


# REGIONAL SNAPSHOT ON

# HEALTH

community health needs assessment findings

Amador • El Dorado • Nevada • Placer • Sacramento • Yolo

## Working Together to Improve the Health of the Communities We Serve

For two decades Dignity Health, Kaiser Permanente, Sutter Health Sacramento Sierra Region, and UC Davis Health System have partnered to improve community health. Identifying health disparities and barriers to health for vulnerable and underserved populations is a critical first step in this process. Working within federal and state guidelines the hospitals collaborate to conduct an extensive community health needs assessment every three years. Based on the findings of the assessment, each hospital develops an implementation strategy that describes how the hospital will address significant health needs in the communities they serve. This document guides the hospital's community benefit programs.

## Conducting Community Health Needs Assessments

Beginning in 2012 health needs assessments were conducted for the designated service areas of the nonprofit hospitals that serve the greater Sacramento region. Each of these hospitals is listed below:

| Dignity Health | Kaiser Permanente | Sutter Health Sacramento Sierra Region | UC Davis Health System |
|---|---|---|---|
| Mercy Hospital of Folsom<br>Methodist Hospital of Sacramento<br>Mercy General Hospital<br>Mercy San Juan Medical Center<br>Woodland Healthcare<br>Sierra Nevada Memorial Hospital | Kaiser Permanente Roseville Medical Center<br>Kaiser Permanente Sacramento Medical Center<br>Kaiser Permanente South Sacramento Medical Center | Sutter Medical Center, Sacramento (includes Sutter General, Sutter Memorial, and Sutter Center for Psychiatry)<br>Sutter Davis Hospital<br>Sutter Amador Hospital<br>Sutter Roseville Medical Center<br>Sutter Auburn-Faith Hospital | UC Davis Medical Center |

In each assessment, a "health need" was defined as a poor health outcome and its associated driver. A "health driver" was defined as a behavioral, environmental, and/or clinical factor, as well as more "upstream" social economic factors that impact health. The objective of the assessments is stated below:

*Within each hospital's service area, identify communities and specific groups within these communities experiencing health disparities, especially as these disparities relate to chronic disease, and further identify contributing factors that create both barriers and opportunities for these populations to live healthier lives.*

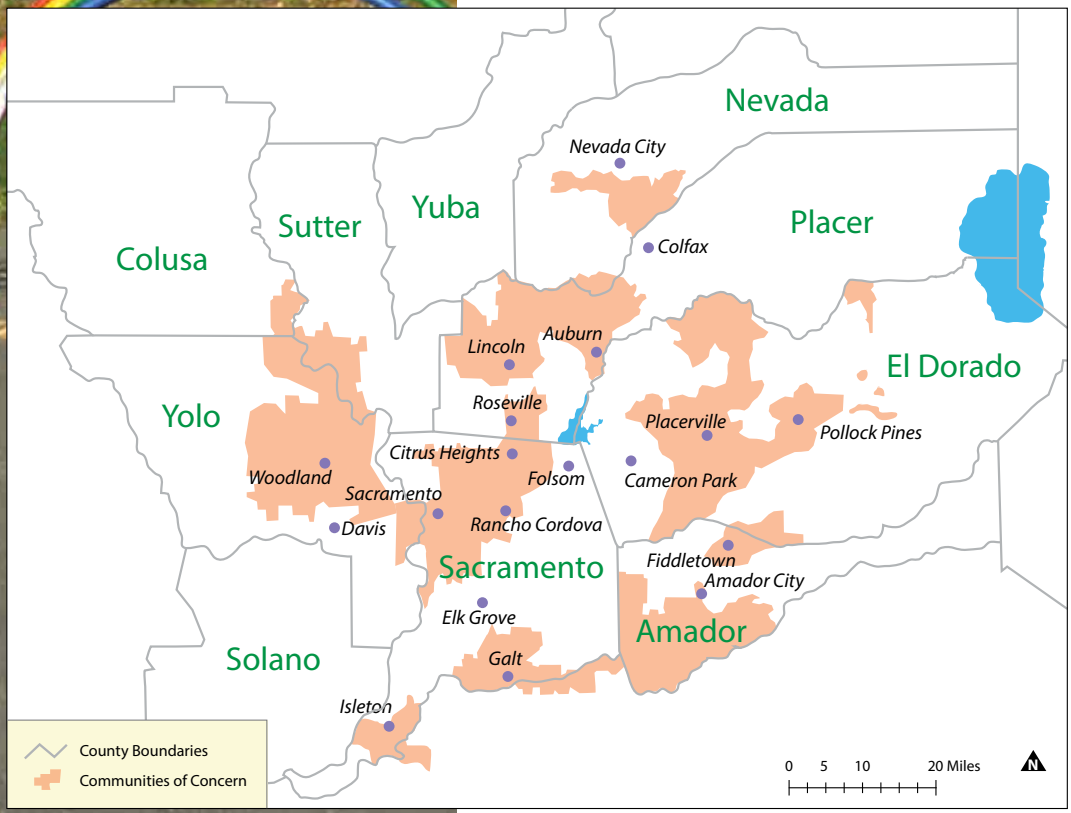
*"…the biggest problem is a total lack of a health safety net…our biggest health need is access to healthcare."*


## Identifying Communities of Concern

A community-based participatory research orientation was used to conduct each assessment that included both primary and secondary data. Primary data were collected from interviews with approximately 200 community health experts and during community health forums, and focus group interviews were held with approximately 330 community members. In addition, a community health assets assessment collected data on over 500 assets across the region.

Secondary data were collected for each ZIP code included in the assessments. These included health outcome data, socio-demographic data, and behavioral and environmental data at the ZIP code or census tract level. Health outcome data included emergency department (ED) visits, hospitalization, and mortality rates related to heart disease, diabetes, cancers, stroke, hypertension, chronic obstructive pulmonary disease, asthma, and safety and mental health conditions. Life expectancy at birth, infant mortality, and overall mortality were also included. Socio-demographic data included data on race and ethnicity, poverty (within female-headed households, families with children, people over 65 years of age), educational attainment, health insurance status, and housing arrangement (own or rent). Behavioral and environmental data helped describe general living conditions in each hospital service area such as crime rates, access to parks, availability of healthy food, traffic accidents, and federally designated health professional shortage areas.

Analysis of both primary and secondary data revealed specific Communities of Concern in each hospital service area that were living with a high burden of disease. Each of these communities had consistently high rates of negative health outcomes that frequently exceeded county, state, and Healthy People 2020 benchmarks. They were confirmed by community health experts as areas prone to experiencing poorer health outcomes relative to other communities in the service area. These Communities of Concern are noted in the figure below.




The figure shows the ZIP code boundaries across the region of an area described as a Community of Concern.

## Health Outcome Indicators in Communities of Concern

In virtually every instance, age-adjusted rates of ED visits and hospitalization due to heart disease, diabetes, stroke, and hypertension were drastically higher in these Communities of Concern compared to other communities in each of the hospital service areas. Mortality data for these conditions showed high rates as well.

## Environmental and Behavioral Findings in Communities of Concern

Analysis of environmental indicators showed that many of these communities had conditions that were barriers to active lifestyles, such as elevated rates of crime and a traffic climate unfriendly to bicyclists and pedestrians. Access to healthy food outlets was limited, while the concentration of fast food outlets and convenience stores was high. Analysis of the health behaviors of these residents also show many behaviors that correlate to poor health, such as having a diet that is limited in fruit and vegetable consumption.

*"We should work at making the healthy choice the easy choice."*

## Social Determinants of Health in Communities of Concern

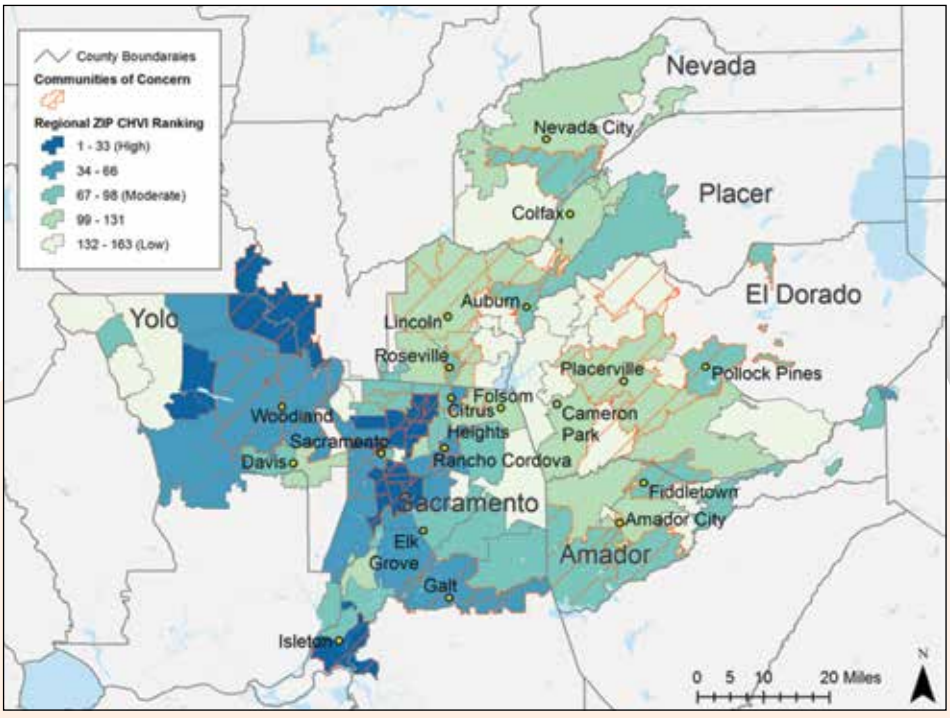
Research has helped develop a better understanding of the relationship between an individual's living conditions and socio-economic status—including the conditions of the neighborhoods in which one lives, employment status, education attainment, race and ethnicity, income level, and similar—and one's health status. These are often referred to as the "social determinants of health." To identify communities across the region with higher occurrences of these social determinants that point to poorer health, a "vulnerability index" for each ZIP code was developed. The index was compiled by identifying the percent of the population living in each ZIP code in each of the conditions below, and then combining these into one overall index. A ZIP code was considered more vulnerable, or more likely to have negative or unwanted health outcomes, if it had higher percentages of populations living in one or more of these conditions. (For a detailed description of the Community Health Vulnerability Index, and to see the index for each County, visit www.healthylivingmap.com).

- Households over the age of 65 living in poverty
- Families with children living in poverty
- Female-headed households living in poverty
- Over the age of 25 without a high-school diploma
- Non-white (race) or Hispanic (ethnicity)
- Limited English spoken at home
- Unemployed
- Uninsured
- Renting versus owning a home

*"A lot of people have turned to drugs and alcohol because they can't get medical treatment."*

The map below shows the degree or level of vulnerability for each ZIP code located in the six counties included in the map.

ZIP codes with darker shades are those most vulnerable to poor health outcomes among all ZIP codes located in the six-county region. (To see the vulnerability index for each county, visit www.healthylivingmap.com).



## Health Needs in Communities of Concern

When examining the findings from secondary data analysis (vulnerability index, health outcomes, environmental, and behavioral indicators) with those of the primary data (health expert interviews and focus groups of community residents), a consolidated list of priority health needs of each of these communities was identified. Each Community of Concern had specific health needs unique to it; however, many of these communities shared similar health needs. The top health needs identified consistently across the region are listed below (not in priority order).

- Access to primary health care
- Access to mental health services
- Access to dental care
- Access to affordable and healthy food
- Access to safe places for physical activity
- Access to specialty care
- Access to a safe, violence free, pedestrian-friendly environment
- Health education
- Access to prevention programs
- Culturally competent care

Each individual assessment is available by visiting each hospital's website or www.healthylivingmap.com.

## Plans to Address Health Needs

The participating hospitals used the results of the assessments to develop implementation plans. Each of these plans details which of the identified health needs the hospital is focusing on, and the specific plans developed to address health needs. Each plan can be found on the hospital's website, or by visiting www.healthylivingmap.com. The implementation plans contain specific programs and activities designed to improve population health in the identified Communities of Concern. Examples of the types of activities undertaken by hospitals include:

- Free mammogram screening for uninsured populations
- Partnerships with other community-based organizations to conduct insurance outreach through Covered California
- In partnership with other nonprofit hospitals, investing resources to build the capacity of community health centers, including Federally Qualified Health Centers, and mental health programs for underserved populations
- Health education prevention and treatment programs focused on diabetes and other chronic diseases
- Emergency department "navigator" programs designed to refer patients seeking primary care through the ED to additional resources available
- Programs to expand transportation services in rural counties, including free transportation services for healthcare-related needs for seniors and underserved populations
- Senior recreation and respite programs
- Funding the efforts of "Promotoras" and other community health workers
- Supporting physician volunteerism to serve underserved populations
- Programs specifically targeting homeless populations to help get them into stable housing
- Prenatal care programs
- Programs for survivors of domestic or community violence

*"Your average next door neighbor…can't walk anywhere or drive to a grocery store in this neighborhood and get fresh fruits and vegetables…they have to go out of the neighborhood…"*

**To get a copy of the full report, visit www.healthylivingmap.com**

Assessments conducted by Valley Vision, Inc.

Dignity Health.

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