DSRIP Population Health Projects:

Introduction to Population Health and Community Needs Assessment

June 2014

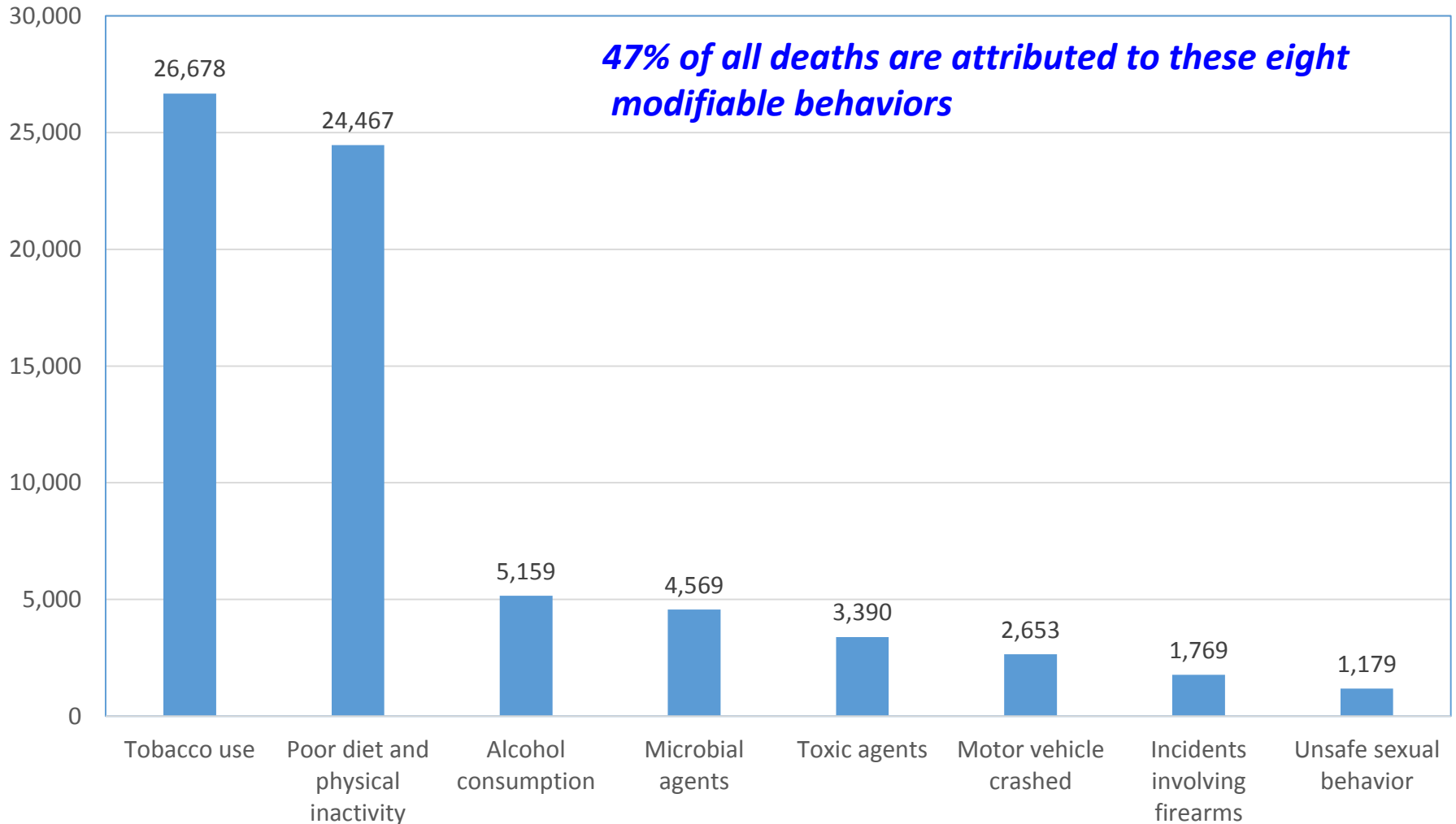Office of Public Health

NYS Department of Health

Agenda

A. Introduction to Population Health and Community Needs Assessment, required by DSRIP.

B. Overarching theme – Link to the NYS Prevention Agenda 2013-2017. (for info, click icon at www.health.ny.gov)

   1) 2013 County Health Department Community Health Assessments and Health Improvement Plans
   2) 2013 Hospital Community Service Plans

C. DSRIP Population Health Projects' Future Webinars

   1. Cardiovascular Health
   2. Diabetes Prevention and Control
   3. Asthma Control
   4. Tobacco
   5. HIV, HCV and STD Care and Prevention
   6. Maternal and Child Health
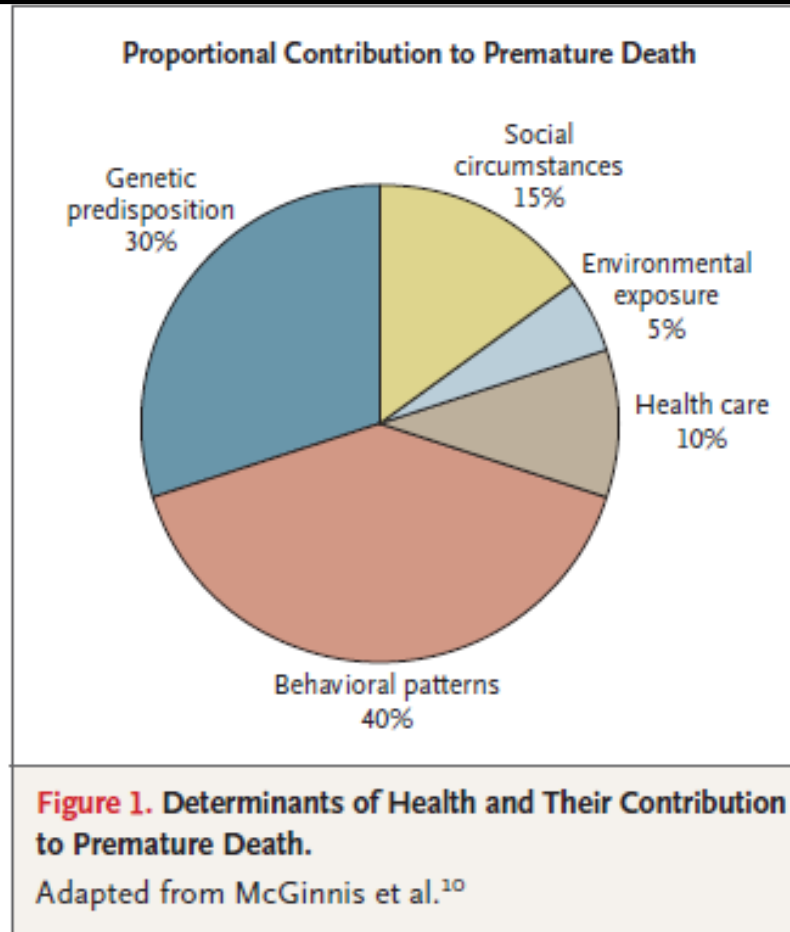
Leading Causes of Death, New York State, 2000 - 2011
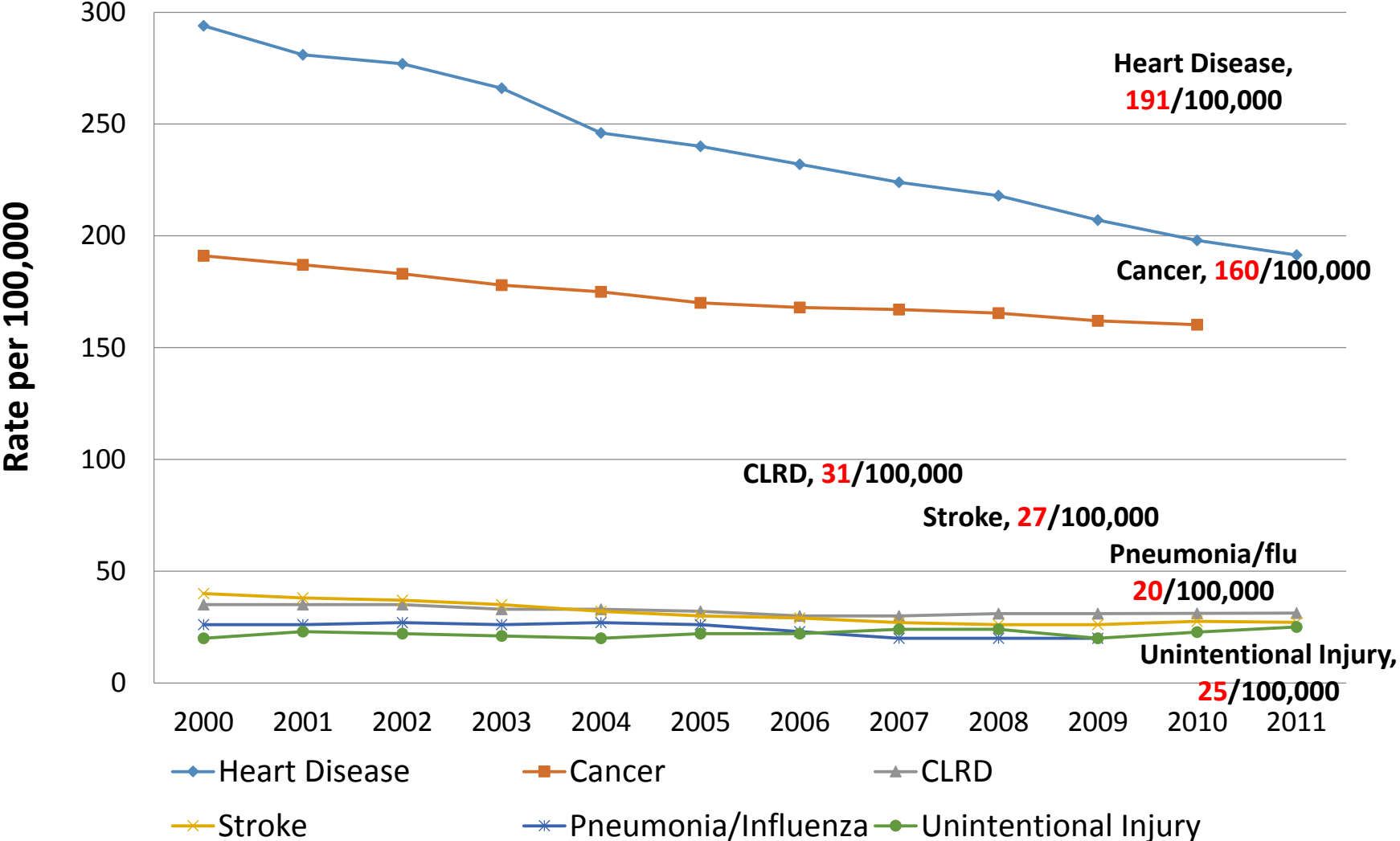
Rates are age-adjusted to the 2000 U.S. population

Estimated Number of Deaths Due to Modifiable Behaviors, New York State, 2012

47% of all deaths are attributed to these eight modifiable behaviors

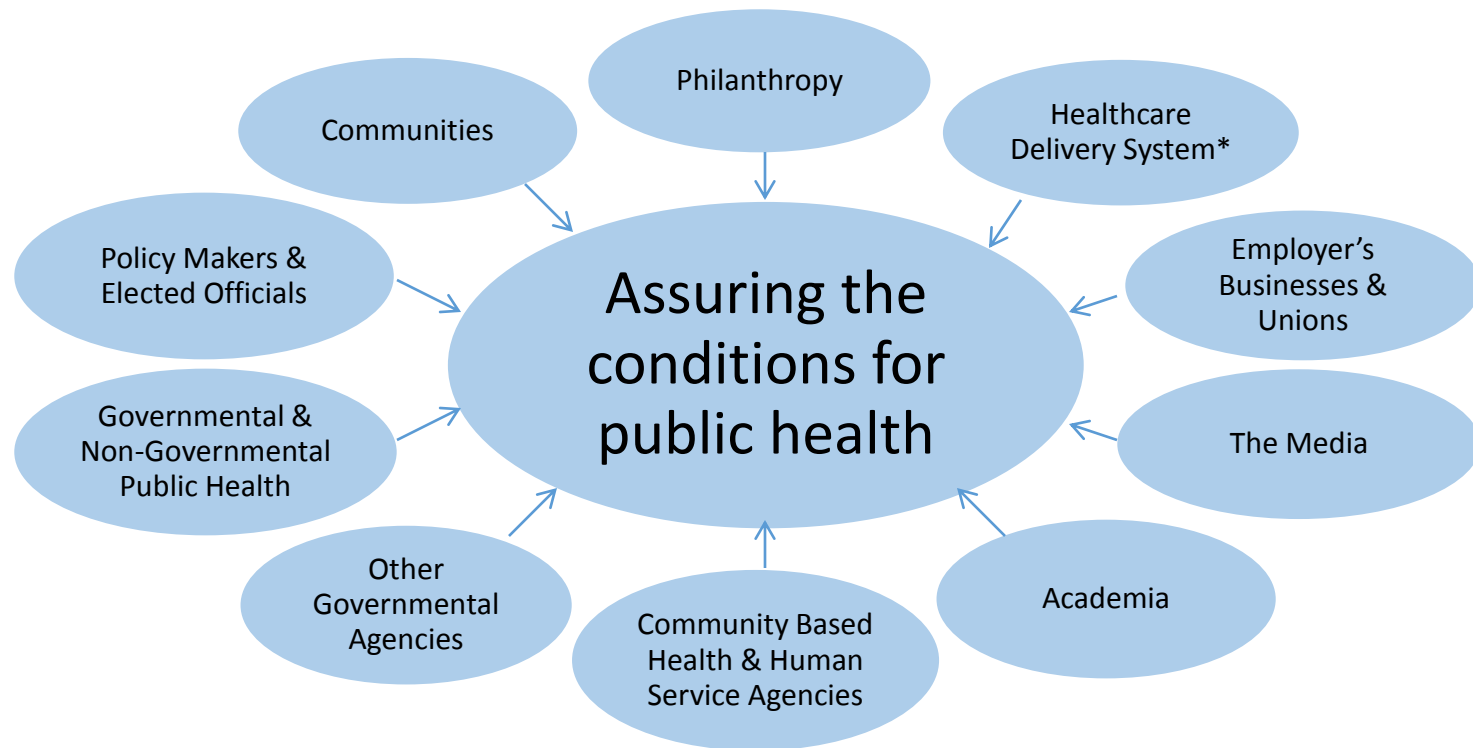| Behavior	Deaths
Tobacco use	26,678
Poor diet and physical inactivity	24,467
Alcohol consumption	5,159
Microbial agents	4,569
Toxic agents	3,390
Motor vehicle crashed	2,653
Incidents involving firearms	1,769
Unsafe sexual behavior	1,179

Estimates were extrapolated using the results published in "Actual Causes of Death in the United States, 2000" JAMA, March 2004, 291 (10) and NYS 2012 Vital Statistics data

What Determines Health?

Proportional Contribution to Premature Death

Genetic predisposition 30%

Social circumstances 15%

Environmental exposure 5%

Health care 10%

Behavioral patterns 40%

Figure 1. Determinants of Health and Their Contribution to Premature Death.

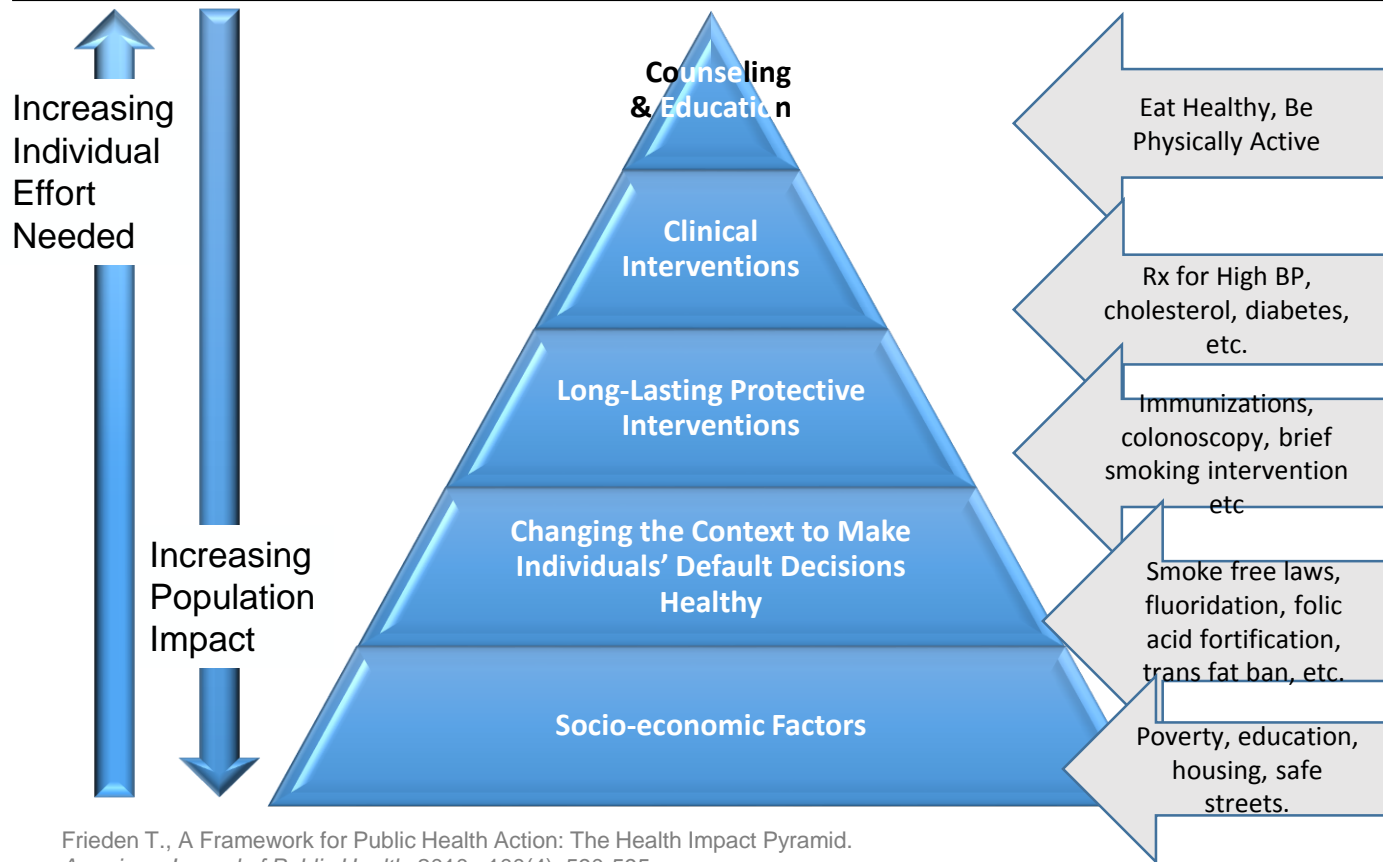Adapted from McGinnis et al.[10]

Schroeder *NEJM 2007*

5

The Public Health System

Adapted from : The Future of the Public's Health in the 21st Century. IOM 2003

Health Impact Pyramid
Framework for Improving Health

Increasing Individual Effort Needed

Increasing Population Impact

Counseling & Education

Clinical Interventions

Long-Lasting Protective Interventions

Changing the Context to Make Individuals' Default Decisions Healthy

Socio-economic Factors

Eat Healthy, Be Physically Active

Rx for High BP, cholesterol, diabetes, etc.

Immunizations, colonoscopy, brief smoking intervention etc

Smoke free laws, fluoridation, folic acid fortification, trans fat ban, etc.

Poverty, education, housing, safe streets.

Frieden T., A Framework for Public Health Action: The Health Impact Pyramid. *American Journal of Public Health.* 2010; 100(4): 590-595

Community Needs Assessment

- CNA Guidance on DSRIP website:

http://www.health.ny.gov/health_care/medicaid/redesign/dsrip_community_needs_assessment.htm

- To choose the most effective projects, the PPS needs to understand the broad health status and health care system in the geographic region in which they are functioning

- The assessment forms the basis and justification for system transformation, clinical improvement and population health improvement.

- Build on recently completed community health assessments tied to Prevention Agenda

Prevention Agenda and Local Community Needs Assessments

- As part of *Prevention Agenda 2013-17,* all 58 local health departments completed a Community Health Assessment and 148 hospitals completed Community Service Plans that included a community health needs assessment.

- Access to these assessments is available on PA Website:

    http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/docs/chip_csp.pdf

- Good assessments are listed here:

    http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/implementation/examples.htm

- Every local health department and hospital received feedback highlighting strengths and opportunities for improvement.

What Makes a Good Needs Assessment?

- "Good" assessments have the following strengths[*]:
  - Clearly state purpose of assessment
  - Compare data with similar communities, benchmarks and over time
  - Document process and methods
  - Include secondary and primary data
  - Organized and presented in an easy understand manner
  - Serve as resource to prioritize and plan services (should be the basis of each DSRIP plan)

  [*] Stoto MA, Straus SG, Bohn C, Irani P. "Assessing and improving the usefulness of community health assessments: A web-based tool for obtaining feedback from users." Journal of Public Health Management and Practice. (2007)

Good Examples of Community Health Assessments

COMMUNITY HEALTH NEEDS ASSESSMENT

Improved health trends (continued)

- Positive blood lead in children less than 72 months of age decreased in the last decade
- Smoking decreased in the Capital District, with all three counties having lower current smoking rates than the Rest of State
- Particularly in lower income, inner-city neighborhoods, many of the comparative health rates (e.g., mortality, etc.) are 3 to 7 times higher than the county average

Measurements not as positive (continued):

- While the Capital District had good health insurance coverage, still slightly less than 10% of residents were not covered by any form of health insurance
- Obesity and its related diseases were also health issues in the Capital District:
  - Adult residents had seen an increase in obesity since 2003, with rates equal to or greater than Rest of State
  - Obesity in the Capital Region's school childre[n] Schenectady Counties having childhood obesit[y]
- Diabetes prevalence in adults increased since 2003
- Asthma ED visit and hospitalization rates were also h[igher than] Rest of State, with hospitalization rates showing an incr[ease]
- Positive blood lead in children less than 72 months of a[ge] of State.
- Similarly, while the trend is decreasing, Albany and Sch[enectady] with the highest gonorrhea rates
- Chlamydia rates were also much higher in the Capital Dis[trict] decade
- Albany and Rensselaer Counties presented some of the h[ighest] York State
- Substance abuse indicators also show there is a grow[ing problem] including:
  - Drug-related hospitalization and newborn drug-rela[ted] than Rest of State, with increasing trends
  - Binge drinking had also increased in the Capital Dis[trict]

Albany Medical Center is part of the Healthy Capital District Initiative (HCDI). They looked at strengths and gaps through a comprehensive data set, and set criteria for selecting priorities.

HCDI focused the presentation on:

- health conditions where two of the three counties in the region had higher or significantly higher rates than other Upstate counties; or
- a very high number of people in the region were impacted; or
- the disparity between rates for the general population and a sub-population was high

In a series of three Prioritization Task Force meetings, a total of 19 health indicators that met these criteria were presented. For each selected indicator, data was presented as available on prevalence; then rates for mortality, hospitalizations, emergency department visits and health behaviors; trends over the past 10 years; and equity data for gender, age, race/ethnicity, and neighborhood groupings when available.

Task force participants shared their views for each indicator on three dimensions:

1. the impact of the condition on quality of life and cost of health care
2. community awareness and concern about the condition
3. the opportunity to prevent or reduce the burden of this health issue on the community.

Source: http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/docs/chip_csp.pdf From among 58 local health department (LHD) Community Health Assessments-Community Health Improvement Plans (CHA-CHIPs) and 148 hospital Community Service Plans (CSPs) submitted in 2013 and reviewed.

Good Examples of Community Health Assessments..contd

Group 9
Vision of a healthy community: This group illustrated a healthy community in terms of incorporating green spaces, safe play spaces and community gardens with access to fresh vegetables in a setting where different perspectives are shared and voices are heard. They described the importance of parents, children, seniors and health care workers each having a voice in the decisions that are made in the community. The group illustrated the importance of respecting cultural diversity by adding religious symbols and incorporating different colored stick figures arranged in a circle holding hands.

Oneida County Department of Health creatively engaged stakeholders in visualization process to identify strengths, weaknesses, opportunities and threats (SWOT).

Threats	Opportunities
Funding *Stressors ("Tyranny of the moment") Perceived competition ($, "clients", etc.) *Geography (Transportation) & Social Factors (teen pregnancy, education, isolation, employment, etc.) Diversity (Language) Physician Shortages	*"Self Care" & Wellness are "In" & Fun Community Involvement *Welcoming new businesses Existing Coalitions & potential collaborations Retaining college students after graduation Funding moving to health & wellness opportunities Diversity (ideas, experiences, etc.) Continued "Stop ACES" initiative Make exercise "fun"

* Top 2

Health Systems	Health Status
*Shortage of Physicians including specialists Cost of health care	Birth Outcomes & Maternal Child Health Lead *Obesity – childhood & adult

Good Examples of Community Health Assessments.. contd

Mercy Medical Center (Nassau County)
used multiple data sources

2. **Mercy Medical Center Local Health Needs Assessment: Process, Methods, and Results.**

The assessment of needs specific to Mercy's service area was made on the basis of several sources of data:

- A community health needs assessment survey distributed widely (see I.3(a)) by Mercy throughout the service area resulted in 244 persons completing the survey to date. It is a 19-question health assessment survey in which respondents were asked about their own health and health concerns/needs and (in the case of one question) those of "you and your neighbors".
- Zip code-level data from the U.S. Census and from the New York State Prevention Quality Indicators website[7].
- County data sources such as the Nassau County Diabetes Report and the 2010 Update of the Nassau County Community Health Assessment (a 3-volume report not to be confused with the Nassau County Health Needs Assessment described above)[8].
- NYSDOH hospitalization data through SPARCS (Statewide Planning and Research Cooperative System), a comprehensive data reporting system between the healthcare industry and government.
- Mercy internal records and the first-hand experience of Mercy's outpatient clinicians.

Components of a Community Needs Assessment

A. Description of the Community to Be Served

B. Description of health care and community resources available

C. Identification of Health/Health Care Challenges

D. Summary of Assets and Resources to be Mobilized

E. Summary of Proposed DSRIP Projects

F. Documentation of Process and Methods Used to Conduct Assessment and to Obtain Input from Community

http://www.health.ny.gov/health_care/medicaid/redesign/dsrip_community_needs_assessment.htm

A. Description of the Community

1. Demographics:
   - Assessment of Medicaid and uninsured population
   - Distribution of population related to gender, race, ethnicity, age, income, disability status, mobility, educational attainment, housing, insurance status, employment status

2. Health Status of Population and Distribution of Health Issues
   - Leading Causes of Death and Premature Death
   - Leading Causes of Hospitalization and Preventable Hospitalization
   - Analysis of Medicaid data for population proposed to be served
   - Rates of Ambulatory Care Sensitive Conditions
   - Disease Prevalence
   - MCH outcomes
   - Health Risk Factors
   - Access to Health Care
   - Quality of Health Care
   - Population health measures (see the Prevention Agenda Dashboard at https://health.ny.gov/preventionagendadashboard

- Pay Particular Attention to Metrics in Domain 3 and 4

B. Description of Health Care and Community Resources

1. Description and assessment of availability, accessibility, affordability, acceptability and quality of health services and issues that may influence utilization of services.

- Refers to both medical and behavioral health services

Health Care resources can include:

Hospitals, ambulatory surgical centers, urgent care centers, health homes, federally qualified health centers, primary care providers, specialty medical providers, dental care, rehab services, behavioral health services, local health departments, home care resources, pharmacies, laboratories, managed care organizations, area health education centers, etc.

- Pay Particular Attention to Metrics in Domain 2

B. Description of Health Care and Community Resources

2. Description and assessment of capacity, service area, population served, gaps and any areas of expertise

Community Resources include:

Housing services for the homeless, food banks, community gardens, clothing and furniture banks, specialty education programs for special needs children, community outreach/service agencies, transportation services, religious service organizations, peer and family mental health advocacy organizations, libraries with open access computers, educational agencies, family support organizations peer supports, alternatives to incarceration, HIV Prevention/Outreach Services, etc.

List of DOH Public Health and Community Contracts with expertise in population health areas in Domain 3 and 4:

http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/contractor_map.htm

- Pay Particular Attention to Metrics in Domain 2

C. Identification of Main Health and Health Care Challenges Facing the Community

Discussion of contributing causes of poor health status, including broad determinants of health, such as:

➢behavioral risk factors,

➢environmental risk factors (the natural and built environment, including geography),

➢socioeconomic factors,

➢policy environment (e.g., smoke-free parks, menu labeling, zoning for walkable communities, etc.),

➢service gaps,

➢factors related to access to health insurance and health services,

➢other unique characteristics of the community that contribute to health status.

D. Summary of Assets and Resources to be Mobilized to Address Projects

These may include as partnerships with community-based providers and services

Could include local health department, hospitals and health care providers and community-based organizations; businesses; academia; the media; and resources available through other sectors of government.

Tie needs assessment finding directly to your proposed DSRIP projects.

E. Summary Chart of Projects Selected for Implementation

Each PPS should prepare an Excel document that lists by Domain the projects chosen for implementation with a clear summary of the community needs assessment findings, linked to DSRIP measures.

F. Documentation of process and methods used to conduct assessment and seek input from collaborating organizations

Community input into the assessment and the identification of projects is critical.

Methods to seek input include:

- community/town forums and listening sessions;

- Key informant interviews;

- community focus groups;

- presentations and discussions at other organizations' local meetings;

- Publication of summary of findings in the local press with feedback or comment forms;

- publication on the organization's web page with a website comment form.

Data Resources

New York State Health Assessment 2012

- http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/background.htm

Prevention Agenda Dashboard

- https://health.ny.gov/preventionagendadashboard

DSRIP Data Page

- http://www.health.ny.gov/health_care/medicaid/redesign/dsrip_performance_data.htm

- New York State Office of Mental Health Behavioral Health Planning Data for DSRIP Project

(http://www.omh.ny.gov/omhweb/special-projects/dsrip/index.html)

Resources for Community Needs Assessment

Catholic Health Association, Assessing and Addressing Community Health Needs
http://www.chausa.org/Pages/Our_Work/Community_Benefit/Assessing_and_Addressing_Community_Health_Needs/

Association for Community Health Improvement:
http://www.communityhlth.org/communityhlth/resources/communitybenefit.html

Mobilizing for Action through Planning and Partnerships (MAPP)
http://www.naccho.org/topics/infrastructure/mapp/

Healthy People MAP-IT Framework
http://healthypeople.gov/2020/implement/MapIt.aspx

Empire State Public Health Training Center video modules on data for community health assessment
www.empirestatephtc.org/videos/vid-cadir.cfm

For More Information:

DSRIP Webpage:

http://www.health.ny.gov/health_care/medicaid/redesign/delivery_system_reform_incentive_payment_program.htm

Contact the DSRIP Team:

- Most answers to questions can be found by checking the DSRIP FAQ.
- Still Have Questions? Email the New York State DSRIP Team with your questions and comments at: dsrip@health.state.ny.us.

'Like' the MRT on Facebook:
http://www.facebook.com/NewYorkMRT

Follow the MRT on Twitter: @NewYorkMRT