

Addressing the Social Determinants of Health in Your Community Health Assessment

January 11, 2012

Presented by:

Julie Willems Van Dijk

Anne Barna



Webinar Logistics

- The lines are muted. If you wish to mute/unmute your line to ask/answer a question, please do the following:
- To **unmute** your own line, **press *7**
- To **mute** your own line, **press *6.**

- Throughout the presentation and during the Q&A session, if you have a question, please use ReadyTalk's 'raise your hand' feature or use the chat box to indicate you have a question. The facilitator will call your name and ask for your question.

PROJECT REQUIREMENTS: ADDRESSING THE SOCIAL DETERMINANTS OF HEALTH

Reena Chudgar, NACCHO



Setting the Gold Standard for CHAs and CHIPs



- Your work will set the standard for others!
- Demonstration Project Key Features:
 - Engaging community members and LPHS partners in a meaningful way.
 - Addressing the social determinants of health.**
 - Using QI and quality planning techniques.

Project Requirements: Addressing the Social Determinants of Health

The CHAs conducted 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.

Sites must engage non-traditional partners (i.e., those not historically involved in community health improvement processes) to address the root causes of health inequities in their communities. (CHIP)

Project Requirements: Addressing the Social Determinants of Health

The project seeks to ensure that the CHAs conducted have a particular focus on the following:

- **Identifying populations** within their jurisdictions with an **inequitable share of poor health outcomes**;
- **Assessing the social determinants of health** in their jurisdiction and ensuring that they are **considered in indicator and data source selection, data collection, and data analysis**; and
- **Include relevant data and other resources from the County Health Rankings project** will be used to help understand these (social determinants of health) conditions.

Webinar Learning Objectives

1. Present to their partners and to community members the variety of elements that relate to or impact social health and health inequities.
2. Discuss why examining and addressing the root causes of health and health inequities is important in health improvement efforts.
3. Identify which additional partners, particularly non-traditional partners, need to be invited to participate in their community health improvement process to ensure a focus on the social determinants of health and health inequities in the site's CHA and CHIP.
4. Discuss the Barry-Eaton District Health Department's and its partners' efforts to focus on discussing the social determinants of health or health inequities with community members, local public health system partners and elected officials in preparation for focusing on these issues in the CHA and applying a social determinants of health model to CHA conduct and CHIP development.

Webinar Learning Objectives

5. Identify the types of indicators that may need to be considered in a CHA to gather information on the social determinants of health and health inequities among sub-populations.
6. Describe how the social determinants of health are relevant within the context of PHAB accreditation, including in the PHAB CHA and CHIP-related Standards and Measures Version 1.0.
7. Re-state the CHA/CHIP demonstration site project requirements for addressing the social determinants of health.
8. Identify what their site needs to do in the next three months to position itself to meet the CHA/CHIP demonstration site project requirements for addressing the social determinants of health in the CHA and CHIP.

Addressing the Social Determinants of Health in Community Health Assessment

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Health Institute

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Barry-Eaton District Health Department

January 11, 2012

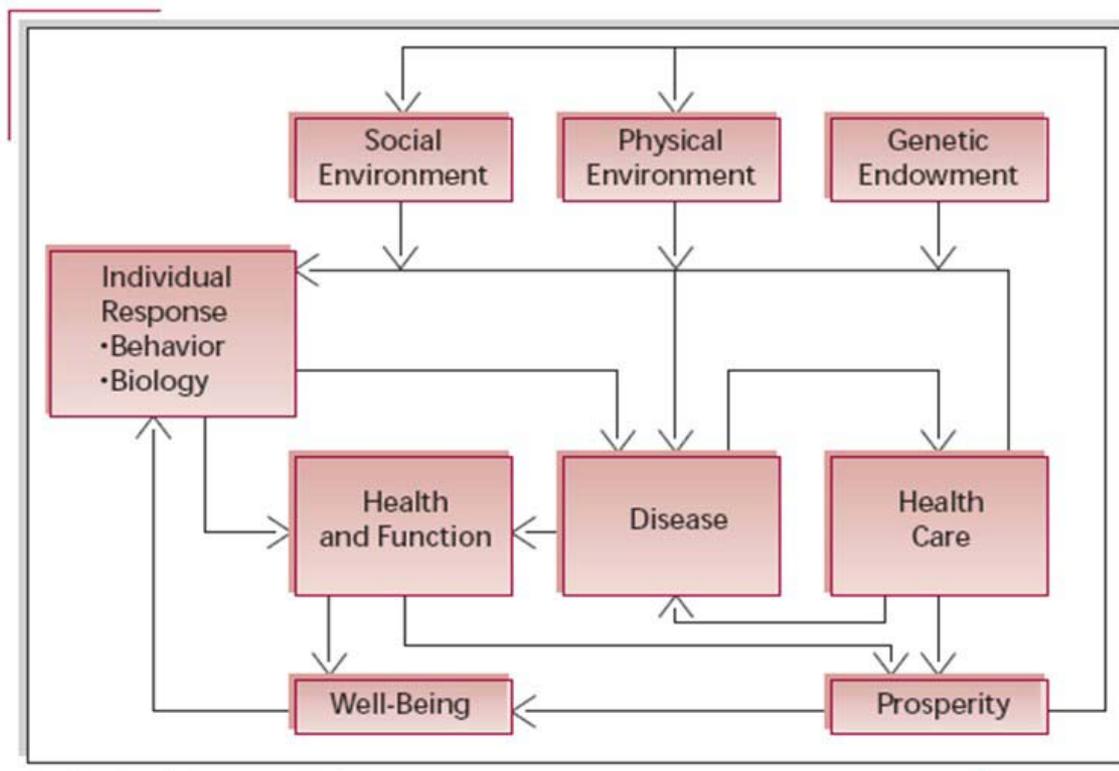


PHAB Standards & Specific Mention of Social Determinants of Health, Disparities, or Equity

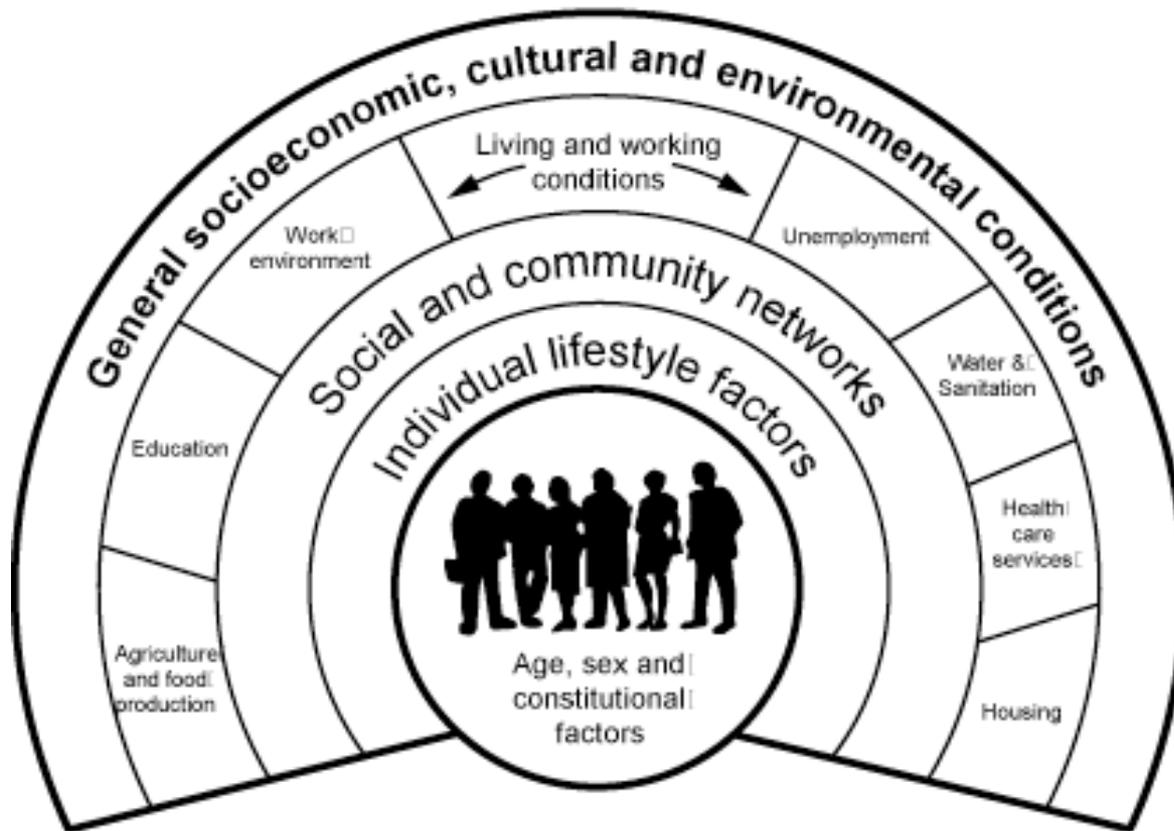
- Community Assessment—Health status disparities, health equity, and high health risk populations must be addressed (Standard 1.1.2L)
- Data Collection—May collect data on social conditions (such as unemployment, poverty, or lack of accessible facilities for physical activity) (Standard 1.2.4L)
- Data Analysis—May consider social conditions that affect health and may consider reports of health disparities (Standard 1.3.1A)

Evans & Stoddart Multiple Determinants of Health, 1994

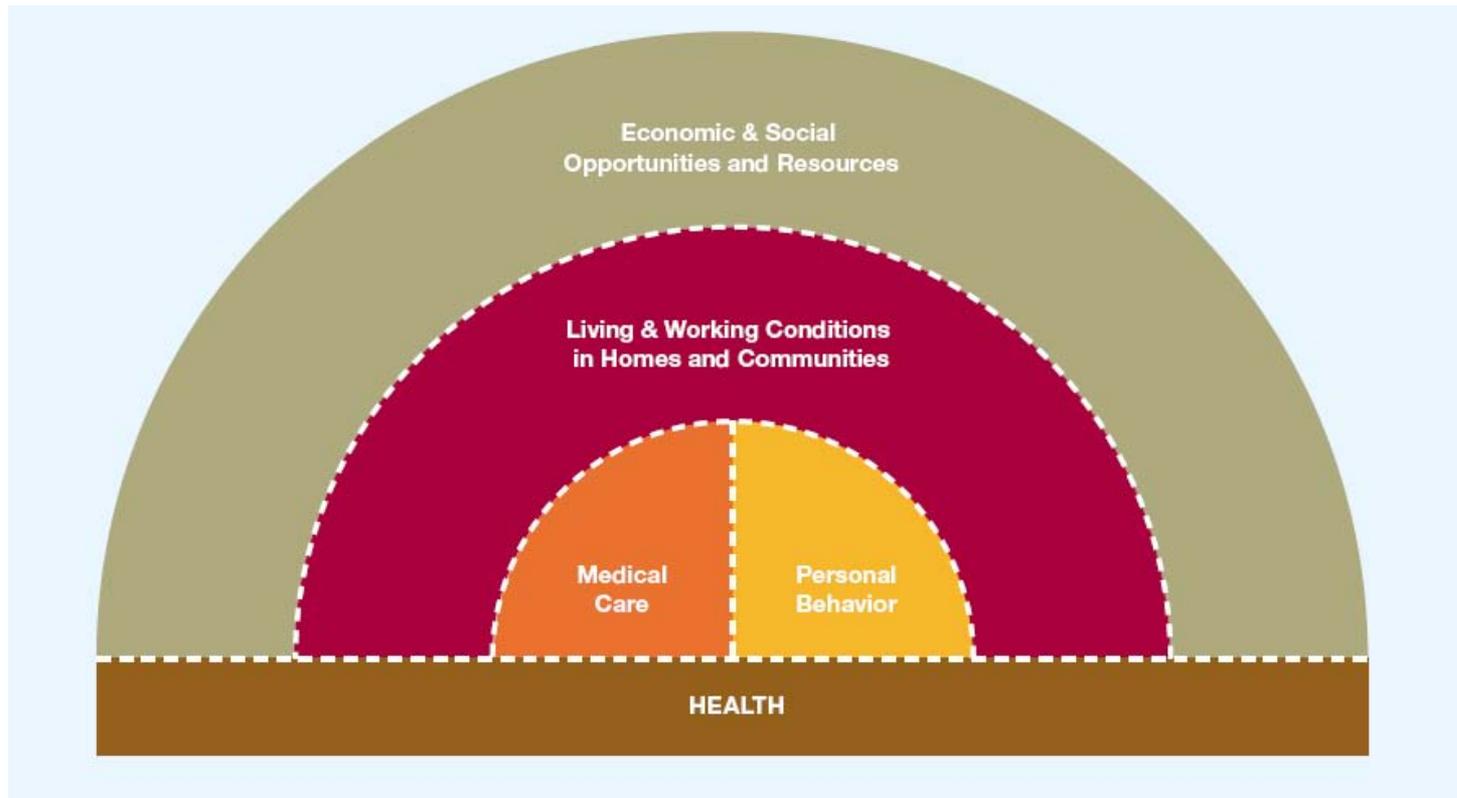
MODEL OF THE DETERMINANTS OF HEALTH

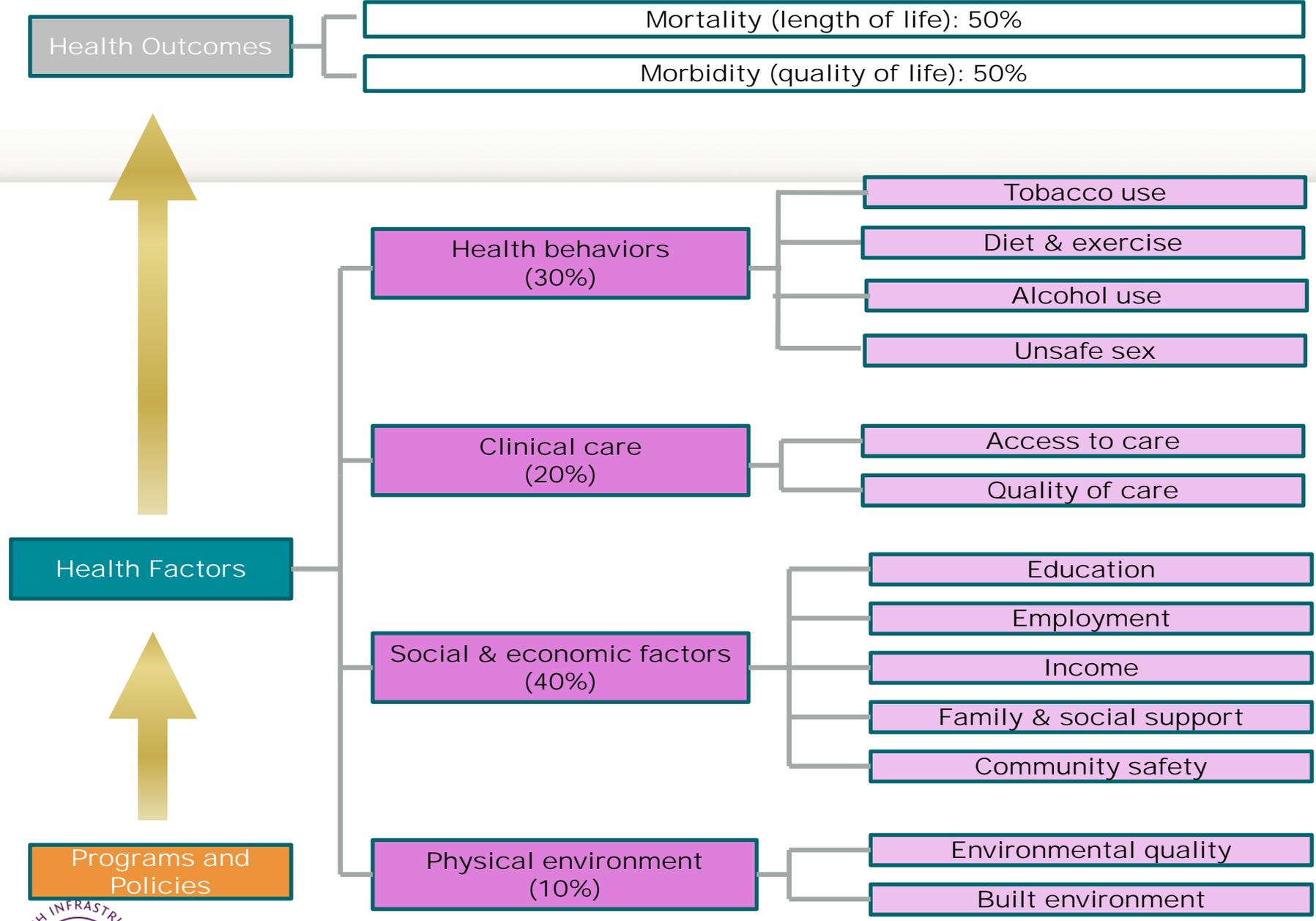


Dahlgren G, Whitehead M. Policies and strategies to promote social equity in health. Stockholm: Institute of Futures Studies, 1991.



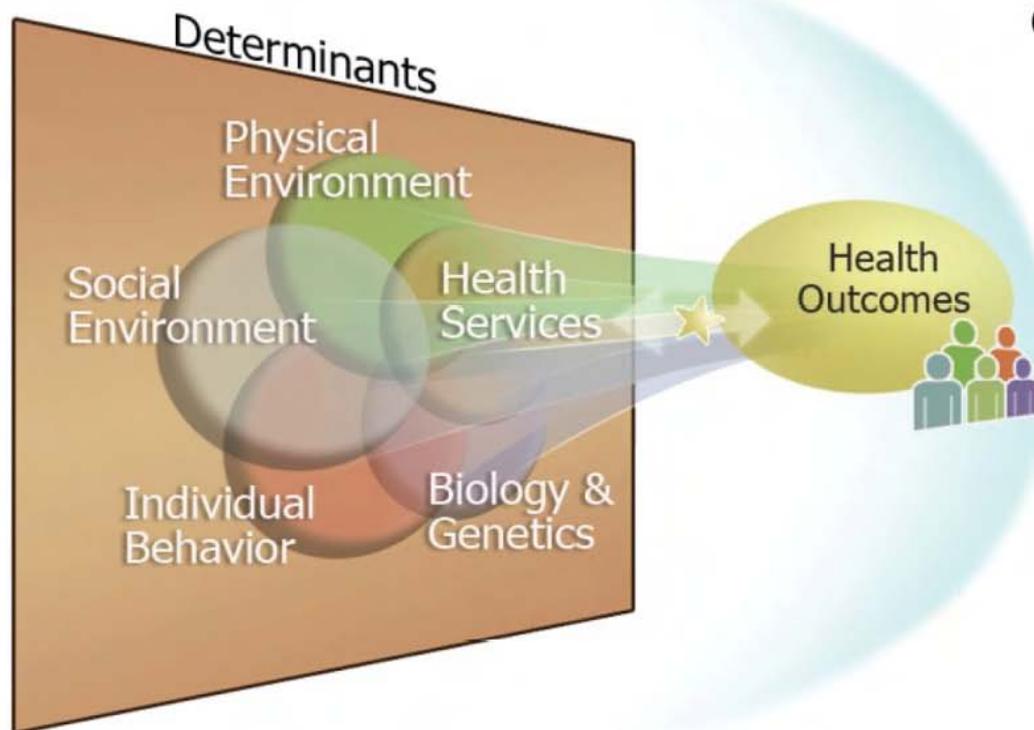
RWJF Commission to Build a Healthier America. *Overcoming Obstacles to Health, 2008*





Healthy People 2020

A society in which all people live long, healthy lives

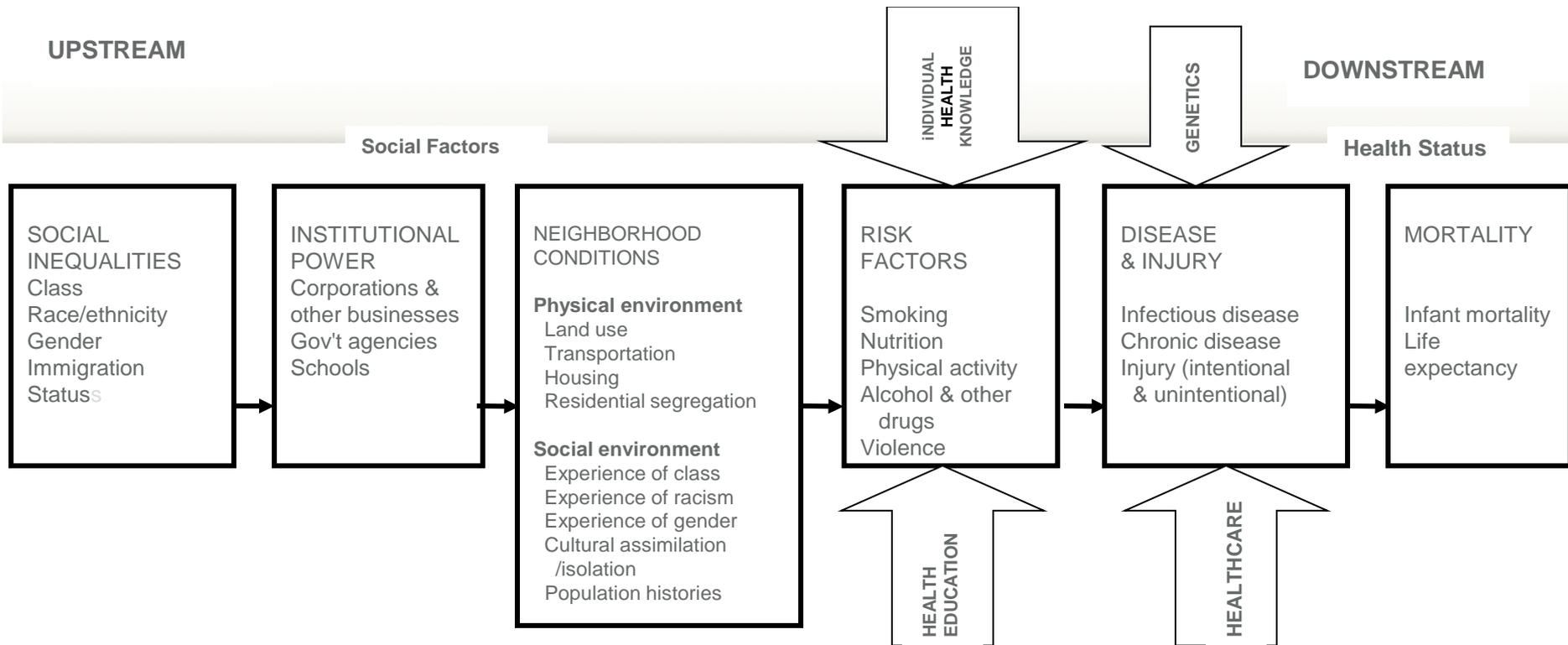


Overarching Goals:

- Attain high quality, longer lives free of preventable disease, disability, injury, and premature death.
- Achieve health equity, eliminate disparities, and improve the health of all groups
- Create social and physical environments that promote good health for all.
- Promote quality of life, healthy development and healthy behaviors across all life stages.

FRAMEWORK FOR UNDERSTANDING HEALTH INEQUITIES

BAY AREA REGIONAL HEALTH INEQUITIES INITIATIVE



Do we know how much each of the major determinants contributes to health?

- a. Historical perspective
- b. Literature review
- c. Analysis of ability to predict health outcomes

Historical Perspective

- 1930-1950: Sanitary revolution and improvements in **environmental health**
- 1950-1970: Increasing role of **health care**
- 1970-1990: Contribution of **health behaviors** (smoking/diet/exercise) increases
- 1990-present: **Social and economic** determinants

Review of the Literature

DISPARITIES & POLICY

The Case For More Active Policy Attention To Health Promotion

To succeed, we need leadership that informs and motivates, economic incentives that encourage change, and science that moves the frontiers.

*by J. Michael McGinnis, Pamela Williams-Russo, and
James R. Knickman*



Review of the Literature

The oft cited McGinnis et al (2002) paper states:
"...using the best available estimates, the impacts of various domains on early deaths in the US distribute roughly as follows:
genetic predispositions, about 30%;
social circumstances, 15%;
environmental exposures, 5%;
behavioral patterns, 40%; and
shortfalls in medical care, 10%."

Analytic Approach

Determinant Category	Empirically Derived Weight
Health care	21%
Health behaviors	27%
Social and economic factors	55%
Physical environment	-3%

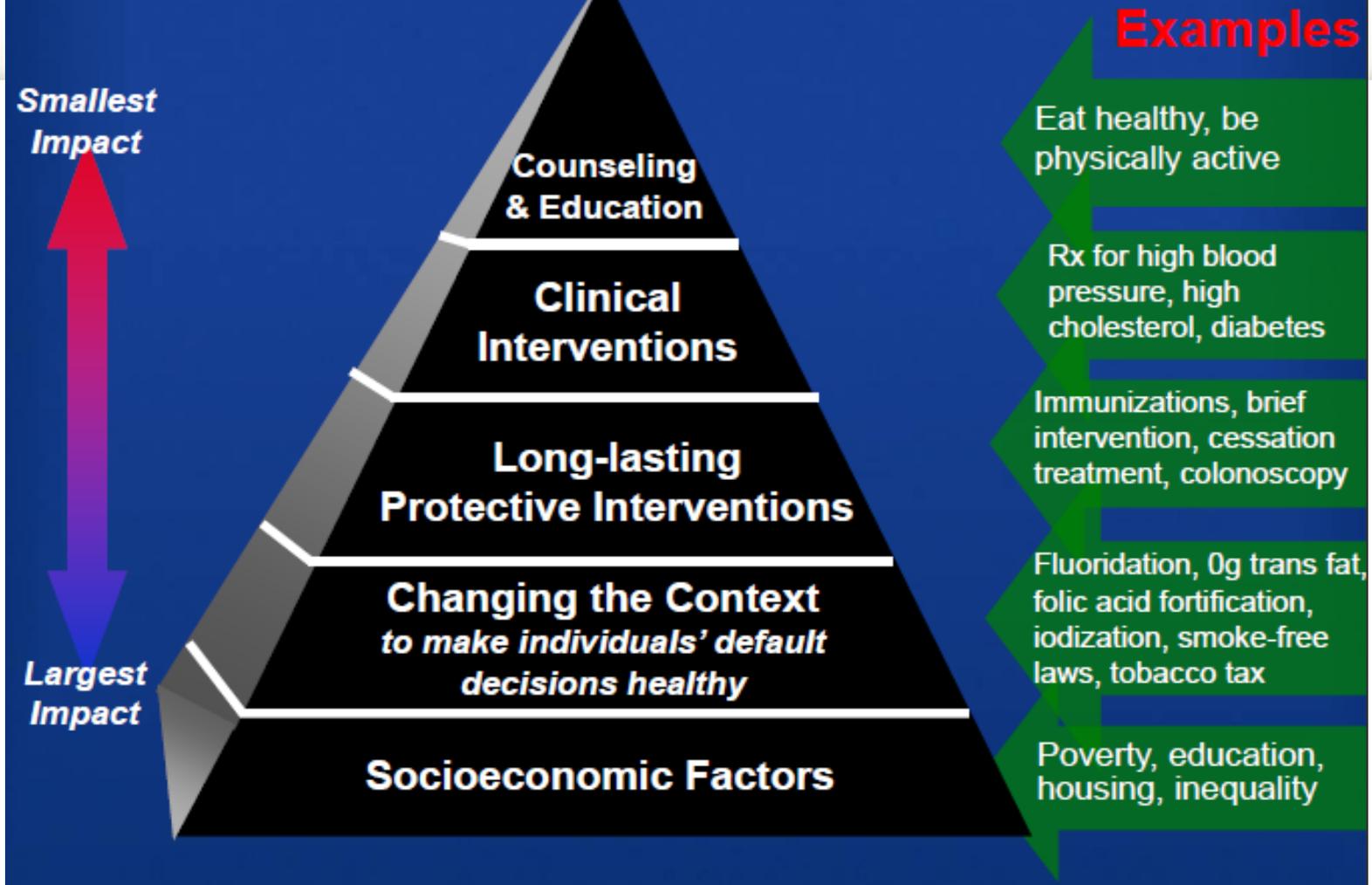
Speaking to Our Partners

(From *A New Way to Talk About the Social Determinants of Health*, Robert Wood Johnson Foundation, 2010;

<http://www.rwjf.org/vulnerablepopulations/product.jsp?id=66428>)

- Avoid jargon—such as social determinants
- Connect with messages they believe in
- One fact—not dozens
- Offer solutions
- Incorporate the role of personal responsibility
- Mix conservative & progressive values
- Focus on improving health for all

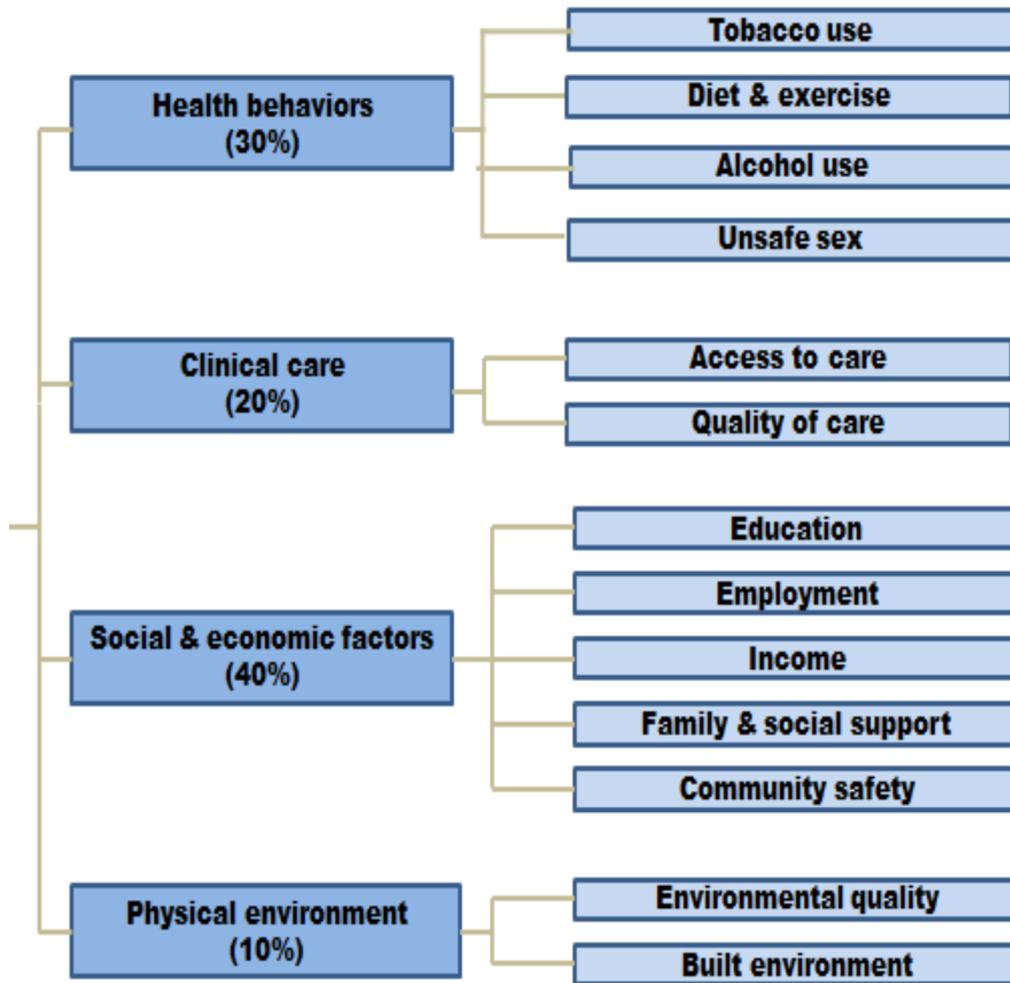
Factors that Affect Health



<http://www.cdc.gov/about/grand-rounds/archives/2010/download/GR-021810.pdf>



Health Factors



Possible Partners

Addiction specialists, Educators, Advocacy groups, Policy makers, Faith leaders, Wellness coordinators, Bar owners/tenders, Health care providers, Community members

Health care providers (all types), Ombudsmen, Advocacy groups, Community members

Educators, Business owners, Policy makers, Advocacy groups, Labor Unions, Neighborhood organizations, United Way, Economic development, Law enforcement, Community members

Planning/Zoning, Transportation, Foresters, Community members

Social Determinants of Health Indicators

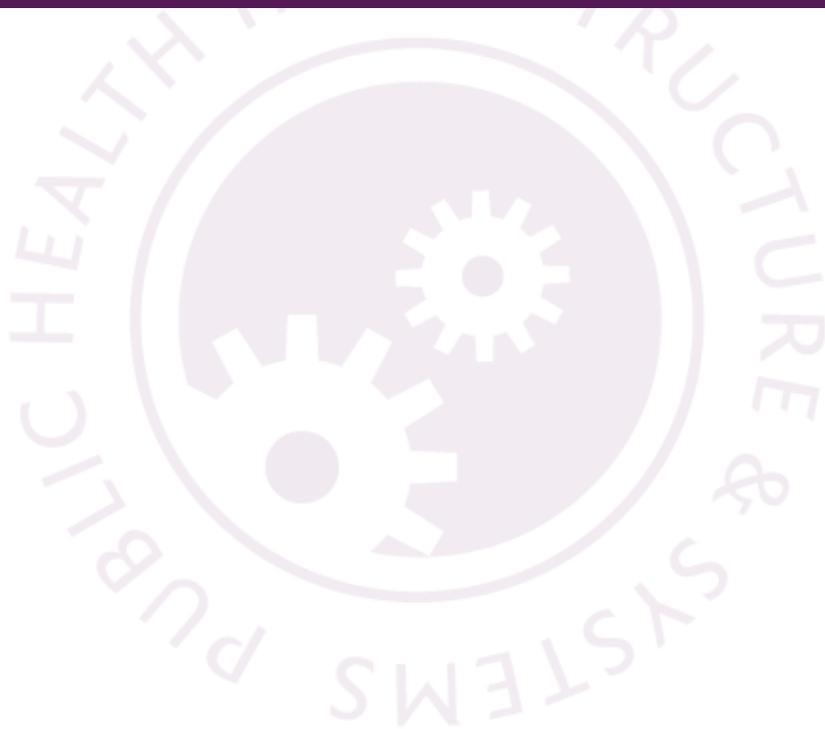
- Use your model to guide your indicator selection
- Treat all determinant areas as actionable
- Disaggregate as many indicators as possible
- Consider multiple ways to disaggregate data:
 - Race/ethnicity
 - Income
 - Education
 - Geography
 - Gender

Possible Data Categories

- Economic security and financial resources
- Livelihood security and employment opportunity
- School readiness and educational attainment
- Environmental quality
- Availability and utilization of quality medical care
- Adequate, affordable, and safe housing
- Community safety and security
- Civic involvement
- Transportation

Engaging the Community on the Social Determinants of Health in the Capital Counties, Michigan (Clinton, Eaton, Ingham)

January 11, 2012



Our efforts to focus on discussing the social determinants of health or health inequities with community members, local public health system partners, health department staff, and elected officials.

Barry-Eaton District Health Department and Mid-Michigan District Health Department

- Serve Eaton and Clinton Counties, respectively
- Serve primarily “rural/suburban/non-minority” communities with medium to high median incomes
- Relatively conservative values and view of limited role of government entities – however there are a sizable number of moderate independents



- Traditionally have focused on service provision, such as narrowly defined categorical clinical services (WIC, Immunizations, Family Planning) and Environmental Health (assurance of Public Health Code, etc.)

Ingham County Health Department

- Serves the City of Lansing (the capital city of Michigan), a Midwest post-industrial community with sizable populations of color and persons living in poverty.
- the rest of the county (“out-county”), is similar to Eaton and Clinton counties in income, land use, mindset.
- Serves East Lansing, home to Michigan State University (40,000 students) with a large community of students and faculty.
- Historically a more progressive health department.



Ingham County Health Department, continued

1998-2008 Ingham Community Voices / Capital Area Community Voices

See chapter 3 in [Community Voices: Health Matters](#) by Treadwell, Po, and Perez (2011)

Notion: working 'with' rather than 'for' the community and leading from behind

“It represents a movement to create change from the bottom up. It is the antithesis of ‘officials’ telling the man on the street what’s best for him.”

Five community practices for accelerating community improvement:

- Engaging and mobilizing community members
- Facilitating dialogue and creating connections
- Identifying and supporting civic leadership
- Using all the assets of the community for change
- Sharing and using data and information to support and monitor progress

Ingham County Health Department, continued

Dialogue methodology has become ‘the way we do things here’
Dialogue is different than **DEBATE**.

Debate	Dialogue
<p data-bbox="227 625 929 679">Highlights competing factions</p> <p data-bbox="227 753 571 808">“Best” solution</p> <p data-bbox="227 943 819 998">Emphasis on persuading</p>	<p data-bbox="967 625 1580 739">Highlights commonality of purpose</p> <p data-bbox="967 818 1551 932">Multiple, complementary solutions</p> <p data-bbox="967 1011 1489 1065">Emphasis on listening</p>



‘Facilitated Dialogue’ is adapted from the Technology of Participation methods developed by the Institute of Cultural Affairs. <http://www.ica-usa.org/>

Ingham County Health Department, continued

2005 Ingham County Social Justice Project Began

2008 Social Justice Facilitator Cohort 1 Trained

2008 Social Justice Workshops Began

Hundreds of health department staff (primarily ICHD) and community members have completed a four-day workshop on social justice and health equity concepts, resulting in an increase in recognition of the importance of social determinants of health, a decline in the perceived importance of behavior on health outcomes, and nearly 8 in 10 recognized opportunity and power as social determinants



Distinguishing **Disparity** from **Inequity**

Health Disparity

A disproportionate difference in health between groups of people.

(By itself, disparity does not address the chain of events that produces it.)

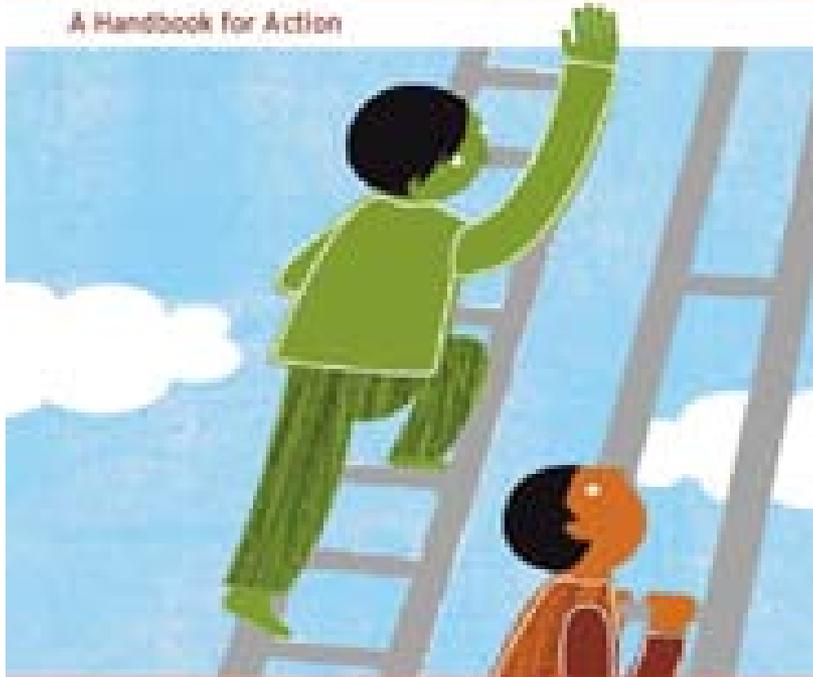
Health Inequity

Differences in population health status and mortality rates that are systemic, patterned, unfair, unjust, and actionable, as opposed to random or caused by those who become ill.*



Tackling Health Inequities Through Public Health Practice:

A Handbook for Action



The National Association of County & City Health Officials
The National County Health Department Learning Institute



DISCUSSION:

What do you notice about this picture?

How might it depict the difference between “disparity” and “inequity”?



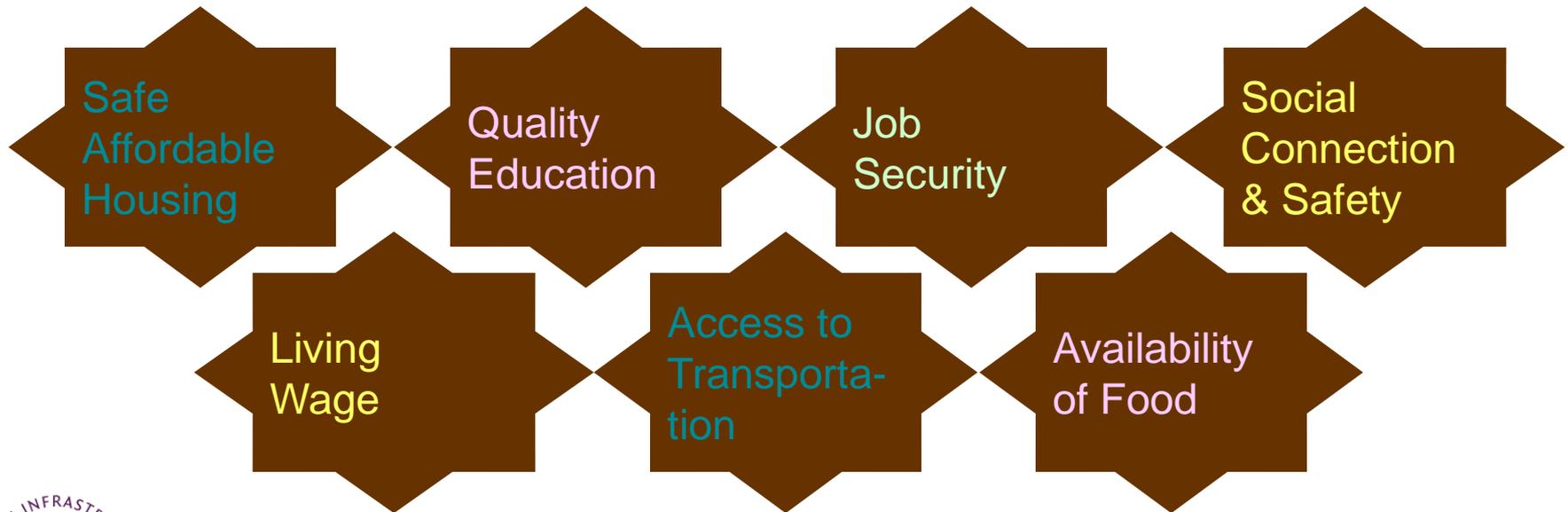
This image is from the cover of the *first* edition.

Where does Prevention Begin? Where do we Focus?

Social Determinants of Health

The economic and social conditions that influence the health of individuals, communities, and jurisdictions as a whole.

They include, but are not limited to:



Institutional Racism

Root Causes
Class Oppression

Gender Discrimination and Exploitation

LABOR MARKETS

TAX POLICY

Power and Wealth Imbalance

HOUSING POLICY

EDUCATION SYSTEMS

GLOBALIZATION & DEREGULATION

SOCIAL SAFETY NET

SOCIAL NETWORKS

Safe Affordable Housing

Job Security

Social Determinants of Health

Living Wage

Quality Education

Transportation

Availability of Food

Social Connection & Safety

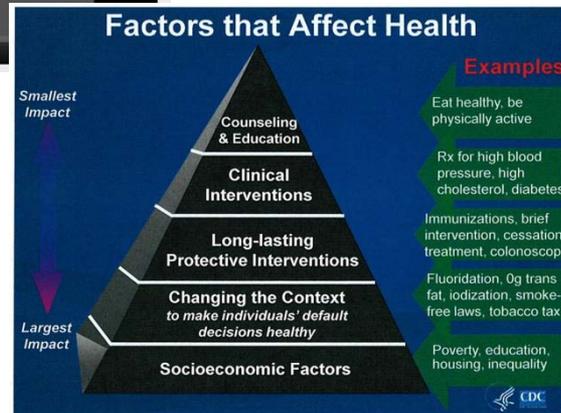
Psychosocial Stress / Unhealthy Behaviors

Disparity in the Distribution of Disease, Illness, and Wellbeing



Adapted from R. Hofrichter, *Tackling Health Inequities Through Public Health Practice*.

In Eaton County...



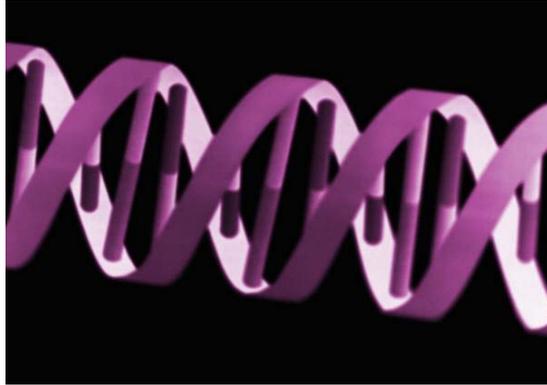
Telling the story of public health to our board of health:

www.healthiestnation.org

Board Orientation and Ongoing Education: Allowed us to introduce the notions of

- the difference between 'healthcare' and 'public health'
- 10 essential services
- disparities
- policy change

What makes someone healthy..or not? How can we prevent you from being unhealthy?



Prevention: Behaviors and Conditions affect health

Behaviors

Tobacco Use

Substance Misuse

Poor Nutrition

Lack of Exercise



Conditions

Targeted sales

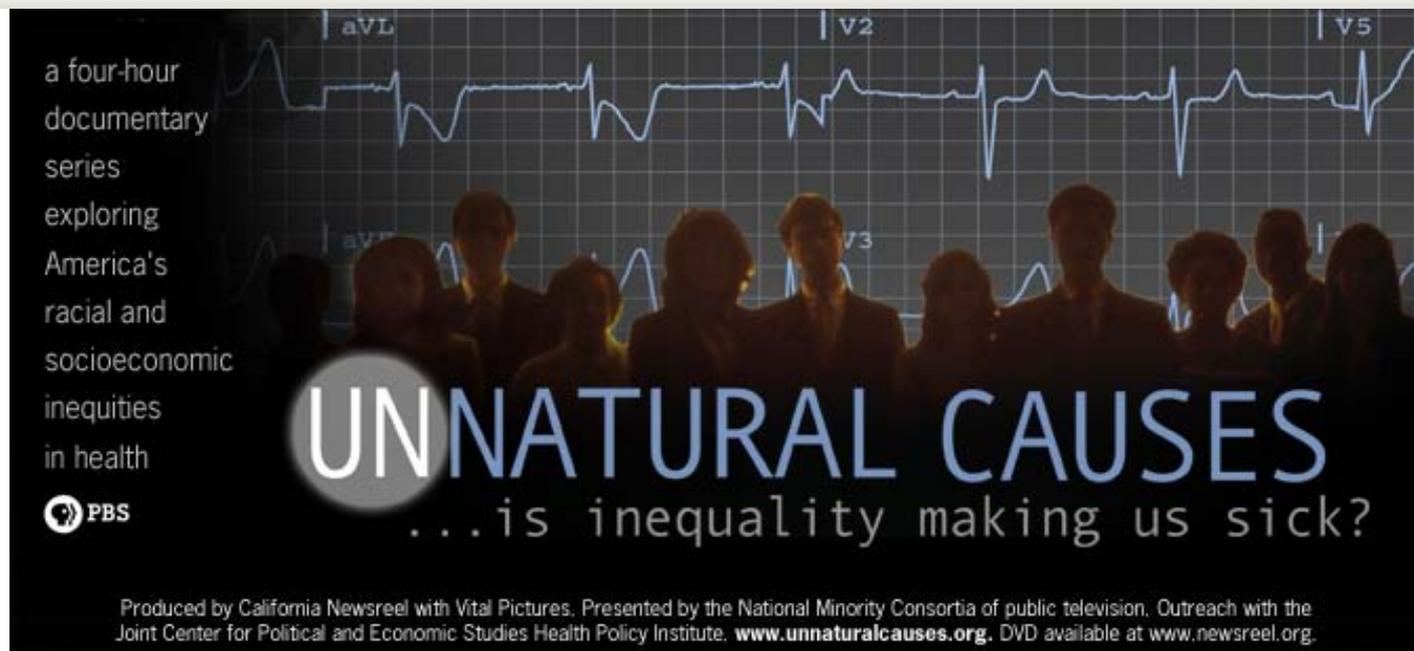
Marketing/No taxation

Food Deserts

Poor infrastructure

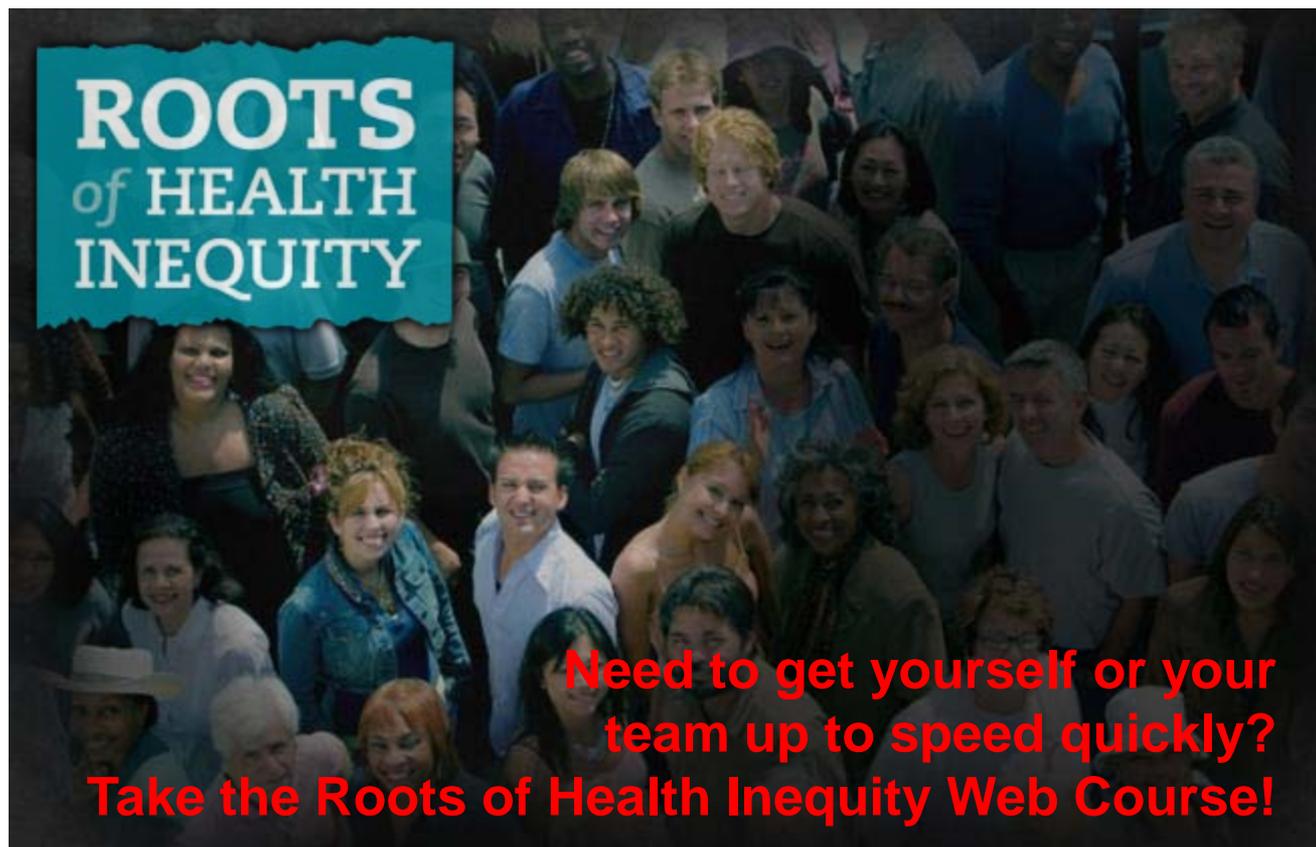


TOOLS



Hold a film-viewing and dialogue session using an episode from the film as the ‘trigger’ information – you might also include local data relating to the topic of the episode.

TOOLS



Many of the concepts discussed in the social justice workshops are addressed in this course.



Healthy! Capital Counties SM

a community approach to better health



Changing the Questions

Instead of only asking:

Why do people smoke?

Who lacks health care coverage and why?

How do we connect isolated individuals to social supports?

How can we create more green space, bike paths, and farmer's markets in vulnerable neighborhoods?

Perhaps we should also ask:

What social conditions and economic policies predispose people to the stress that encourages smoking?

What policy changes would redistribute health care resources more equitably in our community?

What institutional policies and practices maintain rather than counteract people's isolation from social supports?

What policies and practices by government and commerce discourage access to transportation, recreational resources, and nutritious food in neighborhoods where health is poorest?

Your QUESTION is so important!

*Healthy! Capital Counties
visioning question.*

What would our community be
like if everyone had an equal
chance of living a healthy life?

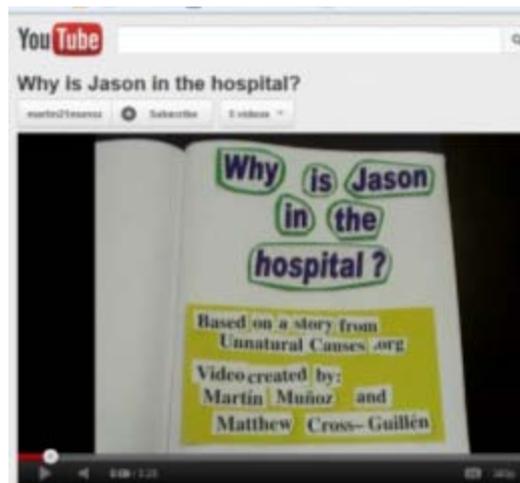
versus just...

What are the community's
health needs?
or How can we be healthy?



How have *Social Justice* and *Social Determinants of Health* have been woven into our work so far?

“Some people have fewer opportunities than others to live in good health.”



WATCH:

Why is Jason in the Hospital?

What indicators would you use to measure whether the community was getting healthier or not? Be creative!

→ List, then sort

List color-coded:

HEALTH INEQUITY

- Measuring the gap and disparity among the entire populations overall well-being
- Income gap
- Existence and extent of social connection/social capital
- Unemployment
- Affordable and safe housing
- Cultural competencies related to veterans

COMMUNITY CONDITIONS

- Barriers to access
- Community resources
- Parks
- Smoke-free environments
- Resiliency of youth (protective factors of youth in schools, middle and high school age)

FOOD

- Access to healthy foods
- Neighborhood access to affordable fresh produce
- Consumption of healthy food
- Fruit and vegetable consumption
- Nutrition
- Neighborhood food security

HEALTHCARE

- Access to healthcare (3)
- To afford health insurance coverage (2)
- Health coverage and medical home
- Decrease in emergency room use
- Inappropriate use of inpatient care

BEHAVIORS and ADDICTIONS

- Increased physical activity
- Tobacco use
- Tobacco-related death
- Prescription and Over-the-Counter-related Poisoning and Deaths
- Alcohol-related fatalities and injuries

HEALTH OUTCOMES

- Lower rates of diabetes and hypertension
- Improved oral health
- Years of premature mortality
- Longevity (years of life lost)
- Health outcomes

INFANTS and CHILDREN

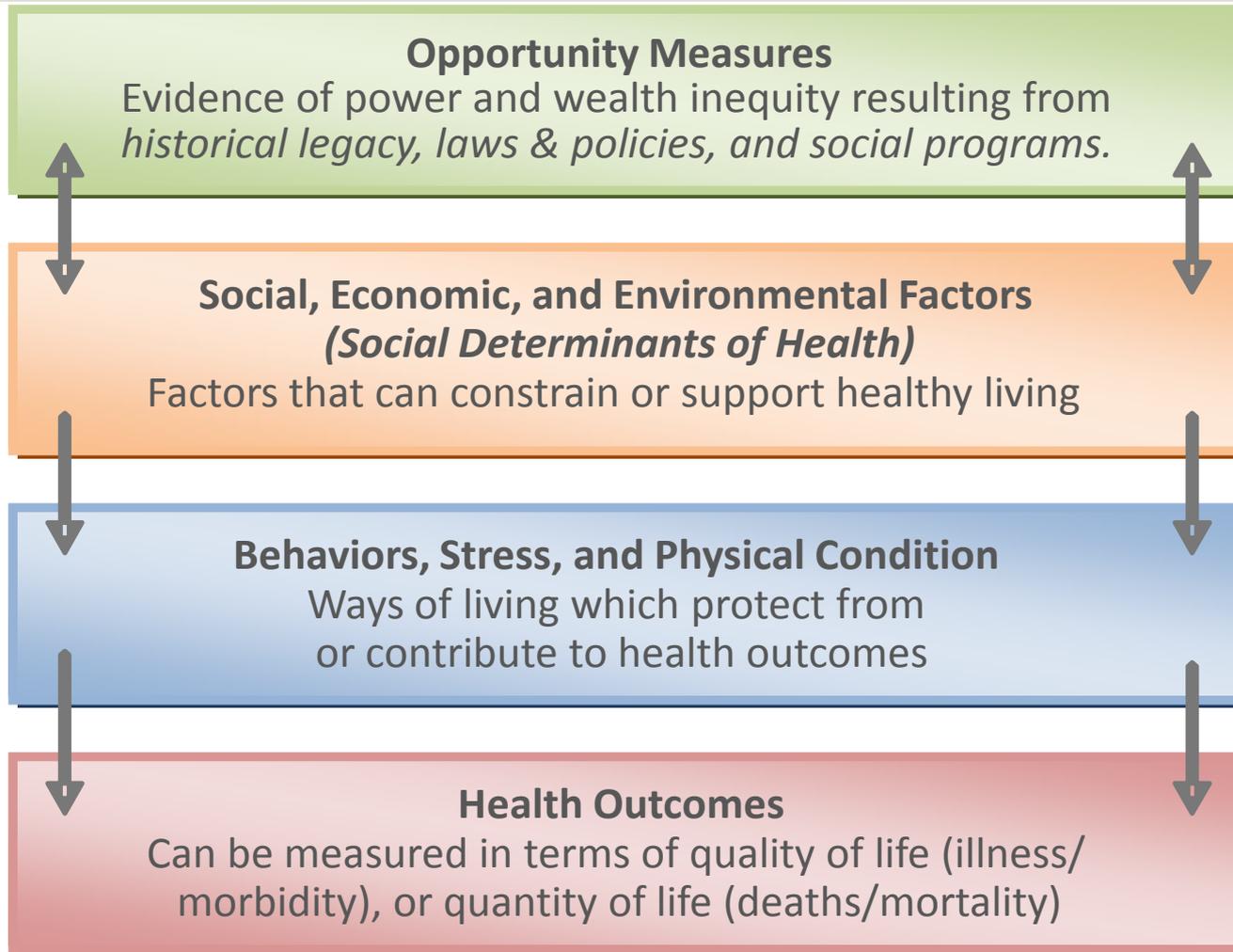
- Low birth weight
- Infant mortality
- Child abuse
- Sudden Infant Deaths
- Stillborns (drugs, diet, prenatal care)

OBESITY and WEIGHT STATUS

- Healthy weight in all age groups
- Obesity (4)
- Body Mass Index (BMI) (2)
- Children with appropriate BMI



Our Model for How Health Happens:



Indicator sources we used:

- LOCAL Advisory Committee list
- County Health Rankings
- Health Indicator Warehouse section on social determinants
- Healthy People 2020 Critical Health Indicators
- LOCAL conversations with knowledgeable local people on specialized topics, such as the built environment or water quality

DOMAIN	INDICATOR GROUP	INDICATOR	MEASURES	SOURCE	Geographic Level *
Opportunity Measures	Income	Income Distribution	Gini coefficient of income inequality	ACS	HCC geo groups
	Segregation	Housing Segregation	Gini coefficient of minority-headed households	ACS	HCC geo groups
Social, Economic, and Environmental Factors	Social and Economic Factors	Income	% children in poverty	ACS	HCC geo groups
		Education	Education distribution in >25 adults	ACS	HCC geo groups
		Social Connection & Support	Social Capital	BRFS	HCC geo groups
		Community Safety	Rate of violent crimes per person	Possibly uniform crime report/MSP	HCC geo groups
		Affordable Housing	Households who spend more than 30% of income on housing	ACS	HCC geo groups
		Quality of Care	Rate of Ambulatory-Care Sensitive Hospitalizations (Preventable)	MDCH Vital Statistics	HCC geo groups
	Environmental Factors	Environmental Quality	% water wells showing evidence of significant nitrate contamination	Local Health Departments	HCC geo groups
		Built Environment	Food Desert Status	USDA	Census tract
Behaviors and Physical and Mental Condition	Health Behaviors	Diet and Exercise behaviors	Weight Distribution (BMI Categories)	MiPHY	County
			Weight Distribution (BMI Categories)	BRFS	HCC geo groups
		Tobacco Use	Current Smoking in adolescents	MiPHY	County
			Current Smoking in adults	BRFS	HCC geo groups
		Alcohol Use	Binge Drinking in adolescents	MiPHY	County
			Binge Drinking in adults	BRFS	HCC geo groups
	Clinical Care	Access to Care	Persons with a primary medical provider	BRFS	HCC geo groups
		Communicable Disease Prevention	% children 19-35 months who receive recommended immunizations	MCIR	HCC geo groups
	Mental Condition	Mental Health	Adolescents with major depressive episodes	MiPHY	County
			Poor mental health days in adults	BRFS	HCC geo groups
Health Outcomes	Illness (Morbidity)	Maternal & Child	Low birthweight births	MDCH Vital Records	HCC geo groups
		Quality of Life	Perceived health status (good vs. poor)	BRFS	HCC geo groups
		Consequences of Social Norms	Alcohol-related motor vehicle injuries	MSP: OHSP	HCC geo groups
	Deaths (Mortality)	Premature Death	% deaths before age 75	MDCH Vital Records	HCC geo groups
		Maternal & Child Health	Infant Mortality Rate	MDCH Vital Records	HCC geo groups
		Chronic Disease	Deaths due to cardiovascular disease	MDCH Vital Records	HCC geo groups
		Safety Policies and Practices	Deaths due to accidental Injury	MDCH Vital Records	HCC geo groups

DRAFT

*HCC Geo Groups = for the Cities of Lansing, East Lansing, and Lansing Township, the geo groups are four groups of census tracts by median home value. For the rest of Clinton, Eaton, and Ingham counties, the geo groups are four groups of townships and cities divided by population density and median home value.

Ideas for Social Determinant Indicators to Include (besides those previously mentioned)

- NACCHO's list of social determinant domains and examples of possible indicators and sources (e-mailed with the November CHA/CHIP Update)
- CDC's Data Set Directory of Social Determinants of Health at the Local Level
- Connecticut Health Equity Index Project

Social determinant questions...purple alludes to inequity

Do people have money to meet basic needs? What about enough to live a life of quality?

Are kids in our community ready for school? Will **every** child go to a safe, well-resourced, high-performing school?

Are people secure in their employment?

Do we have clean air, clean water, in communities built to enhance health?

Can **all** people get health care? Of high quality?

Does **everyone** have a safe home at a reasonable price?

Is the community **empowered** to improvement through civic action or grassroots action?

Can people get where they need to go?

Are we safe?



Questions and Discussion



Project Reminders

- Community Health Improvement Process Cost-Tracking Report Due by 8 p.m. ET, Tuesday, 1/17/12 to CHACHIP@naccho.org

Last Word

The next CHA/CHIP training webinar will be on:

‘Collecting Quantitative Data in Your CHA ’

Presenters: Julie Willems Van Dijk

Monday, 1/23/12 at 2:30 PM ET

**Please complete the evaluation before
logging off the webinar.**