



Looking Back and Looking Forward: Community Health Needs Assessments in the San Francisco Bay Area

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Outline

- Community benefits and community health needs assessments (CHNA) legislative history
- CHNA components
- Schematic for evaluation of CHNAs
- Summary of findings
- Next steps



Community Benefits & CHNAs

- 1969: IRS redefines charity, focus on community benefit
- Community benefit: the promotion of health for a class of persons sufficiently large so that the community as a whole benefits
 - ▣ Improve access to healthcare services
 - ▣ Enhance the health of the community
 - ▣ Advance medical or health knowledge
 - ▣ Relieve or reduce the burden of government or other community efforts



Evolution of CHNA Requirement

- 1994: California passes SB 697
- 1997: Community Benefit reports made public
 - ▣ Submit to the Office of Statewide Health Planning and Development (OSHPD)
 - ▣ CHNA not submitted to OSHPD
- 2010: Affordable Care Act
- 2012: New IRS requirement goes into effect
 - ▣ CHNA conducted every 3 years and made public
 - ▣ Community benefit plan submitted annually



CHNA requirements—501 (c)3 Hospitals

- CHNA should include input from:
 - ▣ Persons with special knowledge of or expertise in public health
 - ▣ Federal, tribal, regional, State, or local health or other departments or agencies
 - ▣ Leaders, representatives, or members of medically underserved, low-income, and minority populations, and populations with chronic disease needs, in the community served by the hospital facility



APHA, NACCHO, ASTHO et al.

Consensus Statement

- Define “special knowledge of or expertise in public health” as: persons with public health training or experience who possess technical CHNA competencies
- Hospitals should consult state **and** local health departments
 - Consultation should be documented



Key Elements of CHNA Report (per IRS)

- Community served by hospital
- Process of conducting CHNA
- Broad community input
- Prioritized health needs
- Community resources
- Implementation plan
- Widely available to public



Implementation Plan

- How identified needs will be met
- Why certain identified needs will not be addressed
- Any planned collaboration with governmental, non-profit, or other health care organizations, in meeting health need



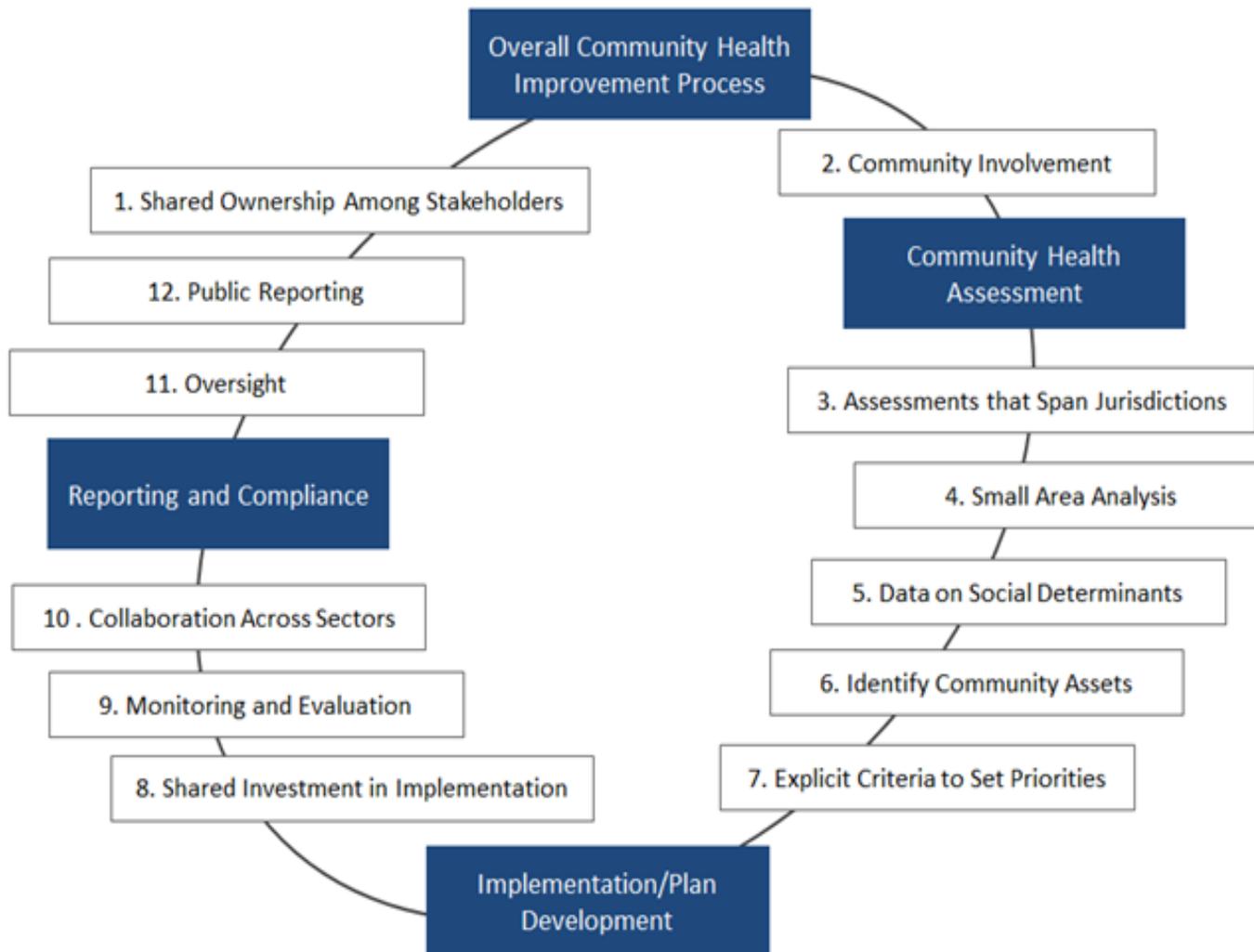
Objective

- Identify strengths, challenges, and opportunities for further collaboration between public health and health care on community health needs assessment



Methods

- Review of CHNA models
- Development of CHNA Descriptive Framework
- Systematic review of 9 San Francisco (SF) Bay Area CHNAs
 - ▣ Conducted under SB 697 between 2008–2011



Stephen Fawcett, Christina Holt, and Jerry Schultz. Work Group for Community Health and Development / World Health Organization Collaborating Centre, University of Kansas



CHNA Descriptive Framework

- Authorship
- Collaboration & Stakeholders
- Process
- Data
 - ▣ Demographics, inequities
 - ▣ Chronic, communicable disease, mortality
 - ▣ Maternal, child, adolescent health
 - ▣ Mental health, substance use/abuse
 - ▣ Health care access, utilization, services
 - ▣ Built environment, community safety, education, transportation
- Priorities & Implementation Plan
- Measurement of impact



CHNA Reports—SF Bay Area

- Reports ranged from 54–277 pages & a website
- Authorship
 - Hospital vs. health department lead team
 - Multi-organization team vs. consultants
- Collaborations & Stakeholders
 - Static report vs. on-going community-based process
 - 6/9 included hospitals, health departments, CBOs, and other stakeholders
- Process
 - Variability in documentation
 - 6/9 do not include survey or focus group data
 - 7/9 included sub-county level data
- Priorities & Implementation Plan
 - 3/9 identified priorities or implementation plans

CHNAs in SF Bay Area: Data

Data included	N=9 No. (%)
Demographic	8 (89)
Languages/linguistic isolation	7 (78)
Vital statistics	8 (89)
Maternal, child, adolescent Health	8 (89)
Chronic disease	9 (100)
Communicable disease	7 (78)
Mental health/substance use/abuse	9 (100)
Health inequities/disparities	9 (100)
Access to healthcare	9 (100)
Behavioral risk factor	9 (100)

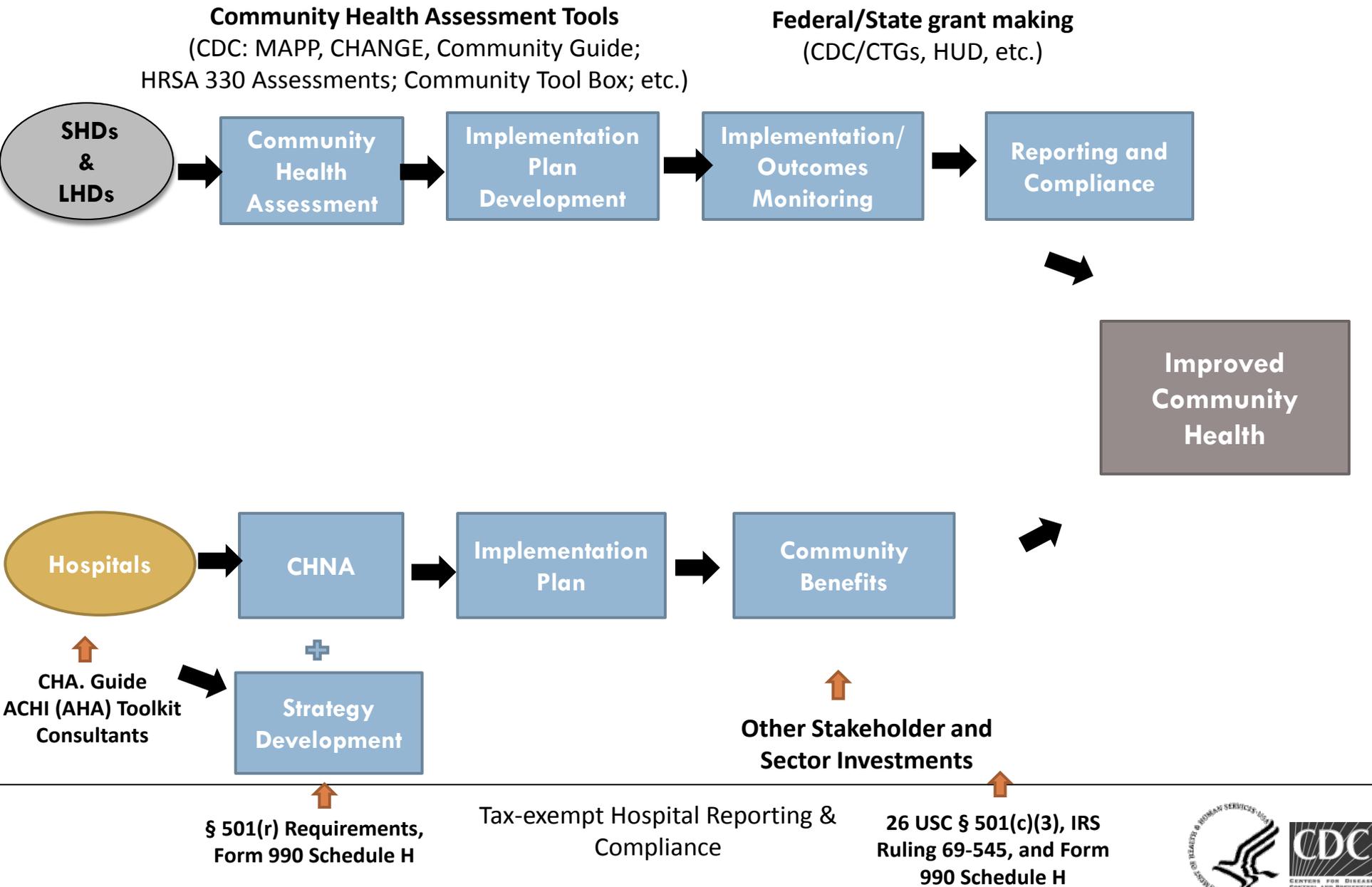


Limitations

- Review of published CHNA only
- Resource and staff constraints not evaluated

A QI Approach to Community Health Improvement

A Framework for Alignment and Shared Accountability





Unanswered questions

- Synchronize SB 697, IRS requirement, public health accreditation, and other CHNAs
- No gold standard practice
 - ▣ Balance need to standardize and individualize
- Collaboration
 - ▣ Resources
 - ▣ Staff
 - ▣ Leadership
- Measurement & impact
- Accountability & oversight

Thank You!

- CDPH
 - James Watt
 - Joan Chow
 - Pennan Barry

Questions & Local Experiences?



Public health is at its best when we see—and help others see—the faces and lives behind the numbers.

Bill Foege



CHNA Data Sources

- <http://www.Healthycity.org>
- <http://communityindicators.net/>
- Census, American Community Survey, American Housing Survey
- Behavioral Risk Factor Surveillance Survey (BRFSS), Youth Risk Behavioral Surveillance System
- California Health Interview Survey
- California Healthy Kids Survey, California Department of Alcohol and Drug Programs
- Community/Built Environment
 - City/Town/regional planning
 - Safety/Crime data
 - Housing, Foreclosures data, Homelessness survey
- Department of Education, Department of Finance
- National School Lunch Program Participation, California Nutrition Network
- WIC data
- Hospitalization Data: Hospitals, OSHPD



Assessments span jurisdictions

- Identify community health goals and target populations
- Characterize the broader context, contributors to community health, ongoing efforts
 - ▣ Demographics & Surveillance Data
 - ▣ Moderators: Health disparities/inequities, access to care, food insecurity, cultural barriers, education, transportation, housing, crime/safety
 - ▣ Community context: resources, political will, leadership



Small area analysis

- Identify communities with disproportionate unmet health needs in particular places
 - ▣ Geography: sub-county, census tracts, zip code
 - ▣ Specific population: race/ethnicity, children, women...
- Mapping by zip code, neighborhood, census tract
 - ▣ Sharing of hospital utilization data



Synchronizing Efforts

- Community health needs assessment is dynamic
- Public health accreditation
- CDC Community Transformation Grant
- Communities Putting Prevention to Work
- Local planning



Kaiser Permanente, 2010

- Northern California: \$809 million
- Southern California: \$634 million
- All other areas/regions: \$364



Community Benefit Breakdown

	2010 (millions)	Percentage change from 2009
Charity Care	\$505 (28%)	18%
Medicaid Members	\$568 (32%)	14%
Medicaid Non-members	\$193 (11%)	8%
Medical Research and Libraries	\$157 (9%)	26%
Children's Health Insurance Program	\$125 (7%)	10%
Grants and Donations	\$89 (5%)	-45%
Health Professions Training Programs	\$79 (4%)	-3%
Other Community Service Activities	\$38 (2%)	-22%
Funding to States for Vulnerable Populations	\$34 (2%)	4%
Consumer Health Education	\$20 (1%)	3%

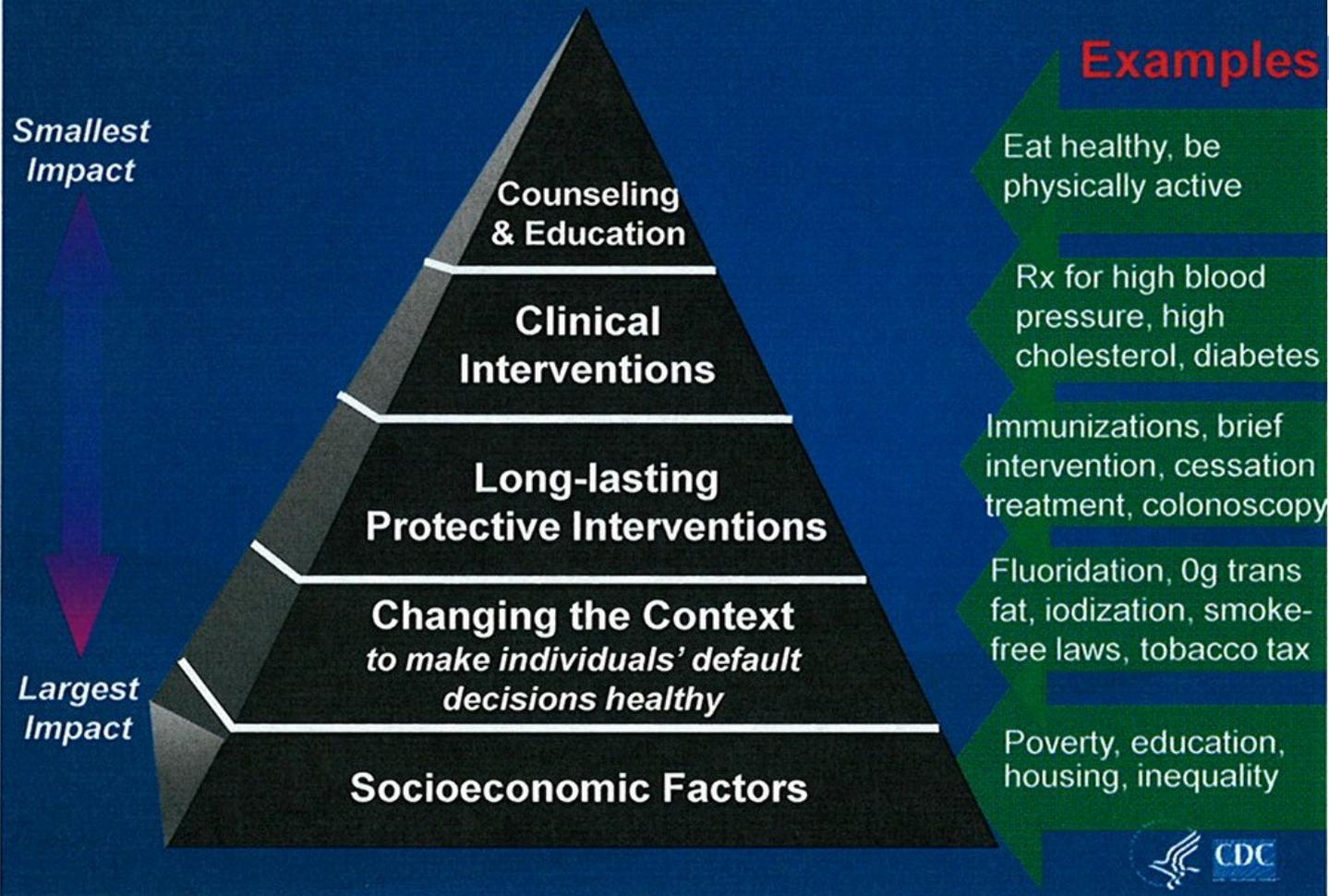
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Factors that Affect Health





Multiple hospitals

- Multiple hospitals
 - ▣ “If a hospital operates more than one hospital facility, 501(r)(2)(B)(i) requires the organization to meet all of the section 501(r)(i) requirements including the CHNA requirements separately with respect to each hospital facility.”



Data

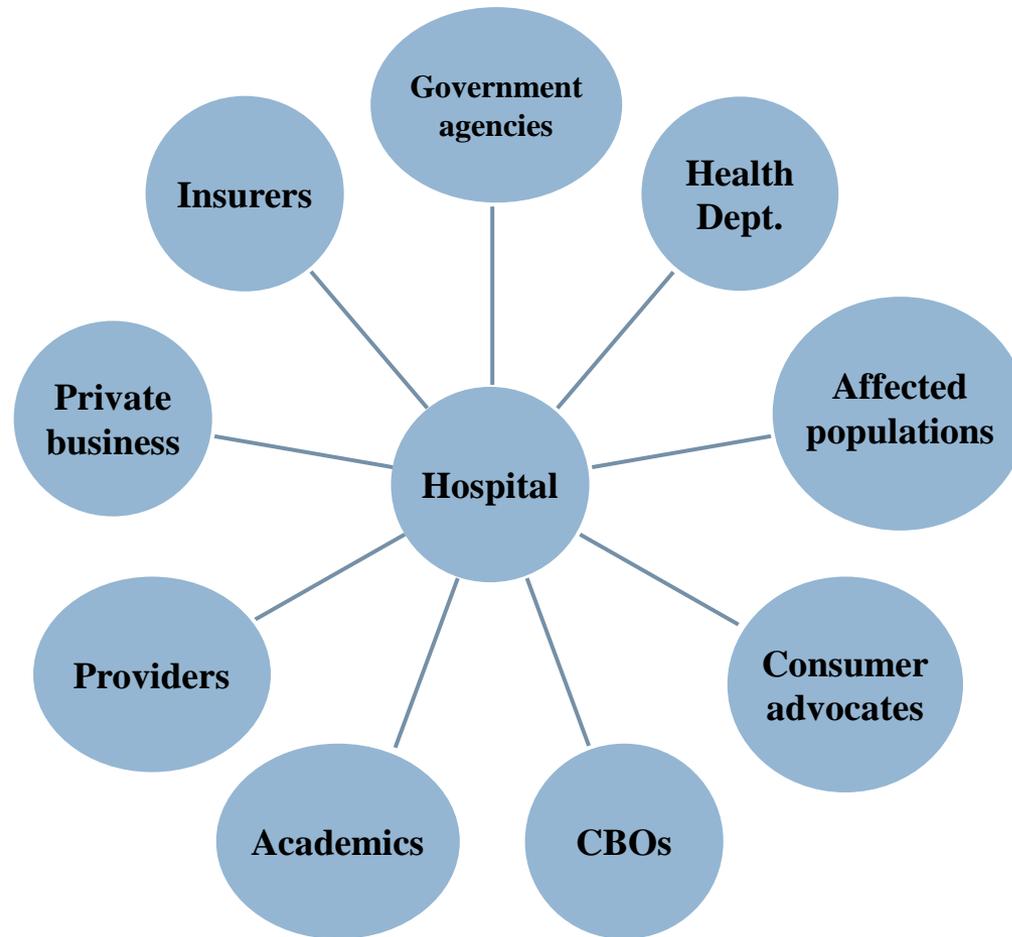
- Demographics: race/ethnicity, SES, age distributions
- Vital statistics
- Maternal-child health
- Access to health care and clinical services
- Behavioral risk factor data
- Chronic & Infectious Diseases
- Mental Health/Substance Abuse/Tobacco/Alcohol
- Environmental Health/Built Environment
- Health inequities



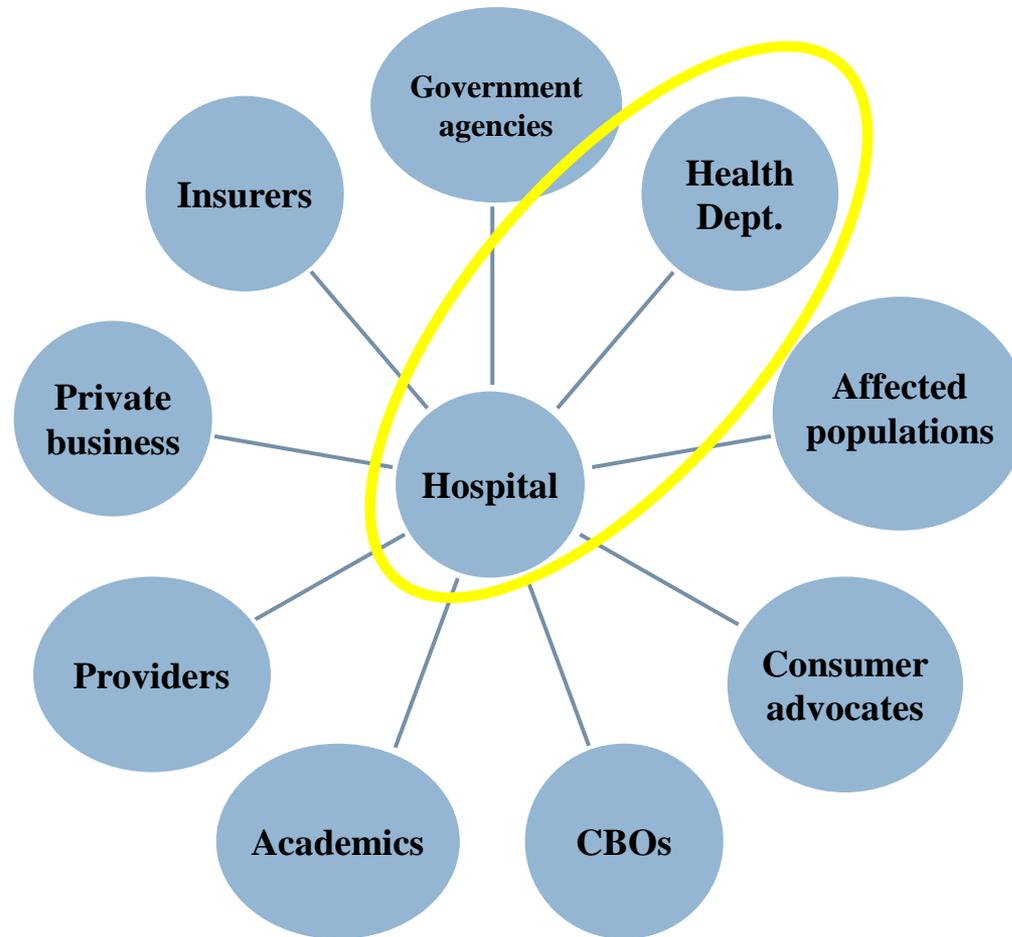
How can we ensure CHNA...

- Accurately identify priority community health problems
- Responsive community health improvement plans
- Public health agencies, community stakeholders, and hospitals address these problems in a collaborative, coordinated, and non-redundant way?

CHNA Opportunities for Collaboration



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