Community Health Status Indicators: Informing Community Health Assessment and Improvement

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Community Health Needs Assessment and Implementation Strategies – Drivers

- IRS requirements for tax-exempt hospitals and community benefits every 3 years (n>3,000)
- National voluntary public health department accreditation every 5 years (PHAB) (n~2,400)
- Federally Qualified Health Centers (n>1,200)
- Healthy People 2020/National Prevention Strategy
- Other state requirements for needs assessment
- Grant requirements or grant-related activities
Not-for-Profit Hospitals, Atlanta, 2011

Source: Karen Minyard, GSU NNPHI
Local Health Jurisdictions, Atlanta, 2011

Source: Karen Minyard, GSU NNPHI
Final Regulations for Tax-exempt Hospitals

Key Provisions

- Hospital organizations must conduct a community health needs assessment (CHNA) and adopt an implementation strategy for addressing “significant” community health needs at least once every three years.

- Hospitals “may not define its community to exclude medically underserved, low-income, or minority populations who live in geographic areas from which the hospital draws its patients.”

In conducting a CHNA the hospital must *solicit* and take into account input from:

- “At least one . . . governmental public health department . . . with knowledge, information, or expertise relevant to the health needs of that community;
- Members of medically underserved, low-income, and minority populations in the community served . . . or individuals or organizations serving or representing [their] interests . . . ; and
- *Written comments* received on the [hospital’s] most recently conducted CHNA and most recently adopted implementation strategy.”

The hospital must consider the health department and community member “input in identifying and prioritizing the community’s needs, as well as in identifying resources potentially available to meet those needs.”

Health needs may include “financial and other barriers to accessing care, preventing illness, ensuring adequate nutrition, or social, behavior and environmental factors that influence health in the community.”

Final Regulations for Tax-exempt Hospitals
Key Provisions (cont’d)

- In prioritizing significant health needs a hospital “may use any criteria . . . including, but not limited to, the burden, scope, severity, or urgency of the health need; the estimated feasibility and effectiveness of possible interventions; the health disparities associated with the need; or the importance the community places on addressing the need.”

The CHNAs must be made “widely available” to the public (i.e., published on the hospital website).

CHNA’s for tax years beginning after 12/29/2015 must “include an impact evaluation of the actions taken by the hospital on significant health care needs it identified in its previous CHNA.”

Common Elements for the Community Health Improvement Process

- Prepare and organize
- Engage the community
- Develop a goal or vision
- Conduct community health assessment(s)
- Prioritize health issues
- Develop community health improvement plan
- Implement community health improvement plan
- Evaluate and monitor outcomes
Community Health Improvement (CHI) Process

Organize

Assess

Prioritize and Plan

Implement

Monitoring

Improved Health Status

Data and Analytic Tools

Evaluate

Shared Ownership among Stakeholders
Ongoing Involvement of Community Members
Effective Community Health Assessments

4 Products

- **Secondary data analysis** (already collected and analyzed)
  - Compare indicators against peer communities, national & state avgs, HP 2020 benchmarks
  - Examine trends
  - Identify most prevalent, severe and important outcomes and determinants

- **Community opinions**
  - Primary data (qualitative and quantitative)
  - Collected through key interviews, town halls, listening sessions, and surveys
  - Identify community’s prioritized set of outcomes and determinants

- **Assessment of health disparities**
  - Examine secondary data by sex, race/ethnicity, SES, and geography

- **Assets of the Health System and Community**
Holistic model of population health where health outcomes and disparities are the result of complex interactions between health determinants and individual biology and genetics.

Modifiable Determinants + Genetics + Individual Biology

CHI Outcomes & Determinants

• Synthesized 10 seminal sources
  • 2 IOM Reports
  • 3 Published Guidance Reports
  • 2 Professional Organization Web-based Guidance
  • 3 State Health Department Web-based Guidance

• 42 Most Frequently Recommended
  • Health Outcomes
    • Mortality
    • Morbidity
  • Health Determinants
    • Health Care Access/Quality
    • Personal Behaviors
    • Social Factors
    • Physical Environment
<table>
<thead>
<tr>
<th>Health Outcome Metrics</th>
<th>Health Determinant and Correlate Metrics</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mortality</strong></td>
<td><strong>Health Care (Access &amp; Quality)</strong></td>
</tr>
<tr>
<td>Mortality - Leading Causes of Death (9)</td>
<td>Health Insurance Coverage (6)</td>
</tr>
<tr>
<td>Infant Mortality (6)</td>
<td>Tobacco Use/Smoking (8)</td>
</tr>
<tr>
<td>Injury-related Mortality (3)</td>
<td>Age (9)</td>
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<tr>
<td>Motor Vehicle Mortality (3)</td>
<td>Air Quality (4)</td>
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<tr>
<td>Suicide (4)</td>
<td><strong>Health Behaviors</strong></td>
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<tr>
<td>Homicide (4)</td>
<td>Physical Activity (5)</td>
</tr>
<tr>
<td>STDs (chlamydia, gonorrhea, syphilis) (4)</td>
<td>Sex (6)</td>
</tr>
<tr>
<td>AIDS (3)</td>
<td><strong>Demographics &amp; Social Environment</strong></td>
</tr>
<tr>
<td>Tuberculosis (4)</td>
<td>Race/Ethnicity (9)</td>
</tr>
<tr>
<td></td>
<td><strong>Physical Environment</strong></td>
</tr>
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<td>Housing (5)</td>
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* Numbers in parenthesis indicate the number of 10 Guidance Documents that recommended that specific outcome or determinant/correlate.
Assessing Health Status Drivers

- **PHAB Requirement – CHA/CHIP should:**
  - “Consider multiple determinants of health, especially social determinants like social and economic conditions that are often the root causes of poor health and health inequities among sub-populations in their jurisdictions.”

- **IRS Regulation**
  - Health needs may include “financial and other barriers to accessing care, preventing illness, ensuring adequate nutrition, or social, behavior and environmental factors that influence health in the community.”

Health Status Drivers

Factors that Affect Health

- Counseling & Education
- Clinical Interventions
- Long-lasting Protective Interventions
- Changing the Context to make individuals’ default decisions healthy

Social Determinants of Health

Examples
- Eat healthy, be physically active
- Rx for high blood pressure, high cholesterol, diabetes
- Immunizations, brief intervention, cessation treatment, colonoscopy
- Fluoridation, 0g trans fat, folic acid fortification, iodization, smoke-free laws, tobacco tax
- Poverty, education, housing, inequality

Redesigning the Community Health Status Indicators (CHSI) Web-application

[Website Link]

www.cdc.gov/CommunityHealth
**CHSI 2015 Goals**

- **Improve the ability of stakeholders to:**
  - Comprehensively assess health status and identify disparities
  - Promote a shared understanding of the wide range of factors that drive health
  - Mobilize multi-sector partnerships to work collaboratively to improve population health

*CHSI 2015 was designed to complement existing sources of community health indicators including the County Health Rankings & Roadmaps.*
CHSI 2015 Stakeholders

- **Primary**
  - Organizations leading a CHI Process
    - State, local, tribal and territorial health departments – for accreditation
    - Non-profit hospitals (for IRS-required CHNA)
    - FQHCs, United Way and community organizations conducting CHNAs

- **Secondary**
  - Multi-sector partners that share responsibility for creating healthy communities
  - Legislatures, policy makers, and business leaders
  - General public
**CHSI Background**

- **Produced** health profiles for all 3,141 US counties
- 1998 Collaboration led by HRSA
  - Public Health Foundation (PHF), ASTHO, and NACCHO
- 2000 Released in individual hard copy formats
- 2004 Steering Committee to evaluate, update, and expand CHSI
  - HRSA, CDC, National Library of Medicine, PHF, faculty from Johns Hopkins
  - Advisory partners: NACCHO, ASTHO, National Association of Local Boards of Health (NALBOH)
- 2008, 2009 Converted to an on-line format
- 2012 Primary responsibility transferred to CDC
CHSI 2015 Redesigned Web Application

- **New and Updated Features**
  - Updated & refined set of peer counties
  - Reorganized in a population health framework
  - New and updated indicators
  - Indicators by subpopulations & census tract maps to identify disparities
  - Peer county comparisons for outcomes & determinants
  - Summary comparison page
  - Improved user interface
  - Improved indicator visualization

- **Annual Release Strategy**
  - Biannual updated data release
  - Biannual improved functionality release
CHSI 2015 is an interactive web application that produces health profiles for all 3,143 counties in the United States. Each profile includes key indicators of health outcomes, which describe the population health status of a county and factors that have the potential to influence health outcomes, such as health care access and quality, health behaviors, social factors and the physical environment.

The social factors and the physical environment are especially important because they represent the conditions in which people are born, work, and play. Neighborhoods with affordable healthy food, safe and accessible housing, and quality employment opportunities can positively influence behaviors and help to create healthy lifestyles. The World Health Organization and others call the living conditions that can affect health and quality of life the "social determinants of health".

Healthy People (HP) 2020 highlights the importance of addressing the social determinants of health by including as one of its four overarching goals, "Create social and physical environments that promote good health for all". CHSI 2015 supports this goal by including a broad range of indicators, including multiple indicators related to the social and physical environment.

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**CHSI 2015 Goals**

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**New Features**

- **Summary Comparison Page** - "at a glance" graphic of how a county compares to those of its peers for all indicators.
- **Distribution Bar Charts** of each indicator value benchmarked against peer counties, all U.S. counties, and HP 2020 objectives, where applicable.
- **Tract Maps and Indicators by age group, sex, and race/ethnicity** to identify potential health disparities.
Choose a County: Allegheny County, PA

CHSI 2015 is an interactive web application that produces health profiles for all 3,143 counties in the United States. Each profile includes key indicators of health outcomes, which describe the population health status of a county and factors that have the potential to influence health outcomes, such as health care access and quality, health behaviors, social factors and the physical environment.

The social factors and the physical environment are especially important because they represent the conditions in which people are born, work, and play. Neighborhoods with affordable healthy food, safe and accessible housing, and quality employment opportunities can positively influence behaviors and help to create healthy futures. The World Health Organization has identified health inequities and environmental conditions as the leading contributors to health disparities.
Allegheny County, PA

The following Summary Comparison Report provides an “at a glance” summary of how the selected county compares with peer counties on the full set of Primary Indicators. Peer county values for each indicator were ranked and then divided into quartiles.

Better
(most favorable quartile)

Moderate
(middle two quartiles)

Worse
(least favorable quartile)

Mortality

Alzheimer's disease deaths

Chronic lower respiratory disease (CLRD) deaths

Diabetes deaths

Female life expectancy

Male life expectancy

Motor vehicle deaths

Stroke deaths

Unintentional injury (including motor vehicle)

Cancer deaths

Chronic kidney disease deaths

Coronary heart disease deaths
<table>
<thead>
<tr>
<th>Morbidity</th>
<th>Adult overall health status</th>
<th>Adult diabetes</th>
<th>Alzheimer's diseases/dementia</th>
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<tbody>
<tr>
<td></td>
<td>HIV</td>
<td>Adult obesity</td>
<td>Cancer</td>
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<td>Gonorrhea</td>
<td>Older adult depression</td>
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<td></td>
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<td>Older adult asthma</td>
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<td></td>
<td></td>
<td>Preterm births</td>
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<td></td>
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<td>Syphilis</td>
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<tr>
<td>Health Care Access and Quality</td>
<td>Cost barrier to care</td>
<td>Older adult preventable hospitalizations</td>
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<td></td>
<td>Primary care provider access</td>
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<tr>
<td></td>
<td>Uninsured</td>
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<tr>
<td>Health Behaviors</td>
<td>Teen Births</td>
<td>Adult female routine pap tests</td>
<td>Adult binge drinking</td>
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<td></td>
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<td>Adult physical inactivity</td>
<td>Adult smoking</td>
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<tr>
<td>Social Factors</td>
<td>High housing costs</td>
<td>Children in single-parent households</td>
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<td></td>
<td>On time high school graduation</td>
<td>Inadequate social support</td>
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<td></td>
<td>Poverty</td>
<td>Unemployment</td>
<td>Violent crime</td>
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<tr>
<td>Physical Environment</td>
<td>Housing stress</td>
<td>Access to parks</td>
<td>Annual average PM2.5 concentration</td>
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<tr>
<td></td>
<td>Living near highways</td>
<td>Limited access to healthy food</td>
<td></td>
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</tbody>
</table>
CHSI 2015 Data Displays

The rate of violent crime for Allegheny County, PA is:

421.5 (per 100,000)
Coronary heart disease deaths (rate per 100,000 persons)

The age adjusted coronary heart disease death rate for Allegheny County, PA is:

- **144.7 (per 100,000)**

Social Factors

Poverty (percent)

The percent of individuals living in poverty in Allegheny County, PA is:

- **12.7 %**

Distribution | Description | Populations | Census Tracts | Associated Indicators
---|---|---|---|---

Poverty (percent)
CHSI 2015 and CHR&R Combined Resources

- **Comprehensive set of outcomes (mortality, morbidity) and determinant indicators benchmarked against:**
  - Peer counties
  - Best performing 10% of counties
  - U.S and State averages; and
  - **HP 2020** targets

- **Resources to help identify vulnerable populations and disparities**
CHSI 2015 and CHR&R Combined Resources

- Graphs of historical trend data for select indicators;
- Rated strategies for addressing priority focus areas
- Common population health framework reinforces shift from disease treatment to prevention & promotes understanding of modifiable upstream factors that drive health
The findings and conclusions in this presentation are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.