Leveraging the Community Health Needs Assessment Process to Improve Population Health: Lessons Learned from Kaiser Permanente

Association for Community Health Improvement (ACHI) – 2015 Conference
What We’ll Review

- Rule and spirit in responding to final regs - to advance hospitals toward population health planning
- Kaiser Permanente’s approach to health needs assessment and planning
- KP’s aspiration to leveraging all the assets of our organization to improve community health
- Planning for evaluating impact
- Lessons learned

- Discussion and the work ahead
Defining Population Health

The Institute of Medicine Roundtable for Population Health Improvement uses the following definition:

Population Health is “the health outcomes of a group of individuals, including the distribution of such outcomes within the group” ²

While not a part of the definition itself, it is understood that such population health outcomes are the product of multiple determinants of health, including medical care, public health, genetics, behaviors, social factors, and environmental factors.

Implications for Population Health Planning

“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”

- Leadership for health improvement involves the following systems:
  - Clinical Care
  - Government Public Health
  - Non-government agencies

### Importance of non-medical and social needs

**Definition of health need:** The regulations expand the definition of "health needs" to include what we would consider Social Determinants of Health and Prevention, e.g. (i) preventing illness, (ii) ensuring adequate nutrition; and (iii) addressing social, behavioral and environmental factors that influence health.

### Impact

**Evaluation:** CHNA report must include an evaluation of the impact of actions taken by the hospital to address the significant health needs identified in the hospital's prior CHNA/IS, and add chapter to each CHNA.

### Community engagement

**Prioritizing health needs:** The final regulations require a hospital facility to take into account community input not only in identifying significant health needs but also in prioritizing them.

### Strategy

**Due dates:** 4.5 months added, allowing more for IS process.
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.
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
Approach to Selecting Common Data Indicators

Based on the Mobilizing Action Toward Community Health (MATCH) model

* Adapted from The County Health Rankings model
Community Health Needs Assessment Data Platform

**www.chna.org/kp**

- Free to all – KP and community partners
- Makes publicly available data from wide range of national and CA sources
- Lives within Community Commons
- Served as basis for national CHNA.org
- For this cycle: Adding new indicators – Mental Health, Environmental, Violence
- Creating new reports in excel for ease of analysis
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

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

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

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

**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

How We Visualize Our Health Needs

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

- **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?
### Criteria Used for Selecting Health Needs for IS

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Definition</th>
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<tr>
<td><strong>Magnitude/scale of the problem</strong></td>
<td>The health need affects a large number of people within the community.</td>
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<tr>
<td><strong>Severity of the problem</strong></td>
<td>The health need has serious consequences (morbidity, mortality, and/or economic burden) for those affected.</td>
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<td><strong>Health disparities</strong></td>
<td>The health need disproportionately impacts the health status of one or more vulnerable population groups.</td>
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<td><strong>KP assets</strong></td>
<td>KP can make a meaningful contribution to addressing the health need because of its relevant expertise and/or unique assets as an integrated health system and because of an organizational commitment to addressing the health need.</td>
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<tr>
<td><strong>Ability to leverage</strong></td>
<td>Opportunity to collaborate with existing community partnerships working to address the health need, or to build on current programs, emerging opportunities, or other community assets.</td>
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Most Frequently Selected Health Needs Across KP Hospitals

- Obesity/HEAL/Diabetes (identified by all facilities/regions)
- Access to Care
- Mental Health
- Violence/Injury Prevention
- Economic Security
- Oral Health
- Cardiovascular Disease/Stroke
- Substance Abuse/Tobacco
- Asthma
- HIV/AIDS/Sexually Transmitted Diseases
- Maternal and Infant Health
Sample source list for obesity/overweight:


4. County Health Rankings: http://www.countyhealthrankings.org/policies


6. Strategic Directions and Examples of CDC-Recommended Evidence and Practice-Based Strategic Table: http://www.ehhd.org/filestorage/103/272/996/RecommendedEvidenceandPracticeBasedStrategies.pdf
## Evidence-Base Snapshot: Obesity/Overweight

### Long-Term Goal: Reduce obesity/overweight among at risk populations

<table>
<thead>
<tr>
<th>Evidence-informed intermediate goals</th>
<th>Evidence to inform strategies (sample list)</th>
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<tr>
<td>Increase physical activity</td>
<td><strong>Access and availability</strong>&lt;br&gt;Develop joint use agreements to allow public access to existing facilities&lt;sup&gt;4&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td><strong>Knowledge, attitude, skills</strong>&lt;br&gt;Behavioral interventions to reduce screen time&lt;sup&gt;4&lt;/sup&gt;</td>
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<tr>
<td>Increase healthy eating</td>
<td><strong>Access and availability</strong>&lt;br&gt;Increase the availability of lower-calorie and healthier food and beverage options for children in restaurants&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
<tr>
<td>Improve Weight management skills</td>
<td><strong>Clinical care</strong>&lt;br&gt;Clinicians screen for obesity in children ages 6 years and older and offer them or refer them to comprehensive, intensive behavioral interventions to promote improvement in weight status&lt;sup&gt;5&lt;/sup&gt;</td>
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### KP Approaches to Developing Strategies

| Programs and Services | • Any core program, service, or operation that KP provides as part of the CB portfolio, which are provided year after year and will not be discontinued.  
  • *Examples: Educational Theatre, Medi-Cal, GME* |
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<td>Community Investments</td>
<td>• Grants and other monetary contributions to external community partners.</td>
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</table>
| Leveraging Organizational Assets | • Materials, time, expertise, and/or other resources that KP provides to respond to community needs  
  • *Examples: screenings, education classes/materials, Surgery Days, clinical guidelines/processes* |
| Collaboration and Partnerships | • Engagements with community partners to address the health need and/or its drivers. Efforts are no necessarily reliant on the provision of programs, grants or assets.  
  • *Examples: serving on organizational boards, participation in a collaborative or community planning group* |
Long Term Goal: KFH-San Diego aims to reduce obesity/overweight and prevent Type 2 Diabetes and improve management of this disease among vulnerable populations through:

**Programs**
- Educational Theatre Program’s Amazing Food Detective to educate students on healthy eating and active living
- KP Physician Champion conducts diabetes self-management education in community gathering places for adults with Type 2 diabetes

**Community Investments**
- Grants to organizations that work on environmental and policy change efforts related to healthy eating and physical activity
- San Diego Childhood Obesity Initiative’s Leadership Council to promote environmental and policy change related to healthy eating

**KP Assets**

**Collaboration/Partnerships**
**Goals/Strategy Example: Colorado**

**Long-term Outcome**
- Increase access to affordable, healthy foods, expand opportunities to lead physically active lifestyles and build economically vibrant communities in the KP Colorado service area

**Intermediate Outcome**
- Increase the number of policies, community programs and social and economic resources to support and promote healthy eating

**Strategy**
- **Grant-making** to increase access to daily recommended levels of physical activity before, during, and after school

**Expected Outcomes**
- Increased number of children who get recommended daily minutes of physical activity
Total Health Impact

Total Health Impact – Leveraging Multiple Assets of KP

- Procurement & Supply
- Health Care Services
- Treasury
- Environmental Stewardship
- National Facility Services
- Technology
- Human Resources
- Communications
- Research
- Government Relations
- Labor Mgmt Partnership
- Community Benefit
Deploying Kaiser Permanente Assets for Total Health

Physical and Mental Health Care
“Body, Mind and Spirit”

Individual / Family

Home / School / Worksite

Neighborhood / Community

Society

Clinical Prevention

Health Education

Walking Promotion

Access to Social and Economical Supports

Worksite / Workforce Wellness

Public Policy

Research and Technology

Community Health Initiatives

Environmental Stewardship

Public Information
Strategy Example: Leveraging External Partnerships and Internal Assets for Impact

**External Partners**
- Improving food systems
- Safe transportation and public spaces
- Improving access and linkages to care systems

**KP Resources**
- Cultivating Physician Champions and Graduates
- Supporting Community Access to Care
- Improving Safety-Net Provider Capacity
Strategic Planning

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

Grants, Programs, Assets, Partnerships

Address Health Needs & Improve Health

Expected Outcomes and Impacts?

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

Evaluation
## Improving Prevention, Detection, and Treatment for Obesity, Diabetes, and Heart Disease

**Goal:**
Improve prevention, detection, and treatment for all persons who have or are at risk of obesity, diabetes, and/or heart disease.

<table>
<thead>
<tr>
<th>Population Impact</th>
<th>Desired Outcomes</th>
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<tr>
<td>A. Increased proportion of community members that consume healthy foods.</td>
<td>DO 1.1 Improved policies that enable access to healthy foods</td>
</tr>
<tr>
<td>B. Increased proportion of community members that are physically active</td>
<td>DO 1.2 Decreased access of unhealthy foods and beverages</td>
</tr>
<tr>
<td>C. Increased proportion of community members who manage their chronic conditions effectively</td>
<td>DO 1.3 Increased proportion of schools that offer healthier foods and beverage options</td>
</tr>
<tr>
<td>D. Reduced incidence and prevalence of obesity, diabetes, and heart disease.</td>
<td>DO 1.4 Increased number of healthy food outlets</td>
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### Strategic Priorities

<table>
<thead>
<tr>
<th>SP 1. Increase access of healthier food options</th>
<th>SP 2. Increase policies and environments that enable daily physical activity</th>
<th>SP 3. Improve quality of care provided to individuals who have or at risk of obesity, diabetes and/or heart disease*</th>
<th>SP 4. Improve the knowledge, skills, and beliefs of individuals to support healthy behaviors</th>
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<tr>
<td>DO 2.1 Enhanced policies that promote walkable and bike-able communities</td>
<td>DO 2.2 Increased proportion of schools that meet daily physical education requirements and recommendations for all students</td>
<td>DO 3.1 Increased proportion of patients who are regularly assessed for obesity, diabetes and/or heart disease</td>
<td>DO 4.1 Improved capacity of individuals to manage their chronic conditions</td>
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<tr>
<td>DO 2.3 Increased proportion of settings that offer physical activity opportunities and spaces</td>
<td>DO 3.2 Increase proportion of patients that have their glycemic, lipid, and/or blood pressure under control</td>
<td>DO 3.3 Increased proportion of patients who receive linguistic and culturally appropriate education &amp; counseling to prevent and manage diabetes, obesity, and heart disease</td>
<td>DO 4.2 Improved capacity of individuals to recognize and make healthy behavioral choices regarding food/beverages and physical activity</td>
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### Obesity & Related Conditions

**DO 2.1 Enhanced policies that promote walkable and bike-able communities**

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**DO 4.1 Improved capacity of individuals to manage their chronic conditions**

**DO 4.2 Improved capacity of individuals to recognize and make healthy behavioral choices regarding food/beverages and physical activity**
NCAL Regionwide Access to Care Investment Framework 2014-16

**Long-Term Goal**

All community members have access to high quality health care services in coordinated delivery systems

**Intermediate Goals**

- Increase Coverage & Access to Health Care
  - for low income and uninsured populations

- Improve Health Care Services & Delivery System
  - for low income and uninsured populations

- Increase Access to Social Non-Medical Services
  - for vulnerable and low income populations

**Investment Strategies (Grants & Assets)**

- Support outreach, enrollment & retention efforts
- Maintain services for those without coverage
  - KP participation in Medi-Cal
  - KP Charitable Coverage
  - KP MFA/Charity Care
  - KP volunteers – Operation Access

- Increase capacity to manage chronic conditions
- Increase care coordination across systems - right care/place/time
- Promote integration of care (primary/behavior care)
  - KP Physician champions, technical assistance
  - KP QOS consulting
  - KP RHE materials and classes

- Support promising models for managing non-medical needs
- Increase and systematize navigation and Information & referral systems.
  - KP Pilots

**Outcomes**

- Core: # grants, total $ in grants
- # people reached
- Examples: # people enrolled
- # people who retain coverage
- #, types of services

- Core: # grants, total $ in grants
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- Examples: Use of data for clinical, operational decision making
- Clinical data: # HGA1C, blood pressure control, RX adherence
- Improved financial metrics, & operational efficiencies

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- Examples: # of people referred
- Use of social non-medical services

**Investment Strategies & Outcomes**

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Lessons Learned

Focus on Non-Medical and Social Needs

- Aligned and standard approach across hospitals – new language and framework
- Surfaced new & emerging health needs
- Better understand the drivers and disparities of health needs identified
- Continue focusing on ‘upstream’ prevention – policy, systems and environments

Strategy and Evaluation

- Better understanding of how to address health needs through evidence-base research and best practices
- Move toward outcome-driven strategy planning
- Distinguish between attribution vs contribution
Lessons Learned

Collaboration and Shared Accountability

- Stimulate deep thinking about Kaiser Permanente's role as an anchor institution and potential to impact Community Health
- More intentional about leveraging KP assets and partnerships - both within and outside our walls
- More intentional community engagement to inform both health needs as well as strategies to address those needs.
- Identify all community partners co-accountable toward population health – including public health departments and other hospitals serving same/similar populations.
- Better understand how to collaborate and around which process areas (e.g. primary data collection and strategy)
- Identify shared outcomes among accountable partners
Contact and Resources

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Community Health Needs Assessment and Strategy Reports
KP.org/chna

Community Health Needs Assessment Data Platform
CHNA.org   CHNA.org/kp

County Health Rankings & Roadmaps
http://www.countyhealthrankings.org/