Hospital Community Health Needs Assessment (CHNA): Kaiser Permanente Process and Learnings

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Kaiser Permanente Overview and Mission

- Founded in 1945
- America’s oldest and largest private, nonprofit healthcare organization
- 16,942 physicians representing all specialties
- 223,402 employees
- 9.3 million members
- Operations in 8 states and Washington, D.C. with 38 medical centers and 618 medical offices

**Mission:** To provide high-quality, affordable health care services and to improve the health of our members and the communities we serve.
## CHNA Driving Meaningful Change

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<tr>
<th>Meet Federal Regulations</th>
<th>Inform Investments</th>
<th>Seize Opportunities</th>
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<td>- ACA requires CHNA and Implementation Strategies (IS) responding to needs for all non-profit hospitals, every three years</td>
<td>- Robust set of data to understand health needs program wide</td>
<td>- Opportunity to strengthen KP leadership and impact in population health</td>
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<td>- IS must be adopted by Board and filed with IRS as part of Form 990</td>
<td>- Assessment data and process will inform Community Benefit portfolio</td>
<td>- Leverage all KP assets</td>
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<td>- $50,000 fine per hospital if requirements not met</td>
<td>- Continue to impact community health through <em>collaborative</em> relationships</td>
<td>- Explore new community based collaborations</td>
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“The final regulations also clarify that a hospital facility that collaborates with a governmental public health department in conducting its CHNA may adopt a joint CHNA report produced by the hospital facility and public health department, as long as the other requirements applicable to joint CHNA reports are met.”

https://www.federalregister.gov/articles/2014/12/31/2014-30525/additional-requirements-for-charitable-hospitals-community-health-needs-assessments-for-charitable#h-40
Measures of total population health should be viewed as the health outcomes and behaviors that could be achieved through the shared and collective efforts of an interconnected system of partners whose mission and vision in some capacity is linked to improving health: clinical care, government public health, non-government agencies.

Many Factors Drive and Shape Health

Health is driven by multiple factors that are intricately linked

Drivers of Health

- Personal Behaviors: 40%
- Family History and Genetics: 30%
- Environmental and Social Factors: 20%
- Medical Care: 10%

Source: McGinnis et al, Health Affairs, 2002
Framework for Assessing Community Health

Health Outcomes
- Length of Life (50%)
- Quality of Life (50%)

Health Factors
- Health Behaviors (30%)
  - Tobacco Use
  - Diet & Exercise
  - Alcohol & Drug Use
  - Sexual Activity
- Clinical Care (20%)
  - Access to Care
  - Quality of Care
- Social & Economic Factors (40%)
  - Education
  - Employment
  - Income
  - Family & Social Support
  - Community Safety
- Physical Environment (10%)
  - Air & Water Quality
  - Housing & Transit

Policies & Programs
Understanding Community Health Using KP Community Health Needs Assessment Data Platform

- [www.chna.org/kp](http://www.chna.org/kp)
- Aggregation and comparison of needs across regions/service areas
- Improved efficiency
- Valuable to internal and external partners
- Sharing our assets with our communities and the field
- Available at no cost
### How we organize our data

#### Sample indicators for each category*

**Demographics**
- Total population
- Race/ethnicity
- Age

**Health Outcomes (Morbidity & Mortality)**
- Children with asthma
- Overweight Adult and children
- Heart disease mortality

**Clinical Care (Access to Care)**
- Consistent source of primary care
- Adults 18-64 ever tested for HIV
- Adults with dental visits in past year

**Social & Economic Factors**
- Poverty level
- Education level
- Uninsured level

**Physical Environment**
- Fast food restaurants
- Park access
- Particular matter 2.5 above standard

**Health Behavior**
- Adult Tobacco use
- Children consuming 5+ serving F/V consumption
- Initiate breastfeeding

#### Example of a health need and its health indicators:

- **Health Behaviors**
  - 5+ f/v per day
  - Physical activity

- **Physical Environment**
  - Park access
  - Fast food restaurants

- **Clinical Care**
  - Adults taking HbA1c test in past year

- **Morbidity/Mortality**
  - Diabetes prevalence

* List not exhaustive
How we define our population


Orange County

KP-KFH Anaheim Service Area
Example

Diabetes Hospital Discharges, Rate (Per 10,000 Pop.) by ZCTA, OSHPD 2011

Diabetes Prevalence, Percent of Adults Age 20+ by County, CDC NCCDPHP 2011
Develop high level summary of a specific health need identified in the community that provides an integrated analysis of gathered data

- **Narrative summary of the issue** – why is it important?
- **Statistical data** - What is the prevalence/incidence of the health issue in the community? (with sources and benchmarks)
- **Associated drivers** – what is driving the health need in the community?
- **Disparities** – subpopulations and geographic areas of greatest impact (with illustrative maps)
- **Community input** – what do community stakeholders think about the issue? (with key supporting quotes)
- **Assets** – what are the assets that can address the health need?

For a complete list of our Community Health Needs Assessment and Implementation Strategy Reports visit: [KP.ORG/CHNA](http://KP.ORG/CHNA)
Most Frequently Prioritized Program-wide Community Health Needs

1. Obesity/HEAL/Diabetes (identified by all facilities/regions)
2. Mental Health
3. Access to Care
4. Asthma
5. Oral Health
6. (tie) Cardiovascular Disease/Stroke
7. (tie) Substance Abuse/Tobacco
8. Violence/Injury Prevention
9. Cancers
10. (tie) HIV/AIDS/Sexually Transmitted Diseases
11. (tie) Maternal and Infant Health
12. Economic Security
Broader engagement of stakeholders during planning

Sample stakeholders involved in planning:

- Senior Operational Leaders
- Community Benefit/Relations Manager/Staff
- Public Affairs Director/Managers
- Medical Directors/Physicians-in-Chief
- Communications Managers
- Compliance Officers
- Human Resources managers
- Research and Evaluation experts
Goals/Strategy Example: Anaheim, CA

**Long-term Goal**
- Reduce obesity and overweight among vulnerable Orange County residents

**Intermediate Goal**
- Increase healthy eating and active living among youth and economically vulnerable residents

**Strategy**
- **Grant-making** to support Healthy Eating and Active Living (HEAL) Zone schools and community organizations to address access to and availability of fresh fruits and vegetables

**Expected Outcomes**
- Increased access to healthy food choices on school campuses and in community settings
Strategic Planning

How do we design and coordinate our health system / operational efforts / partnerships to address health needs and improve community health……?

What are the realistic population level outcomes/impacts of those efforts and how do we monitor and evaluate them?

Evaluation
Current Context

Emergence of accessible data
- Data portals
- Use of geographic based assessments

A move toward population health and prevention

Common health needs
- Obesity/overweight
- Mental health
- Access to care
- Oral health

Better understanding of how to address health needs through evidence-base research and best practices
- Example: County Health Rankings ‘What works in Health’
  http://www.countyhealthrankings.org/policies/new
Questions guiding future assessments

- **Data sets** - What are the common data collected between county, state and national data sources? Is the same data used across assessments?

- **Geographic estimations** – Are the data points the same/different across different geographic estimations? How is this relevant for different audiences and ‘users’ of the data?

- **Shared data frameworks** – How do we organize data to identify health needs? Are we ‘valuing’ and interpreting the data the same way?

- **Common health needs** - Which issues are common across accountable partners? How are they similar/different for the different sub-populations they serve?

- **Drivers** – What is driving the common health needs identified through our respective assessments? Are these drivers the same/different across communities? How can data help us understand those drivers?

- **Timeline** – How can we align our timelines to promote collaboration?
Discussion and Questions