Community Health Needs Assessments that Advance the Social Determinants of Health
September 20, 2016 3:00 pm

Speakers:

Matthew Ingram, Independent Consultant

Elizabeth Ripley and Melissa Kemberling, Mat-Su Health Foundation

Yanique Redwood, Consumer Health Foundation

Pamela Schwartz, Kaiser Permanente

Community Health Needs Assessments that Advance the Social Determinants of Health

Yanique Redwood, PhD, MPH

President and CEO, Consumer Health Foundation

Twitter: @chfprez

September 20
2016

Can Hospitals Heal America's Communities?

"All in for Mission" is the Emerging Model for Impact

Tyler Norris
Vice President of Total Health Partnerships, Kaiser Permanente
Ted Howard
President, The Democracy Collaborative

DEMOCRACY COLLABORATIVE

Consumer Health Foundation

- Private health conversion foundation
- Washington D.C. region
  - D.C.
  - Northern Virginia
  - Suburban Maryland
- Advocacy
  - Health Reform
  - Economic Justice
  - Racial Equity

Economic Justice

- Improving wages
- Access to paid sick days and family leave
- Workforce development
- Community wealth building

A Quote from Dave Zuckerman

"Hospitals and health systems have annual expenditures of $780 billion and an estimated $500 billion in their collective investment portfolios. With such financial clout, these institutions can be a powerful force for revitalizing and rebuilding the economies of America's hardest hit communities: even shifting a relatively small percentage of their purchasing and investments could have an impressive impact."

Our Learning Journey

- Leveraging community health needs assessments to advance the social determinants of health
- Hospitals and health systems as drivers of health-supporting local economies
- Hospitals and health systems as partners in advancing racial equity

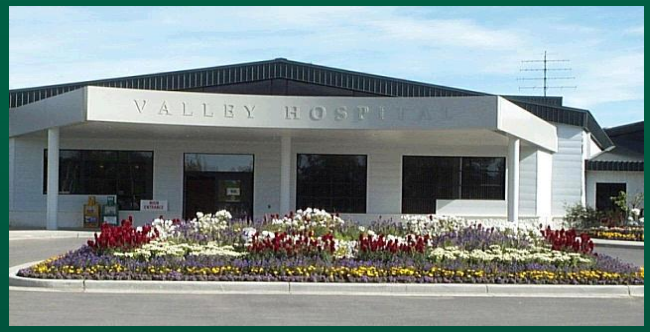
MAT-SU HEALTH FOUNDATION

Presentation for Grantmakers in Health 2016

The Matanuska-Susitna Borough

- 27 communities encompassing 24,682 square miles (size of WV)
- Fastest growing population in Alaska, and one of the fastest growing in the nation

Valley Hospital dba Mat-Su Health Foundation



MAT-SU HEALTH FOUNDATION

MSHF & MSRMC
—at the Apex of Health Reform

MAT-SU HEALTH FOUNDATION

2016
Mat-Su CHNA Report

MSHF &
Mat-Su Regional Medical Center

Partners

Alaska Mental Health Trust Authority
Chickaloon Traditional Tribal Council
CCS Early Learning
Identity
Knik Tribal Council
Mat-Su Health Services
Sunshine Community Health Center

2016

Focus on factors that affect health

because

health is where we live, learn, work and play

MAT-SU HEALTH FOUNDATION

Where we Live

Gender

Age

Culture

Sexual Orientation

Housing

Food

Where we Live

Social support

Community Safety

Home safety

Transportation

Community of residence

Legal issues

Where we Learn

Education Level

Graduation rates

3rd grade reading level

Health Literacy

Information about resources

MAT-SU HEALTH FOUNDATION

Where we Work

Income level

Occupation

Military status

Insurance

Where we Play

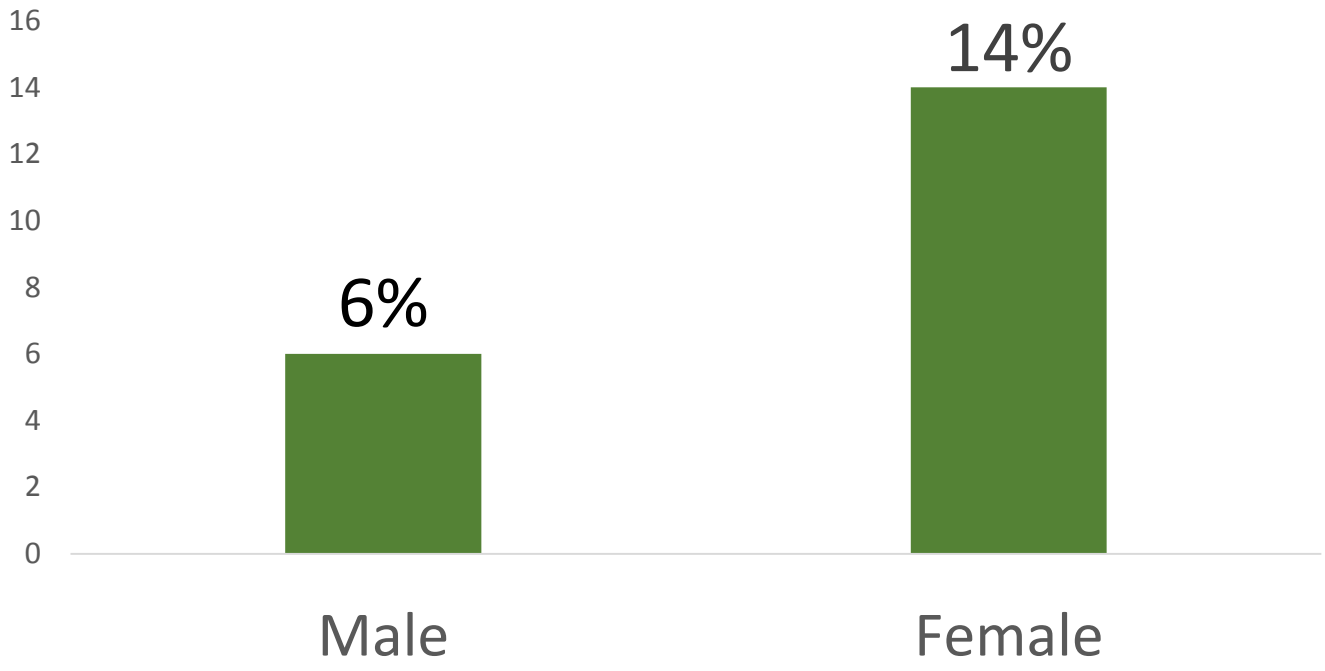
Family support

Social support

Environment

Ever told you have Asthma (%)

(Source: Alaska Behavioral Health Risk Factor Surveillance Survey)



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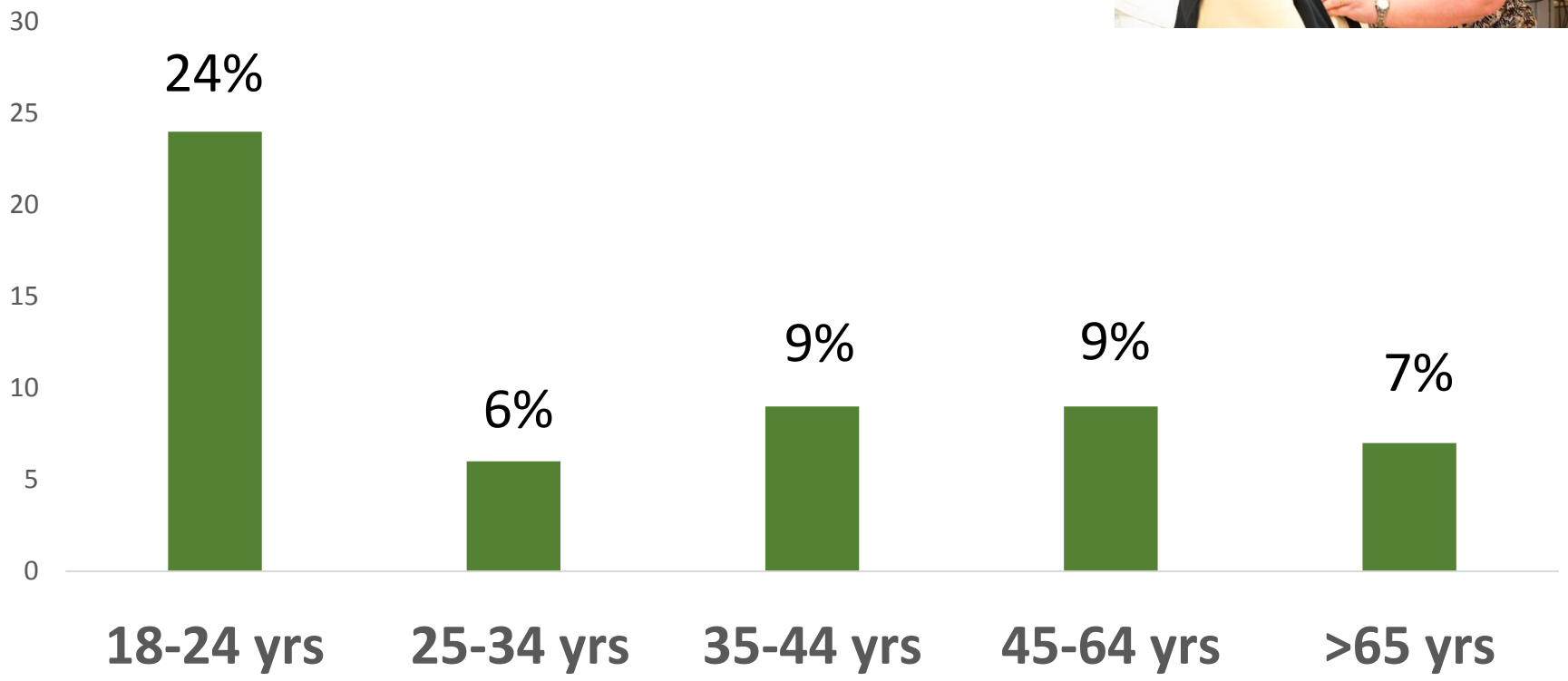

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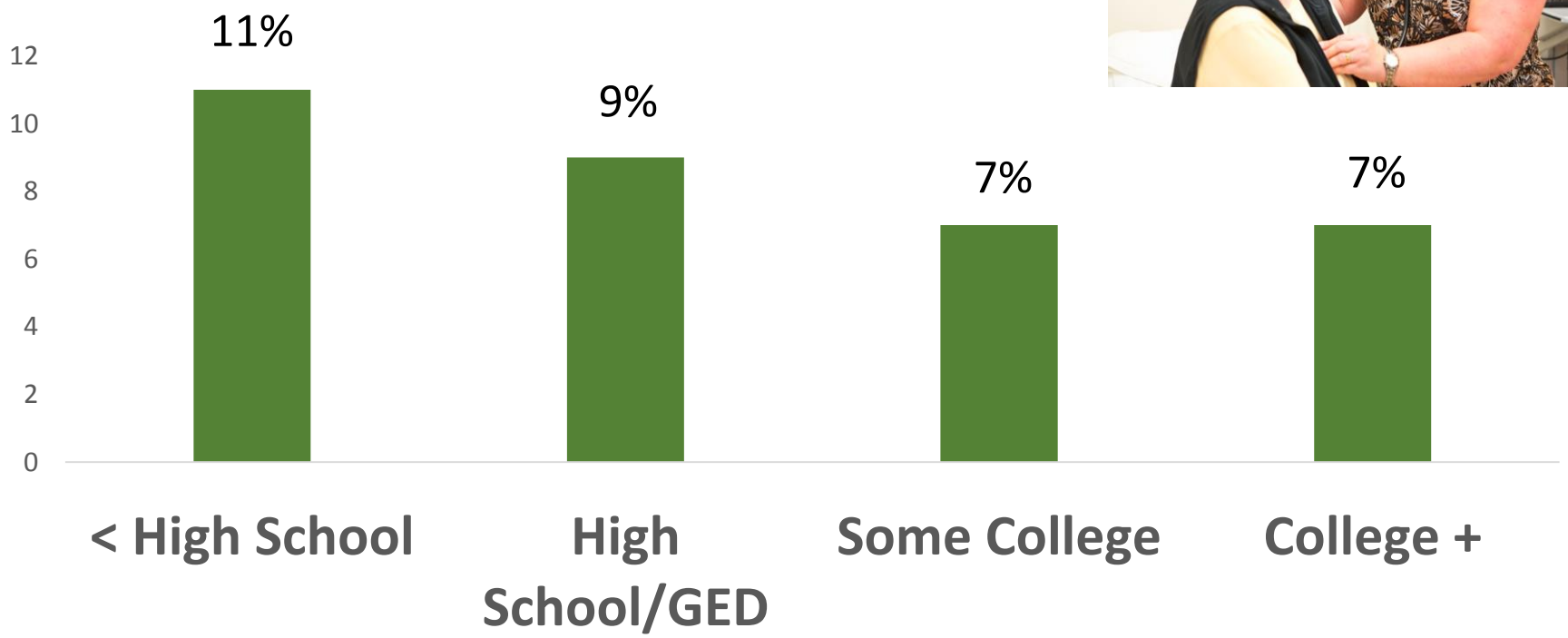
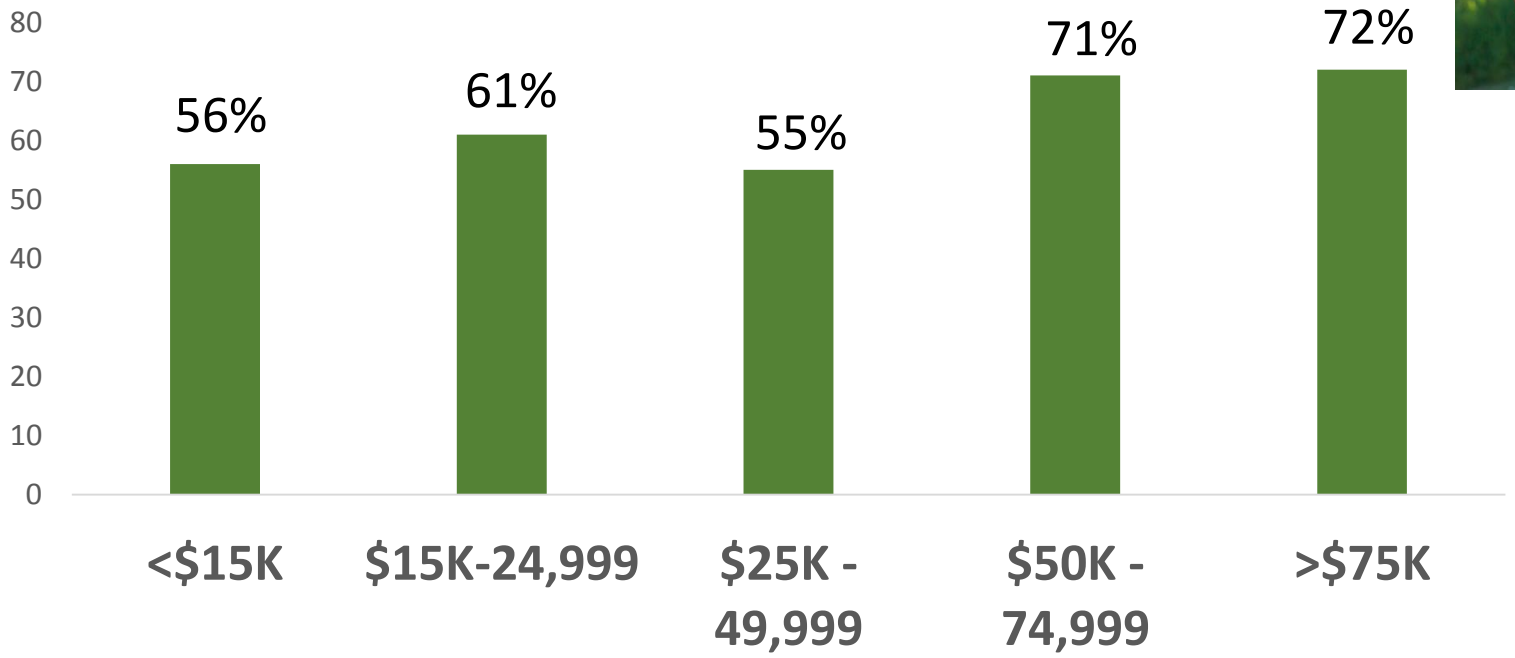


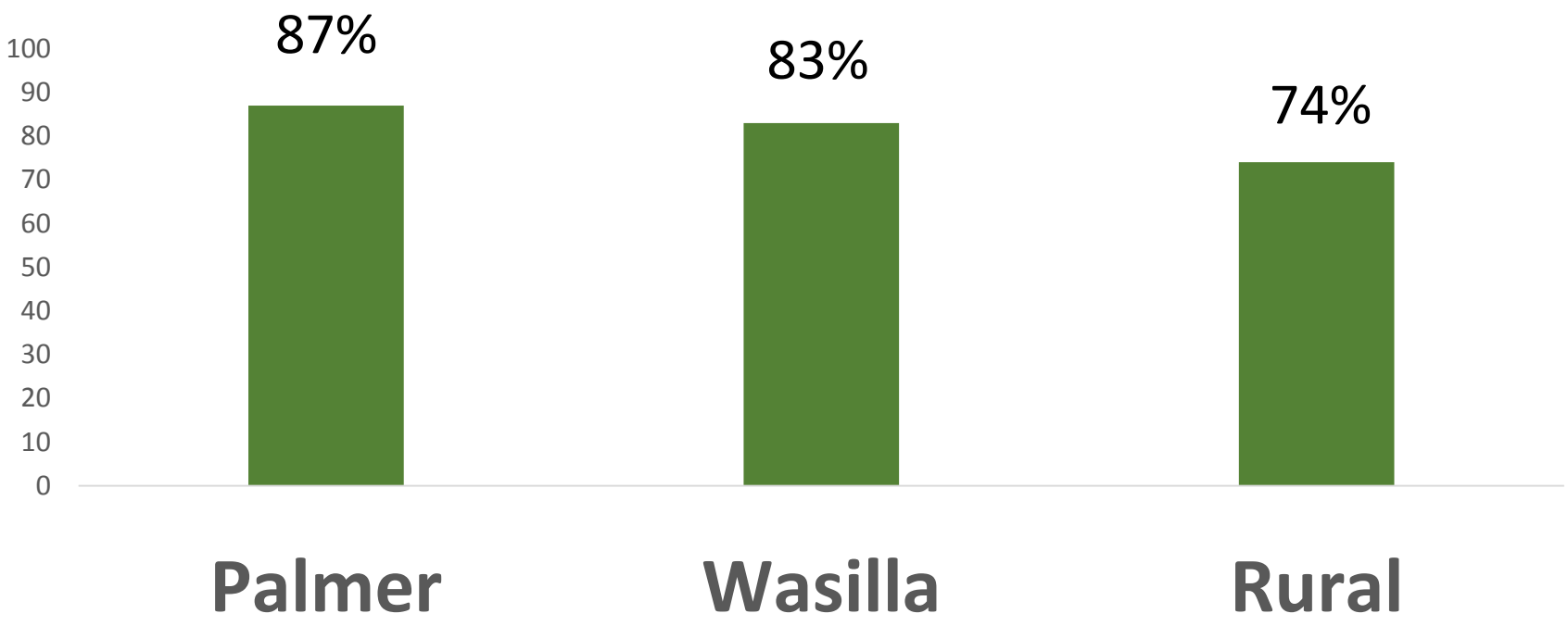
Report Positive Mental Health Outlook (%)

(Source: Alaska Behavioral Health Risk Factor Surveillance Survey)



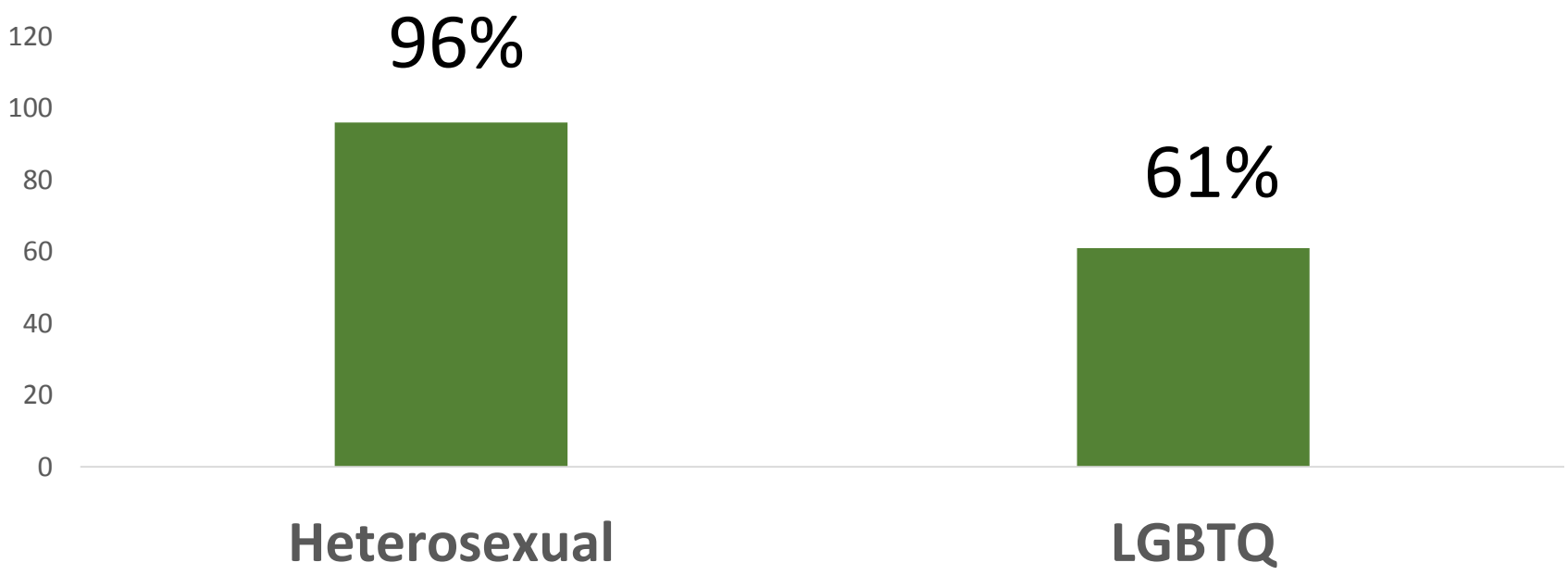
Access to Care/Cost no Issue (%)

(Source: Alaska Behavioral Health Risk Factor Surveillance Survey)



Satisfied with the health care received (%)

(Source: Alaska Behavioral Health Risk Factor Surveillance Survey)



2016

Mat-Su residents named top factors that affect health…

- Transportation
- Family and social connection and support
- Income/Poverty
- Education and Information
- Preventative services
- Safe parks and recreation

} Access to care

Leveraging the Community Health Needs Assessment to Advance Health Equity

Matthew Ingram
Founder, Driving Force Consulting
matthew@drivingforceconsulting.com
Strategy | Grantmaking | Community Benefit

The Context

Sonoma County Community Health Needs Assessment History

- Multi-agency collaboration
- Previous CHNA findings
- District hospital involvement
- Alignment with Health Action and *Portrait of Sonoma County* findings

HEALTHACTION
A 2020 VISION FOR SONOMA COUNTY

A PORTRAIT OF
SONOMA COUNTY
SONOMA COUNTY HUMAN DEVELOPMENT REPORT 2014

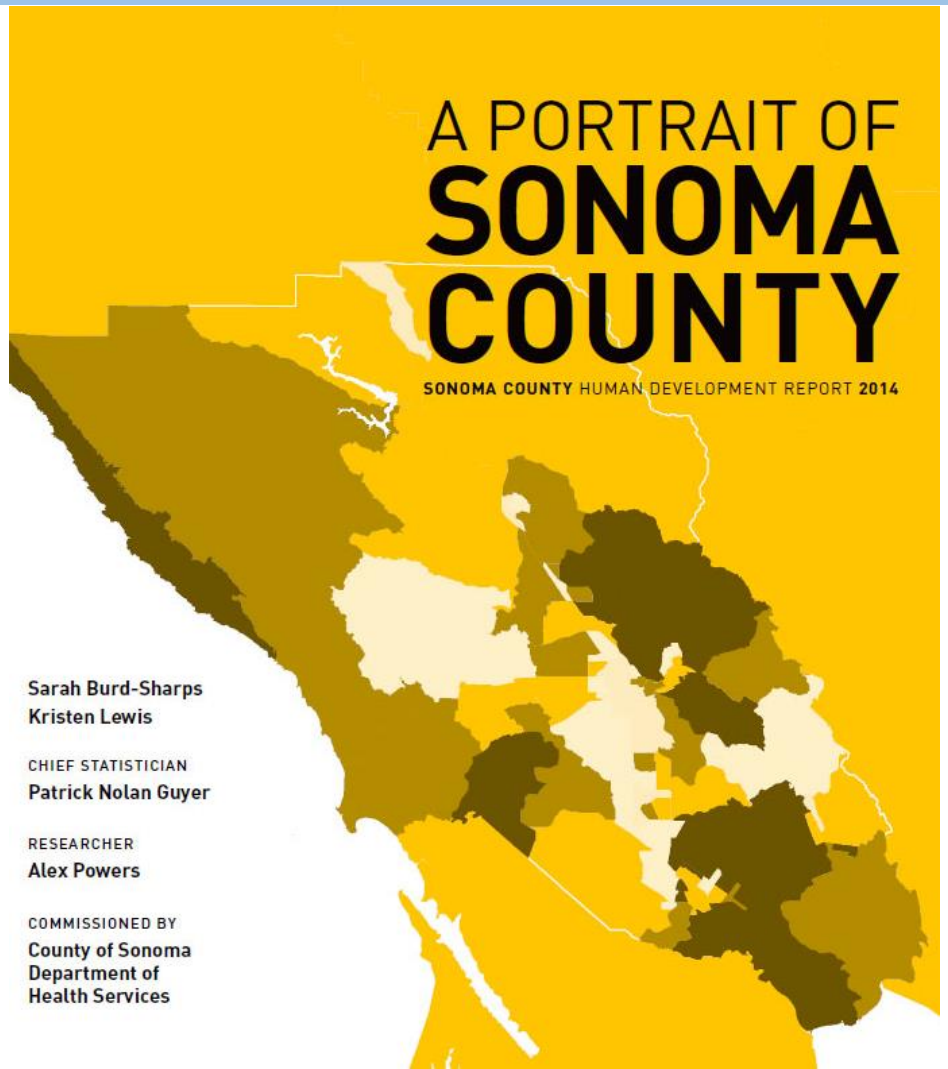
The Context

HEALTH ACTION

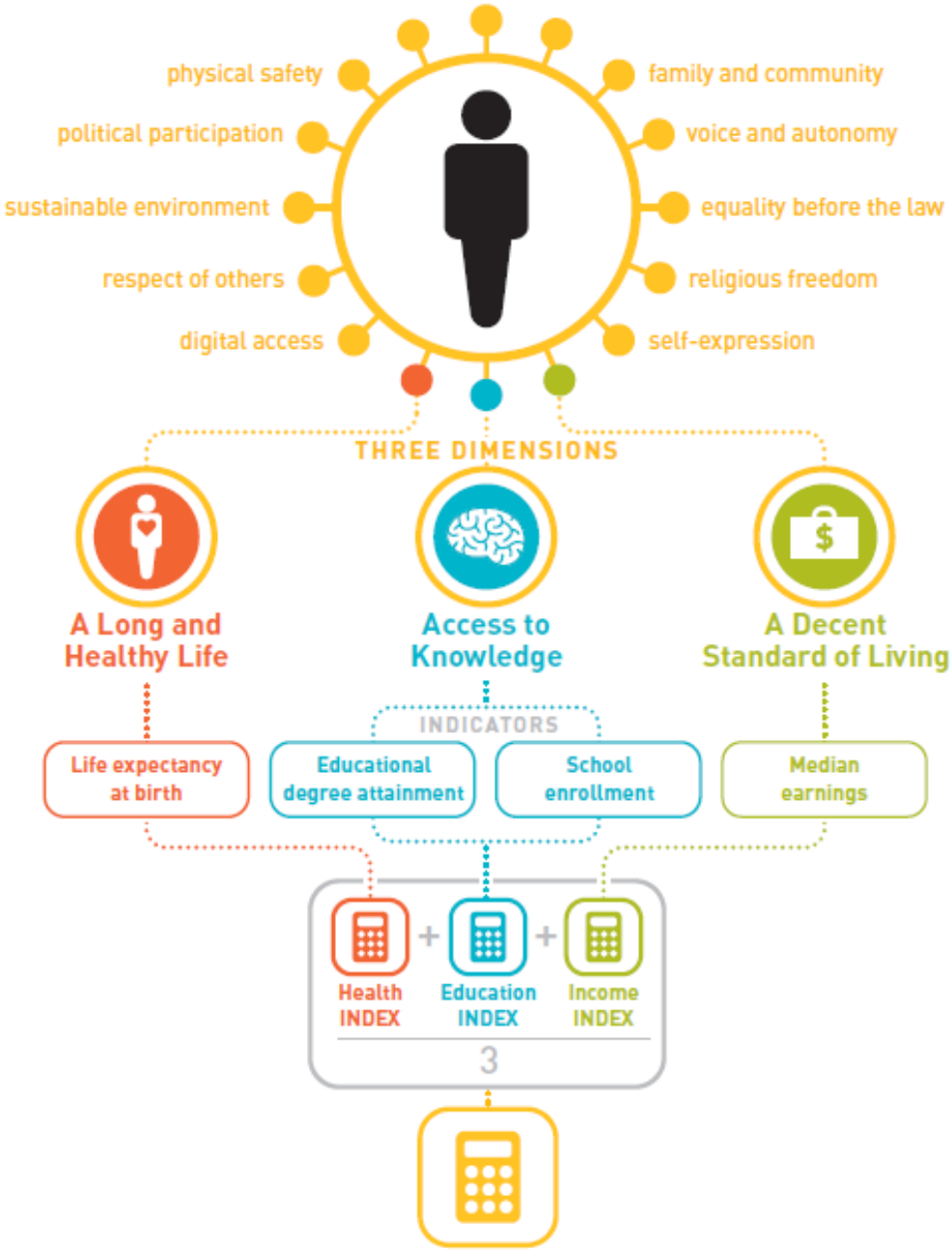
SONOMA COUNTY ASPIRES TO ACHIEVE EQUITY AND IMPROVE HEALTH FOR ALL

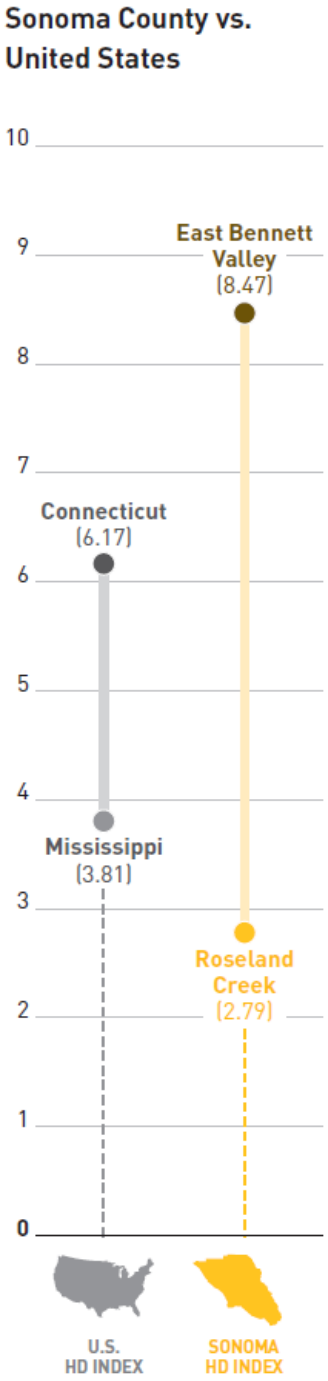
DATA | HEALTH ASSESSMENTS | SUSTAINABILITY | ABOUT HEALTH ACTION

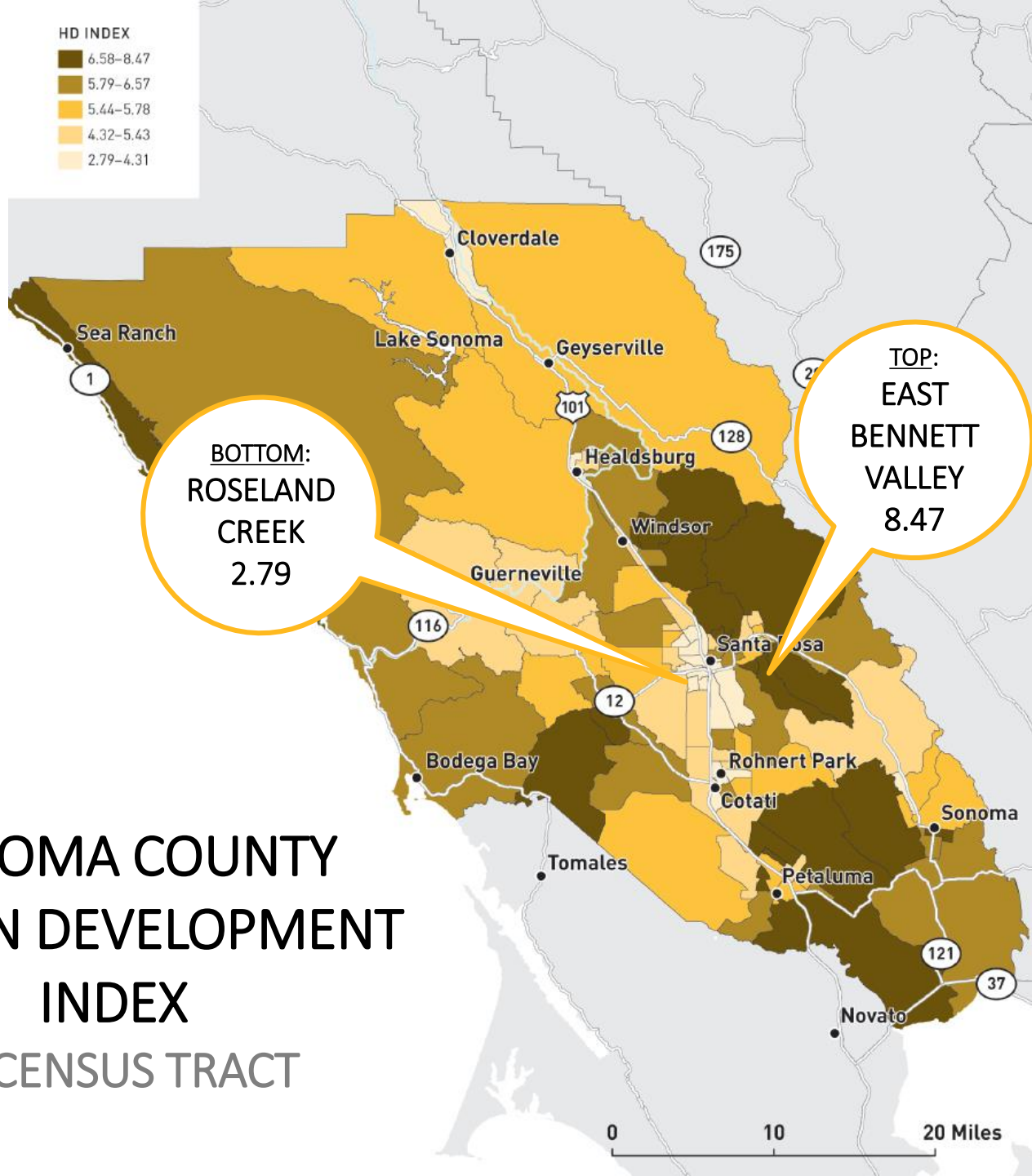
The Context


A PORTRAIT OF
SONOMA
COUNTY
SONOMA COUNTY HUMAN DEVELOPMENT REPORT 2014
Sarah Burd-Sharps
Kristen Lewis
CHIEF STATISTICIAN
Patrick Nolan Guyer
RESEARCHER
Alex Powers
COMMISSIONED BY
County of Sonoma
Department of
Health Services

HOW IS IT MEASURED?





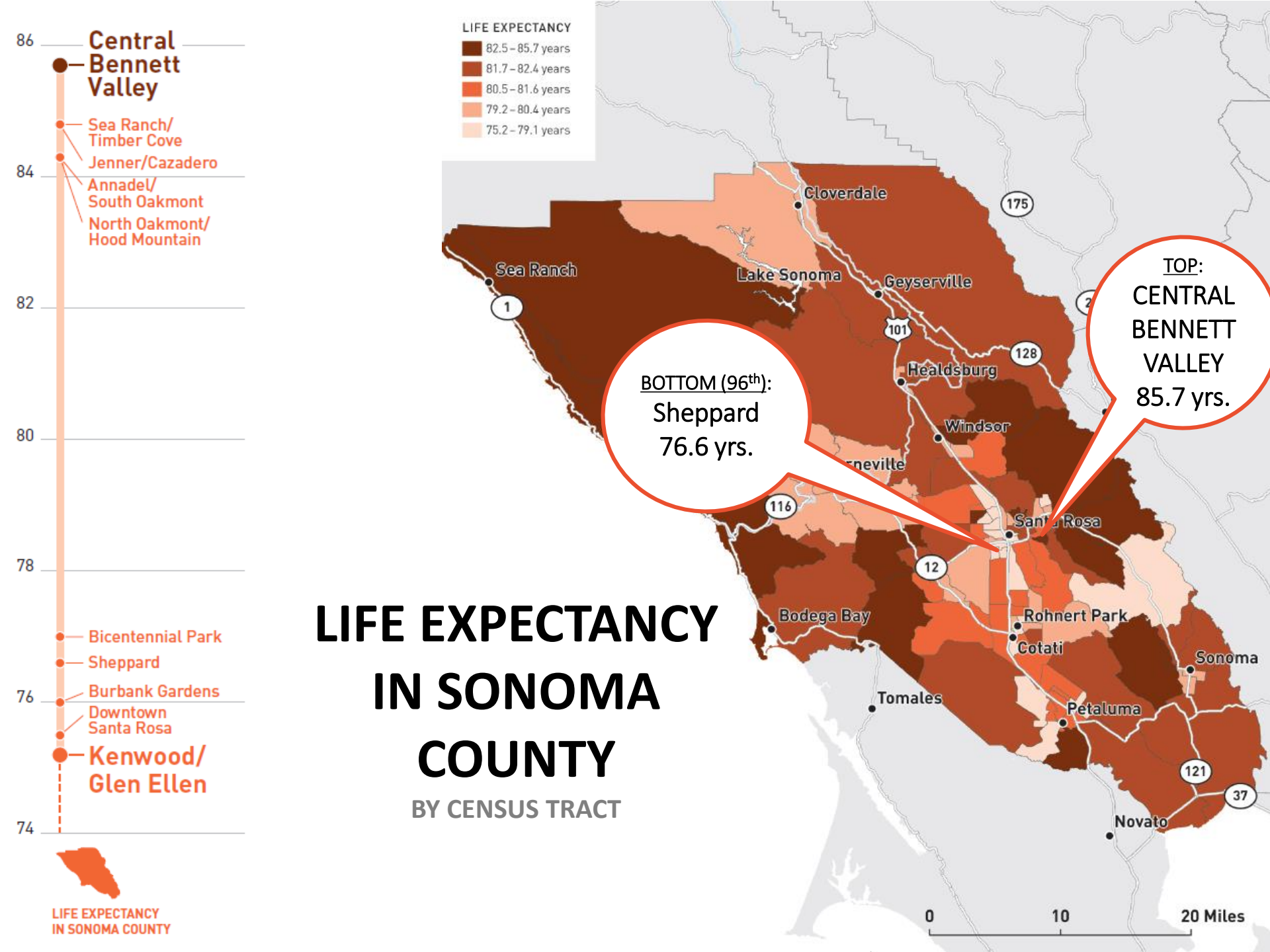


SONOMA COUNTY HUMAN DEVELOPMENT INDEX

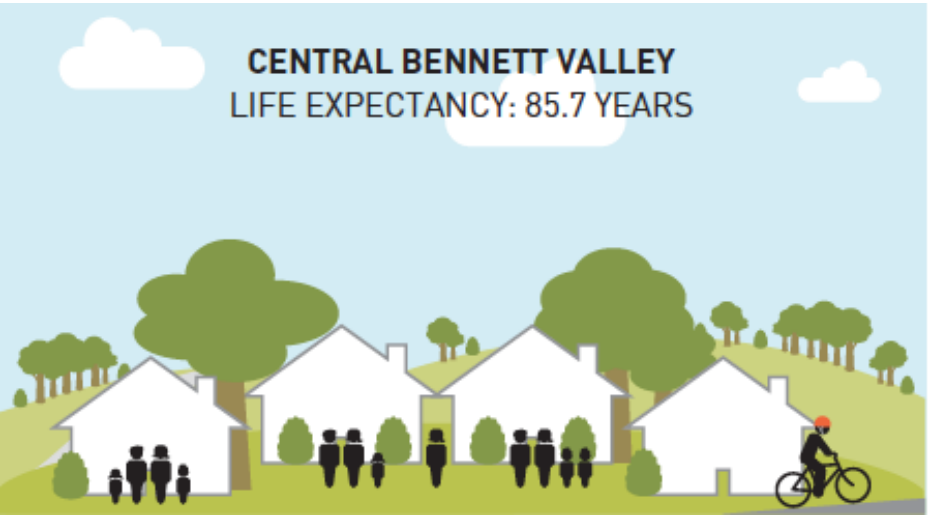
BY CENSUS TRACT

LIFE EXPECTANCY IN SONOMA COUNTY

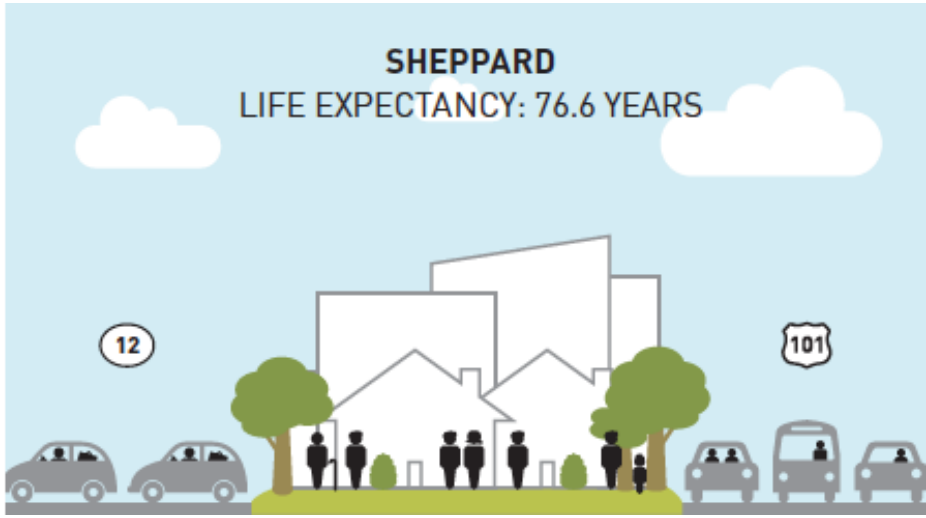
BY CENSUS TRACT



A TALE OF TWO NEIGHBORHOODS



- 6.6% living in poverty
- extensive parks and green space
- 40.8% at least bachelor's degree
- $44,564 median personal earnings



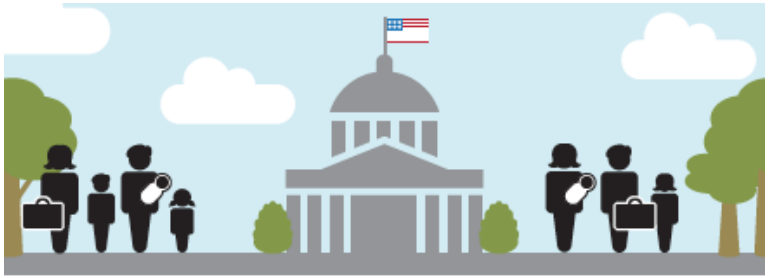
- 18.7% living in poverty
- limited parks and green space
- 8.2% at least bachelor's degree
- $22,068 median personal earnings

HEALTHY COMMUNITIES HAVE

- Green spaces
- Sidewalks and bike paths
- Affordable housing

- Jobs with decent wages
- Work/life balance
- A diverse economy

- Fresh produce stores
- High-quality schools
- Affordable health care
- Accessible public transportation



- Equality under the law
- Accountable government
- Affordable, safe childcare
- Safety and security

CHNA Goals

- Build on existing efforts and successes
- Reduce disparities, advance equity
- Set the stage for systems change work
- Be relevant, add to the conversation

CHNA Team

- Collaborative committee: all local hospitals, county health department, Sonoma Health Action

- External consultant team for data collection, analysis, and report generation: Harder+Company Community Research

Prioritization Criteria

Criteria	Definition
Severity **1x**	The health need has serious consequences (morbidity, mortality, and/or economic burden) for those affected.
Disparities **1.5x**	Health need disproportionately impacts specific geographic, age, or racial/ethnic subpopulations
Prevention **1.5x**	Effective and feasible prevention is possible. There is an opportunity to intervene at the prevention level and impact overall health outcomes. Prevention efforts include those that target individuals, communities, and policy efforts.
Leverage **1x**	Solution could impact multiple problems. Addressing this issue would impact multiple health issues.

Highest Priorities ★★★

Early Childhood Development

Access to Education

Economic and Housing Insecurity

Higher Priority ★★

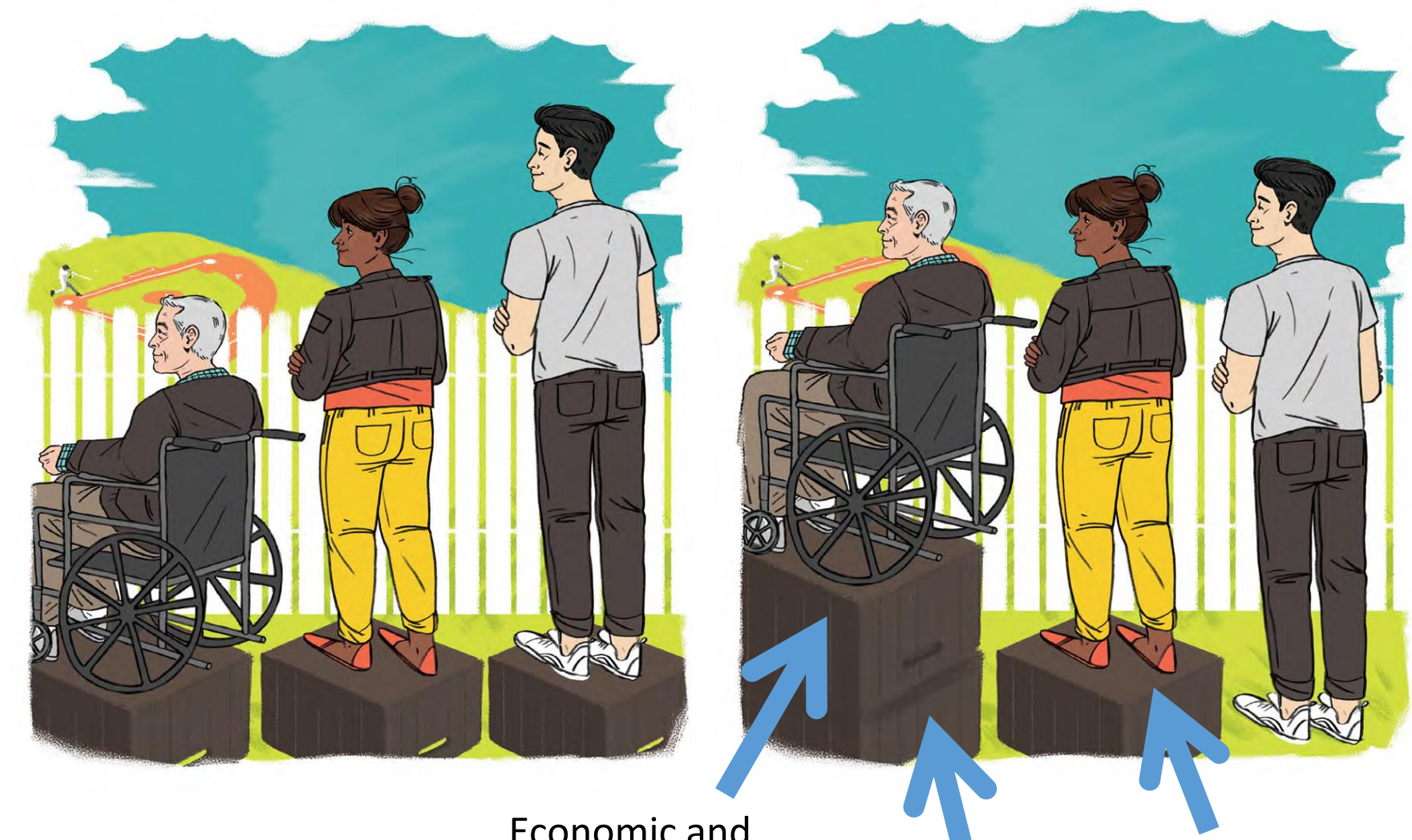
- Access to Health Care
- Mental Health
- Oral Health

High Priority★

- Substance Use
- Obesity and Diabetes
- Violence and Unintentional Injury

Equality

Equity



Next Steps

- **Strategy**

  CHNA is being used as a reference point for Sonoma Health Action planning

- **Stewardship**

  Recently awarded an Accountable Community for Health award to build an ACH in Sonoma County and scale up learnings to all of Health Action

- **Sustainable Financing**

  Working collectively to identify opportunities to fund systems change social interventions sustainably, e.g., capture and reinvest, social impact bonds, policy initiatives for early childhood education

  See ReThink Health: http://www.rethinkhealth.org/about-us/our-approach/

A Health System's Journey: From Health Care to Health Impact

together
WE BUILD A BRIGHTER FUTURE

Pamela M. Schwartz, MPH
Senior Director, Community Impact and Learning
National Community Benefit
Kaiser Permanente

KAISER PERMANENTE®

A History of Community Benefit

Our Mission for 60 Years:

"To improve the health of our members and the communities we serve"

Noon-hour loudspeaker health education program in Kaiser Shipyard, Richmond. Staff physician talking on the common cold

From *Industrial Medicine*, 14:4, April 1945

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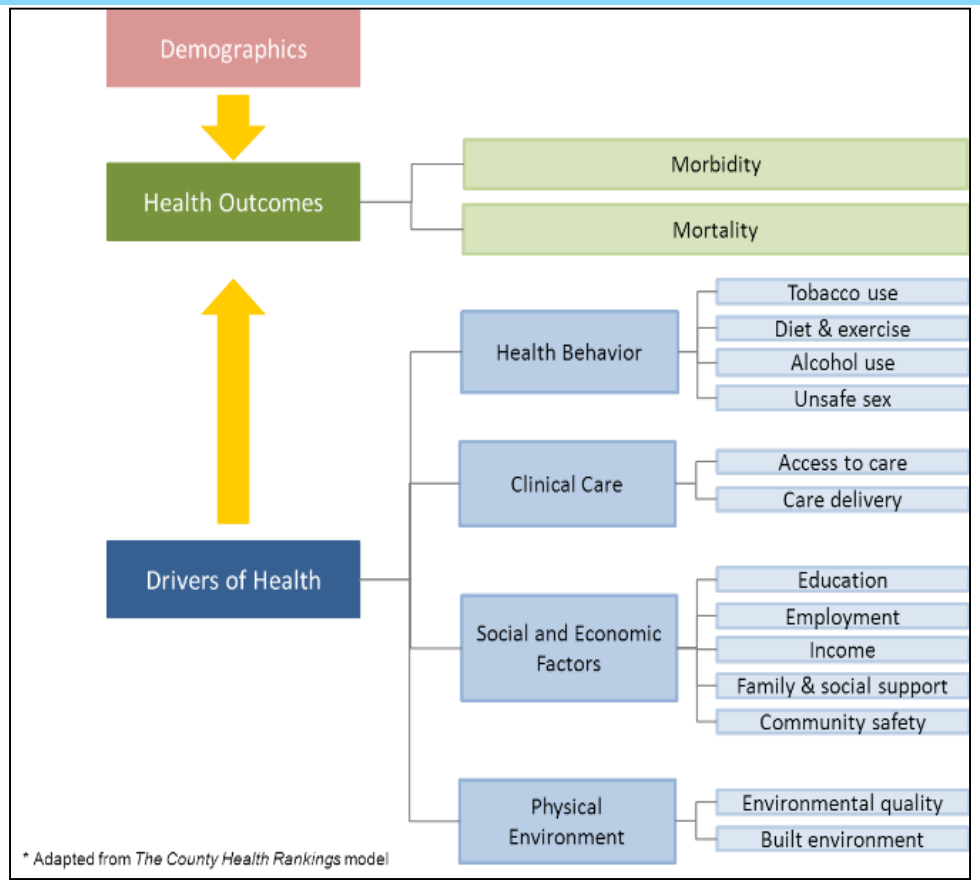
Leading a Common Approach to CHNA

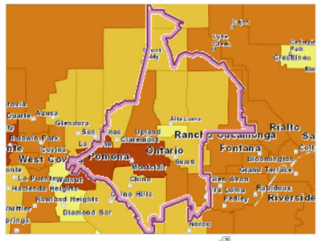


Health Outcomes

Measuring morbidity and mortality rates allows assessing linkages between social determinants of health and outcomes. By comparing, for example, the prevalence of certain chronic diseases to indicators in other categories (e.g., poor diet and exercise) with outcomes (e.g., high rates of obesity and diabetes), various causal relationship may emerge, allowing a better understanding of how certain community health needs may be addressed.

Obesity (Youth)

This indicator reports the percentage of children in grades 5, 7, and 9 ranking within the " High Risk" category (Obese) for body composition on the Fitnessgram physical fitness test. Body composition is determined by skinfold measurements or bioelectrical impedance analysis for the calculation of percent body fat and/or Body Mass Index (BMI) calculation. The percent body fat "high risk" threshold is 27%-35.1% for boys and 28.4%-38.6% for girls, depending on age. The BMI "high risk" threshold is 17.5-25.2 for boys and 17.3-27.2 for girls, depending on age. This indicator is relevant because it is a measure of body's mass that is fat, and high levels of body fat are linked to obesity, heart disease, diabetes, and other health issues.



View full map

Report Area	Student Population Tested	Number Obese	Percent Obese
Ontario (Service Area)	35,452	11,566	32.62%
California	1,300,153	387,743	29.82%

Note: No county data available. See FOOTNOTES for more details.
Data Source: California Department of Education, Fitnessgram Physical Fitness Testing Results, 2011. Source geography: School District.

Total Students Obese ("High Risk" Fitness Zone), by Race / Ethnicity

Report Area	White (Non-Hispanic)	Black (Non-Hispanic)	Asian (Non-Hispanic)	American Indian/Alaskan Native (Non-Hispanic)	Hispanic/Latino	Multi-Race
Ontario (Service Area)	1,424	643	337	3	8,532	314
California	64,345	23,555	18,287	1,404	242,523	17,260

Note: No county data available. See FOOTNOTES for more details.

Percent Students Obese ("High Risk" Fitness Zone), by Race / Ethnicity

Report Area	White (Non-Hispanic)	Black (Non-Hispanic)	Asian (Non-Hispanic)	American Indian/Alaskan Native (Non-Hispanic)	Hispanic/Latino	Multi-Race
Ontario (Service Area)	23.14%	27.46%	18.55%	2.65%	37.02%	28.94%
California	19.82%	30.27%	16.69%	19.97%	36.74%	23.89%

Note: No county data available. See FOOTNOTES for more details.

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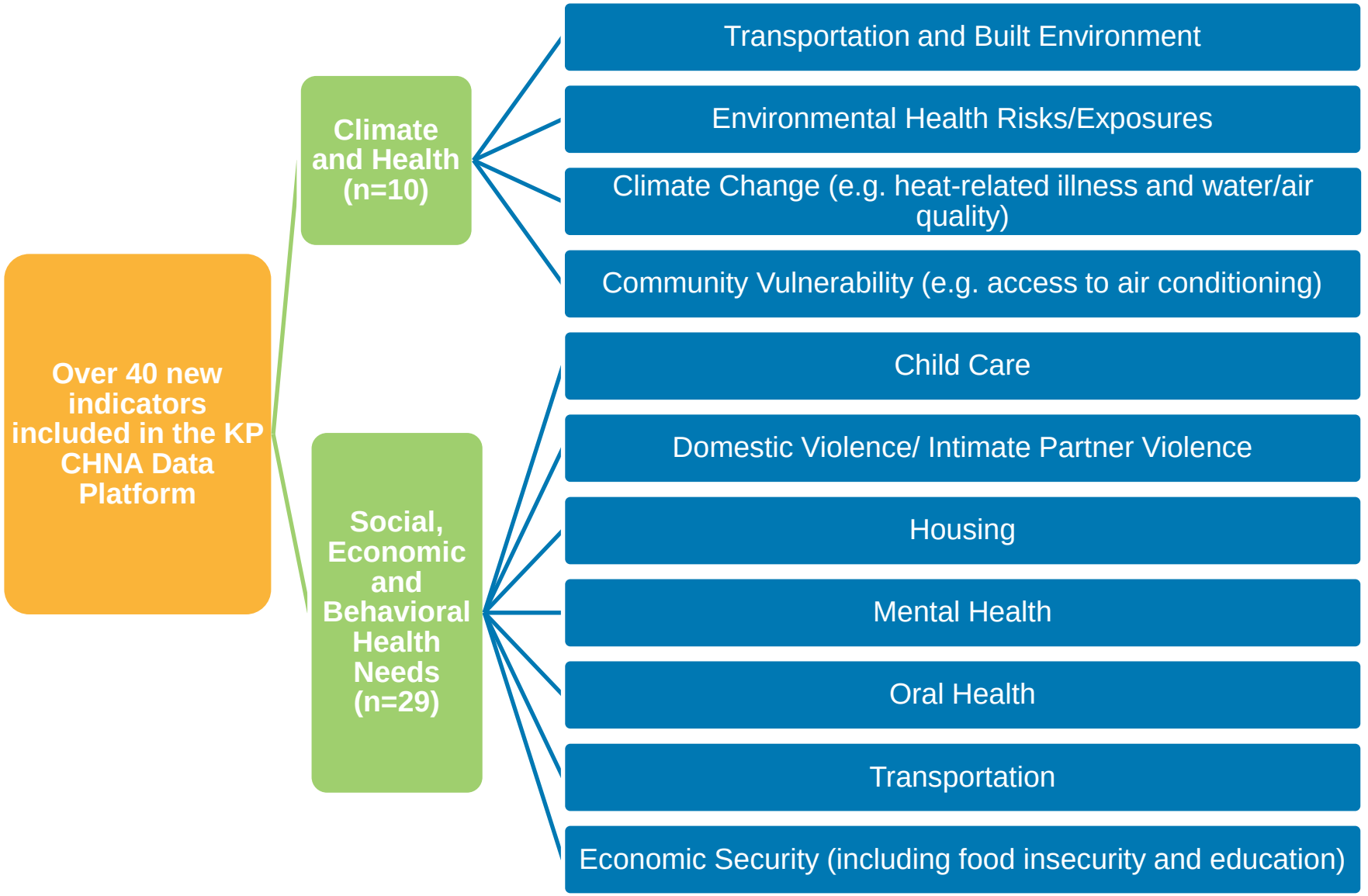
Using CHNA Indicators to Identify Upstream Health Needs



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Social Determinants of Health: Rising to the Top

	2016 Program-Wide Health Needs	Number of Service Areas Prioritized	Compared to 2013 Health Needs
1 (tie)	Obesity/HEAL/Diabetes	42	=
1 (tie)	Behavioral Health (including mental health and substance abuse)	42	↑
1 (tie)	Access to Care	42	=
2	Economic Security (including housing, education and other basic needs)	38	↑
3	Violence/Injury Prevention	30	↑
4	CVD/Stroke	26	↑
5	Asthma	25	↓
6	Cancers	24	↑
7	HIV/AIDS/STIs	23	↑
8	Oral Health	21	↓
9	Maternal & Infant Health	15	=
10	Climate & Health	14	↑
11	Transportation and Built Environment	12	↑

Other identified needs: Dementia/Alzheimer's Disease, Education & Youth Development, Infectious Disease, Cultural Competency, Stigma

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Exploring New Ways to Address Health Needs

- 2016 CHNAs reflect increased attention on the social determinants of health
- Emerging health needs pose opportunities to address emerging organizational imperatives

Access to Care

Economic Security

Behavioral Health

Climate and Health

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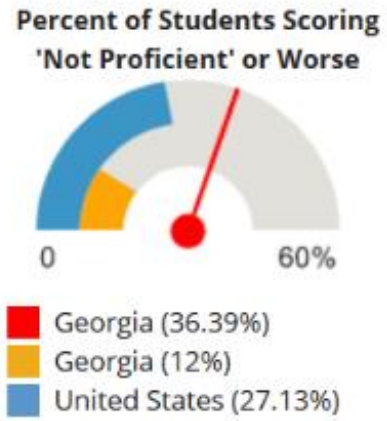
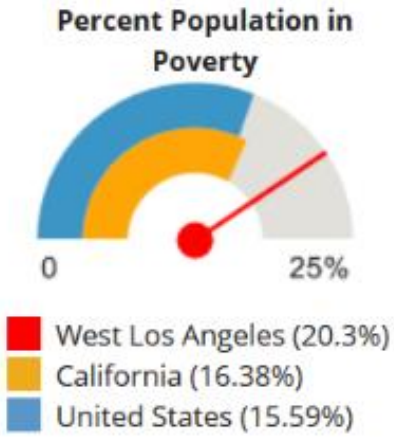
What is Economic Security?

Educational Opportunities



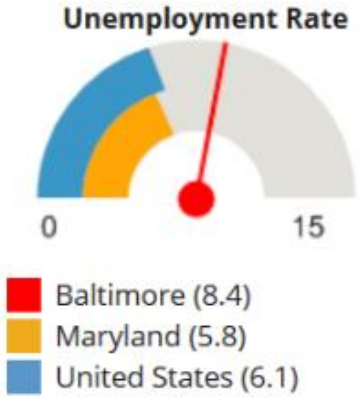
Participants express concern about current opportunities and health literacy for under-educated adults, as well as the future implications of today's low graduation rates and academic performance.
—KP Georgia KII theme

Permanent Affordable Housing



"Rent is too expensive, parents have to work long hours, kids live mostly by themselves, and there is no time for home cooked meals. In unsafe communities, kids have to stay indoors and get no exercise."
—KFH West LA community member

Employment Opportunities



"We have found to be the drivers of health needs as less clinical, but more the social determinants of health…employment is one, there also disparate outcomes about educational attainment, housing, poverty, and even where they live geographically."
—KP Mid-Atlantic interviewee

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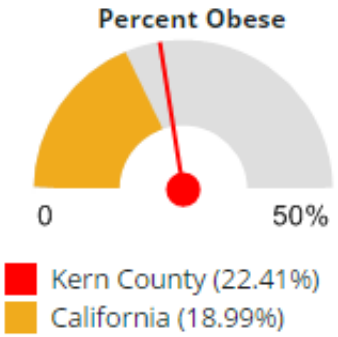
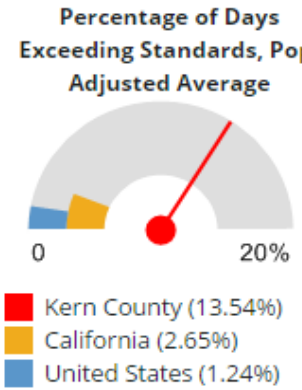
Addressing Health Needs Through a Climate Change Lens

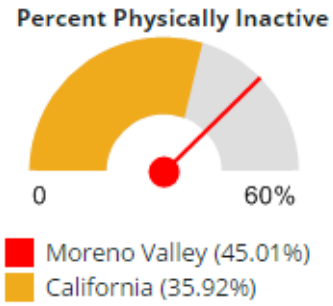
Obesity/HEAL/Diabetes

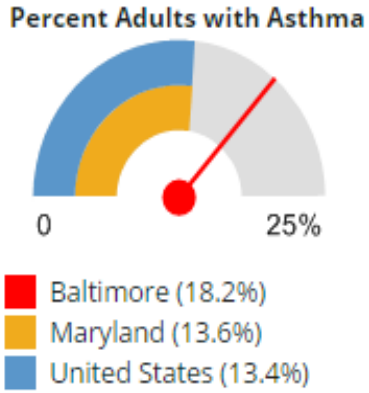




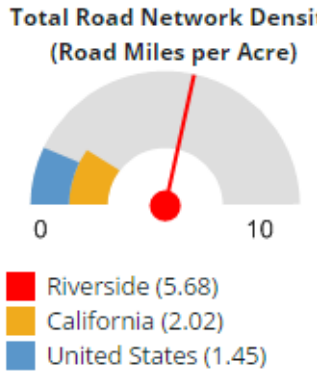
"If you suffer from asthma then you may not go outside and be active and then you are gaining weight and you're not eating healthy food." (Kern County, CA)

"…physical education programs have been scaled back in public schools, and outdoor sports and exercise programs can be challenging because of the hot climate." (Moreno Valley, CA)





Economic Security



"The lack of jobs available in Riverside County also increases commutes for residents, increasing the use of cars on the road and more pollution in the air." (Riverside County, CA)

Planning for Impact: KP Levers for Addressing the Social Determinants of Health

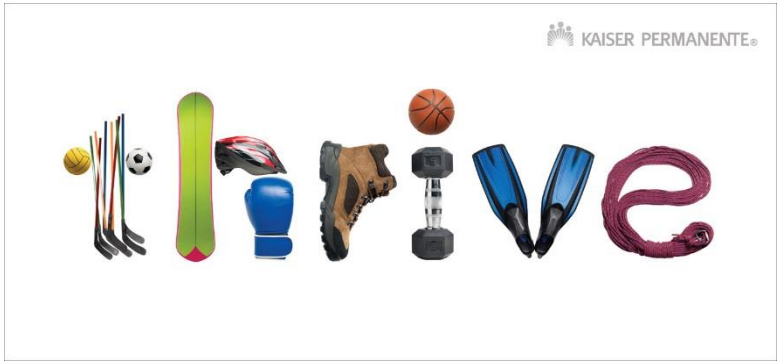
Strategic and Authentic Community Engagement

Aligning Investments with Community Needs

Strengthening Community Partnerships for Impact

COMMUNITY PARTNERSHIPS

Leveraging KP's Organizational Assets



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Responding to Needs Through Upstream Investments

	Community Health Need	Illustrative Impact
	Economic Security	Families Forward in Orange County, CA linked **133 families to permanent affordable housing.**
	Access to Care	In 2015, **CHWs** in OR **served 2,300 people** through groups, home visits, community events and one-on-one support
	Obesity/HEAL/ Diabetes	51 jurisdictions in Maryland and Virginia have adopted resolutions and **policies enabling residents to make healthier choices**
	Obesity/HEAL/ Diabetes	In 2014 and 2015, the Alameda Co. Community Food Bank distributed over **770,000 meals**
	Behavioral Health	A school-based health center in the NW expects to serve **300 students with trauma-informed care**

Partnering and Collaborating for Community Health Improvement

SAFE ROUTES to School
NATIONAL PARTNERSHIP

Supporting transportation policy and implementation

Atlanta Regional Collaborative for Health Improvement

Addressing regional health and economic interests, investments and incentives

Health Care Without Harm

SCHOOL FOOD FOCUS

California Ed-Med Collaborative

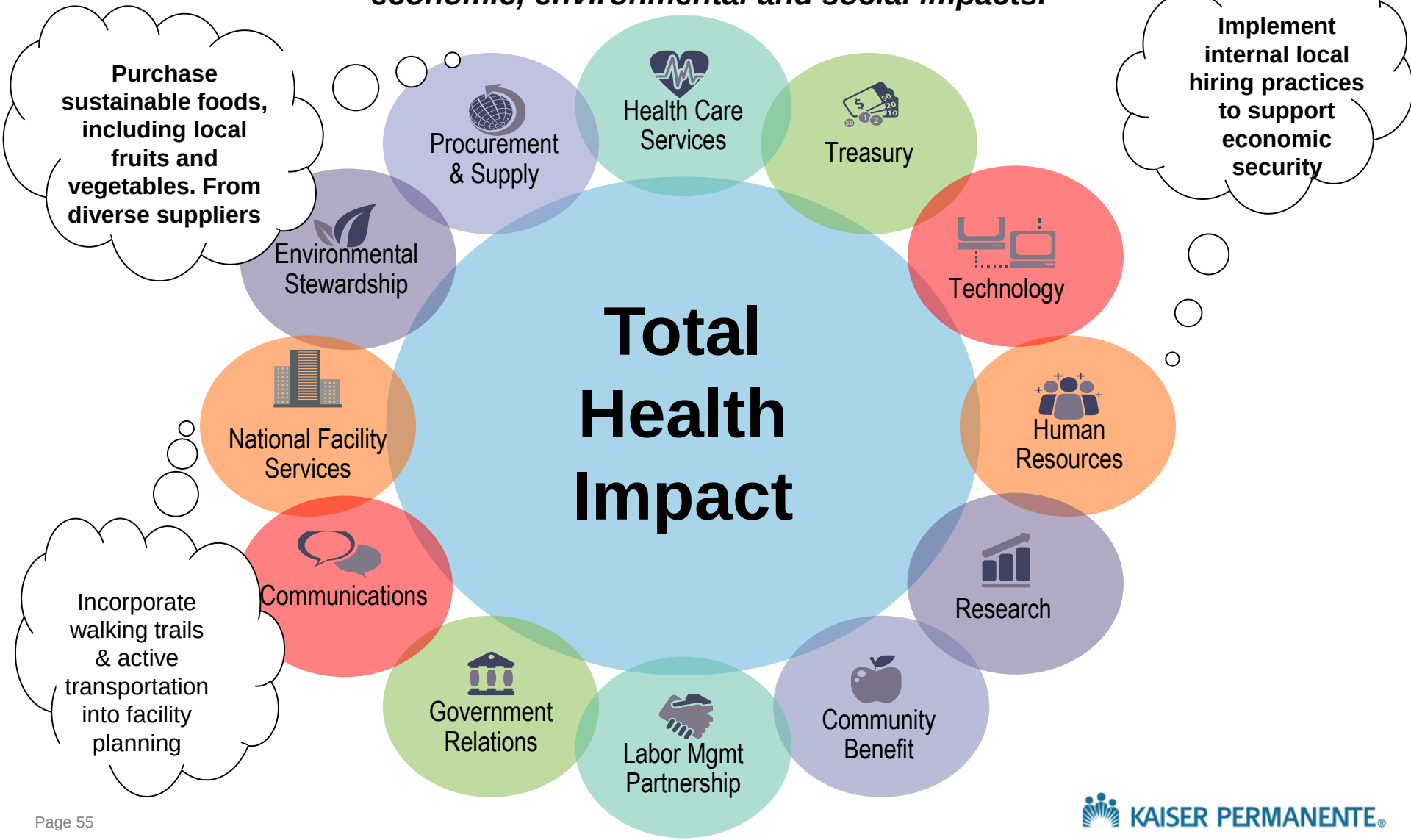
Sustainably Producing and Procuring Poultry Products in Schools and Hospitals

Creating STEM (Science, Technology, Engineering and Mathematics) *employment pipelines for youth*

KAISER PERMANENTE®

Total Health Impact: Applying All KP Assets for Health

We can leverage many of our activities in key functional areas to understand the economic, environmental and social impacts.



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Aligning CHNA with KP's Total Health Strategy

Opportunity to Align the CHNA process to Advance Total Health

Purchase and serve local, sustainably produced food

Develop a walking trail at a new facility

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The Role of CHNA in Advancing Community Health Improvement

Health systems must find ways to leverage internal and external resources to advance community health. The CHNA process is a vehicle for driving KP to be accountable to our communities.

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- More webinars on this topic?
- New topics you want to tackle or learn more about?
- Innovative work that you want to share?
- A question you want to pose to your colleagues?

Contact GIH at equity@gih.org.