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
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
Consumer Health Foundation

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

Community Health Needs Assessments
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
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
MSHF & MSRMC
—at the Apex of Health Reform
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
Focus on factors that affect health because health is where we live, learn, work and play
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
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)
Ever told you have Asthma (%)  
(Source: Alaska Behavioral Health Risk Factor Surveillance Survey)

<table>
<thead>
<tr>
<th>Age Group</th>
<th>%</th>
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<tbody>
<tr>
<td>18-24 yrs</td>
<td>24%</td>
</tr>
<tr>
<td>25-34 yrs</td>
<td>6%</td>
</tr>
<tr>
<td>35-44 yrs</td>
<td>9%</td>
</tr>
<tr>
<td>45-64 yrs</td>
<td>9%</td>
</tr>
<tr>
<td>&gt;65 yrs</td>
<td>7%</td>
</tr>
</tbody>
</table>
Ever told you have Asthma (%)  
(Source: Alaska Behavioral Health Risk Factor Surveillance Survey)
Report Positive Mental Health Outlook (%)
(Source: Alaska Behavioral Health Risk Factor Surveillance Survey)

- <$15K: 56%
- $15K-24,999: 61%
- $25K - 49,999: 55%
- $50K - 74,999: 71%
- >$75K: 72%
Access to Care/Cost no Issue (%)
(Source: Alaska Behavioral Health Risk Factor Surveillance Survey)

- Palmer: 87%
- Wasilla: 83%
- Rural: 74%
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
The Context

SONOMA COUNTY ASPIRES TO ACHIEVE EQUITY AND IMPROVE HEALTH FOR ALL

DATA

HEALTH ASSESSMENTS

SUSTAINABILITY

ABOUT HEALTH ACTION

HEALTH

EDUCATION

INCOME

COMMUNITY
The Context
HOW IS IT MEASURED?

Three Dimensions:

1. A Long and Healthy Life
   - Life expectancy at birth

2. Access to Knowledge
   - Educational degree attainment
   - School enrollment

3. A Decent Standard of Living
   - Median earnings

Calculations:

Health INDEX + Education INDEX + Income INDEX = 3

Combining these dimensions provides a comprehensive measure of human development.
SONOMA COUNTY HUMAN DEVELOPMENT INDEX
BY CENSUS TRACT

TOP: EAST BENNETT VALLEY 8.47
BOTTOM: ROSELAND CREEK 2.79
LIFE EXPECTANCY IN SONOMA COUNTY
BY CENSUS TRACT

TOP: CENTRAL BENNETT VALLEY
85.7 yrs.

BOTTOM (96th):
Sheppard
76.6 yrs.
A TALE OF TWO NEIGHBORHOODS

CENTRAL BENNETT VALLEY
LIFE EXPECTANCY: 85.7 YEARS

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

SHEPPARD
LIFE EXPECTANCY: 76.6 YEARS

- 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
• 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
<table>
<thead>
<tr>
<th>Criteria</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Severity</strong></td>
<td>The health need has serious consequences (morbidity, mortality, and/or economic burden) for those affected.</td>
</tr>
<tr>
<td>1x</td>
<td></td>
</tr>
<tr>
<td><strong>Disparities</strong></td>
<td>Health need disproportionately impacts specific geographic, age, or racial/ethnic subpopulations</td>
</tr>
<tr>
<td>1.5x</td>
<td></td>
</tr>
<tr>
<td><strong>Prevention</strong></td>
<td>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.</td>
</tr>
<tr>
<td>1.5x</td>
<td></td>
</tr>
<tr>
<td><strong>Leverage</strong></td>
<td>Solution could impact multiple problems. Addressing this issue would impact multiple health issues.</td>
</tr>
<tr>
<td>1x</td>
<td></td>
</tr>
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</table>
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

Economic and Housing Security

Access to Education

Early Childhood Development
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

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

Pamela M. Schwartz, MPH
Senior Director, Community Impact and Learning
National Community Benefit
Kaiser Permanente
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, 16th, April 1945
Leading a Common Approach to CHNA

Drivers of Health

- Demographics
- Health Outcomes
  - Morbidity
  - Mortality

Health Behavior
- Tobacco use
- Diet & exercise
- Alcohol use
- Unsafe sex

Clinical Care
- Access to care
- Care delivery

Social and Economic Factors
- Education
- Employment
- Income
- Family & social support
- Community safety

Physical Environment
- Environmental quality
- Built environment

* Adapted from The County Health Rankings model

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 relationships 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) on the Fitnessgram physical fitness test. Body composition is determined by standardized measures or bioelectrical impedance analysis for the calculation of percent body fat and in Body Mass Index (BMI) calculation. The percent body fat “high risk” threshold is 35-39.9% for boys and 38.5% for girls, depending on age. The BMI “high risk” threshold is 17.6 for boys and 17.3-27.3 for girls, depending on age.

This indicator is relevant because it is a measure of body's mass that is fat, and obesity of body fat is linked to obesity, heart disease, diabetes, and other health issues.

<table>
<thead>
<tr>
<th>Repart Area</th>
<th>Student Proportion Tested</th>
<th>Number Obese</th>
<th>Percent Obese</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ontario (Siena Area)</td>
<td>35,452</td>
<td>11,556</td>
<td>33.22%</td>
</tr>
<tr>
<td>California</td>
<td>1,920,169</td>
<td>367,749</td>
<td>19.02%</td>
</tr>
</tbody>
</table>

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


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

<table>
<thead>
<tr>
<th>Repart Area</th>
<th>White (Non-Hispanic)</th>
<th>Black (Non-Hispanic)</th>
<th>Asian (Non-Hispanic)</th>
<th>American Indian/Alaskan Native (Non-Hispanic)</th>
<th>Hispanic/Latino</th>
<th>Multi-Race</th>
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<tbody>
<tr>
<td>Ontario (Siena Area)</td>
<td>1,431</td>
<td>648</td>
<td>337</td>
<td>3</td>
<td>6,532</td>
<td>314</td>
</tr>
<tr>
<td>California</td>
<td>64,340</td>
<td>23,955</td>
<td>19,267</td>
<td>1,404</td>
<td>242,523</td>
<td>17,260</td>
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<td>Ontario (Siena Area)</td>
<td>23.14%</td>
<td>27.46%</td>
<td>18.55%</td>
<td>2.69%</td>
<td>37.02%</td>
<td>28.94%</td>
</tr>
<tr>
<td>California</td>
<td>16.92%</td>
<td>30.27%</td>
<td>16.69%</td>
<td>19.87%</td>
<td>39.74%</td>
<td>23.69%</td>
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Kaiser Permanente
Over 40 new indicators included in the KP CHNA Data Platform

Climate and Health (n=10)
- Transportation and Built Environment
- Environmental Health Risks/Exposures
- Climate Change (e.g. heat-related illness and water/air quality)
- Community Vulnerability (e.g. access to air conditioning)

Social, Economic and Behavioral Health Needs (n=29)
- Child Care
- Domestic Violence/Intimate Partner Violence
- Housing
- Mental Health
- Oral Health
- Transportation
- Economic Security (including food insecurity and education)
### Social Determinants of Health: Rising to the Top

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<thead>
<tr>
<th>2016 Program-Wide Health Needs</th>
<th>Number of Service Areas Prioritized</th>
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<tr>
<td>1 (tie) Obesity/HEAL/Diabetes</td>
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<td>38</td>
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<tr>
<td>3 Violence/Injury Prevention</td>
<td>30</td>
<td>▲</td>
</tr>
<tr>
<td>4 CVD/Stroke</td>
<td>26</td>
<td>▲</td>
</tr>
<tr>
<td>5 Asthma</td>
<td>25</td>
<td>▼</td>
</tr>
<tr>
<td>6 Cancers</td>
<td>24</td>
<td>▲</td>
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<td>7 HIV/AIDS/STIs</td>
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<td>8 Oral Health</td>
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<tr>
<td>9 Maternal &amp; Infant Health</td>
<td>15</td>
<td>▼</td>
</tr>
<tr>
<td>10 Climate &amp; Health</td>
<td>14</td>
<td>▲</td>
</tr>
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<td>11 Transportation and Built Environment</td>
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Other identified needs: Dementia/Alzheimer’s Disease, Education & Youth Development, Infectious Disease, Cultural Competency, Stigma
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Other identified needs: Dementia/Alzheimer’s Disease, Education & Youth Development, Infectious Disease, Cultural Competency, Stigma
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
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**

“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

**Employment Opportunities**

“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
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
- Leveraging KP’s Organizational Assets
## Responding to Needs Through Upstream Investments

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

Supporting transportation policy and implementation

Atlanta Regional Collaborative for Health Improvement
Addressing regional health and economic interests, investments and incentives

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

- Purchase sustainable foods, including local fruits and vegetables. From diverse suppliers.
- Implement internal local hiring practices to support economic security.
- Incorporate walking trails & active transportation into facility planning.
- Total Health Impact: Applying All KP Assets for Health
Aligning CHNA with KP’s Total Health Strategy

Health Need: Obesity/HEAL

National Function: Facilities

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
The Role of CHNA in Advancing Community Health Improvement

- **Do Good Things**: Authentically engage and partner with community to identify health needs.
- **Plan for Impact**: Commit to addressing community needs by partnering and leveraging all of our assets towards community health.
- **Be Accountable for All of Our Impacts**: Be accountable for delivering on our commitments to communities and positively impact Total Health.

*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.*
• 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.