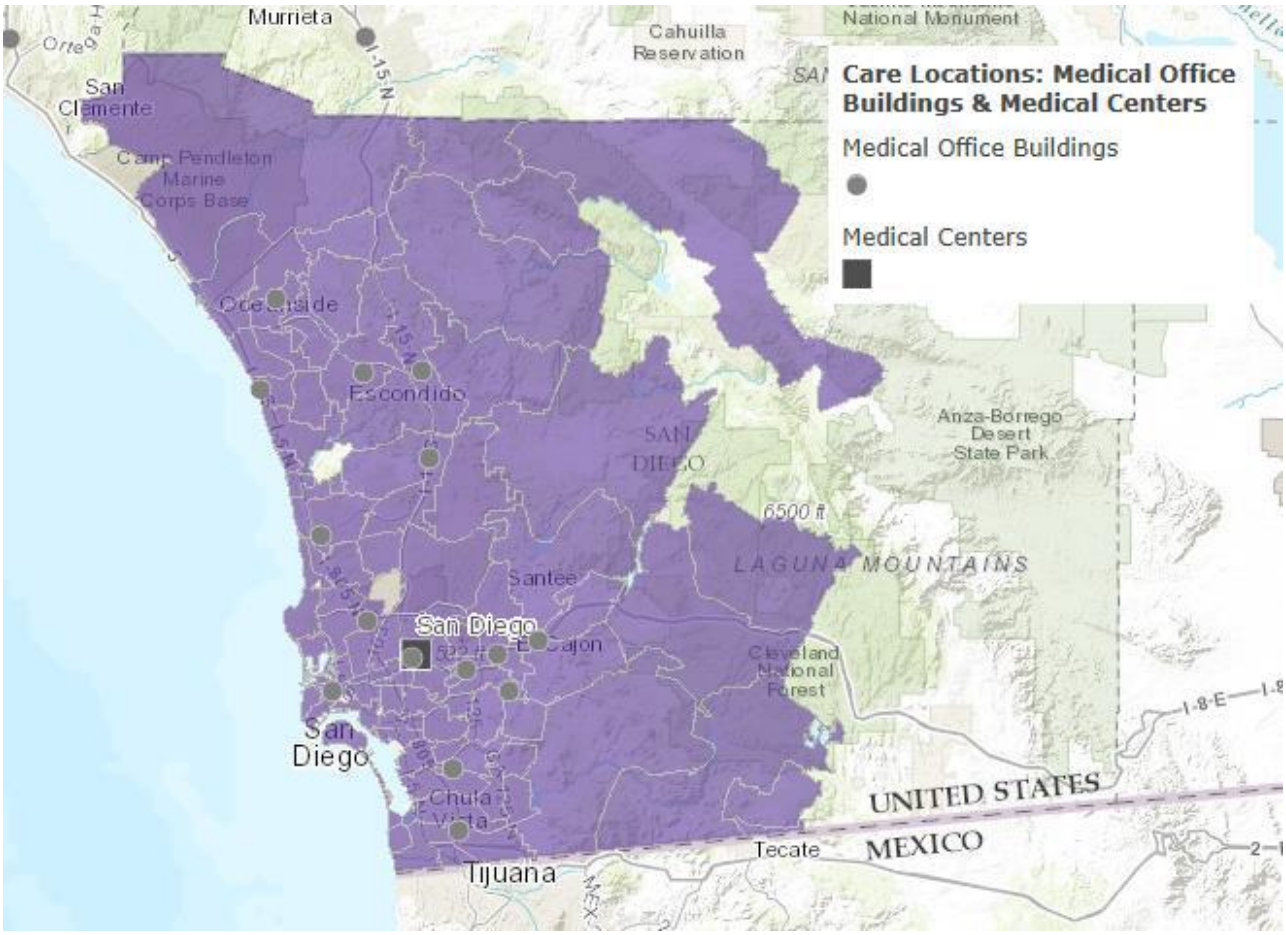
We believe good health is a basic aspiration shared by all, and we recognize that promoting good health extends beyond the doctor's office and the hospital. Like our approach to medicine, our work in the community takes a prevention-focused, evidence-based approach. We go beyond traditional corporate

philanthropy or grant-making to leverage financial resources with medical research, physician expertise, and clinical practices. Historically, we have focused our investments in three areas—Health Access, Healthy Communities, and Health Knowledge—to address critical health issues in our communities.

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

In addition, Kaiser Permanente seeks to promote community health upstream by leveraging its assets to positively influence social determinants of health – social, economic, environmental – in the communities we serve.

IV. Kaiser Foundation Hospitals – San Diego Service Area



The Kaiser Foundation Hospital (KFH)-San Diego medical service area includes a large part of San Diego County. The following 42 cities and communities are included in the service area: Bonita, Chula Vista, Coronado, Del Mar, Descanso, Dulzura, El Cajon, Encinitas, Leucadia, Olivenhain, Escondido, Fallbrook, Rainbow, Guatay, Imperial Beach, Jamul, La Jolla, La Mesa, Lakeside, Lemon Grove, Lincoln Acres, Mount Laguna, National City, Oceanside, Pala, Palomar Mountain, Pauma Valley, Pine Valley, Potrero, Poway, Ramona, Rancho Santa Fe, San Diego, San Luis Rey, San Marcos, San Ysidro, Santee, Solana Beach, Spring Valley, Tecate, Valley Center, Vista and Warner Springs.

KHF-San Diego Demographic Data	
Total Population	3,138,265
Race	
White	71%
Black	5%
Asian	11%
Native American/ Alaskan Native	1%
Pacific Islander/ Native Hawaiian	<1%
Some Other Race	7%
Multiple Races	5%
Ethnicity	
Hispanic or Latino	33%
Non-Hispanic	67%

KFH-San Diego Socio-economic Data	
Living in Poverty (<200% FPL)	33%
Children in Poverty	19%
Unemployed	7%
Uninsured	16%
No High School Diploma	14%

Note: *Percentages were pulled from the CHNA Data Platform in May 2016 (http://www.communitycommons.org/groups/community-health-needs-assessment-chna/)

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 Diego's planned response to the needs identified through the 2016 Community Health Needs Assessment (CHNA) process. For information about KFH San Diego's 2016 CHNA process and for a copy of the report please visit www.kp.org/chna.

VI. List of Community Health Needs Identified in 2016 CHNA Report

The list below summarizes the, health issues that were identified as either *health drivers* (social determinants of health) or *health outcomes* (indicators of morbidity and mortality), identified for the KFH San Diego service area through the 2016 Community Health Needs Assessment process. Together, *health drivers* and *health outcomes* are referred to as *health needs* in the CHNA and below.

1. Diabetes (Type 2)
2. Obesity
3. Cardiovascular Disease
4. Behavioral/Mental Health
5. Unintentional Injury
6. High Risk Pregnancy
7. Asthma

8. Dementia & Alzheimer's Disease
9. Breast Cancer
10. Acute Respiratory Infections/Pneumonia
11. Back Pain
12. Colorectal Cancer
13. Lung Cancer
14. Prostate Cancer
15. Skin Cancer
    - Cervical Cancer*
    - Chlamydia*
    - HIV*
    - Oral Health*

*These health needs are identified for the Kaiser Permanente service area and not part of the set of collective health needs identified by the collaborative.

In addition, ten health drivers associated with the health needs were identified and prioritized through community input and the secondary data analysis. Below is the list of health drivers in order or priority

1. Food Insecurity & Access to Healthy Food
2. Access to Care or Services
3. Homeless/Housing Issues
4. Physical Activity
5. Education/Knowledge
6. Cultural Competency
7. Transportation
8. Insurance Issues
9. Stigma
10. Poverty

VII. Who was Involved in the Implementation Strategy Development

The implementation strategy was developed through a process that involved the KFH-San Diego hospital operational leadership and community partners. The core planning team consisted of the KHF-San Diego service area's Operations Leadership Team (OLT), comprised of stakeholders representing both Kaiser Foundation Hospital/Health Plan and the Southern California Permanente Medical Group (SCPMG) and included:

- Kerry Forde, Assistant Administrator Quality, Regulatory, Risk Management and Patient Safety
- Lynette Seid, San Diego Area Chief Financial Officer
- Sam Totah, Chief Operating Officer
- Tana Lorah, Manager, Government & Community Relations
- Veronia Delarosa, Assistant Medical Group Administrator
- Werner Spitzfaden, Department Administrator

The following key organizational stakeholders were engaged as part of the strategy development process. A total of 31 individuals were engaged. Representatives from these groups are individuals who are knowledgeable about community health needs and can provide a broader perspective on the strategies and organizational assets that can be implemented to address the selected health needs.

- KP San Diego Community Benefit Committee

In addition, KFH-San Diego engaged community partners as outlined in sections a. and b. below.

a. Partner Organizations

The following community stakeholders collaborated with KFH-San Diego in developing the Implementation Strategy (IS) Report. These partners represent multiple sub-populations in the KFH-San Diego community and were able to provide multiple perspectives on developing a strategy to address health needs.

- Lemon Grove HEAL Zone Steering Committee
- International Rescue Committee New Roots Fresh Farm Steering Committee
- Hospital Association of San Diego and Imperial Counties CHNA Workgroup
- 2-1-1 San Diego

b. Community Engagement Strategy

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

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

KFH-San Diego created an iterative process by which community partners were engaged in the strategy development process. KFH-San Diego identified a list of four priority health needs through a process outlined in Section VIII. Community partners were given an opportunity to provide their feedback and ideas regarding the draft strategies for the four prioritized health needs. To facilitate these conversations, community partners were asked to identify their areas of expertise and were organized into smaller groups to discuss each health need. KFH-San Diego in partnership with the Hospital Association of San Diego & Imperial Counties engaged a total of 265 individuals in six community partner meetings between May and November 2016. Participants included a combination of community organization staff, community residents as well as county representatives (see Table 2 below).

During these meetings, participants were engaged in conversations around existing resources and assets that could be leveraged to address the needs, ideas for additional resources/assets that would be needed, possible strategies to select, collaboration opportunities, and how to track the progress and outcomes of the work. Facilitators captured these conversations and community partners were also asked to fill out surveys that documented their thinking. All surveys and notes were collected and analyzed by the external consultant to determine themes and were presented to the core hospital leadership team, who used this information to inform the selection of strategies.

Community partners shared a number of valuable information such as identifying new partners and activating existing community bases to engage on the implementation of strategies developed in this report. The community partner engagement process was valuable for the KFH-San Diego core planning team in ensuring that the strategies are aligned other strategies key community partners are developing and/or implementing and have resulted in new collaborative opportunities.

	DATA COLLECTION METHOD	TYPE	PARTICIPANTS			
	Meeting, focus group, interview, survey, written correspondence, etc.	**Respondent's title/role and organization or focus group name**	**Total number of participants**	**Number of residents**	**Number of organizational reps**	**Number of county reps**
1	Online Survey	Community Residents	*132*	*132*		
2	*Community Presentations*	*San Diego Hunger Coalition/CalFresh Task Force*	*11*		*11*	
3	*Community Presentations*	*Case Manager's Network Meetings / North County Behavioral Health Alliance*	*34*		*3*	
4	*Community Presentations*	*Family Health Centers*	*17*	*10*	*7*	
5	*Community Presentations*	*Resident Leadership Academy*	23	19	4	
6	*Community Presentations*	*Coordinated Care Initiative (CCI) / MediConnect Advisory Committee*	40		39	1
	Community Presentations	Alpine Treatment Center	8		8	

c. Consultant Used

The Center for Nonprofit Management (CNM), established in 1979, is the Southern California source for management education, training, and consulting within the nonprofit community. From core management fundamentals to in-depth consulting in planning, organizational effectiveness and evaluation, executive coaching and other services, CNM enables individuals to become better leaders of more effective organizations. The CNM team has been involved with CHNAs for hospitals throughout Los Angeles County and Southern California for over 12 years. The CNM team conducted the 2004, 2007, and 2010 assessments for the Metro Hospital Collaborative (California Hospital Medical Center, Children's Hospital Los Angeles, Good Samaritan Hospital, Kaiser Foundation Hospital Los Angeles, Queens Care, and St. Vincent Medical Center). CNM conducted the 2013 CHNAs for three Kaiser Foundation hospitals and one non-Kaiser Foundation hospital in the greater Los Angeles area, three Glendale hospitals, and the 2013 Metro Hospital Collaborative (California Hospital Medical Center, Good Samaritan Hospital and St. Vincent Medical Center), and assisted an additional two Kaiser Foundation Hospitals (Panorama City and San Diego) in Community Benefit Implementation Strategy planning based on the needs assessments. In 2016, CNM produced CHNAs for two Kaiser Foundation Hospitals (Baldwin Park and West LA) and is working on the Implementation Strategy for both medical centers; CNM also accomplished CHNAs for Citrus Valley Health Partners, the Glendale and Metro Hospital collaboratives.

VIII. Health Needs that KFH San Diego Plans to Address

a. Process and Criteria Used to Select Health Needs

A series of meetings took place with the core planning team, as described in section VII, to examine and confirm the health needs and related strategies that KFH-San Diego will select for its 2017-2020 implementation strategy period. Early in the process, the planning team voted to focus the planning conversation on the top needs as prioritized by the community in collaboration with the Hospital Association of San Diego and Imperial Counties. In addition, the planning team reviewed a set of additional data available through community data portals as well as KP membership, such as population vulnerability index, the emergency department utilization, risk of future illness, and the overlay of data and geographies for Kaiser Foundation Hospital San Diego Service Area

In considering the health needs to select, the planning team considered the KFH capacities, initiatives, and programs that may be available for addressing priority needs, and began to identify additional assets and local strategies for addressing the priority health needs. This discussion resulted in the selection of four health needs: access to care, obesity/HEAL/diabetes, cardiovascular disease, and mental health.

b. Health Needs that KFH San Diego Plans to Address

Access to Care

Access to Care is defined as access to high-quality, affordable, holistic, and culturally specific care. While access to health insurance has increased because of expanded coverage under ACA, there are still barriers to accessing affordable and timely care. Difficulty navigating the complex systems, lack of holistic health care providers including mental health providers, and a need for more culturally specific care are often cited as issues. According to the 2014 California Health Interview Survey, approximately 15.0% of San Diego adults compared to 15.9% in California self-reported that there was ever a time during the past 12 months when they felt that they might need to see a professional because of problems with their mental health, emotions, nerves, or use of alcohol or drugs. This indicator is a measure of general access to care.

Obesity/HEAL/Diabetes

Obesity/HEAL/Diabetes was chosen as a Health Need for the 2016-2019 Implementation Strategy because of both the impact on the health of the community and the potential to leverage KP assets, collaborations and partnerships to positively impact the community and achieve expected outcomes. Obesity is an important health need due to its high prevalence in the U.S. and San Diego and although it is not a leading cause of death, it is a significant contributor to the development of other chronic conditions, such as diabetes. An assessment of health needs by the Health and Human Services Agency (HHSA) region found that obesity was consistently cited as being among the top 5 most important health problems across all the regions, though it ranked highest in East and South region. Similarly, diabetes was cited as being among the top 5 most important health problems in Central, East and North County (comprised of North Coastal and North Inland). By assessing overlap between community concern and secondary data, uncontrolled type 2 diabetes was found to be a major contributor to poor diabetes-related outcomes and a significant area of need in San Diego County.

About Obesity/HEAL/Diabetes

Obesity is a medical condition in which excess body fat has accumulated to the extent that it may have an adverse effect on health. Overweight and obesity ranges are determined using weight and height to calculate a number known as "body mass index" (BMI). An adult with a BMI between 25 and 29.9 is considered overweight, while an adult who has a BMI of 30 or higher is considered obese. For children and adolescents aged 2-19, overweight is defined as a BMI at or above the 85th percentile and lower than the 95th percentile for children of the same age and sex, while obese is defined as a BMI at or above the 95th percentile for children of the same age and sex.

Adults: 36.3% of adults aged 18 and older self-reported that they have a Body Mass Index (BMI) between 25.0 and 30.0 (overweight) in San Diego County according to 2011-2012 BRFSS data. An additional 20.1% of adults aged 20 and older self-reported that they have a Body Mass Index (BMI) greater than 30.0 (obese) in San Diego County. The percentage of residents with obesity was higher slightly among men (21.3%) than women (18.8%). Excess weight may indicate an unhealthy lifestyle and puts individuals at risk for further health issues. High levels of body fat are linked to obesity, heart disease, diabetes, and other health issues.

Youth: FITNESSGRAM is the required physical fitness test that school districts must administer to all California students in Grades 5, 7, and 9. The percentage of children in grades 5, 7, and 9 ranking within the "Needs Improvement" category (Overweight) for body composition on the FITNESSGRAM physical fitness test was 17.7% in San Diego County for the years 2013-2014. Furthermore, approximately 15.9% of children in grades 5, 7, and 9 ranked within the "Health Risk" category (Obese). Rates of overweight and obese youth were highest among Hispanic/Latino and African American youth.

One of the related chronic conditions with obesity/overweight is Type 2 Diabetes. Type 2 diabetes, once known as adult-onset or noninsulin-dependent diabetes, is a chronic condition that affects the way the body metabolizes sugar (glucose), which is the body's main source of fuel. With type 2 diabetes, the body either resists the effects of insulin — a hormone that regulates the movement of sugar into your cells — or doesn't produce enough insulin to maintain a normal glucose level. If left untreated, type 2 diabetes can be life-threatening. Diabetes is an important health issue because of its prevalence and preventability.

An analysis of mortality data for San Diego County found that in 2012 ‘Diabetes mellitus’ was the seventh leading cause of death. The percentage of adults aged 20 and older who have ever been diagnosed with

diabetes was 7.2% in 2012 in San Diego County and has been steadily rising since 2005 according to the National Center for Chronic Disease Prevention and Health Promotion. It is a relevant target for intervention because hospitalizations due to diabetes-related complications are potentially preventable with proper management and a healthy lifestyle. In San Diego, the discharge rate for diabetes-related complications was approximately 9.0 per 10,000 population overall. As a percentage of total discharges by race, approximately 1.5% of discharges in the black patient population were attributable to diabetes compared to 0.7% of discharges among whites.

Cardiovascular Disease

Cardiovascular Disease was chosen as a Health Need for the 2016-2019 Implementation Strategy because of both the impact on the health of the community and the potential to leverage KP assets, collaborations and partnerships to positively impact the community and achieve expected outcomes. An assessment of health needs by HHSA region found that heart disease was cited as being among the top 5 most important health problems in Central, North Central, and Southern regions of San Diego County. 'Diseases of the heart' were the second leading cause of death in San Diego County in 2012. In addition, 'Cerebrovascular Diseases' were the fifth leading cause of death, and 'Essential (primary) hypertension and hypertensive renal disease' was the tenth. Additionally, high blood pressure was selected as a problem that has a substantial impact on overall community health in North Central region.

About Cardiovascular Disease

The World Health Organization defines cardiovascular disease (CVD) as a group of disorders of the heart and blood vessels that include coronary heart disease, cerebrovascular disease, peripheral arterial disease, rheumatic heart disease, congenital heart disease, deep vein thrombosis and pulmonary embolism.17 Coronary Heart Disease is the most common form of heart disease and the leading cause of death in the U.S.18 High blood pressure, high cholesterol, and smoking are all risk factors that could lead to CVD and stroke. About half of Americans (49%) have at least one of these three risk factors.

The 2011-2012 California Health Interview Survey estimates that 135,000 adults, or 5.8% of the adult population, in San Diego County have ever been told by a doctor that they have coronary heart disease or angina. According to the California Department of Public Health, the age-adjusted death rate for ischemic heart disease and stroke was 148.3 and 32.8 per 100,000 population respectively for San Diego in 2010-2012. While the mortality rates were lower for San Diego County than in California, the rate of death due to coronary heart disease is still above the HP2020 benchmark of 100.8 per 100,000 population.

Additionally, mortality rates for ischemic heart disease and stroke were particularly high for African Americans (211.9 and 60.02 per 100,000 population) and Native Hawaiian/Pacific Islanders (241.4 and 47.0 per 100,000 population) in San Diego County. Unmanaged high blood pressure is also a problem in San Diego. According to the 2006-2010 BRFSS, 31.3% of adults reported that they are not taking medication for their high blood pressure.

Mental and Behavioral Health

Mental and Behavioral Health was chosen as a Health Need for the 2016-2019 Implementation Strategy because of both the impact on the health of the community and the potential to leverage KP assets, collaborations and partnerships to positively impact the community and achieve expected outcomes. Mental and behavioral health is an important health need because it impacts an individual's overall health status and is a comorbidity often associated with multiple chronic conditions, such as diabetes, obesity and asthma. Mental health issues and alcohol/drug abuse issues were consistently selected by the most number of HHSA survey participants across all of the regions as health problems that have the greatest impact on overall community health. In addition, aging concerns including Alzheimer's was cited among the top five most important health problems in all regions in San Diego except the Central Region. By

assessing overlap between community concern and secondary data, the following categories were found to be important health issues within behavioral/mental health in San Diego County:

- Alzheimer's (seniors)
- Anxiety (all age groups)
- Drug and alcohol Issues (teens and adults)
- Mood disorders (all age groups)

About Mental and Behavioral Health

Mental and behavioral health encompasses many different areas including mental health and substance abuse. Because of the broadness of this health issue, it is often difficult to capture the need for behavioral health services with a single measure. Mental Health can be defined as "a state of complete physical, mental and social well-being, and not merely the absence of disease". Mental illness is defined as "collectively all diagnosable mental disorders" or "health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning."

Anxiety: Anxiety is a normal reaction to stress but can become excessive, difficult to control, and ultimately interfere with normal day-to-day living. There are a wide variety of anxiety disorders including post-traumatic stress disorder, generalized anxiety disorder, panic disorder, and social anxiety disorder. National prevalence data estimates that 18% of the population has an anxiety disorder, with phobias and generalized anxiety being the most common. In San Diego County there has been a steady increase in the rate of ED discharges with a primary diagnosis of anxiety. In particular, there has been a 64.2% increase in children up to age 14 from 25.0 per 100,000 in 2010 to 41.0 per 100,000 in 2013.

Substance Abuse: The Substance Abuse and Mental Health Services Administration (SAMHSA) defines substance use disorders as the recurrent use of alcohol and/or drugs which causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home. The percentage of adults age 18 and older in San Diego County who self-report heavy alcohol consumption (defined as more than two drinks per day on average for men and one drink per day on average for women) is 17.2%. An analysis of OSHPD trends shows that there has been a significant increase in the rate of ED visits and hospitalizations per 100,000 population in San Diego County attributable to substance and alcohol abuse. Acute substance abuse hospitalization rates increased 37.4% from 2010 to 2013 and increased most among 15-24 year olds (58.0%). Acute alcohol hospitalization rates grew most among 25-44 year olds with a 45.9% increase between 2010 and 2013. Finally, emergency department (ED) visits related to chronic alcohol use among seniors age 65 and older increased 89.7% during the same time period.

Alzheimer's disease: Alzheimer's is the most common form of dementia although all dementias are characterized by a decline in memory, thinking skills, and ability to perform everyday activities. According to the 2015 San Diego County Senior Health Report, roughly 60,000 individuals in San Diego are living with Alzheimer's disease or other dementia (ADOD) in 2012. It is projected that the number of San Diego adults age 55 and older with ADOD will increase by 55.9% between 2012 and 2030. The largest majority of individuals live in East region though the largest percentage increase is projected in North Central. ADOD also affects caregivers physically and emotionally so significant increases in the number of people living with ADOD will have an impact that extends beyond those affected.

Mood Disorders: Mood disorders are particularly prevalent in the community and increasing. Data from the Centers for Medicare and Medicaid show that among the fee-for-service population, 14.5% suffer from depression compared to 13.4% in California in 2012. In addition, an analysis of OSHPD data shows that the rate of ED discharges per 100,000 individuals with a primary diagnosis of mood disorders increased by 38.7% from 2010 to 2013 for children up to age 14; hospitalizations also went up by 26.8% in this age

group. Mood disorders are often associated with comorbidities including diabetes, obesity and asthma. Suicide is also an indicator of poor mental health and is one of the major complications of depression. In San Diego County, the suicide rate according to the California Department of Public Health is 11.3 per 100,000 population which is above the CA State suicide rate of 9.8 per 100,000 and above the HP2020 benchmark of 10.2 per 100,000 population. It is also the eighth leading cause of death in San Diego County. When adjusting for race/ethnicity, non-Hispanic whites are more likely to commit suicide followed by Native Hawaiian/Pacific Islander (15.4 and 14.2 per 100,000, respectively).

Needing Mental Health Care: According to the 2014 California Health Interview Survey, approximately 15.0% of San Diego adults compared to 15.9% in California self-reported that there was ever a time during the past 12 months when they felt that they might need to see a professional because of problems with their mental health, emotions, nerves, or use of alcohol or drugs. This indicator is a measure of general poor mental health status and demand for mental and behavioral health services.

IX. KFH San Diego's Implementation Strategies

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

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

The following represents the goals, strategies and expected outcomes for each of the health needs KFH-San Diego plans to address for the 2017-2019 Implementation Strategy (IS) timeline. KFH- San Diego will draw on a broad array of organizational resources to implement these strategies, such as grant-making, in-kind resources, collaborations and partnerships, as well as several internal KFH programs. For the purpose of this report, examples of resources are provided to illustrate how KFH-San Diego plans to implement the strategies. For examples of how these resources have been deployed to date, please visit the 2016 Community Health Needs Assessment Report www.kp.org/chna under the chapter: Implementation Strategy Evaluation of Impact.

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

Access to Care

Access to Care is defined as access to high-quality, affordable, holistic, and culturally specific care. KFH-San Diego's **long-term goal** for addressing access to care is that all community members have access to timely, coordinated, high quality health care from a trained and diverse workforce. It aims to visualize this goal by organizing its' strategies around the following **strategic priorities (or intermediate goals):**

- Increase coverage and access to comprehensive, quality health care services for low income and uninsured populations.
- Improve the capacity of healthcare systems to provide quality healthcare services, including the social and non-medical needs of their patients.
- Improve the capacity of the primary care workforce to meet community needs.

These priorities have guided the development of the following core **strategies** to address access to care in the community. These strategies focus on coverage and access, capacity of healthcare systems, and capacity of primary care providers. A large sub-set of these strategies are aligned with the Hospital Association of San Diego & Imperial Counties (HASDIC) Community Health Needs Assessment (CHNA) Collaborative and will enable greater collaboration with public health and community health partners in addressing this health need.

- Support the provision of high quality healthcare (including preventive services and specialty care) for underserved populations including the reduction of barriers to accessing care. KFH – San Diego will collaborate with 2-1-1 San Diego and other local community health organizations to provide significant assistance in conducting outreach and enrollment in the Kaiser Permanente Child Health Plan to improve the access to health care for low-income children under the age of 18.
- Support the development of community-based organizations, leaders, and networks, and build their capacity to advance equity and improve access to healthcare.
- Support partnerships and networks that sustain and scale change and lift up priorities, evidence and experience of communities, and to share information about what works in improving access to health care for the underserved
- Leverage KP assets to drive coverage and access to healthcare for the underserved, build the capacity of the primary care workforce and improve appropriate utilization of healthcare services. KFH-San Diego will address access to care by having physicians collaborate with Champions for Health through the ConsultSD program. eConsultSD is a web-based secure communications tool for primary care physicians in community clinics to consult with KFH-San Diego specialist physicians on a case-by-case basis for uninsured and low-income patients in San Diego County.

Successful implementation of these strategies is expected to contribute to the following set of **outcomes** in the community:

- Improved individual/public knowledge on how to navigate the healthcare delivery system
- Improved individual/public understanding of health insurance and medical care coverage
- Improved core clinical, financial, and operational, and data-informed decision-making capacities among safety net partners.
- Improved capacity, readiness and effectiveness of community-based organizations, community leaders and residents to address access to healthcare

Obesity/HEAL/Diabetes

KFH-San Diego's **long-term goal** for addressing obesity and overweight is that all community members eat healthy and move more as a part of daily life. It aims to visualize this goal by organizing its' strategies around the following **strategic priorities (or intermediate goals):**

- Improve access to opportunities for physical activity in the community
- Improve access to healthy food options in the community
- Improve linkages between health care services and community-level services

These priorities have guided the development of the following core **strategies** to address obesity and overweight in the community. A large sub-set of these strategies are aligned with the Hospital Association of San Diego & Imperial Counties (HASDIC) Community Health Needs Assessment (CHNA) Collaborative and will enable greater collaboration with public health and community health partners in addressing this health need.

- Support multi-level, multi-component initiatives in community settings to support access to healthy, affordable food and activity-promoting environments. An example of an initiative for this strategy is the Healthy Eating Active Living (HEAL) Zones. HEAL Zones are multi-year, place-based investments that support policy, advocacy and/or system changes in communities. These initiatives aim to lower the prevalence of obesity and overweight by increasing access to fresh fruit, vegetables and healthy beverages and increasing safe places to be play and be physically active.
- Support local governments, schools and/or community based organizations to provide healthy food options (including accessible drinking water) and to adopt healthy food policies, including procurement practices. For example, KFH- San Diego partners with Jacobs and Cushman San Diego Food Bank to increase healthy eating by providing low-income people with 20 pounds of nutritious foods (monthly) combined with nutrition education that will improve nutritional choices and knowledge leading to healthier eating and reduction of obesity and support the management of diabetes.
- Support local governments, schools and/or community based organizations to enroll community members into available food programs, most importantly Afresh and the Supplemental Food Program for Women, Infants, and Children (WIC); Promote use of Cal Fresh and WIC benefits at farmer's markets for purchasing fresh fruits and vegetables.
- Support policies that prioritize underserved neighborhoods for park investments and encourage communities to use parks to their full potential.
- Support the development of community-based organizations, leaders and networks, and build their capacity to advance equity and prevent obesity and to promote healthy eating and active living.
- Support partnerships and networks that sustain and scale change and lift up priorities, evidence, and experience of communities and to build the field of healthy eating and active living. KFH-San Diego Community Benefit liaison collaborates with San Diego County Childhood Obesity Initiative (COI) by being a member of their leadership council and participating in their all-day strategic planning retreat. They provide guidance on matters related to policy and environmental change strategies to be incorporated into the COI's strategic plan, to prevent and reduce childhood obesity in San Diego County.
- Leverage KP assets to drive community health and champion organizational practice changes within KP that promote healthy eating and active living. KFH-San Diego donates property in El Cajon and partners with International Rescue Committee in the New Roots Fresh Farm Community Garden project to provide opportunities for healthy eating and active living for refugee and other underserved populations.

Successful implementation of these strategies is expected to contribute to the following set of **outcomes** in the community:

- Adoption and implementation of policies and environments that increase availability and enable access to healthy food (including fresh produce and safe drinking water) and/or physical activity
- Reduced availability and marketing of unhealthy foods and beverages, including sugar-sweetened beverages
- Increased enrollment and use of federal food programs
- Improved capacity, readiness and effectiveness of community-based organizations, community leaders and residents to collaborate and to promote policy, system and environmental change

Cardiovascular Disease

KFH-San Diego has a **long-term goal** for improving cardiovascular health and quality of life through prevention, detection, and treatment of risk factors for heart attack and stroke. It aims to visualize this goal by organizing its' strategies around the following **strategic priorities (or intermediate goals):**

- Improve clinical system processes to enable the delivery of quality health care services that address CVD.
- Improve linkages between health care services and community-level services to address CVD.
- Improve patient access to CVD preventive services including affordable medications and behavioral counseling and support.
- Improve access to healthy eating and physical activity opportunities among those with or at risk of CVD.

These priorities have guided the development of the following core **strategies** to address obesity and overweight in the community. A large sub-set of these strategies are aligned with the A large sub-set of these strategies are aligned with the Hospital Association of San Diego & Imperial Counties (HASDIC) Community Health Needs Assessment (CHNA) Collaborative and will enable greater collaboration with public health and community health partners in addressing this health need.

- Support health care providers in the use of population health management tools (e.g. clinical decision-support systems, data, team-based care) to screen, provide preventive care, and treat CVD. An example of an initiative for this strategy is an evidence-informed cardiovascular disease (CVD) risk-reduction program called *ALL HEART.* The Community Clinic Health Network (CCHN) serves as the Project Office translate the ALL (*A*spirin, *L*isinopril, and *L*ipid lowering medications) protocol across the San Diego County and key areas in the Southern California Region.
- Support programs that improve referral of patients to evidence-based health promotion programs that teach self-management and empowerment techniques for chronic disease management and prevention.
- Increase healthy eating and active living among vulnerable populations by supporting programs that focus on wellness and promote healthy food choices and exercise
- Support community based initiatives that promote cardiovascular screenings, health and wellness checkup and increase care management related to patient care for vulnerable populations)
- Support the development of community-based organizations, leaders and networks, and build their capacity to advance equity and address CVD. This includes proving support and partnership with community clinics serving populations in vulnerable communities who are directly addressing cardiovascular disease.
- Support partnerships and networks that sustain and scale change and lift up priorities, evidence, and experience of communities to build the field of cardiovascular health. Work with the Be There Initiative to promote cross-organizational leadership and communication. An example of a

partnership is the collaboration between KFH-San Diego and Be There San Diego. Together we will promote cross-organizational leadership and communication to educate the entire San Diego community to understand and manage factors like hypertension, high cholesterol, and diabetes.
- Leverage KP assets to drive community health and champion organizational practice changes within KP that improve CVD and promote health.

Successful implementation of these strategies is expected to contribute to the following set of **outcomes** in the community:

- Improved referrals and coordination between healthcare providers and community resources and programs to address the medical and social needs of at-risk CVD patients.
- Improved clinical systems and processes to support CVD population health management (panel management, team based-care, QI infrastructure, data-based decision making, supportive leadership and culture).
- Improved patient assessment and care for chronic conditions (obesity, diabetes, and/or heart disease) and social non-medical needs by healthcare providers.
- Improved referrals and coordination between healthcare providers and community resources and programs
- Improved capacity, readiness and effectiveness of community-based organizations, community leaders and residents to collaborate and to promote policy, system and environmental change

Mental and Behavioral Health

KFH-San Diego's **long-term goal** in addressing mental and behavioral health is that all community members have optimal levels of mental health and well-being and access to high quality mental and behavioral health care services when needed. It aims to visualize this goal by organizing its' strategies around the following **strategic priorities (or intermediate goals):**

- Improve the knowledge, capacity and infrastructure of health care, organizations and communities to address mental and behavioral health
- Promote positive mental health by fostering community cohesion and social and emotional support

These priorities have guided the development of the following core **strategies** to address obesity and overweight in the community. A large sub-set of these strategies are aligned with A large sub-set of these strategies are aligned with the Hospital Association of San Diego & Imperial Counties (HASDIC) Community Health Needs Assessment (CHNA) Collaborative and will enable greater collaboration with public health and community health partners in addressing this health need.

Support community based initiatives that promote positive mental health by fostering community connection to one's neighbors and participation in local activities and create access to safe local public spaces where people can congregate

- Support integration of healthcare with community-based mental health services, such as: increase patient navigators and case managers who can help patients access services, strengthening of referral networks, and/or co-location of services between primary care and mental health providers. KFH-San Diego will address mental and behavioral health by having employees conduct health and wellness screening in collaboration with Think Dignity, a non-profit partner who empowers and organizes the community to advance basic dignity for those living on the streets of San Diego County.
- Support school and youth development organizations in learning about and addressing mental and behavioral health, including suicide prevention and trauma-informed care.

- Enhance access to high quality substance abuse treatment including medication-assisted treatments to decrease the burden of addiction and promote resiliency and recovery.
- Support partnerships and networks that sustain and scale change and lift up priorities, evidence, and experience of communities and to share information about what works in improving behavioral and mental health to build the field. KFH-San Diego Community Benefit liaison will become an active member of the San Diego North County Behavioral Health Alliance, which provides leadership and coordination of services amongst the providers of mental health and substance abuse treatment service in the North County. It also provides advocacy and problem-solving for emerging issue affecting the needs of those living with and recovery of behavioral health issues.
- Leverage KP assets to drive community health and champion organizational practice changes within KP that promote mental and behavioral health.

Successful implementation of these strategies is expected to contribute to the following set of **outcomes** in the community:

- Increased access (availability and affordability) of mental and behavioral health services in healthcare and community settings.
- Improved screening and identification of mental and behavioral needs among patients.
- Improved referrals and coordination between healthcare providers and community resources and programs
- Improved community cohesion, networks and social support
- Improved capacity, readiness and effectiveness of community-based organizations, community leaders and residents to address mental and behavioral health.

In addition to addressing the selected health needs described above, Kaiser Permanente, as an integrated health care delivery system, dedicates resources that target broader health system needs and upstream determinants of health.

Research

Kaiser Permanente conducts, publishes, and disseminates high-quality epidemiological and health services research to improve the health and medical care throughout our communities. Access to reliable data is a significant need of the overall health care system and can also be implemented in service of the identified health needs. Deploying a wide range of research methods contributes to building general knowledge for improving health and health care services, including clinical research, health care services research, and epidemiological and translational studies on health care that are generalizable and broadly shared. Conducting high-quality health research and disseminating its findings increases awareness of the changing health needs of diverse communities, addresses health disparities, and improves effective health care delivery and health outcomes in in diverse populations disproportionally impacted by heath disparities. Research projects encompass epidemiologic and health services studies as well as clinical trials and program evaluations. They cover a wide range of topics including clinical trials, building scientific expertise in health services and policy, and implementation science to bridge the gap between research and practice.

Our Commitment to Total Health

Kaiser Permanente is aware of the significant impact that our organization has on the health of our communities as a consequence of our business practices including hiring, purchasing, and environmental stewardship. We have explored opportunities to align our hiring practices, our purchasing, our building and our environmental stewardship efforts with the goal of improving the conditions that contribute to

health in our communities. The following strategies are illustrations of the types of organizational business practices we implement to address priority health needs and contribute to community health and well-being. These strategies are not exhaustive of everything we do and is intended as an illustrative list.

- **Implement green business practices and building standards to address climate and health**, such as purchasing clean wind and solar energy; and renovating all buildings to meet "KP brand" expectations around environmental stewardship and the built environment.

- **Contribute toward supplier diversity in the community to address economic security** by implementing policies and standards to procure supplies and services from diverse suppliers/service providers; working with vendors to support sub-contracting with diverse suppliers/service providers; supporting vendors that hire under/unemployed residents (with living wages and benefits); partnering with community-based workforce development programs to support a pipeline for diverse suppliers/service providers; and building capacity in target communities/populations.

- **Promote alternative transportation to address climate and health**, such as supporting active transportation policies and practices.

- **Develop the health care workforce to address access to care and economic security** by implementing health care workforce pipeline programs to introduce diverse, underrepresented school age youth and college students to health careers; partnering with local vocational schools, community colleges, workforce investment boards, local hiring halls or community-based workforce development programs to create pipelines from target communities; and providing 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.

X. Evaluation Plans

KFH San Diego will monitor and evaluate the strategies listed above for the purpose of tracking the implementation of those strategies as well as to document the anticipated impact. Plans to monitor will be tailored to each strategy and will include the collection and documentation of tracking measures, such as the number of grants made, number of dollars spent, and number of people reached/served. In addition, KFH San Diego 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

The 2016 KFH San Diego CHNA process focused on compiling additional data--both primary and secondary--to better understand and confirm the priority Health Needs first identified in 2013. Through the CHNA process, stakeholders affirmed that Access to Health Care, Obesity, Diabetes, Cardiovascular Disease and Behavioral/Mental Health persisted as the most pressing Health Needs in 2016. At the same time, stakeholders recommended that Obesity and Diabetes be combined into one Health Need, and that Behavioral/Mental Health become the first priority. Therefore, in 2016, there were no Health Needs considered by the ISET committee that were subsequently excluded from the KFH San Diego Community Benefits Implementation Strategy.

Health needs were selected at the collaborative level within the CHNA Workgroup with the Hospital Association of San Diego and Imperial Counties. Community Benefit Staff at KFH- San Diego brought the list of the 4 identified needs to the IS Team to review along with the more extensive list of health needs. The KFH-San Diego Team vetted the other area health needs and determined it would select and align with the 4 health needs selected by the CHNA Workgroup. KFH-San Diego determined it would have a greater community impact addressing top health needs in tandem with the other hospital partners.

The other health needs that were not selected include: Unintentional Injury, High Risk Pregnancy, Asthma, Dementia & Alzheimer's Disease, Breast Cancer, Acute Respiratory Infections/Pneumonia, Back Pain, Colorectal Cancer, Lung Cancer, Prostate Cancer, Skin Cancer, Cervical Cancer, Chlamydia, HIV, and Oral Health. Individually, all of these health issues are relevant to the KFH-San Diego Medical Center. The committee believes these issues can still be addressed under access to health care category, but supports the top 4 health needs as a priority.

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-San Diego will look for collaboration opportunities that address needs not selected where it can appropriately contribute to addressing those needs, or where those needs align with current strategy and priorities.