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CHNA: The Role of the Hospital in Addressing Specific Community Health Needs

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Community Health Needs Assessments:

The Role of the Hospital in Addressing Specific Community Health Needs

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Abstract

The Patient Protection and Affordable Care Act (ACA) added a requirement for nonprofit hospitals to keep their tax-exempt status under the Internal Revenue System Code 501(c) 3. This code requires all nonprofit hospitals to complete Community Health Needs Assessment (CHNA) reports every three years and must include input from community stakeholders and underserved individuals representing the low-income, minority and chronically ill population.

In addition to the CHNA, implementation strategies are required to be executed in the geographic areas served in order to meet the identified prioritized needs from the CHNA. Oftentimes, CHNAs are difficult to conceptualize and operationalize within the general acute care settings, especially in large health care systems. The current landscape calls on healthcare organizations to play an active role in total health for communities. It is important to integrate the necessary stakeholders within the organization and execute on an overarching strategy to provide services to the community.

Kaiser Permanente (KP) has been committed to community health through its mission, vision and values. Beyond that, there is a structure and dedicated public health resources in place for addressing the health needs of the communities served by KP. The national and regional community benefit departments within KP plays an active role in the organization and are often looked to for providing expertise on addressing community health needs.

In the recent past, KP launched a statewide effort to improve the behavioral health program. Senior leadership identified the need to strengthen processes in screening, treating and following up on behavioral health patients. It consisted of community outreach through television campaigns, improving clinic environments, screening in the emergency room, expanding behavioral health resources by way of hiring, etc. Nonetheless, a critical piece was missing - how the organization will serve the non-member population the same way it serves its members.

Although the treatment is intended to be equal for uninsured non-members, there is a difference in follow-up treatment and disposition of the patient due to benefits. In order to close this gap, community partnership and outreach is not only in the best interest of the individual, but also that of the organization. By investing resources and creating active partnerships in the community, KP can reduce costs, contribute significantly to the overall health of communities, and more effectively deliver on its mission.

To achieve this, the hospital must take on a collaborative and active role in screening, treating and catching patients who fall through the cracks and present in the emergency rooms. Patients who present in the emergency rooms have clear needs for follow-up and treatment, whether it is through KP or community health services. Nonetheless, KP should ensure patients have a follow up plan. This paper illustrates how hospitals can play a more active role in community health initiatives. The example presented is that of behavioral health needs in Richmond, California. Behavioral health encompasses mental health and substance use disorders.

I. Introduction

Behavioral health issues involve all parts of the social-ecological model ranging from the individual recognizing their own mental health issue to the interpersonal level where the stigma associated with it. The role of one particular organization (KP) and community will be explored throughout this paper. Their role is integral and part of the solution to preventing behavioral health issues. The public policy level was included in the fieldwork project deliverable.

Soumya Sahoo. (2015, March 14). *Socio-Ecological Model.* [Image]. Retrieved from http://www.slideshare.net/drswaroopsoumya/public-health-model.

According to the National Alliance on Mental Illness (NAMI, 2015), one in four adults in the United States have experienced a mental health issue in a given year. The World Health Organization (WHO) states that nearly fifty percent of individuals will develop at least one mental illness during their lifetime (Kessler, Berglund, Demler, Jin, Merikangas, Walters, 2005). WHO also stated that depression is the leading cause of disability worldwide and is a

major contributor to the overall global burden of disease. A recent study conducted by Mental Health America (2015) highlighted that California has the highest number of adults with mental illness with a volume of 4.9 million. The statistics found in the annual report show that the child/youth population and the lack of treatment are the areas of concern (Mental Health America, 2015).

Many health indicators contribute to mental health needs including social pathologies, health problems and life conditions. In 2005, The World Health Organization published a "Promoting Mental Health" handbook that included in-depth analysis of the different factors contributing to mental health (World Health Organization, 2015). The report outlines the need to address each aspect of the social-ecological model in order to alleviate the mental health need problem. The emphasis is on the different overlapping aspects impacting an individual and their mental health state.

As the California population grows, the number of psychiatric facilities and available psychiatric beds continue to decline (see graphs below). The goal is to have 50 public psychiatric beds per 100,000 persons (California Hospital Association, 2016). While the resources and funds diminish, Contra Costa County has a percent of 3.4 adults with serious mental illnesses and only 16.9 psychiatrists per 100,000 people (California Healthcare Foundation, 2015). Meanwhile, according to a study published in *Modern Healthcare* (2015),

the rate for the country is 12.4 per 100,000 (Robeznieks, 2015).

California's Acute Psychiatric Bed Loss October 25, 2016. (n.d.). Retrieved November 10, 2016, from http://www.calhospital.org/sites/main/files/file-attachments/6_-_psychbeddata.pdf

Unfortunately, over the years, mental health organizations receive county, state and federal fund cuts, which exasperated the problem. The effects of such funding cuts are profound and becoming more obvious as the rates of suicide, depression, anxiety, mental illness continue to be high. This problem becomes more obvious when analyzing the landscape of behavioral health needs in Richmond, which is a diverse community with a large low-income population.

The combination of behavioral health service shortages for prevention and treatment and the

rising need has led to an unmet health need. Thus, emergency departments inevitably become the safety net. Emergency departments (EDs) are already operating at capacity and adding more unavoidable and preventable emergencies visits creates a strain. EDs that are operating at capacity or over capacity experience delayed treatments and halt patient flow throughout the hospital. This leads to less than optimal patient care outcomes and increased costs to hospitals. For example, each psychiatric patient boarding in the ED costs approximately $2,264 (Nicks, Manthey, 2012). Most of the time, boarded patients are medically stable and waiting for a transfer to a psychiatric facility. Meanwhile, their condition often escalates as they wait for a transfer. This disrupts overall patient flow.

Richmond is an area of concern because of its limited capacity of overall inpatient beds and ED space. Due to the closure of Doctor's Medical Center, the Richmond ED has seen two thirds of ambulance patients that would have gone to Doctor's. Amongst that population, there are patients with specific behavioral health needs. Behavioral health diagnoses are a significant portion of ED visits in KP Richmond (internal proprietary company data cannot be disclosed). More than half of the patients seen in the KP RCH ED are nonmembers of KP.

In order to prevent ED overcrowding, KP provided a significant financial contribution to LifeLong Medical Care to expand services of urgent care. Nevertheless, KP Richmond experiences increased volumes of patients presenting in the ED since the closure of Doctor's

Medical Center. It is clear that there continues to be an opportunity to better connect patients to community resources and services in order to avoid unnecessary ED visits.

II. Background

Community health needs assessment reports have become a vital deliverable for KP in identifying these kinds of health needs and building integrated strategies amongst the health plan, hospitals, medical group and community benefit. Since the ACA's enactment in 2013, KP has taken on the responsibility of conducting CHNAs in the geographic service areas served. Some service areas conduct the CHNA using internal resources, while other service areas collaborate with external hospitals in proximity to KP and contract external resources for their CHNA. The findings of the CHNAs inform implementation strategies for the service areas for the following three years.

While CHNAs provide an understanding of the community needs, they are not always fully integrated into business strategy and hospital operations. This results in a disconnect between what is uncovered in CHNAs and what is being implemented and the services provided by hospitals. Hospital leadership understand the value in CHNAs and have become more active in incorporating them into operations. A recent example is that of behavioral health needs.

About 10 out of 13 CHNAs in KP Northern California identified behavioral health needs as a

top priority. Implementation strategies document the actions to be taken to address this need; however, execution is difficult and outcomes are not always tracked. Over the years, hospital leaders began to pay closer attention to CHNAs for various reasons. It helps drive the mission of KP, deliver on its vision, become more affordable and help keep communities healthy. As a result, the behavioral health program at KP has become a high priority over the two last years. Given the structure of large healthcare organizations, many departments and key stakeholders are looking at this issue from different angles. This results in silo efforts that need to be integrated.

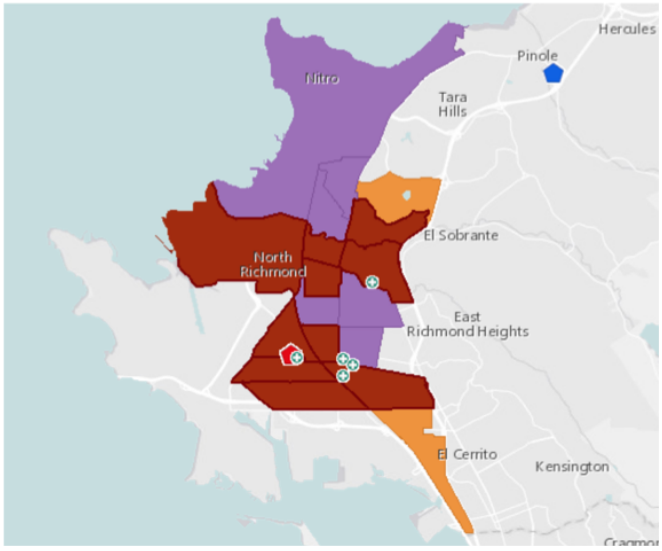
III. Richmond Behavioral Health Needs

The indicators of behavioral health included in the Community Commons Platform, a Kaiser Permanente sponsored platform for community health needs assessments, include depression, mentally unhealthy days, suicide mortality, and access to mental health. These are described in the following table.

	% of adults needing mental health professional *2013-14*	% of Medicare Population with Depression *2016*	Average of Mentally Unhealthy Days (last 30 days) *2006-12*	Suicide Mortality Rate - Age adjusted (per 100,000) *2010-12*	Access to mental health Care Provider Rate (per 100,000) *2006*
RCH Total	11.57	13.83	3.4	9.28	na
CA Total	15.9	13.9	3.6	9.8	280.6

Kaiser Permanente. (2013) *Community Health Needs Assessment*. Retrieved November 18, 2016 from https://share.kaiserpermanente.org/wp-content/uploads/2013/09/Richmond-CHNA-2013.pdf

Although Richmond has similar rates when compared to the state for the indicators above, the poverty rate is twice as much than the average for Contra Costa County (Kaiser Permanente Community Commons, 2016). Poverty and education are additional indicators determining overall mental health. Many live below the federal poverty line (see the orange areas in the map below) and over one-fifth of the population do not have a high school diploma (see the purple areas in the map below). The red highlights the areas where individuals have both indicators. These are two indicators of overall health and have significant impact on behavioral health. The cross icons indicate community health centers and the red hexagon shows the KP Richmond hospital, the only general acute care hospital in the area. The blue hexagon shows the KP clinic.



Kaiser Permanente. (n.d.) *Community Commons*. Retrieved November 18, 2016 from http://www.communitycommons.org

According to the 2013 KP Community Health Needs Assessment report, almost 15 percent of Richmond residents self-report having poor mental health. This is higher than the state number of 14 percent. Also, dual diagnoses with behavioral health usually include substance use disorders and risky behaviors. The Richmond area has a number of 19 percent of adults who drink heavily, while the state has a number of 16.8 percent. The CHNA report highlighted the need for affordable and culturally relevant mental health services for the local community.

For the combined Oakland and Richmond service areas, mental health needs are significantly higher when compared to the rest of the state. In these areas, adults are more likely to visit the ED for severe mental illness at a rate of 408.5 per 100,000 compared to 301.7 per 100,000 for the state. Adults who are black have a significantly higher rate of 1126.5 per 100,000 (Health Alameda County, 2015). Attempted suicides and assault are significantly higher for youth in the Oakland and Richmond areas. KP Oakland saw 952.3 per 100,000 people ages 13-20 and KP Richmond saw 779.3. Both are higher than the state with a rate of 738.7 per 100,000 (California EpiCenter Data Platform for Overall Injury Surveillance, 2011-2013). The suicide mortality rate (age adjusted) in the KP Richmond area was 11.8 per 100,000, which is higher than the state with a rate of 9.8 (California Department of Public Health, 2010-2012).

The current landscape shows how behavioral health needs have significant impacts on individuals, entire communities, emergency rooms, clinics, and general acute care hospitals. The ED has become the "catch all" for individuals who cannot access the care they need when they need it. This can be supported by a study published in the Annals of Emergency Medicine, which showed the effects of how decreasing county behavioral health services led to a significant increase in emergency room visits and hospitalizations related to behavioral health issues (Nesper, A., Morris, B., Scher, L., Holmes, J., 2015).

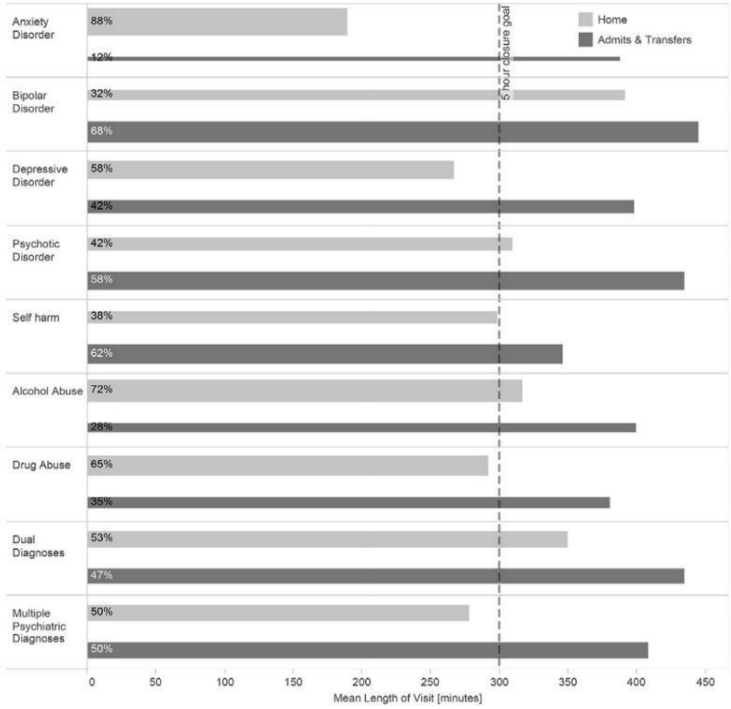
The American College of Emergency Physicians conducted a national survey of ED physicians that showed that ED staff spent twice as long to place a patient in an inpatient psychiatric bed than a medical bed. The study showed that 79 percent of physicians said that patients were boarded in the ED and a third waited 6 hours or more. Even more, 6-10 percent of patients were in the ED for over 24 hours and on average, patients spend 11.5 hours per visit in the ED (Weiss, A. P., Chang, G., Rauch, S. L., Smallwood, J. A., Schechter, M., Kosowsky, J., Orav, E. J., 2012). This is a reflection of the inadequate number of services available for this population. A secondary and significant outcome due to this issue is translated to all patient care in the ED. Each hour in the ED, regardless of condition, can have a significant effect on overall care due to the delays in treatment.

TABLE 1. Psychiatric-related Emergency Department Visit Rates by Patient Characteristics for 2000

	Estimated Number of Visits	Rate/ 1,000	95% CI
Total	4,333,000	21.1	19.8, 22.3
Age (yr)			
18–24	501,000	18.5	15.9, 21.0
25–44	2,044,000	24.9	23.4, 26.4
45–64	1,134,000	18.7	16.9, 20.6
65+	654,000	20.0	18.8, 22.2
Gender			
Male	2,013,000	20.4	18.9, 21.9
Female	2,320,000	21.7	20.3, 23.2
Race			
White	3,508,000	23.2	21.9, 24.5
African American	680,000	28.7	26.5, 31.0
Insurance status			
Private	1,250,000	8.3	6.5, 10.1
Medicaid	952,000	65.9	64.0, 67.9
Medicare	686,000	18.4	16.2, 20.7
Uninsured	1,019,000	32.7	30.8, 34.6
Region			
Northeast	1,111,000	27.4	25.6, 29.2
Midwest	940,000	19.7	17.7, 21.7
South	1,274,000	17.1	15.3, 18.8
West	1,008,000	21.8	19.9, 23.7

Hazlett, S. B., (2004). Epidemiology of Adult Psychiatric Visits to U.S. Emergency Departments. Academic Emergency Medicine, 11(2), 193-195. doi:10.1197/j.aem.2003.09.014

This problem can be supported by a nationwide trend. According to the table above, psychiatric related emergency department visits in 2000 in the United States reached 4.3 million. This translates to 21 visits per 1,000 adults. These types of visits increased 15 percent from 1992 and now account for 5.4 percent of all ED visits across the country. (Hazlett, et. al. 2004). A retrospective study analyzed all mental health ED visits using the National Hospital Ambulatory Medical Care Survey from 2001-2011. The study found that of 65 million ED mental health visits, 41 percent were due to substance abuse, 23 percent to depression, and 26 percent to anxiety. (Lippert SC, et.al 2016) See the table below.



Lippert, S., Nesper, A., Jain, N., Fahimi, J., Pirrotta, E., & Wang, N. (2016). 142 Mental Health Emergency Department Visits: 24 Hours and Counting, Characteristics Associated With Prolonged Length of Stay. *Annals of Emergency Medicine, 68*(4). doi:10.1016/j.annemergmed.2016.08.154

The role of general acute care hospitals in caring for behavioral health patients is complicated due to the coordination of care with different providers and avenues of funding. Behavioral health services in the state of California are financed and managed through a shared state-county model and are subject to state and federal standards affecting eligibility and benefits. In 2012, California eliminated the state Department of Mental Health and the Department of Alcohol and Drug programs. Thus, the behavioral health services programs were transferred to the Department of Health Care Services with a goal to improve state and local coordination and

integration of the services. This integration is still underway. Funding for mental health services and for substance use disorders are mostly from realignment funds, county revenues, state and federal funds (Medicaid, CHIP, etc.), grants, etc. Public safety realignment changes to mental health funding include counties administering 90% of revenue dedicated to public mental health services in the state. Additionally, California's Investment in Mental Health Wellness Act of 2013 granted $150 million for mental health services. This grant was intended to increase capacity for crisis intervention, stabilization, residential treatment, rehabilitation and mobile crisis support teams.

Contra Costa County released a Mental Health Expenditure Plan outlining details on funds being distributed for 80 programs. The total amount of the three-year expenditure is about $41.6 million. The breakdown is as follows:

- Full service partnership: $17,459,363 annually
- General system development: $14,109,268 annually
- Prevention and early interventions: $8,037,813 annually
- Innovation: $2,019,459 annually
- Workforce education: $638,871 one time
- Capital facilities/IT: $6,000,000 one time

Below is a table from the expenditure plan describing the various benefits for mental health care for Medicare members (California Healthcare Foundation, 2015).

Table 4. Mental Health and Substance Use Disorder Benefits in Medi-Cal (2015): Services and Populations, by Coordinating Entity

	COUNTY MENTAL HEALTH PLANS (MHP)	COUNTY SUBSTANCE USE DISORDER (SUD) SERVICES	MEDI-CAL MANAGED CARE PLANS (MCP)
Target Population	Children and adults who meet medical necessity or EPSDT* criteria for Medi-Cal specialty mental health services	Children and adults who meet medical necessity or EPSDT criteria for Drug Medi-Cal substance use disorder services	Children and adults in managed care plans who meet "mild to moderate" medical necessity criteria or EPSDT criteria for mental health services
Outpatient Services	▸ Mental Health Services (assessments plan development, therapy, rehabilitation, and collateral) ▸ Medication Support ▸ Day Treatment Services and Day Rehabilitation ▸ Crises Intervention and Crises Stabilization ▸ Targeted Case Management ▸ Therapeutic Behavior Services	▸ Outpatient Drug Free ▸ Intensive Outpatient (newly expanded to additional populations) ▸ Residential Services (expansion to additional populations on hold) ▸ Medication-Assisted Treatment, including methadone, buprenorphine, disulfiram, naloxone, and naltrexone	Services carved-in effective 1/1/2014: ▸ Individual/group mental health evaluation and treatment (psychotherapy) ▸ Psychological testing when clinically indicated to evaluate a mental health condition ▸ Outpatient services for monitoring medication treatment ▸ Psychiatric consultation ▸ Outpatient laboratory, medications, supplies, and supplements ▸ Screening Brief Intervention and Referral for Treatment (SBIRT), for people with, or at risk of developing, alcohol use disorders
Inpatient Services	▸ Acute Psychiatric Inpatient Hospital Services ▸ Psychiatric Inpatient Hospital Professional Services ▸ Psychiatric Health Facility Services		
Residential Services	▸ Adult Residential Treatment Services ▸ Crises Residential Treatment Services		
New Services		▸ Inpatient Detoxification Services (limited to general acute care hospitals, pending expansion to other settings)	

*The EPSDT program is the child health component of federal Medicaid for eligible children under age 21.

Note: Does not include provisions of DMC-ODS waiver (see page 24).

Source: California Department of Health Care Services, 2014 (edited), updated here for 2015.

California Healthcare Foundation. (2015) *Locally Sourced: The Crucial Role of Counties in the Health of Californians.* Retrieved November 10, 2016, from http://www.chcf.org/publications/2015/10/locally-sourced-crucial-role-counties

IV. Scope of the Project

February through August of 2016 was spent working with the Northern California Community Benefit Department for Kaiser Permanente. Kaiser Permanente is one of the nation's largest not-for-profit health plans, serving 10.6 million members with 186,497 employees serving in 8 states. In Northern California there are 3,969,733 members, 21 hospitals, 238 medical offices and 14 service areas. Currently, there are 52 place-based collaboratives to improve community health for over 636,000 community members. A total of 850,461 people were served by Medicaid and Children's Health Insurance Plan. Additionally, KP served 87,875 people through Charitable

Health Coverage. More than 200,000 medical financial assistance individuals were approved in 2015. The mission of the organization is “to provide high-quality, affordable health care services and to improve the health of our members and the communities served.” The brand is “we stand for total health” and falls in line with community behavioral health initiatives.

During the fieldwork, all Kaiser Permanente Northern California service areas submitted their CHNA reports as well as Implementation Strategies. The submitted reports had to be collated and edited to fit a standard template provided by the national community benefit department. Data extraction and analysis was required for certain sections of the reports. Ad hoc work included researching nonprofit external hospitals in Northern California as well as conducting a cross walk of information requested of grantees to minimize redundancy.

Beginning August 2016, the east bay community benefit department requested a specific needs assessment for behavioral health in the Richmond community to inform a service area strategy. The request was to identify the health needs, create a SWOT analysis, interview key stakeholders and research current internal strategies, programs and initiatives. The assessment also included a list of political figures who would support behavioral health initiatives, recommendations for community outreach, partnerships with organizations, strategy building and integration, expansion of services, etc.

A literature review was conducted in order to build the assessment report. The review included all aspects of the social-ecological model. The individual behaviors were analyzed and summarized in the assessment. The research on regulations, funding, political figures was meant to identify potential policy supporters that KP could collaborate with. At the community level, a list included the various organizations in which KP collaborated or supported as well as organizations that did not have a partnership with KP. Unfortunately, the interpersonal level was difficult to obtain due to not having direct access with the community members. Information from the CHNA indicated the need for social support, which speaks to the interpersonal level of the social-ecological model. Below are some excerpts from the final assessment/report provided to the east bay community benefit department for KP.

Below is a list of political figures presented in the report:

- Tony Thurmond: State assembly member. He served on the Richmond City Council in 2005. http://asmdc.org/members/a15/
- Melvin Willis: RCH City Council Member. Ran under the Richmond Progressive Alliance. Strong advocate for increased health/mental health investments in Richmond
- Ben Choi: RCH City Council Member.
- Jovanka Beckles: RCH City Council Member. Cares about families and depression. http://www.ci.richmond.ca.us/2754/Jovanka-Beckles
- Bill Lindsay: City Manager. Responsible for annual budget.

http://www.ci.richmond.ca.us/59/City-Manager

- Contra Costa Behavioral Health Department Directors: Cynthia Belon, Behavioral Health Division Director
- Contra Costa Behavioral Health Department: Fatima Matal Sol – Alcohol and Other Drugs Program Director
- Mathew Liu –CCHS, Behavioral Health
- Nancy O'Brien –CCHS, Behavioral Health, WCC Adolescent Unit
- Supervisor John Gioia – District 1 Supervisor serving WCC
- Duane Chapman, Chair of the Contra Costa Mental Health Commission, Volunteer for RCH Police Dept Crime Prevention
- Will Taylor, Executive Director NAMI CC County
- Gigi Crowder, NAMI CC FaithNet Chair and Founder of the Mental Health Friendly Communities

This is a list of organizations in the Richmond area that have an interest in behavioral health initiatives:

- (Accessing Health Services) Healthy Richmond http://www.ci.richmond.ca.us/2413/Healthy-Richmond
- (unsure if they still meet) Richmond Health Equity Partnership. Focuses on health inequities affecting overall health. Partners with Contra Costa Health, the school district, a UC Berkeley professor, CA endowment, and local CBOs.

http://www.ci.richmond.ca.us/2574/Richmond-Health-Equity-Partnership-RHEP

- Brighter Beginnings: http://www.brighter-beginnings.org/
- LifeLong Medical
- North Richmond Center for Health (liaison to psych): http://cchealth.org/centers/north-richmond.php
- BAART (substance abuse): http://baartprograms.com/
- Asian Community Mental Health Services: http://www.acmhs.org/services/behavioral-health-care-services/
- CA Endowment http://www.calendow.org/places/richmond/
- Familias Unidas, Mental Health Provider for Latino Population. Lorena Huerta, Executive Director
- Early Childhood Mental Health Program
- Restorative justice programs:
    - SEEDS Community Resolution Center http://www.seedscrc.org/ ,
    - Mindful Life
    - Bay Area Peacekeepers, Inc.
    - CCISCO
    - Catholic Charities of the East Bay
    - Dovetail Learning, Inc
    - East Bay Center for the Performing Arts

- Intertribal Friendship House
- Omega Boys Club of San Francisco
- Reentry Solutions Group
- Richmond Community Foundation/City of Richmond
- RYSE
- West Contra Costa Family Justice Center
- Youth Speaks/RAW Talent

Another aspect of the fieldwork included training in lean methodology in order to address the impact on emergency rooms to improve patient throughput as well as a focus on the discharge of patients. The process improvement projects included various front line care providers such as patient care coordinators (PCC) who are dedicated to finding placements and resources for psychiatric patients who are being discharged from the ED or the inpatient units. The role of the PCC has been identified as critical in quick placement of psychiatric patients once they are medically stable. Patient dispositions often include behavioral health treatment and/or follow-up or admission into a psychiatric facility. Strengthening the process for patient disposition is another angle in which KP can play a more active role in behavioral health needs. Part of the recommendations section in the Richmond report included applying more lean methods into patient disposition in a consistent and standard manner.

Overall, the fieldwork provided the opportunity to experience the role of hospitals in conducting community health needs assessments, prioritizing needs, establishing implementation strategies and focusing on specific health needs of the communities served. The application of lean methodology uncover areas of opportunity to improve patient flow and disposition. This must continue to be an area of focus for hospitals.

V. Public/Population Health Impact: Findings and Significance

As previously stated, CHNA reports have brought to light the health needs of the communities served by Kaiser Permanente. Although the Richmond community mirrors much of the state's overall indicators for mental health, there are high rates of poverty and lack of educational attainment. With the limited number of mental health services, the impacts on hospitals are significant due to the emergency visits for psychiatric emergencies. Kaiser Permanente is keeping a close eye on these patient visits in order to better understand how to prevent recurrence. The east bay leadership is focusing its attention in the primary care setting and deploying a strategy for 2017. Each service area was tasked with building their own behavioral health strategy that would be aligned with the overarching strategy.The fieldwork described above will inform the strategy stakeholders in order to meet the request. Although the significance of CHNA reports is well understood throughout Kaiser Permanente Northern California, silos inevitably exist in the large organization. This means that extra effort has to be

made in order to bring all stakeholders of the organization together. Organizations like KP have the adequate resources to play an active role in all levels of care: from primary care to tertiary care. Significant improvements can have a profound impact on communities in which KP operates. The community benefit department tracks the impact the organization has had in the communities and recently published the amount of funds they have distributed on behalf of KP. Approximately 2.1 billion dollars have been invested in the communities served in Northern California. The call to action is to continue investing but also collaborate with the community and provide resources to carry out initiatives.

All in all, KP is rightfully turning their attention to behavioral health. During the fieldwork, recommendations were made to integrate different levels of the organization and departments. Connections were made between the Behavioral Health Department within KP and the Community Benefit Department. Additionally, a workshop was facilitated where different disciplines came together to solve the problems related to delivering care to behavioral health patients, members and non-members. The overall topics included: improving treatment and stabilization of patients, leveraging technology and informatics, and expansion of treatment services.

The overall recommendation made is to actively include community benefit leaders into the behavioral health strategy building and execution for both member and nonmember populations.

Community benefit can bring in expertise on measuring population health impact as a result of implementing key tactics and improved services. They are the experts in ensuring that all aspects of the social-ecological model are met in the communities served. This will lead to improved overall care and community health. The mission, values and brand of the organization would be carried out in meaningful and impactful ways.

VI. Conclusion

The Patient Protection and Affordable Care Act has required nonprofit hospitals to conduct community health needs assessments and implementation strategies every three years. The fieldwork described throughout the body of this paper shows how CHNAs inform health needs of communities and lead to strategic planning to ensure those needs are met. Kaiser Permanente has used the CHNAs to build strategies such as the behavioral health strategy. They have used key informant interviews and research to build the content of the strategy. However, the community benefit department possesses specific community health expertise and are critical to validate the content and approach taken on as a result of the strategy. KP and other healthcare organizations must continue to bring population and community health to the forefront.

The CHNAs have many benefits to healthcare organizations, communities, individuals and populations and a potential amendment to or repeal of the ACA could have profound

implications in the healthcare landscape. Any changes could affect accessibility to services, including an increase in the uninsured, funding cuts, restrictions on eligibility for certain services, etc. Regardless of the outcome of potential changes to ACA, healthcare organizations that want to continue providing high quality service and care to the populations they serve will see that community health investments and partnerships are beneficial and a must. Should there be an amendment to the ACA, it is important that the state and counties continue to increase funding for community health services. Healthcare organizations must keep community health as part of their business through population health management, a new component to the Triple Aim model from the Institute of Healthcare Improvement (American Hospital Association, 2012). Currently, Kaiser Permanente east bay service area leadership continuously meet and discuss population health metrics and approaches to managing care.

It is important to keep in the forefront the voice of the patient and continue telling their stories. One that stands out is a patient that was admitted to KP Oakland through the ED with renal dysfunction. The patient also suffered from schizophrenia and refused medication, medical treatment, food, and was overall resistant. He also suffered from suicidal thoughts, which led him to being in a 5150 hold. Finally, the patient accepted medical care and treatment could be started. When the patient was medically stable and ready for discharge, another challenge came about. The patient refused to go back to his place of residency and it was determined that the residence

was inappropriate for the level of care he needed. Thus, the coordinator spent days attempting to locate a residence with appropriate psychiatric services leading to a two week-long stay in the hospital. The length of stay for this patient was significantly longer than a patient without psychiatric needs. Anecdotal feedback from coordinators reinforce this barrier stating that they have to spend significantly more time (up to four times more) to place a patient with behavioral health needs. The nurse manager overseeing this specific case stated that she would not be surprised if he came back through the ED as many psychiatric patients do. This story reinforces the need to continue the critical work in behavioral health and ensure high quality care throughout the continuum including follow-up beyond discharge.

In conclusion, KP has prioritized health needs of the member population and continues to work on behavioral health needs for the member and nonmember population. Community benefit must be brought to the table for strategy building, public health expertise and plan execution. Meanwhile, hospital leaders must continue to support CHNAs and manage population health through daily operations. This will lead to a top down and bottom up approach to solving the problem of behavioral health unmet needs for all.

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Appendices

Final Learning Objectives

Goal 1: Requirements for Community Health Needs Assessments for Kaiser Permanente Northern California Areas				
Objective (s)	*Activities*	*Start/End Date*	*Who is Responsible*	*Tracking Measures*
Read and understand regulatory requirements for CHNAs	Read prior assessments, reports, presentations, meeting with preceptor.	March 1, 2016 – March 31, 2016	YZ	Time log, check-ins
Collate CHNA submittals into a standard format/template	Review and synthesize CHNA content to ensure it is in the correct format. Make changes as necessary.	April 2016 – May 2016	YZ	Time log, email

Goal 2: Standardization of Information Requested for Year-End Grantee Reports				
Objective (s)	*Activities*	*Start/End Date*	*Who is Responsible*	*Tracking Measures*
Conduct a cross-walk for year-end reports from grantees in order to create a standard for what is asked	Reviewed report templates from almost all service areas and created a cross-walk. Made recommendations on what should be kept and what should be removed.	June 2016 – July 2016	YZ	Cross walk submitted through email. Presented at a joint community benefit managers meeting.

Goal 3: Learn Lean Methodology to Improve Throughput from ED				
Objective (s)	*Activities*	*Start/End Date*	*Who is Responsible*	*Tracking Measures*
Review training on Lean Methodology for Health Care	Read 2 books, attend week long training, observe 2 projects in	August 2016-December 2016	YZ	Training attendance, certificate for course completion,

	progress, participate in 1 new project			check ins with lean consultants
Understand how lean methodology can be applied to community behavioral health services	Outlined in Goal #4. Provide recommendations on how to integrate Behavioral Health into hospital operations, specifically, the ED	October 2016-December 2016	YZ	Final report (goal #4)

Goal 4: Mental Health Services Needs Assessment for Richmond CA				
Objective (s)	*Activities*	*Start/End Date*	*Who is Responsible*	*Tracking Measures*
Assist in needs assessment for behavioral health services in Richmond CA	Review literature, read Contra Costa reports, research, etc.	October 10, 2016 -November 31, 2016	YZ	Check ins with Community Benefit Manager for East Bay Service Area, emails, phone calls.
Provide final report on mental health services	Synthesize information, provide recommendations to inform strategic plan	October 10, 2016 -November 31, 2016	YZ	Final report submission to manager

Master of Public Health Program FIELDWORK TIME LOG

Student Information	
Student's Name: Yesmina Zavala	Campus ID # 2015900049715
Student's Phone: 415-606-7315	Student's Email: yzdiaz@gmail.com
Preceptor Information	
Preceptor's Name: Dana Williamson	Preceptor's Title: Lead Consultant
Preceptor's Phone: 510-625-6372	Preceptor's Email: Dana.E.Williamson@kp.org
Organization: Kaiser Permanente	
Student's Start Date: February 2016	Student's End Date: December 2016 Hours/week: varies

Time Log:

_____X_____ Spring 2016 **_____X_____Fall 2016**

_____X_____ Summer 2016 **_____na**

Week	Hours Worked	Activity Performed
28-Oct-15	2.00	orientation to CB
8-Feb-16	4.00	meetings w/ preceptor and reading CHNA 2015 toolkit, completed grant summaries in NCAL reports
15-Feb-16	3.00	combined report sections from 2014 and 2015

22-Feb-16	1.00	completed report proofreading, formatting, content summarizing
7-Mar-16	2.25	template for board summaries, added content to specific sections
14-Mar-16	1.00	write descriptions for health needs for board summaries
21-Mar-16	1.50	worked on board summaries
28-Mar-16	2.00	worked on board summaries
4-Apr-16	1.00	metric tables
11-Apr-16	2.00	worked on site health need definitions
25-Apr-16	9.00	CHNA summary template completed CHNA summaries for various sections for all NCAL areas
9-May-16	2.00	research non-profit hospitals in service areas
23-May-16	1.00	ongoing work
30-May-16	2.00	ongoing work
20-Jun-16	2.00	GIFTS training and met with CB regarding grant writing
27-Jun-16	4.00	created crosswalk of grant outcomes reports, attended web meeting
11-Jul-16	1.00	check in with dana
1-Aug-16	3.00	observe process improvements (entire month of Aug), training, meetings
29-Aug-16	18.00	research on emergency room visits in richmond observe process improvements (entire month of Sept), training, meetings, check in with preceptor, one to one training with consultants
12-Sep-16	10.00	lean book, research, meetings with CB
3-Oct-16	27.00	observe process improvements (entire month of Oct), training, meetings
10-Oct-16	50.00	lean training for healthcare; lean book
17-Oct-16	38.50	lean process observation, real time (patient throughput) research RCH mental health services literature search met with CB east bay manager

		read several materials synthesis information research politics
24-Oct-16	9.00	create a communication tool for lean projects event on precision medicine - chronic condition management (including mental health) using technology read BHC newsletter for Contra Costa read KP BH report work on report for CB read study on impact of mental health services on EDs
31-Oct-16	59.00	researched community stakeholders, CBOs, etc observe process improvements (entire month of Nov), training, meetings, week long event continued research and writing report
7-Nov-16	12.00	continued research and writing report check in with Susanna and reply to emails met w hospital managers to discuss disposition of patients w mh issues checked emails, revisions to report, check in with preceptor
14-Nov-16	13.00	brainstorming innovative ways to use information and data to make better decisions on caring for patients. focus on behavioral health. updated report, webex on inpatient population with mental illnesses (presented by stanford psych), continued research and writing
5-Dec-16	9.00	PLACEHOLDER: Already scheduled to observe more process improvements, attend training, meetings, will be fulfilled by Dec 10
5-Dec-16	10.75	Conducted more in depth research on organizations in Richmond. Conducted data analysis for ED visits in KP RCH

Preceptor Signature:  *Date:* 11/17/16

Preceptor Signature: _____ *Date:* _____

Student Evaluation of Field Experience

Student Information	
Student's Name: Yesmina Zavala	Campus ID #
Student's Phone: 415-606-7315	Student's Email: yzdiaz@gmail.com
Preceptor Information	
Preceptor's Name: Dana Williamson	Preceptor's Title: Lead Consultant, Community Health Impact & Reporting
Preceptor's Phone: (510) 625-6372	Preceptor's Email: Dana.E.Williamson@kp.org
Organization: Kaiser Permanente - Northern California Office	
Student's Start Date: February 2016	Student's End Date: December 2016 Hours/week: varied

SA = Strongly Agree A = Agree D = Disagree SD = Strongly Disagree N/A = Not Applicable					
My Field Experience…					
Contributed to the development of my specific career interests	SA	A	D	SD	N/A
Provided me with the opportunity to carry out my field learning objective activities	SA	A	D	SD	N/A
Provided the opportunity to use skills obtained in MPH classes	SA	A	D	SD	N/A
Required skills I did not have Please list:	SA	A	D	SD	N/A
Required skills I have but did not gain in the MPH program Please list:	SA	A	D	SD	N/A
Added new information and/or skills to my graduate education Please list:	SA	A	D	SD	N/A
Challenged me to work at my highest level	SA	A	D	SD	N/A
Served as a valuable learning experience in public health practice	SA	A	D	SD	N/A
I would recommend this agency to others for future field experiences.	Yes			NO	
My preceptor…					
Was valuable in enabling me to achieve my field learning objectives	SA	A	D	SD	N/A

Was accessible to me	SA	A	D	SD	N/A
Initiated communication relevant to my special assignment that he/she considered of interest to me	SA	A	D	SD	N/A
Initiated communication with me relevant to general functions of the agency	SA	A	D	SD	N/A

Please use the following key to respond to the statements listed below.

2. Would you recommend this preceptor for future field experiences? Please explain.

X Yes No Unsure

Dana Williamson has an MPH and is a well-known employee throughout Northern California Kaiser Permanente. She has expertise in Public Health and understands the role of a preceptor. She ensures the student is sure of the assignments and makes herself available as needed. Important note: the student should be a full-time intern and not have a job. It was very difficult to have projects since they required a 9-5 schedule.

I also had a preceptor in the East Bay Service Area. Susanna Osorno-Crandall is the Community Benefit Manager for the area. She has expressed interest in continuing as a preceptor for USF. Her email is Susanna.Osorno-Crandall@kp.org

3. Please provide additional comments explaining any of your responses.

Overall, my fieldwork experience was everything I could ask for. I saw the CHNA process from the highest level and went down to the details with Richmond. It was a unique experience to work with public health professionals within my organization. I wouldn't have had that experience otherwise.

4. **Summary Report**: All students are required to prepare a written summary of the field work to be submitted with this evaluation form.
Please refer to the capstone paper for my summary.

Student Signature Date

MPH Program Competency Inventory

USF MPH Competencies	Notes
1. Assess, monitor, and review the health status of populations and their related determinants of health and illness.	Community Health Needs Assessments provided this experience.
2. Demonstrate the ability to utilize the proper statistical and epidemiologic tools to assess community needs and program outcomes.	Completed research and pulled necessary data to make a compelling case for behavioral health services for the targeted population. Built a health profile.
3. Identify and prioritize the key dimensions of a public health problem by critically assessing public health literature utilizing both quantitative and qualitative sources.	Literature searches were conducted in order to extrapolate the true health need and provide evidence based solutions.
4. Specify approaches for assessing, preventing, and controlling environmental hazards that pose risks to human health and safety.	This was addressed throughout the MPH program (not specific to fieldwork).
5. Apply theoretical constructs of social change, health behavior and social justice in planning community interventions.	Analyzed organizations that could be partners for different health initiatives affecting community health.
6. Articulate the relationship between health care delivery and financing, public health systems, and public policy.	Fieldwork was in a health-care organization. Financials were analyzed and policies were identified. Funding from the state and government were also researched.
7. Apply evidence-based principles to the process of program planning, development, budgeting, management, and evaluation in public health organizations and initiatives.	Partnered with the finance team to evaluate opportunities.
8. Demonstrate leadership abilities as collaborators and coordinators of evidence based public health projects.	Made connections and introductions between regional departments and the east bay departments.
9. Identify and apply ethical, moral, and legal principles in all aspects of public health practice.	Referred to this throughout my program.

10. Develop public health programs and strategies responsive to the diverse cultural values and traditions of the communities being served.	The behavioral health strategy will include my findings.
11. Effectively communicate public health messages to a variety of audiences from professionals to the general public.	This is something I practice regularly. The use of infographics is an effective tool.
12. Advance the mission and core values of the University of San Francisco.	Worked with integrity, respect and followed-thru on all deadlines